

Exhibit A

**PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR**

**WASHINGTON COUNTY
HEALTH BENEFIT PLAN**

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INTRODUCTION

This document is a description of Washington County Health Benefit Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan.

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

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

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

The Plan believes that it is a “grandfathered” health plan under the Patient Protection and Affordable Care Act (“the Affordable Care Act”). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost-sharing. However, grandfathered health plans must comply with certain other consumer protections under the Affordable Care Act, such as the elimination of Lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator. Individuals may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. Individuals may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

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

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated, even if the expenses were incurred as a result of an accident, Injury or disease that occurred, began, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

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

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

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

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

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

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

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

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

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

Claim Provisions. Explains the rules for filing claims.

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

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

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

**ELIGIBILITY, FUNDING, EFFECTIVE DATE
AND TERMINATION PROVISIONS**

A Plan Participant should contact the Plan Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

ELIGIBILITY

Eligible Classes of Employees. All Active and Retired Employees of the Employer.

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage from the first day that he or she:

- (1) is a Full-Time, Active Employee of the Employer. An Employee is considered to be Full-Time if he or she normally works at least 30 hours per week and is on the regular payroll of the Employer for that work.

An Employee's status as a Full-Time Employee will be determined on the basis of the average number of hours worked during an initial or standard look back measurement period, as applicable, as established by the Plan in accordance with applicable law. The Employee's eligibility (or lack of eligibility) for Plan coverage on the basis of his or her Full-Time or Part-Time status will extend through the stability period established by the Plan in accordance with applicable law. In calculating the average hours worked, the Plan will count hours paid and hours for which the Employee is entitled to payment (such as paid holidays, vacation, pay, etc.).

- (2) is a Retired Employee of the Employer.
- (3) is in a class eligible for coverage.
- (4) completes the employment Waiting Period of 59 days as an Active Employee. A "Waiting Period" is the time between the first day of employment and the first day of coverage under the Plan. .

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

- (1) a covered Employee's Spouse.

The term "Spouse" shall mean the person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives. The Plan Administrator may require documentation proving a legal marital relationship.

Domestic partners are not eligible for coverage as Dependents.

- (2) a covered Employee's child less than 26 years.
- (3) a covered Employee's child who reaches age 26 and is Totally Disabled, incapable of self-sustaining employment by reason of mental retardation or physical disability, provided:
 - (a) such child is or was under the limiting age of dependency at the time of application for coverage in the Plan, or;
 - (b) 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.

The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

Except for Dependents considered Totally Disabled, when a child reaches age 26, coverage will end on the last day of the child's birthday month.

The terms "child" or "children" shall include natural children, step-children, adopted children, or children placed with a covered Employee in anticipation of adoption.

If a covered Employee is the Legal Guardian of a child or children, these children may be enrolled in this Plan as covered Dependents.

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

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

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

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

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

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

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

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

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

FUNDING

Cost of the Plan. Washington County shares the cost of Employee coverage under this Plan with the covered Employees. The enrollment application for coverage will include a payroll deduction authorization. This authorization must be filled out, signed and returned with the enrollment application.

The covered Employees pay the entire cost for coverage for their Dependents. The enrollment application for coverage will include a payroll deduction authorization. This authorization must be filled out, signed and returned with the enrollment application.

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

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

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization. The covered Employee is required to enroll for Dependent coverage also.

Enrollment Requirements for Newborn Children. A newborn child of a covered Employee who has Dependent coverage is not automatically enrolled in this Plan. Charges for covered nursery care will be applied toward the Plan of the covered parent. If the newborn child is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollments" following this section, there will be no payment from the Plan and the covered parent will be responsible for all costs.

Charges for covered routine Physician care will be applied toward the Plan of the newborn child. If the newborn child is required to be enrolled and is not enrolled in this Plan on a timely basis, there will be no payment from the Plan and the covered parent will be responsible for all costs.

If the child is not enrolled within 31 days of birth, the enrollment will be considered a Late Enrollment.

TIMELY OR LATE ENROLLMENT

- (1) **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two married Employees are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Waiting Period as long as coverage has been continuous.

- (2) **Late Enrollment** - An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees and their eligible Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during open enrollment.

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. Coverage begins on January 1st .

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or his dependents (including their spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 31 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 31 days after the birth, marriage, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator.

SPECIAL ENROLLMENT PERIODS

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

- (1) **Individuals losing other coverage creating a Special Enrollment right.** An Employee or Dependent who is otherwise eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage is due to each of the following conditions:
 - (a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.
 - (b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
 - (c) The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated.
 - (d) The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, as described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.
 - (e) For purposes of these rules, a loss of eligibility occurs if:
 - (i) the Employee or Dependent has a loss of eligibility on the earliest date a claim is denied that would meet or exceed a Lifetime limit on all benefits.
 - (ii) the Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (i.e.: part-time employees).
 - (iii) the Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

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

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

(2) Dependent beneficiaries. If:

- (a) the Employee is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and
- (b) a person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll.

The Dependent Special Enrollment Period is a period of 31 days and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 31-day period.

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

- (a) in the case of marriage, the date of the marriage;
- (b) in the case of a Dependent's birth, as of the date of birth; or
- (c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

(3) Medicaid and State Child Health Insurance Programs. An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if:

- (a) The Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or a State child health plan (CHIP) under Title XXI of such Act, and coverage of the Employee or Dependent is terminated due to loss of eligibility for such coverage, and the Employee or Dependent requests enrollment in this Plan within 60 days after such Medicaid or CHIP coverage is terminated.
- (b) The Employee or Dependent becomes eligible for assistance with payment of Employee contributions to this Plan through a Medicaid or CHIP plan (including any waiver or

demonstration project conducted with respect to such plan), and the Employee or Dependent requests enrollment in this Plan within 60 days after the date the Employee or Dependent is determined to be eligible for such assistance.

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

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

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan on the first day of the month after the Employee satisfies all of the following:

- (1) The Eligibility Requirement.
- (2) The Active Employee Requirement.
- (3) The Enrollment Requirements of the Plan.

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

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

TERMINATION OF COVERAGE

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

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

- (1) The date the Plan is terminated.
- (2) The date on which the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the COBRA Continuation Options.)
- (3) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

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

Retirees are allowed two 15-day grace periods every 12 months. If the required contribution is not received within 15 days from the due date, the Retiree will be terminated from the Plan and the COBRA Continuation Options will be made available.

Upon an Employee's termination, the Human Resource Department will initiate a reconciliation of the employee's various elected insurance options. This will ensure that all providers have been paid an accurate premium and that the employee will be charged the appropriate amount. If a refund is due the employee, it will be forthcoming.

This is necessary to improve accountability and fiscal responsibility in the employee benefit program. Currently, it is the County's policy to deduct, through payroll, premiums for health coverage and any other voluntary insurance that individual employees elect to purchase. The payroll deductions occur bi-weekly, or 26 times annually. In most instances, the providers will bill the County on a monthly basis. This timing difference between payroll deductions and billing cycles tends to create accounting problems, especially at the time of an employee's termination.

To protect the County from potential loss to its self-insured health fund, the termination date of employment will be the termination date of insurance.

Continuation During Periods of Employer-Certified Disability, Leave of Absence or Layoff. A person may remain eligible for a limited time if Active, full-time work ceases due to disability, leave of absence or layoff. This continuance will end as follows:

For disability leave only: the end of the 12 week period that next follows the month in which the person last worked as an Active Employee.

For leave of absence or layoff only: the end of the 12 week period that next follows the month in which the person last worked as an Active Employee.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

Continuation of a surviving Spouse, following death of Retired Employee. A surviving Spouse of a deceased Retired Employee may remain eligible for coverage, provided both were covered under the Plan at the time of the Retired Employee's death. This continuance will end if the surviving Spouse discontinues paying the required contribution.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

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

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

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

- (1) An Employee who previously retired from Washington County, continues to participate in the county's health plan, and returns to active employment does not have to satisfy the employment Waiting Period.

- (2) An Employee returning to work directly from COBRA coverage does not have to satisfy the employment Waiting Period.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan before leaving for military service.

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

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

- (1) The date the Plan or Dependent coverage under the Plan is terminated.
- (2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the COBRA Continuation Options.)
- (3) The date a covered Spouse loses coverage due to loss of dependency status. (See the COBRA Continuation Options.)
- (4) On the last day of the calendar month that a person ceases to be a Dependent as defined by the Plan. (See the COBRA Continuation Options.)
- (5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

OPEN ENROLLMENT

Every November, during the annual open enrollment period, covered Employees and their covered Dependents who are Late Enrollees will be able to enroll in the Plan.

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

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

SCHEDULE OF BENEFITS

BlueCard PPO/Point-of-Service Plan

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the Claims Administrator's established Coverage Policy, Allowable Charge, and the benefit limits and exclusions described more fully herein including, but not limited to the determination that: care and treatment is Medically Necessary; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

A list of Network Providers will be given to covered Employees and updated as needed.

Deductibles payable by Plan Participants, per Calendar Year

Per person \$500
Per family \$1,000

The Calendar Year deductible will be waived for the following services.

- Accident-related expenses
- In-Network Preventive Care

Maximum Payable by Plan Participants, per Calendar Year

In-Network Services

Unless otherwise stated, the Plan will pay 80% of covered In-Network charges until the Plan Participant has paid the amount specified in the chart below in out-of-pocket expenses. Once the out-of-pocket maximum has been reached, the Plan will pay 100% of covered In-Network expenses.

Out-of-Network Services

Unless otherwise stated, the Plan will pay 60% of covered Out-of-Network charges until the Plan Participant has paid the amount specified in the chart below in out-of-pocket expenses. Once the out-of-pocket maximum has been reached, the Plan will pay 80% of covered Out-of-Network expenses.

Out-of-pocket maximum	Per person	Per family
In-Network	\$3,000	\$3,000
Out-of-Network	\$4,000	\$8,000

The above out-of-pocket amounts are totally separate and do not contribute toward or offset each other.

Charges for the following services do not contribute toward the out-of-pocket maximum.

- Calendar Year deductible
- Copayments

ACCIDENT BENEFITS

In-Network and Out-of-Network reimbursement rate.....80%, no deductible

The Calendar Year deductible will be waived for charges incurred as the result of an accident provided the initial treatment is received with seven days of the date of the accident and follow-up care occurs within 90 days. Charges for services 90 days after the date of accident will be reimbursed at standard Plan reimbursement levels.

HOSPITAL BENEFITS

Prenotification is required for all Out-of-Network and out-of-state Hospital admissions.

Penalty for failure to provide prenotification\$200

- Penalty is in addition to the Calendar Year deductible.

Reimbursement rates

In-Network facility.....80%, after deductible

Out-of-Network facility..... 60%, after deductible

- If emergency room services are sought due to an accidental Injury or Medical Emergency (as defined by the Plan) In-Network and Out-of-Network covered charges will be reimbursed at 80%, Calendar Year deductible will be waived.

Urgent Care Services

Primary Care Physician Copay, per occurrence \$30, then reimbursed at 100%, no deductible

Specialty Care Physician reimbursement rate 80%, after deductible

Out-of-Network reimbursement rate 60%, after deductible

Room and Board Allowances

Covered charges for room and board during an inpatient admission shall be limited to the lesser of the billed charge or the Allowable Charge established by the Plan.

IN-NETWORK PRIMARY CARE PHYSICIAN BENEFITS

Includes In-Network general practitioners, family practitioners, pediatricians, doctors of internal medicine, and nurse practitioners.

Services rendered in an office setting

Per office visit copay\$30

Reimbursement rate..... 100%, deductible waived

All other services

Reimbursement rate..... 80%, after deductible

- If treatment is sought due to an accidental Injury or Medical Emergency (as defined by the Plan) the Calendar Year deductible will be waived.

IN-NETWORK SPECIALISTS BENEFITS

Reimbursement rate..... 80%, after deductible

- If treatment is sought due to an accidental Injury or Medical Emergency (as defined by the Plan) the Calendar Year deductible will be waived.

ALL OUT-OF-NETWORK PHYSICIANS

- Reimbursement rate 60%, after deductible
- If treatment is sought due to an accidental Injury or Medical Emergency (as defined by the Plan) Covered Charges will be reimbursed at 80% and the Calendar Year deductible will be waived.

OTHER BENEFIT LIMITS AND MAXIMUMS

Ambulance Services

Ground Ambulance, per trip maximum.....\$500
 Air Ambulance, per trip maximum\$1,000

Chiropractic services

Calendar Year limit 30 visits

Diabetes Self-Management Training

Lifetime limit one training course

Eyeglasses and Contact Lenses following cataract surgery

Lifetime limit one pair

- Must be delivered within six months of cataract surgery.

Gastric Bypass Surgery

In-Network and Out-of-Network reimbursement rate..... 50%, after deductible
 Lifetime limit..... one gastric bypass surgery, not to exceed \$8,000

- Coverage is only available to Employees

Home Health Care Services

Calendar Year limit 40 visits

Physical and Occupational Therapy

Combined Calendar Year limit..... 45 visits

Prosthetics and Orthotics

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

Routine Obstetrical Ultrasounds

Benefit limit One Ultrasound per Pregnancy

Skilled Nursing Facility

Calendar Year limit 30 visits

Speech Therapy

Calendar Year limit 30 visits

ROUTINE PREVENTIVE CARE

Routine Well Adult Care

Calendar Year maximum.....\$750
 In-Network reimbursement rate..... 100%, deductible waived
 Out-of-Network reimbursement rate 80%, deductible waived

- Available for Plan participants age 18 and older.

- Colonoscopies are not subject to the Calendar Year maximum and will be paid at the standard reimbursement rates. Routine colonoscopies are limited to one every five years for individuals age 50 and older.

Prostate Cancer Screenings

Calendar Year limit one
 In-Network reimbursement rate 100%, deductible waived
 Out-of-Network reimbursement rate 80%, after deductible

- Prostate cancer screenings are covered for men age 40 and older.
- Not subject to the Preventive Care maximum.
- The Plan allows one routine PSA exam per Calendar Year.

Routine Well Child Care

In-Network reimbursement rate 100%, deductible waived
 Out-of-Network reimbursement rate 80%, deductible waived

- Available for Dependents from birth to age 18
- Not subject to the Preventive Care maximum.

SPECIAL IN-NETWORK EXCEPTIONS

- Non-contracted suppliers and specialists will be reimbursed at the In-Network level of benefits.
- If services are not available from an In-Network provider, Covered Charges will be reimbursed at the In-Network level of benefits.
- If services from an In-Network provider are not accessible, Covered Charges will be reimbursed at the In-Network level of benefits.
- Covered charges for emergency and accident services will be reimbursed at the In-Network level of benefits.
- Covered charges for Inpatient or Outpatient Services rendered by an Out-of-Network anesthesiologist, pathologist or radiologist in connection with an In-Network facility will be paid at the In-Network level of benefits.

PRESCRIPTION DRUG COVERAGE

Prescription Drugs are covered under the prescription drug card program administered by the pharmacy benefits manager.

Copays, per 34-day supply

Generic drugs\$15
 Preferred drugs\$35
 Non-Preferred drugs\$60

- Non-maintenance drugs are limited to one 34-day supply, per fill.
- Maintenance Drug prescriptions may be refilled up to a 100-day supply, per fill, subject to three copay amounts.

SCHEDULE OF BENEFITS

Dental Plan

Deductible payable by Plan Participants, per Calendar Year

Per person.....\$25

Calendar Year maximum

Per person.....\$1,500

Lifetime Orthodontia maximum

Per person.....\$1,000

Reimbursement rates

Diagnostic and Preventive services 80%, after deductible
Restorative services 80%, after deductible
Orthodontic services 50%, after deductible

SUPPLEMENTARY ACCIDENT CHARGE BENEFITS

This benefit applies when an accident charge is incurred for care and treatment of a Covered Person's Injury and:

- (1) the Injury is sustained while the person is covered for these benefits; and
- (2) the initial charge is for a service delivered within seven days of the date of the accident and all follow-up care is received within 90 days; and
- (3) to the extent that the charge is not payable under any other benefits under the Plan (other than Medical Benefits).

BENEFIT PAYMENT

Benefits will be paid as described in the Schedule of Benefits.

ACCIDENT CHARGE

An accident charge is an Allowable Charge incurred for the following:

- (1) Physician services.
- (2) Hospital care and treatment.
- (3) Diagnostic X-rays and lab tests.
- (4) Local professional ambulance service.
- (5) Surgical dressings, splints and casts and other devices used in the reduction of fractures and dislocations.
- (6) Nursing service.
- (7) Anesthesia.
- (8) Use of a Physician's office or clinic operating room.

MEDICAL BENEFITS

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

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible shown in the Schedule of Benefits.

This amount will not accrue toward the 100% maximum out-of-pocket payment.

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

Deductible for a Common Accident. This provision applies when two or more Covered Persons in a Family Unit are injured in the same accident.

These persons need not meet separate deductibles for treatment of injuries incurred in this accident; instead, only one deductible for the Calendar Year in which the accident occurred will be required for them as a unit for expenses arising from the accident.

BENEFIT PAYMENT

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

OUT-OF-POCKET LIMIT

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

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

PLAN ALLOWANCE

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

(1) **Covered In-Network Services**

For covered in-network services (those received from an In-Network Provider) received in Arkansas, the Plan Allowance is the Network Fee Schedule established by the terms of the provider's contract with the Claims Administrator. For covered in-network services received outside the state of Arkansas, the Claims Administrator may not have a direct contract with each provider outside Arkansas; where that is the case, the Plan Allowance for covered in-network services is determined by the allowance or fee

schedule of the provider's contract with the Blue Cross and Blue Shield plan in the state where services were provided (known as the "Host Plan").

(2) Covered Out-of-Network Services

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

- (a) for services received in Arkansas, the Plan Allowance for covered out-of-network services of Physicians and other individual Providers, as well as ambulatory surgery centers, home health, hospice, and freestanding dialysis centers or imaging centers, will be the amount of the fee schedule that the Claims Administrator has contracted with providers in Arkansas for its Preferred Payment Plan network ("PPP"); for hospitals classified as acute care hospitals, the Plan Allowance for covered out-of-network Inpatient and Outpatient Services will be the amount calculated using the Arkansas Blue Cross and Blue Shield Facility Pricing Guidelines.
- (b) for services received outside of Arkansas, the Plan Allowance for covered out-of-network services will be either the amount provided to the Claims Administrator by the Host Plan in that state or, if no such amount is available to the Claims Administrator from a Host Plan, then the Plan Allowance will be the amount determined under the formulas for services received in Arkansas, as referenced in (a), above, or (c), below.
- (c) for any services of any provider that are not addressed in any of the existing provider contracts or pricing guidelines referenced above, the Plan Allowance for covered out-of-network services will be the amount established by Claims Administrator using such pricing methods, benchmarks or sources as Claims Administrator may deem appropriate in the circumstances.

(3) Patient's Share of the Plan Allowance and Billed Charges of the Provider

The Plan calculates and pays Plan benefits on the basis of the Plan Allowance, an amount that may vary substantially from the amount a provider chooses to bill. Once the Plan Allowance is determined with respect to any provider's billed charges, the Covered Person may be responsible for a percentage or portion of the Plan Allowance, depending on the terms of the Plan with respect to Copays, Coinsurance and Deductible. For example, if services are provided by an In-Network Provider, the Plan may pay 80% of the Plan Allowance, in which case the Covered Person would be responsible for the remaining 20% of the Plan Allowance, but not for the difference between the Plan Allowance and the provider's billed charges. In this situation, the in-network provider contract protects the Covered Person from additional billing beyond the Plan Allowance. For an Out-of-Network Provider, the circumstances are substantially different. For example, if services are provided by an Out-of-Network Provider, the Plan may pay only 50% of the Plan Allowance, in which case the Covered Person would be responsible for the remaining 50% of the Plan Allowance. However, the Covered Person might also be held responsible by the Out-of-Network Provider for paying the difference between the Plan Allowance and the provider's full, billed charges.

COVERED CHARGES

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

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

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

The Expectant Mother is encouraged to enroll in the Special Delivery Program by the 14th week of Pregnancy. Special Delivery can be accessed by calling 1-800-742-6457. This program is designed to encourage the Covered Person to actively participate in obtaining comprehensive prenatal care. Services that are not normally offered, such as skilled nursing assessments or nursing assistant care in the home for conditions including Pregnancy-induced hypertension, diabetes mellitus, and preterm labor, are covered through the Special Delivery program. The Special Delivery nurse can assist in coordinating home health care in lieu of hospitalization for those high risk patients who the Physician feels would benefit from this alternative care.

Group health plans generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

- (3) **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

- (a) the patient is confined as a bed patient in the facility;
- (b) the confinement starts immediately following a Hospital confinement or a period of Home Health Care Utilization;
- (c) the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and
- (d) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

Covered charges for a Covered Person's care in these facilities are limited to the covered daily charge limit shown in the Schedule of Benefits.

- (4) **Physician Care.** The professional services of a Physician for surgical or medical services are limited to one treatment per day.

- (a) Charges for **multiple surgical procedures** will be a covered expense subject to the following provisions:
 - (i) Coverage is provided for services of Physicians for surgery, either as an inpatient or outpatient. If coverage is provided for two or more surgical operations performed during the same surgical encounter or for bilateral procedures, payment for the secondary or subsequent procedure will be made at a reduced rate.
 - (ii) Payment for a covered assistant surgeon shall be limited to a single Physician, qualified to act as an assistant for the surgical procedure. Covered Charges for assistant surgery services or minimum assistant surgery services will be paid at a reduced rate which will never exceed 20% of the surgeon's Allowable Charge.

- (5) **Home Health Care Services and Supplies.** Charges for Home Health Care Services and Supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility

confinement would otherwise be required. Covered services must be provided through and billed by a licensed home health agency.

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits.

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

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

Bereavement counseling services for the patient's immediate family (covered Spouse and/or covered Dependent Children) are covered. Bereavement services must be furnished within six months after the patient's death.

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

- (a) **Acquired Immune Deficiency Syndrome (AIDS) treatment.** Treatment of AIDS is covered as any other illness.
- (b) Local Medically Necessary professional land or air **ambulance** service to a Hospital or Skilled Nursing Facility where necessary treatment can be provided. Billed charges for ambulance services which do not result in transport to a medical facility are not covered
- (c) **Anesthetic**; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.
- (d) **Cardiac rehabilitation** as deemed Medically Necessary when performed by a licensed therapist and furnished in accordance with a written treatment plan established and certified by the treating Physician.
- (e) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included. High-dose chemotherapy requires prior approval from the Plan.
- (f) Initial **contact lenses** or glasses required following cataract surgery.
- (g) **Contraception** coverage under Medical Benefits is limited to charges related to intrauterine devices.
- (h) **Diabetes Self-Management Training.** Includes instruction, medical nutrition therapy relating to diet, caloric intake and diabetes management, 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 of Diabetes Self-Management Education Program as developed by the American Diabetes Association. Does not include programs in which the primary purpose is weight reduction.
- (i) **Dietitian services.** Coverage is limited to Diabetic Self-Management Training.
- (j) Coverage is provided for **Durable Medical Equipment (DME)** when prescribed by a Physician according to the guidelines specified below.

- (i) Durable Medical Equipment is equipment which (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.
 - (ii) 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.
 - (iii) Replacement of DME is covered only when necessitated by normal growth or when it exceeds its useful life. Maintenance and repairs resulting from misuse or abuse of DME are the responsibility of the Covered Person.
 - (iv) When it is more cost effective, the Plan, in its discretion will purchase rather than lease equipment. In making such purchase, the Plan may deduct previous rental payments from its purchase Allowance.
- (k) Coverage of **gastric bypass surgery** is only available to Employees. Benefits are limited as shown in the Schedule of Benefits Section. Complications are not covered. To be eligible for this benefit, the Employee must have been employed by Washington County for at least six months. The surgery must be Medically Necessary and recommended in writing by a bariatric surgeon. The employee is required to complete all regular counseling first within 12 months prior to the surgery. Inpatient hospitalizations associated with gastric bypass surgery require precertification.
- (l) **Genetic testing** is covered in accordance with established Coverage Policy.
- (m) **Hearing exams** are covered when ordered by a Physician during treatment of a medical condition.
- (n) **Inhalation therapy** to administer drugs or provide oxygen.
- (o) **Laboratory studies.**
- (p) **Medical Foods and Low Protein Modified Food Products.** Covered for treatment of phenylketonuria if administered under the order of a licensed Physician and prescribed as Medically Necessary for the therapeutic treatment of phenylketonuria.
- (q) Treatment of **Mental Disorders and Substance Abuse.** Covered charges for care, supplies and treatment of Mental Disorders and Substance Abuse will be limited as follows:
- (i) All treatment is subject to the benefit payment maximums shown in the Schedule of Benefits.
 - (ii) Physician's visits are limited to one treatment per day.
 - (iii) Psychiatrists (M.D.), psychologists (Ph.D.), licensed Clinical Social Worker (L.C.S.W.) or Licensed Professional Counselors (L.P.C.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.
- (r) **Obesity treatment** coverage, including gastric bypass surgery or any other procedure performed for the purpose of weight loss, is subject to prior written approval from the Claims

Administrator, acting on behalf of the Plan Administrator. Benefits for approved treatment will be limited as described in the Schedule of Benefits

- (s) Injury to or care of **mouth, teeth and gums**. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:
- (i) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
 - (ii) Emergency repair due to Injury to sound natural teeth.
 - (iii) Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.
 - (iv) Excision of benign bony growths of the jaw and hard palate.
 - (v) External incision and drainage of cellulitis.
 - (vi) Incision of sensory sinuses, salivary glands or ducts.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, surgical extraction of impacted teeth, temporomandibular joint disharmony, cranial mandibular disharmony, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

- (t) **Organ transplant limits.** Coverage is provided for human-to-human organ or tissue transplants in accordance with the following specific conditions:
- (i) Not all transplants are covered. There must be a specific Coverage Policy which allows benefits for the transplant in question, and the Covered Person must meet all of the required criteria necessary for coverage set forth in the Coverage Policy and in this Plan Document.
 - (ii) Except for kidney and cornea transplants, coverage for transplant services requires Prior Approval from the Claims Administrator. A request for approval must be submitted to the Claims Administrator prior to receiving any transplant services, including transplant evaluation.
 - (iii) The transplant benefit is subject to the deductible, coinsurance and any applicable copays or maximums specified in the Schedule of Benefits.
 - (iv) Notwithstanding any other provisions, the Allowable Charge for an organ transplant, including any charge for the procurement of the organ, Hospital services, Physician services and associated costs, including costs of complications arising from the original procedure that occur within the Transplant Global Period, shall be limited to the lesser of (a) 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 Covered Person chooses to use that facility. If the Covered Person receives the transplant from a facility that is not in the Blue Distinction Centers for Transplant network, but is contracted with a local Blue Cross and/or Blue Shield Plan, the Allowable Charge shall be the price contracted by such Blue Cross and/or Blue Shield Plan. If the Covered Person receives the transplant from a facility that is not in the Blue Distinction Centers for Transplant network and does not contract with the local Blue Cross and/or Blue Shield plan, the Allowable Charge for the transplant services provided in the Transplant Global Period is eighty

(80%) percent of the average Allowed Charge authorized by participating facilities in the Blue Distinction Centers for Transplant network located in the geographic region where the transplant is performed.

- (v) Charges for obtaining donor organs or tissues are Covered Charges under the Plan when the recipient is a Covered Person. When the donor has medical coverage, his or her plan will pay first. The benefits under this Plan will be reduced by those payable under the donor's plan. Donor charges include those for evaluating the organ or tissue, removing the organ or tissue from the donor, and transportation of the organ or tissue from within the United States and Canada to the place where the transplant is to take place.
- (u) The initial purchase, fitting and repair of **orthotic appliances** such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness. Coverage includes foot orthotics. Repair and replacement due to loss or misuse is not covered.
- (v) **Podiatric services.** Surgical and medical foot care rendered by a Physician, but not including charges for foot orthoses, supporting devices for the foot, treatment of subluxations of the foot, 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.
- (w) **Prescription Drugs** (as defined) are covered under the Prescription Drug Card programs administered by the pharmacy benefits manager. Coverage under Medical Benefits is available for injectable medications while confined as an inpatient, or when provided and administered by a Physician in a clinic setting.
- (x) **Routine Preventive Care.** Covered charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits.

Charges for Routine Well Adult Care. Routine well adult care is care by a Physician that is not for an Injury or Sickness.

Charges for Routine Well Child Care. Routine well child care is routine care by a Physician that is not for an Injury or Sickness.

- (y) The initial purchase, fitting and repair of fitted **prosthetic devices** which replace body parts. Replacement prosthetic devices require prior approval.
- (z) **Reconstructive Surgery.** Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges.

This mammoplasty coverage will include reimbursement for:

- (i) reconstruction of the breast on which a mastectomy has been performed,
- (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- (iii) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

in a manner determined in consultation with the attending Physician and the patient.

- (aa) **Sleep apnea treatment and sleep studies** are covered in accordance with established Coverage Policy.
- (bb) **Spinal Manipulation/Chiropractic services** by a licensed M.D., D.O. or D.C.

- (cc) **Sterilization** procedures.
- (dd) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.
- (ee) **Therapy Services.** Coverage is provided for inpatient and outpatient therapy services when performed or prescribed by a Physician. Such therapy services include physical and occupational therapy. Such therapy services shall include services provided for developmental delay, developmental speech or language disorder, developmental coordination disorder and mixed developmental disorder. Therapy services must be performed by an appropriate registered physical, occupational or speech-language therapist licensed by the appropriate State Licensing Board.
- (ff) Coverage of **Well Newborn Nursery/Physician Care.**

Charges for Routine Nursery Care. Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge.

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

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

Charges for covered routine nursery care will be applied toward the Plan of the covered parent.

Group health plans generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Charges for Routine Physician Care. The benefit is limited to the Allowable Charges made by a Physician for routine pediatric care for the first five days after birth while the newborn child is Hospital confined.

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

- (gg) Diagnostic **X-rays.**

COST MANAGEMENT SERVICES

NOTIFICATION OF MEDICAL SERVICES

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

Please refer to the Employee ID card for the Prenotification Services phone number.

The responsible party must call the Prenotification Services telephone number on the ID card to provide notification of the following services before Medical and/or Surgical services are provided:

Inpatient Admissions

Emergency Inpatient Admissions (call must be made within 48 hours of Admission)

The purpose of the Prenotification program is to alert the Plan of a patient's potential need for long-term and/or extensive care. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

Failure to follow this procedure may reduce reimbursement received from the Plan.

Responsibility for Prenotification

The following table identifies services which require prenotification and who is responsible for providing prenotification.

Services requiring prenotification	Party Responsible for Notification if Provider is In-Network	Party Responsible for Notification if Provider is Out-of-Network*
Inpatient admissions, including emergency admissions	In-Network Hospital The In-Network Hospital is responsible for any penalty amounts incurred for failure to provide prenotification.	Covered Person Failure to provide prenotification will result in a \$200 reduction in benefits paid by the Plan. The Covered Person is responsible for reimbursing the provider for the penalty amount.

*Some out-of-network providers may have contracts with either the Claims Administrator or the Blue Cross and Blue Shield plan in the state where services were provided, which make them responsible for any penalty amounts incurred for failure to obtain precertification. The Covered Person may contact BlueAdvantage at the customer service telephone number listed on the ID card to determine if a specific out-of-network provider has this type of contract.

SECOND AND/OR THIRD OPINION PROGRAM

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

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

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

PREADMISSION TESTING SERVICE

Diagnostic lab tests and x-ray exams will be payable at standard Plan reimbursement levels when:

- (1) performed on an outpatient basis within seven days before a Hospital confinement;
- (2) related to the condition which causes the confinement; and
- (3) performed in place of tests while Hospital confined.

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

CASE MANAGEMENT

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

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

- maximize the benefits available under the Medical Benefits Plan;
- at the same time, identify cost-effective alternatives to high-cost treatment settings such as hospitalization;
- educate Plan Participants and their Physicians on cost-effective alternatives from which they may choose;
- provide health education to Plan Participants to empower them and their families to self-manage aspects of their care as deemed appropriate by their Physician; and,
- help Plan Participants better understand and deal with the complexities of the health care system and their Medical Benefits Plan

DEFINED TERMS

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

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

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

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

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

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

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

Brand Name means a trade name medication.

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

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

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

Coverage Policy - With respect to certain drugs, treatments, services, tests, equipment or supplies, the Claims Administrator has developed specific Coverage Policies, which have been put into writing, and are available upon request from the Claims Administrator. If the Claims Administrator has developed a specific Coverage Policy that applies to the drug, treatment, service, test, equipment or supply that a Covered Person received or seeks to have covered under the Plan, the Coverage Policy shall be deemed to be determinative in evaluating whether such drug, treatment, service, test, equipment or supply meets the 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 coverage criteria.

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

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

Dentist is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

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

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer is Washington County.

Enrollment Date is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

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

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

"Reliable Evidence" shall mean only the following sources:

- (a) the patient's medical records or other information from the treating Physician(s) or from a

consultant(s) regarding the patient's medical history, treatment or condition;

- (b) the written protocol(s) under which the drug, device, treatment or procedure is provided to the patient;
- (c) any consent document the patient has executed or will be asked to execute, in order to receive the drug, device, treatment or procedure;
- (d) published reports and articles in the authoritative medical and scientific literature, signed by or published in the name of a recognized medical expert, regarding the drug, device, treatment or procedure at issue as applied to the Injury, Illness or condition at issue; or
- (e) the written protocol(s) used by another facility studying substantially the same drug, device, medical treatment or procedure.

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

Formulary means a list of prescription medications compiled by the third party payor of safe, effective therapeutic drugs specifically covered by this Plan.

Generic drug means a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

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

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

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

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

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

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

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

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

Injury means an accidental physical Injury to the body caused by unexpected external means.

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

In-Network Transplant Center means a health care facility that provides organ and/or tissue transplants and which has entered into a network participation contract with either the Claims Administrator, or outside the state of Arkansas, with the Blue Cross and Blue Shield plan in the state where services were provided (“Host Plan”), or with the national Blue Cross and Blue Shield Association.

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

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

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

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

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

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

Medical foods are intended for the dietary treatment of phenylketonuria for which nutritional requirements are established by recognized scientific principles and formulated to be consumed or administered entirely under the direction of a Physician.

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

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

Medicare is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder means and includes (whether organic or non-organic, whether of biological, non-biological, chemical or non-chemical origin, and irrespective of cause, basis or inducement) mental disorders, mental illnesses, psychiatric illnesses, mental conditions and psychiatric conditions. This includes but is not limited to, psychoses, neurotic disorders, schizophrenic disorders, affective disorders, personality disorders and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

(This is intended to include disorders conditions and illnesses classified on Axes I and II in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, D.C.)

Morbid Obesity is a diagnosed condition in which the patient has a body mass index (BMI) of 40 or greater, or a BMI of 36-39 with the presence of other high-risk co-morbid conditions.

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

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

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

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

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

Plan means Washington County Health Benefit Plan, which is a benefits plan for certain employees of Washington County and is described in this document.

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

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

Plan Year is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

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

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

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

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

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

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

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

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

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

Substance Abuse is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

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

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

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

PLAN EXCLUSIONS

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan.

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

- (1) **Abortion.** Services, supplies, care or treatment in connection with an abortion unless the life of the mother is endangered by the continued Pregnancy or the Pregnancy is the result of rape or incest and the services are performed in a Hospital setting.
- (2) **Acupuncture.** Services, supplies, care or treatment in connection with acupuncture for analgesic or anesthetic purposes.
- (3) **Administrative Fees.** Fees incurred for acquiring or copying medical records, sales tax, preparation of records for other insurance carriers or insurance agencies, medical evaluation for life, disability or any type of insurance coverage are not covered.
- (4) **Alcohol.** Services, supplies, care or treatment to a Covered Person for an Injury or Sickness which occurred as a result of that Covered Person's illegal use of alcohol. Expenses will be covered for Injured Covered Person other than the person illegally using alcohol. The following must be present for there to be sufficient evidence for the purpose of this exclusion: (1) the results of a valid blood, breath or urine test performed by a qualified Provider indicating that Covered Person's alcohol level exceeds the legal limit in the state where the Injury or Sickness occurred, or (2) a written citation from a law enforcement office, in attendance where the Injury or Sickness occurred, indicating the Covered Person was under the influence of alcohol. The exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
- (5) **Appointments.** Charges resulting from the failure to keep a scheduled visit with a Physician or other Provider are not covered.
- (6) **Biofeedback.** Biofeedback and other forms of self-care or self-help training and any related diagnostic testing.
- (7) **Blood Typing.** Blood typing for paternity testing is not covered.
- (8) **Clinical Trials.** Services or supplies provided in connection with a phase I, II, III< or IV clinical trial or any study to determine the maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with a standard means of treatment or diagnosis of a drug, device or medical treatment or procedure are not covered. This exclusion will not apply to routine items and services that (a) would have been Covered Expenses had they not be incurred during an approved clinical trial, and (b) are provided during an approved clinical trial, as required and defined under PHSA Section 2709.
- (9) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered. Complications from a non-covered abortion are covered.
- (10) **Cochlear Implants.** Services related to cochlear implants including diagnostic tests are not covered for Covered Persons over the age of 18 years.
- (11) **Contraception.** Charges related to oral contraceptives, injectable contraceptives and contraceptive devices other than intrauterine devices, are not covered under Medical Benefits, but may be covered under the Prescription Drug Card program administered by the pharmacy benefits manager. See the Prescription Drug Card Section for information regarding limitations and conditions of coverage.
- (12) **Cosmetic Services.**

- (13) **Cranial electrotherapy stimulation devices.**
- (14) **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.
- (15) **Delivery Charges.** Charges for shipping, packaging, handling or delivering Medications are not separately covered.
- (16) **Dental care or orthodontic services.** However, if a Covered Person has an Accidental Injury, benefits will be provided for Dental care and x-rays necessary to correct damage to Non-diseased Teeth or surrounding tissue caused by the Accidental Injury with the following limitations:
- (a) Only the Non-diseased Tooth or Teeth avulsed or extracted as a direct result of the Accidental Injury and the Non-diseased Tooth or Teeth immediately adjacent will be considered for replacement.
 - (b) Orthodontic services are limited to the stabilization and re-alignment of the accident-involved teeth to their pre-accident position. Reimbursement for this service will be based on a per tooth allowance.
 - (c) This benefit is limited to the first twelve (12) months immediately following the Accidental Injury. If the Covered Person is under age 15, reimbursement for dental care services provided after such twelve (12) month period will be provided if: (a) such reimbursement is requested within such twelve (12) month period, (b) the request for reimbursement is accompanied by a plan of treatment, (c) in the opinion of the Company, under standard dental practices the treatment could not have been provided within such twelve (12) month period and (d) coverage for the injured Covered Person is in force when the treatment is rendered.
 - (d) Injury to teeth while eating is not considered an Accidental Injury.
 - (e) Double abutments are not covered.
 - (f) Dental implants (titanium osseointegrated fixtures or of any other material) are not covered.
- (17) **Dietary and Nutritional services.** Any services or supplies provided for Dietary and Nutritional Services, unless such services or supplies are the sole source of nutrition for the Covered Person. Baby formula, whether prescribed by a Physician or acquired over the counter, is not a covered benefit.
- (18) **Educational or vocational testing.** Services for educational or vocational testing or training.
- (19) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Allowable Charge.
- (20) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy if covered by this Plan.
- (21) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary.
- (22) **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages. The Plan will pay for one pair of eyeglasses or contact lenses within six months following cataract surgery.
- (23) **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, foot orthoses, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).

- (24) **Foreign travel.** Care, treatment or supplies outside of the United States if travel is for the sole purpose of obtaining medical services. Services received outside of the United States must be Medically Necessary to be considered eligible for coverage.
- (25) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.
- (26) **Hazardous Hobby or Activity.** Care and treatment of an Injury or Sickness that results from engaging in a Hazardous Hobby or Activity. A hobby or activity is hazardous if it is an unusual activity which is characterized by a constant threat of danger or risk of bodily harm. Examples of hazardous hobbies or activities are skydiving, auto racing, hang gliding, Jet Ski operating or bungee jumping.
- (27) **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting.
- (28) **High dose Chemotherapy, Autologous Transplants, Allogeneic Transplants or Nonmyeloablative Allogeneic Stem Cell Transplantation,** unless prior approval has been received from the Plan.
- (29) **High frequency chest wall oscillators.**
- (30) **Hippo therapy.**
- (31) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.
- (32) **Hypnotherapy.** Charges for hypnotherapy or related services.
- (33) **Illegal acts.** Charges for services received as a result of Injury or Sickness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
- (34) **Illegal drugs or medications.** Services, supplies, care or treatment to a Covered Person for an Injury or Sickness resulting from that Covered Person's voluntary taking or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person illegally using the controlled substances. A written citation from a law enforcement officer, in attendance where the Injury or Sickness occurred, indicating the Covered Person was under the influence of a controlled substance, drug, hallucinogen, or narcotic not administered on the advice of a Physician must be present for there to be sufficient evidence for the purpose of this exclusion.
- (35) **Impotence.** Care, treatment, services, supplies or medication in connection with treatment for impotence.
- (36) **Infertility.** Care, supplies, services and treatment for infertility, artificial insemination, or in vitro fertilization.
- (37) **Low Vision Enhancement system (L VES).**
- (38) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

- (39) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.
- (40) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.
- (41) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.
- (42) **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.
- (43) **Obesity.** Treatment of obesity or Morbid Obesity is not covered for Dependent Spouses and Children. Employee coverage is limited as described under "Gastric Bypass Surgery" in the Medical Benefits Section.
- (44) **Occupational.** Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment.
- (45) **Orthoptic or pleoptic therapy.** Services or treatment related to orthoptic or pleoptic therapy.
- (46) **Outside the United States of America.** Services or supplies received outside of the United States of America will be paid at the sole discretion of the Company;
- (47) **Peripheral Nerve Stimulators.** Services for peripheral nerve stimulators are not covered.
- (48) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.
- (49) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.
- (50) **Private duty nursing.** Charges in connection with care, treatment or services of a private duty nurse unless included as part of a pre-approved Home Health Care treatment plan.
- (51) **Recreational therapy.** Services or supplies provided by a recreational therapist.
- (52) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.
- (53) **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.
- (54) **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or Pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits.
- (55) **Self-Inflicted.** Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

- (56) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was Covered under this Plan or after coverage ceased under this Plan.
- (57) **Services or supplies** provided by an individual or entity that is not a Provider as defined in this Plan Document are not covered.
- (58) **Sex changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.
- (59) **Sleep studies.** Sleep studies performed outside of a Hospital are not covered.
- (60) **Social Workers.** The services of social workers, unless included as a part of the daily room and board allowance.
- (61) **Specimen Handling.** Collecting, storing, freezing or thawing of any specimens of sperm or embryos for later use, are not covered
- (62) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.
- (63) **Temporomandibular Joint Syndrome and Cranial Mandibular Disharmony.** All diagnostic and treatment services related to the treatment of jaw joint problems including temporomandibular joint (TMJ) syndrome or cranial mandibular disharmony.
- (64) **Transplant donor.** The testing of a transplant donor who is found incompatible.
- (65) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a covered expense.
- (66) **Unlicensed Provider.** Coverage is not provided for treatment, procedures or services received from any person or entity, including but not limited to Physicians, who is required to be licensed to perform the treatment, procedure or service, but (1) is not so licensed, or (2) has had his license suspended, revoked or otherwise terminated for any reason, or (3) has a license that does not include within its scope the treatment, procedure or service provided.
- (67) **War.** Any loss that is due to a declared or undeclared act of war.

PRESCRIPTION DRUG BENEFITS

Managed Pharmacy Program

The Plan has contracted with the pharmacy benefits manager to provide Plan Participants with prescription medication coverage. To use this benefit, individuals should present their identification card to a participating Pharmacy. Participants can obtain prescription medications for the appropriate copayment, subject to the terms, conditions and limitations outlined in this Plan Document.

Copayment

Each Prescription is covered only after the Member pays the applicable copayment to the Participating Pharmacy. Members will be charged one Copayment for each 34-day supply (three copayments for a 100-day supply of Maintenance Medications).

When a Generic Medication is dispensed, the Covered Person will pay the first tier medication copayment specified in the Schedule of Benefits for each initial and refill prescription. If there is no Generic equivalent, or if the Physician indicates “dispense as written,” the Covered Person will pay the second or third tier copayment, as applicable, for each initial and refill prescription.

If a Brand Name Medication is dispensed when a Generic Medication is available and the Physician has NOT indicated “dispense as written,” the Covered Person will pay the second or third tier copayment plus the difference in the cost of the Brand Name Medication and Generic Medication, or the cost of the medication, whichever is less.

If a drug is purchased without the Plan Participant’s identification card or from a non-participating Pharmacy, the amount payable will not exceed the established participating Pharmacy contracted fee, minus the appropriate copayment.

Covered Prescription Drugs

- (1) All drugs prescribed by a Physician that require a prescription either by federal or state law. This excludes any drugs stated as not covered under this Plan.
- (2) Injectable drugs require prior authorization.
- (3) Coverage of any prescription medication is subject to the Formulary. Note: the Formulary is subject to change throughout the year as new medications, dosages or strengths are added to the market.
- (4) Insulin and diabetic supplies when prescribed by a Physician.

Limits to This Benefit

- (1) **Quantity-versus-Time Edits.** Some medications have quantity limitations that are more restrictive than the Plan’s standard 34-day supply. These are medications that are appropriate for dispensing through an outpatient Pharmacy, but because of their high cost and potential for misuse, should be monitored closely.

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

By regulating the quantity that can be obtained each time the prescription is filled and within each 30-day period, we can monitor those cases where the member is getting a quantity that is greater than the manufacturer recommends. This is beneficial information for the prescribing physician and protects the Plan’s financial risk.

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

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

Prior authorization requests and inquiries may be submitted to:

Prior Authorization coordination
P.O. Box 3688
Little Rock, AR 72203-3688
FAX: (501) 378-6647

- (3) **Smoking cessation.** Drugs prescribed for the treatment of smoking cessation are limited to \$500 per Lifetime.

Expenses Not Covered

This benefit will not cover a charge for any of the following:

- (1) **Administration.** Any charge for the administration of a covered Prescription Drug.
- (2) **Appetite suppressants.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.
- (3) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.
- (4) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.
- (5) **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A or medications for hair growth or removal.
- (6) **Excessive Use.** Excessive use of a controlled substance is not covered. For purposes of this exclusion, each Covered Person agrees that the Plan shall be entitled to deny coverage of medications on grounds of excessive use when it is determined (1.) that a Covered Person has exceeded the dosage level, frequency or duration of medications recommended as safe or reasonable by Medical Literature, standard reference compendia or by the pharmacy benefits manager; or (2.) that a Covered Person has obtained or attempted to obtain the same medication from more than one Physician for the same or overlapping periods of time; or (3.) that the pattern of Prescription purchases, changes of Physicians or Pharmacy or other information indicates that a Covered Person has obtained or sought to obtain excessive quantities of Medications. Each Covered Person hereby authorizes the Plan to communicate with any necessary Physician, health care Provider or Pharmacy for the purpose of reviewing and discussing the Covered Person's Prescription history, use or activity to evaluate for excessive use.
- (7) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.

- (8) **FDA.** Any drug not approved by the Food and Drug Administration.
- (9) **Immunization.** Immunization agents or biological sera.
- (10) **Impotence.** A charge for impotence medication.
- (11) **Infertility.** A charge for infertility medication.
- (12) **Injectables.** A charge for hypodermic syringes and/or needles, injectables or any prescription directing administration by injection (other than insulin).
- (13) **Inpatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.
- (14) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".
- (15) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.
- (16) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.
- (17) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.
- (18) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

DENTAL BENEFITS

This benefit applies when covered dental charges are incurred by a person while covered under this Plan.

DEDUCTIBLE

Deductible Amount. This is an amount of dental charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year, a Covered Person must meet the deductible shown in the Schedule of Benefits.

BENEFIT PAYMENT

Each Calendar Year benefits will be paid to a Covered Person for the dental charges in excess of the deductible amount. Payment will be made at the rate shown under Dental Percentage Payable in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount.

MAXIMUM BENEFIT AMOUNT

The Maximum dental benefit amount is shown in the Schedule of Benefits.

DENTAL CHARGES

Dental charges are the charges made by a Dentist for necessary care in connection with dental services or supplies covered in this contract.

DATE OF SERVICE

This is the date that treatment is completed.

COVERED DENTAL SERVICES

Diagnostic and Preventive Dental Procedures

The limits on Class A services are for routine services. If dental need is present, this Plan will consider for reimbursement services performed more frequently than the limits shown.

- (1) Routine oral exams. Limit of two per Covered Person per calendar year.
- (2) Prophylaxis. This includes the routine cleaning of teeth. Limit of two per Covered Person each Calendar Year.
- (3) One bitewing x-ray series every Calendar Year, maximum of four per occurrence.
- (4) One full mouth x-ray every five years.
- (5) Two fluoride treatments for covered Dependent children under age 19 per Calendar Year.
- (6) Space maintainers for covered Dependent children under age 19 per Calendar Year.
- (7) Emergency palliative treatment for pain.
- (8) Sealants: one per tooth every three years for Dependents through age 15 on permanent first and second molars.

Restorative Basic Dental Procedures

- (1) Fillings.
- (2) Periodontics (gum treatments).
- (3) Oral surgery.
- (4) Endodontics (root canals).
- (5) General anesthesia, upon demonstration of Medical Necessity.
- (6) Extractions.
- (7) Inlays, Onlays, and Crowns.
- (8) Partial or Full Dentures to replace one or more natural teeth.
- (9) Fixed Bridges to replace one or more natural teeth.
- (10) Repairs, Relines, and Rebases of Partial or Full Dentures.
- (11) Replacing an existing Partial or Full Denture, Fixed Bridgework, adding teeth to a partial denture, or adding teeth to existing bridgework to replace newly extracted teeth. However; this item will apply only if the following applies:
 - (a) The existing denture or bridgework was placed at least five years prior to its replacement;
 - (b) The existing denture or bridgework cannot currently be made serviceable.

Orthodontic Treatment and Appliances

This is the treatment to correct a malocclusion of the teeth. These services are available for covered Dependent children under the age of 19 and include x-rays, diagnostic casts, treatment planning, active treatment and retention.

Payments for comprehensive orthodontic treatment are made in monthly installments.

ALTERNATE TREATMENT

Frequently, several alternate methods exist to treat a dental condition. For example, a tooth can be restored with a crown or a filling, and missing teeth can be replaced either with a fixed bridge or a partial denture. This Plan has an "alternate treatment" clause which governs the amount of benefits the Plan will pay for treatments covered under the Plan. If a patient chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level. If the patient and the Dentist decide to use the more expensive procedure, the Covered Person is responsible for the additional charges beyond those paid of allowed by this Plan.

EXCLUSIONS

A charge for the following is not covered:

- (1) **Administrative costs.** Administrative costs of completing claim forms or reports or for providing dental records.
- (2) **Broken appointments.** Charges for broken or missed dental appointments.
- (3) **Periodontal splinting** (the use of crowns for stability purposes).
- (4) **Excluded under Medical.** Services that are excluded under Medical Plan Exclusions.
- (5) **Hygiene.** Oral hygiene, plaque control programs or dietary instructions.
- (6) **Implants.** Implants, including any appliances and/or crowns and the surgical insertion or removal of implants; as well as, any surgery necessary to prepare the tissue for implants.
- (7) **Medical services.** Services that, to any extent, are payable under any medical expense benefits of the Plan.
- (8) **No listing.** Services which are not included in the list of covered dental services.
- (9) **Orthognathic surgery.** Surgery to correct malpositions in the bones of the jaw.
- (10) **Personalization.** Personalization of dentures.
- (11) **Replacement.** Replacement of lost or stolen appliances.
- (12) **Crowns, fillings or appliances** that are used to change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic. Also included are temporary replacements.
- (13) **Temporomandibular Joint Dysfunction and Cranial Mandibular Disharmony.** All diagnostic and treatment services related to the treatment of jaw joint problems including temporomandibular joint dysfunction (TMJ) or cranial mandibular disharmony.

HOW TO SUBMIT A CLAIM

Benefits under this Plan shall be paid only if the Plan Administrator, in its discretion, interprets the Plan to provide such benefits to the Covered Person.

Claim for Benefits. "Claim for benefits" means (1) a request for payment for a service, supply, prescription drug, equipment or treatment covered by the Plan or (2) a request for prior approval for a service, supply, prescription drug, equipment or treatment covered by the Plan where the Plan conditions receipt of payment for such service, supply, prescription drug, equipment or treatment on approval in advance by the Claims Administrator.

Who Can Submit a Claim. A Covered Person, a Provider with an assignment of the claim that is approved by the Claims Administrator or a Covered Person's Authorized Representative may submit a claim. See section concerning the Authorized Representative.

The presentation of a prescription to a pharmacist in accordance with the terms of a Plan Managed Pharmacy Benefit Rider is not a claim for benefits under the terms of the Plan. However, a Covered Person may submit a claim if, upon such a presentation, the pharmacist informs the Covered Person that, because of the provisions of the Plan, the Plan will not provide benefits for the requested prescription medication.

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 the Claims Administrator.

- (1) **Post-Service Claims.** The most common claim involves post-service benefit determination. Such a claim results when a Covered Person obtains a medical service, prescription drug, supply, equipment or other treatment and then, in accordance with the terms of the Plan, the Covered Person or the Covered Person's Authorized Representative submits a claim for benefits to the Claims Administrator. Examples of post-service claims are claims involving Physician office visits, maternity care, Inpatient Services and Outpatient Services.

The Covered Person, Provider or Authorized Representative must submit written proof of any service, supply, prescription drug, equipment or other treatment within 180 days following the date on which such service, supply, prescription drug, 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 the date of discharge for that single admission.

Post-Service Claims may be submitted electronically in accordance with the Claims Administrator's electronic claim filing procedures, or such claims may be mailed to BlueAdvantage Administrators of Arkansas, Post Office Box 1460, Little Rock, Arkansas 72203.

If the Claims Administrator is able to process the post-service claim without requesting additional information, it will notify the Covered Person of its claim determination within 30 days of the Claims Administrator's receipt of the claim.

If the Claims Administrator requires information reasonably necessary to determine whether or to what extent benefits are covered under the Plan, the Claims Administrator will suspend the claim and request the needed information. A Covered Person or their treating Provider should supply the Claims Administrator with the required information within a reasonable timeframe of the claim suspension. The timeframe will be determined by the Claims Administrator based on Plan timely filing limitations and Plan Year requirements. Contracted Providers must abide by stipulations within their provider contract in providing requested information. The Provider will be obligated to write-off their charges if he or she fails to provide the information accordingly.

- (2) **Pre-Service Claims.** A pre-service claim results if the terms of the Plan condition receipt of benefits on the Claims Administrator or Plan Administrator giving approval in advance of the Covered Person obtaining a requested medical service, drug, supply, or equipment that such medical service, drug, supply or equipment is Medically Necessary and not Experimental or Investigational. Examples of some Plan benefits requiring pre-service claims are typically claims involving organ transplants and certain high cost injectable medications. Please note that prior approval does not guarantee payment or assure coverage; it means only that the information furnished to the Claims Administrator at the time indicates that the requested service, supply, prescription drug, equipment or treatment is Medically Necessary and not Experimental or Investigational. A pre-service claim receiving prior approval as a pre-service claim must still meet all other coverage terms, conditions and limitations. Coverage for any such pre-service claim receiving prior approval may still be limited or denied if, when, after the requested service, supply, prescription drug, equipment or treatment is completed and the Claims Administrator receives post-service claim(s), investigation shows that a benefit exclusion or limitation applies, that the Covered Person ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment of Employee contribution, that out-of-network limitations apply, or any other basis specified in the Plan applies to limit or exclude the claim.

Pre-Service Claims should be submitted to the BlueAdvantage Administrators of Arkansas Medical Audit and Review Services, FAX (501) 378-6647 or mailed to Post Office Box 3688, Little Rock, Arkansas 72203.

If the Claims Administrator is able to process the pre-service claim without requesting additional information, it will notify the Covered Person of its determination in a time appropriate for the medical exigencies, but in no case later than 15 days from the date it received the pre-service claim.

If the Claims Administrator requires information reasonably necessary to determine whether or to what extent benefits are covered under the Plan, the Claims Administrator will suspend the claim and request the needed information. A Covered Person or their treating Provider should supply the Claims Administrator with the required information within a reasonable timeframe of the claim suspension. The timeframe will be determined by the Claims Administrator based on Plan timely filing limitations and plan year requirements. Contracted providers must abide by stipulations within their provider contract in providing requested information. The provider will be obligated to write-off their charges if he or she fails to provide the information accordingly.

After a Covered Person has received the health intervention that was the subject of an approved pre-service claim, the Covered Person must submit a post-service claim in accordance with Subsection 1, above.

- (3) **Claims Involving Urgent Care.** A claim involving urgent care is a pre-service claim (See Subsection 2 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 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 the Claims Administrator. A claim involving urgent care must include the medical records pertinent to the urgent condition.

If the Claims Administrator is able to process the claim involving urgent care without requesting additional information, it will notify the Covered Person of its determination in a time appropriate for the medical exigencies, but in no case later than 72 hours from the date it received the pre-service claim.

If the Claims Administrator requires information reasonably necessary to determine whether the requested medical service, drug, supply, or equipment is Medically Necessary and not Experimental or Investigational, the Claims Administrator will notify the Physician within 24 hours of receiving the claim and request the needed information. If the Covered Person or treating Provider supplies the Claims Administrator the required information within 48 hours, the Claims Administrator will notify the Covered Person of its claim determination within 48 hours after the Claims Administrator receives such information. If the Claims Administrator does not receive the required information within the 48-hour period, the claim will be denied, subject to appeal. See Claim Review Procedure Subsection that follows.

If the urgent care claim is a request to extend previously approved benefits for ongoing treatment the Claims Administrator 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 the Claims Administrator at the time indicates that requested service, supply, prescription drug, equipment or treatment is Medically Necessary and not Experimental or Investigational. A requested service, supply, prescription drug, equipment or treatment 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 the Claims Administrator receives the post-service claim(s), investigation shows that a benefit exclusion or limitation applies, that the Covered Person 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 the Plan applies to limit or exclude the claim.

After the Covered Person has received the health intervention that was the subject of a claim involving urgent care, the Covered Person, Provider or Authorized Representative must submit a post-service claim in accordance with Subsection 1, above.

- (4) **Claims involving Ongoing Care or Concurrent Review.** The Claims Administrator'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. The Claims Administrator shall give an explanation of the reduction or termination of a benefit to the Covered Person (See Explanation of Benefit Determination Subsection that follows.) with sufficient time prior to the termination or reduction to allow for an appeal (See Claim Review Procedure Subsection that follows.) to be completed before the termination or reduction takes place.

PREFERRED PAYMENT PLAN AND HOSPITAL REIMBURSEMENT PROGRAM PARTICIPATING PROVIDERS

The Plan participates in the Preferred Payment Plan (PPP) and the Hospital Reimbursement Program (HRP) with BlueAdvantage Administrators of Arkansas. Participating Providers agree to accept the allowances of BlueAdvantage Administrators of Arkansas and not charge the Covered Person more than that amount. No Assignment of Benefits by the Covered Person shall be valid until approved and accepted by the Claims Administrator. The Claims Administrator reserves the right to make payment of benefits, in its sole discretion, directly to the provider of service or to the Covered Person.

Contact the Human Resources Office for a list of the participating Providers or for more information about this Plan.

The Claim Process

This Plan uses a direct claims administration system. Under this approach, the PPP or HRP Provider submits the claims directly to the Claims Administrator.

Any payment due for eligible services rendered by Preferred Providers will be made directly to the Provider unless the Provider requests payment be made directly to the Covered Person.

Any payment due for eligible services rendered by Non-Preferred Providers will typically be made directly to the Covered Person; however, the Plan reserves the right to make payment of benefits directly to the Provider of service or to the Covered Person.

PREFERRED PROVIDER ORGANIZATION (PPO)

The Plan participates in a Preferred Provider Organization (PPO). Participating Providers agree to accept the PPO allowances and not charge the Covered Person more than that amount.

No Assignment of Benefits by the Covered Person shall be valid until approved and accepted by the Claims Administrator. The Claims Administrator reserves the right to make payment of benefits, in its sole discretion, directly to the Provider of service or to the Covered Person.

Contact the Human Resources Benefits Office for a list of the participating Providers or for more information about this Plan.

The Claims Process

The Plan uses a direct claims administration system. Under this approach, the PPO Provider submits the claims directly to the Claims Administrator.

Any payment due for eligible services rendered by PPO Providers will be made directly to the Provider unless the Provider requests payment be made directly to the Covered Person.

Any payment due for eligible services rendered by Non-PPO Providers will typically be made directly to the Covered Person; however, the Plan reserves the right to make payment of benefits directly to the Provider of service or to the Covered Person.

BLUECARD® PROGRAM

Out-of-Arkansas Services. The Health Plan participates in a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Programs.” Whenever a Covered Person obtains healthcare services outside of the State of Arkansas (“the service area”), the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between the Health Plan and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside the service area, a Covered Person will obtain care from healthcare Providers that have a contractual agreement (i.e., are “participating Providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, a Covered Person may obtain care from nonparticipating healthcare Providers. The Health Plan’s practices for consideration of payment in both instances are described below.

(1) BlueCard® Program.

- (a)** Under the BlueCard® Program, when a Covered Person accesses covered healthcare services within the geographic area served by a Host Blue, the Health Plan will remain responsible for fulfilling its contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare Providers. Whenever a Covered Person accesses covered healthcare services outside the service area and the claim is processed through the BlueCard Program, the amount a Covered Person pays for covered healthcare services is calculated based on the lower of:

- The billed covered charges for the covered services; or
 - The negotiated price that the Host Blue makes available to the Health Plan.
- (b) Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to the healthcare Provider. Sometimes, it is an estimated price that takes into account special arrangements with the 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.
- (c) Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price used for a Covered Person’s claim because the adjustments will not be applied retroactively to claims already paid.
- (d) Laws in a small number of states may require the Host Blue to add a surcharge to the calculation. If any state laws mandate other liability calculation methods, including a surcharge, the Health Plan would then calculate the Covered Person’s liability for any covered healthcare services according to applicable law.
- (2) **Non-Participating Healthcare Providers Outside the Service Area**
- (a) When covered healthcare services are provided outside of the service area by non-participating healthcare Providers, the amount a Covered Person pays for such services will generally be based on either the Host Blue’s nonparticipating healthcare Provider local payment or the pricing arrangements required by applicable state law. In these situations, a Covered Person may be liable for the difference between the amount that the non-participating healthcare Provider bills and any payment made for the covered services as set forth in this paragraph.
- (b) In certain situations, the Health Plan may use other payment bases, such as billed covered charges, the payment the Health Plan would make if the healthcare services had been obtained within the service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount the Health Plan will pay for services rendered by nonparticipating healthcare Providers. In these situations, a Covered Person may be liable for the difference between the amount that the non-participating healthcare Provider bills and the payment the Health Plan will make for the covered services as set forth in this paragraph

ALL OTHER PROVIDERS

When a Covered Person has a Claim to submit for payment that person must:

- Obtain a Claim form from the Personnel Office or the Plan Administrator.
- Complete the Employee portion of the form. **ALL QUESTIONS MUST BE ANSWERED.**
- Have the Physician complete the Provider's portion of the form. For Plan reimbursements, attach bills for services rendered. **ALL BILLS MUST SHOW:**

Name of Plan
Employee's name
Name of patient
Name, address, telephone number of the Provider of care
Diagnosis
Type of services rendered, with diagnosis and/or procedure codes
Date of services
Charges

Send the above to the Claims Administrator at this address:

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

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within 180 days from the date on which charges for the service were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred.

In order to be a claim, the submission must comply with the filing and coding policies and procedures established by the Claims Administrator and given to the Provider. The Covered Person may request a copy of the claim coding policies and procedures from the Claims Administrator or from the Provider. If the submission fails to comply with the claim filing or code policies or procedures, the Claims Administrator 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 the Claims Administrator shall indicate on the returned submission the proper procedures to be followed.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

EXPLANATION OF BENEFIT DETERMINATION.

Upon making a determination of a claim, the Claims Administrator will deliver to the Covered Person an Explanation of Benefit Determination containing the following information:

- (1) The specific reason or reasons for the determination;
- (2) Reference to the specific Plan provision(s) on which the determination is based;
- (3) A description of any additional information necessary for the claim to be perfected and an explanation of why such information is necessary;
- (4) A description of the Plan's appeal process, see Section B below. If the claim involves urgent care, a description of the expedited appeals process, see Subsection 2 below;
- (5) If the determination was based in whole or in part on a Claims Administrator Coverage Policy an explanation of how to obtain a copy of the Coverage Policy at no cost;
- (6) A statement of a Covered Person's right to bring a legal action under section 502(a) of the Employee Retirement Income Security Act of 1974.

CLAIMS REVIEW PROCEDURE

The Plan Participant will receive an Explanation of Benefits (EOB) explaining the claim determination, and if applicable, the reason or reasons for any denial or reduction of benefits. In cases where a claim for benefits payment is denied or reduced in whole or in part, the Plan Participant or the Authorized Representative may request an informal claim review.

In a situation where the determination, after informal review, remains adverse the Plan Participant or the Authorized Representative may request an appeal of the denial. The Plan Participant also has the right to initiate legal action subsequent to an appeal.

The following describes the informal review and appeals processes:

- (1) **Informal Claim Review.**
Requests for review may be submitted in writing, email, or by telephone to the Claims Administrator. The Covered Person should provide their name, Plan identification number and reference the specific claim(s) they want to have reviewed. Additional relevant documentation may also be provided to the Claims Administrator to assist in the review. A request for an informal claim review must be submitted within 180 days after notice is received of the denial or reduction in benefits.

The Covered Person and the treating health care professional are required to provide the Claims Administrator or the Plan Administrator, upon request, access to information necessary to make a determination. Such information should be provided not later than five days after the date on which the 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. Failure to provide access to such information shall not remove the obligation of the Claims Administrator to make a determination, but the determination may be affected if such requested information is not provided.

A determination shall be rendered within a reasonable period of time, but notification of the determination will be provided not later than 60 days after received.

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

If the review is in regard to an Urgent Care Pre-Service Claim, response will be provided within 72 hours of receipt.

(2) Appeal.

The Covered Person must submit the appeal to the Plan Administrator in writing and include their name, Plan identification number and reference the specific claim(s) they want to have reviewed. Appeals must be submitted within 180 days after notice is received of the denial or reduction in benefits. However, an appeal related to a claim involving urgent care may be made orally. The Covered Person may submit with their request for review any additional written comments, issues, documents, records and other information relating to the claim. Although the Plan Administrator will immediately commence consideration of an oral appeal, the Plan Administrator requires written confirmation of the appeal.

The Covered Person and the treating health care professional are required to provide the Claims Administrator or the Plan Administrator, upon request, access to information necessary to make a determination. Such information should be provided not later than five days after the date on which the 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. Failure to provide access to such information shall not remove the obligation of the Claims Administrator to make a determination, but the determination may be affected if such requested information is not provided.

The appeal will be reviewed by the Plan Administrator utilizing personnel 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. The Plan Administrator 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.

When reviewing a claim in which the determination was based in whole or in part on medical judgment, including determinations with regard to whether a particular treatment is experimental, investigational, or not Medically Necessary or appropriate, the Plan Administrator 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 Plan Administrator shall, upon request, provide the identity of the 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.

A determination shall be rendered within a reasonable period of time, but notification of the determination will be provided not later than 60 days after received.

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

If the review is in regard to an Urgent Care Pre-Service Claim, the Covered Person or Authorized Representative request an expedited review and a health care professional certifies that determination as a general pre-service claim would seriously jeopardize the Covered Person's life or health or ability to regain maximum function, response will be provided within 72 hours of receipt.

If the review is in regard to a Concurrent Care Claim, response will be provided within the timeframes as noted above, depending upon whether the claim is a post-service claim, a pre-service claim or a claim involving urgent care.

The Plan Administrator shall provide notice in a printed form and written in a manner calculated to be understood by the claimant. The notice shall include:

- (a)** The specific reason or reasons for the review determination.

- (b) Reference to the specific Plan provision(s) on which the review determination is based.
- (c) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits.

Relevant information includes:

- (i) Information relied upon in making the benefit determination.
 - (ii) Information 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) Information that demonstrates compliance with the terms of the Plan.
 - (iv) Information that constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.
- (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 of a Covered Person's right to bring a legal action under Section 502(a) of the Employee Retirement Income Security Act of 1974.

Expedited Appeal Procedure. An appeal of a claim involving urgent care or of a claim involving ongoing care is conducted in accordance with this Plan provision. An expedited appeal may be submitted by telephone, followed by a written confirmation. The Plan Administrator will notify the Covered Person and treating health care professional of the determination of the expedited appeal within 72 hours after the Plan Administrator receives the expedited appeal.

AUTHORIZED REPRESENTATIVE

One Authorized Representative. A Covered Person may have one representative and only one representative at a time, to assist in submitting a claim or appealing an unfavorable claim determination.

Authority of Authorized Representative. An Authorized Representative shall have the authority to represent the Covered Person in all matters concerning the Covered Person's claim or appeal of a claim determination. If the Covered Person has an Authorized Representative, references to "Covered Person" in the provision of this document entitled "How to Submit a Claim" refer to the Authorized Representative.

Designation of Authorized Representative. Except to the extent mandated by the U.S. Department of Labor claims rules in the case of a treating health care professionals and urgent care claims, the Plan does not permit appeals on a Covered Person's behalf by any other person or entity not properly designated as the "authorized representative" in the manner specified in this section.

One of the following persons may act as a Covered Person's Authorized Representative:

- (1) An individual designated by the Covered Person in writing in a form approved by the Claims Administrator. A "Designation of Authorized Appeal Representative" form is available from the Claims Administrator or the Plan Administrator;

- (2) The treating provider, if the claim is a claim involving urgent care, or if the Covered Person has designated the provider in writing in a form approved by the Claims Administrator. A “Designation of Authorized Appeal Representative” form is available from the Claims Administrator or the Plan Administrator;
- (3) A person holding the Covered Person's durable power of attorney;
- (4) If the Covered Person is incapacitated due to illness or injury, a person appointed as guardian to have care and custody of the Covered Person by a court of competent jurisdiction; or
- (5) If the Covered Person is a minor, the Covered Person's parent or Legal Guardian, unless the Claims Administrator is notified that the Covered Person’s claim involves health care services where the consent of the Covered Person’s parent or legal guardian is or was not required by law and the Covered Person shall represent himself or herself with respect to the claim.

Term of the Authorized Representative. The authority of an Authorized Representative shall continue for the period specified in the Covered Person’s appointment of the Authorized Representative or until the Covered Person is legally competent to represent himself or herself and notifies the Claims Administrator in writing that the Authorized Representative is no longer required.

Communication with Authorized Representative.

- (1) If the Authorized Representative represents the Covered Person because the Authorized Representative is the Covered Person’s parent or legal guardian or attorney in fact under a durable power of attorney, the Claims Administrator shall send all correspondence, notices and benefit determinations in connection with the Covered Person’s claim to the Authorized Representative.
- (2) If the Authorized Representative represents the Covered Person in connection with the submission of a pre-service claim, including a claim involving urgent care, or in connection with an appeal, the Claims Administrator shall send all correspondence, notices and benefit determinations in connection with the Covered Person’s claim to the Authorized Representative.
- (3) If the Authorized Representative represents the Covered Person in connection with the submission of a post-service claim, the Claims Administrator will send all correspondence, notices and benefit determinations in connection with the Covered Person’s claim to the Covered Person, but the Claims Administrator will provide copies of such correspondence to the Authorized Representative upon request.
- (4) The Covered Person understands that it will take the Claims Administrator at least 30 days to notify all its personnel about the termination of the Covered Person’s Authorized Representative and it is possible that the Claims Administrator may communicate information about the Covered Person to the Authorized Representative during this 30-day period.

COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total allowable expenses.

Benefit plan. This provision will coordinate the medical and dental benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

- (1) Group or group-type plans, including franchise or blanket benefit plans.
- (2) Blue Cross and Blue Shield group plans.
- (3) Group practice and other group prepayment plans.
- (4) Federal government plans or programs. This includes Medicare.
- (5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.
- (6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Eligible Charge. For a charge to be eligible it must be an Allowable Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

Benefit plan payment order. When two or more plans provide benefits for the same allowable charge, benefit payment will follow these rules.

- (1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
- (2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:
 - (a) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").
 - (b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an

Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

- (c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.
 - (d) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:
 - (i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
 - (ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the patient for the longer time are determined before those of the benefit plan which covers the other parent.
 - (e) When a child's parents are divorced or legally separated, these rules will apply:
 - (i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.
 - (ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.
 - (iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.
 - (iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.
 - (f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of allowable charges when paying secondary.
- (3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, if the person was enrolled under both of these parts.
- (4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

Claims determination period. Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of allowable charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the allowable charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

THIRD PARTY RECOVERY PROVISION

Reimbursement

This section applies when a Covered Person, or the legal representative, estate or heirs of the Covered Person (sometimes collectively referred to as the “Covered Person”) recovers damages, by settlement, verdict or otherwise, for an Injury, Sickness or other condition. If the Covered Person has made, or in the future may make, such a recovery, including a recovery from any insurance carrier, the Plan will not cover either the reasonable value of the services to treat such an Injury or Illness or the treatment of such an Injury or Illness. These benefits are specifically excluded.

However, if the Plan does advance moneys or provide care for such an Injury, Sickness or other condition, the Covered Person shall promptly convey moneys or other property from any settlement, arbitration award, verdict or any insurance proceeds or monetary recovery from any party received by the Covered Person (or by the legal representative, estate or heirs of the Covered Person), to the Plan for the reasonable value of the medical benefits advanced or provided by the Plan to the Covered Person, regardless of whether or not [1] the Covered Person has been fully compensated, or “made-whole” for his/her loss; [2] liability for payment is admitted by the Covered Person or any other party; or [3] the recovery by the Covered Person is itemized or called anything other than a recovery for medical expenses incurred.

If a recovery is made, the Plan shall have first priority in payment over the Covered Person, or any other party, to receive reimbursement of the benefits advanced on the Covered Person’s behalf. This reimbursement shall be from any recovery made by the Covered Person, and includes, but is not limited to, uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners or otherwise), workers’ compensation settlement, compromises or awards, other group insurance (including student plans), and direct recoveries from liable parties.

In order to secure the rights of the Plan under this section, and because of the Plan’s advancement of benefits, the Covered Person hereby [1] acknowledges that the Plan shall have first priority against proceeds of any such settlement, arbitration award, verdict, or any other amounts received by the Covered Person; and [2] assigns the Plan any benefits the Covered Person may have under any automobile policy or other coverage, to the extent of the Plan’s claim for reimbursement. The Covered Person shall sign and deliver, at the request of the Plan or its agents, any documents needed to protect such priority or reimbursement right, or to effect such assignment of benefits. By accepting any benefits advanced by the Plan under this section, the Covered Person acknowledges that any proceeds of settlement or judgment, including a Covered Person’s claim to such proceeds held by another person, held by the Covered Person or by another, are being held for the benefit of the Plan under these provisions.

The Covered Person shall cooperate with the Plan and its agents, and shall sign and deliver such documents as the Plan or its agents reasonably request to protect the Plan’s right of reimbursement, provide any relevant information, and take such actions as the Plan or its agents reasonably request to assist the Plan making a full recovery of the reasonable value of the benefits provided. The Covered Person shall not take any action that prejudices the Plan’s rights of reimbursement and consents to the right of the Plan, by and through its agent, to impress an equitable lien or constructive trust on the proceeds of any settlement to enforce the Plan’s rights under this section, and/or to set off from any future benefits otherwise payable under the Plan the value of benefits advanced under this section to the extent not recovered by the Plan.

The Plan shall be responsible only for those legal fees and expenses to which it agrees in writing. No Covered Person hereunder shall incur any expenses on behalf of the Plan in pursuit of the Plan’s rights hereunder. Specifically, no court costs or attorney’s fees may be deducted from the Plan’s recovery without the express written consent of the Plan. Any so-called “Fund Doctrine” or “Common Fund Doctrine” or “Attorney’s Fund Doctrine” shall not defeat this right.

The Plan shall recover the full amount of benefits advanced and paid hereunder, without regard to any claim or fault on the part of any beneficiary of Covered Person, whether under comparative negligence or otherwise.

Subrogation

This section applies when another party is, or may be considered, liable for a Covered Person's Injury, Sickness or other condition (including insurance carriers who are so financially liable) and the Plan has advanced benefits.

In consideration for the advancement of benefits, the Plan is subrogated to all of the rights of the Covered Person against any party liable for the Covered Person's Injury or Illness, or is or may be liable for the payment for the medical treatment of such injury or occupational Illness (including any insurance carrier), to the extent of the value of the medical benefits advanced to the Covered Person under the Plan. The Plan may assert this right independently of the Covered Person. This right includes, but is not limited to, the Covered Person's rights under uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, or other insurance, as well as the Covered Person's rights under the Plan to bring an action to clarify his or her rights under the Plan. The Plan is not obligated in any way to pursue this right independently or on behalf of the Covered Person, but may choose to pursue its rights to reimbursement under the Plan, at its sole discretion.

The Covered Person is obligated to cooperate with the Plan and its agents in order to protect the Plan's subrogation rights. Cooperation means providing the Plan or its agents with any relevant information requested by them, signing and delivering such documents as the Plan or its agents reasonably request to secure the Plan's subrogation claim, and obtaining the consent of the Plan or its agents before releasing any party from liability for payment of medical expenses.

If the Covered Person enters into litigation or settlement negotiations regarding the obligations of other parties, the Covered Person must not prejudice, in any way, the subrogation rights of the Plan under this section. In the event that the Covered Person fails to cooperate with this provision, including executing any documents required herein, the Plan may, in addition to remedies provided elsewhere in the Plan and/or under the law, set off from any future benefits otherwise payable under the Plan the value of benefits advanced under this section to the extent not recovered by the Plan.

The costs of legal representation of the Plan in matters related to subrogation shall be borne solely by the Plan. The costs of legal representation of the Covered Person shall be borne solely by the Covered Person.

COBRA CONTINUATION OPTIONS

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under Washington County Health Benefit Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator is Washington County 280 North College, Suite 510, Fayetteville, Arkansas 72701. The Plan Administrator is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA.

There may be other options available when group health coverage is lost. For example, an individual may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, he or she may qualify for lower costs on their monthly premiums and lower out-of-pocket costs. Additionally, an individual may qualify for a 30-day special enrollment period for another group health plan for which he or she is eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

- (1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
- (2) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes not only common-law employees (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., self-employed individuals, independent contractor, or corporate director).

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

- (1) The death of a covered Employee.
- (2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.
- (3) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.
- (4) A covered Employee's enrollment in any part of the Medicare program.
- (5) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of the COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave. For non-FMLA leaves of absence, the COBRA Qualifying Event date will be the day after the leave ends, if the Employee does not return to work in an Eligible Class.

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

- **Premiums:** This plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive. Qualified Beneficiaries have special enrollment rights under federal law (HIPAA). They have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by a spouse's employer) within 30 days after Plan coverage ends due to one of the Qualifying Events listed above.
- **Provider Networks:** If a Qualified Beneficiary is currently getting care or treatment for a condition, a change in health coverage may affect access to a particular health care provider. An individual may want to check to see if his or her current health care providers participate in a network in considering options for health coverage.

- **Drug Formularies:** For Qualified Beneficiaries taking medication, a change in health coverage may affect costs for medication – and in some cases, the medication may not be covered by another plan. Qualified beneficiaries should check to see if current medications are listed in drug formularies for other health coverage.
- **Severance payments:** If COBRA rights arise because the Employee has lost his job and there is a severance package available from the employer, the former employer may have offered to pay some or all of the Employee's COBRA payments for a period of time. This can affect the timing of coverage available in the Marketplace. In this scenario, the Employee may want to contact the Department of Labor at 1-866-444-3272 to discuss options.
- **Medicare Eligibility:** Individuals should be aware of how COBRA coverage coordinates with Medicare eligibility. If an individual is eligible for Medicare at the time of the Qualifying Event, or if he or she will become eligible soon after the Qualifying Event, he or she has eight months to enroll in Medicare after employment - related health coverage ends. Electing COBRA coverage does not extend this eight-month period. For more information, see <https://www.medicare.gov/sign-up-change-plans/>.
- **Service Areas:** If benefits under the Plan are limited to specific service or coverage areas, benefits may not be available to a Qualified Beneficiary who moves out of the area.
- **Other Cost-Sharing:** In addition to premiums or contributions for health coverage, the Plan requires participants to pay copayments, deductibles, coinsurance, or other amounts as benefits are used. Qualified beneficiaries should check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

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

What is the procedure for obtaining COBRA continuation coverage? The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage.

Note: If a covered employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the Plan Administrator for further information.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

- (1) the end of employment or reduction of hours of employment,
- (2) death of the employee,
- (3) commencement of a proceeding in bankruptcy with respect to the employer, or
- (4) enrollment of the employee in any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce, termination of domestic partnership or legal separation of the Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), the Covered Person, or someone acting on their behalf must notify the Plan Sponsor at Washington County, 280 North College, Suite 510, Fayetteville, Arkansas, 72701, within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any Spouse or Dependent child who loses coverage will not be offered the option to elect continuation coverage.

NOTICE PROCEDURES:

Any notice must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. The notice must be mailed, faxed or hand-delivered to the address shown above.

If mailed, the notice must be postmarked no later than the last day of the required notice period. Any notice provided must state:

- the **name of the plan or plans** under which coverage has been lost or is being lost,
- the **name and address of the Employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, the notice must include a **copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives ***timely notice*** that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage for their Spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If an individual does not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare? Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is

elected. However, a Qualified Beneficiary's COBRA coverage may terminate if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage.

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

- (1) The last day of the applicable maximum coverage period.
- (2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
- (3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.
- (4) The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).
- (5) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
 - (a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
 - (b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

- (1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.
- (2) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:
 - (a) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or
 - (b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

- (3) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.
- (4) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the Plan Sponsor.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to the Plan Sponsor.

Does the Plan require payment for COBRA continuation coverage? For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of \$50 or 10% of the required amount.

Must a qualified beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage? If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

FOR MORE INFORMATION

If an individual has questions about COBRA continuation coverage, they should contact the Plan Sponsor. For more information about rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP THE PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order for an individual to protect his or her family's rights, they should keep the Plan Administrator informed of any changes in the addresses of family members. The individual should also keep a copy, for his or her records, of any notices sent to the Plan Administrator.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. Washington County Health Benefit Plan is the benefit plan of Washington County, the Plan Administrator, also called the Plan Sponsor. An individual or a committee may be appointed by Washington County to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator or a committee member resigns, dies or is otherwise removed from the position, Washington County shall appoint a new Plan Administrator as soon as reasonably possible.

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

DUTIES OF THE PLAN ADMINISTRATOR.

- (1) To administer the Plan in accordance with its terms.
- (2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
- (3) To decide disputes which may arise relative to a Plan Participant's rights.
- (4) To prescribe procedures for filing a claim for benefits and to review claim denials.
- (5) To keep and maintain the Plan documents and all other records pertaining to the Plan.
- (6) To appoint a Claims Administrator to pay claims.
- (7) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

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

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

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

For Dependent Coverage: Funding is derived from contributions made by the covered Employees.

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

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

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

ASSIGNMENT OF BENEFITS

Any payment due for eligible services rendered by Preferred Providers will be made directly to the provider unless the provider requests payment be made directly to the Covered Person.

Any payment due for eligible services rendered by Non-Preferred Providers will typically be made directly to the Covered Person; however, the Plan reserves the right to make payment of benefits directly to the Provider of service or to the Covered Person

Any payment due for eligible services rendered by PPO Providers will be made directly to the provider unless the provider requests payment be made directly to the Covered Person.

Any payment due for eligible services rendered by Non-PPO Providers will typically be made directly to the Covered Person; however, the Plan reserves the right to make payment of benefits directly to the Provider of service or to the Covered Person.

HIPAA PRIVACY FIREWALL

The following summary establishes the circumstances under which the Plan may share a Plan participant's protected health information with the Plan Administrator (the Employer), and limits the uses and disclosures that the Plan Administrator may make of a Plan Participant's protected health information. This is intended to establish the firewall protections required under the Health Insurance Portability and Accountability Act of 1996 and its attendant privacy regulations, 45 C.F.R. Parts 160 and 164, as amended (the "HIPAA Privacy Rules" or "Rules").

There are three circumstances under which the Plan may disclose a Plan Participant's protected health information to the Plan Administrator.

First, the Plan may inform the Plan Administrator whether a Plan participant is enrolled in the Plan.

Second, the Plan may disclose summary health information to the Plan Administrator. The Plan Administrator must limit its use of that information to obtaining quotes from reinsurers or modifying, amending, or terminating the Plan. Summary health information is information that summarizes claims history, claims expenses, or types of claims without identifying the Plan Participant.

Third, the Plan may disclose a Plan Participant's protected health information to the Plan Administrator for Plan administrative purposes. This is because employees of the Plan Administrator perform many of the administrative functions necessary for the management and operation of the Plan.

CERTIFICATION OF FIREWALL AMENDMENT

The Plan Administrator hereby certifies to the Plan that the Plan's terms have been amended to incorporate the terms of this summary. The Plan Administrator has agreed to abide by the terms of this summary. The Plan's privacy notice also permits the Plan to disclose the Plan participant's protected health information to the Plan Administrator as described in this summary.

RESTRICTIONS ON USE OR DISCLOSURE OF PHI

Here are the restrictions that apply to the Plan Administrators use and disclosure of a Plan participant's protected health information.

- (1) The Plan Administrator will only use or disclose a Plan participant's protected health information for Plan administrative purposes, as required by law, or as permitted under the HIPAA Privacy Rules. See the Plan's privacy notice for more information about permitted uses and disclosures of protected health information under HIPAA.
- (2) If the Plan Administrator discloses any protected health information to any of its agents or subcontractors, the Plan Administrator will require the agent or subcontractor to keep Plan participants' protected health information as required by the HIPAA Privacy Rules.

- (3) The Plan Administrator will not use or disclose a Plan participant's protected health information for employment-related actions or decisions or in connection with any other benefit or benefit plan of the Plan Administrator.
- (4) The Plan Administrator will promptly report to the Plan any use or disclosure of a Plan participant's protected health information that is inconsistent with the uses or disclosures allowed in this summary.
- (5) The Plan Administrator will allow a Plan participant or the Plan to inspect and copy any protected health information about the Plan participant that is in the Plan Administrator's custody and control, as permitted or required by the HIPAA Privacy Rules, subject to certain exceptions recognized in the Rules.
- (6) The Plan Administrator will amend, or allow the Plan to amend, any portion of a Plan Participant's protected health information to the extent permitted or required under the HIPAA Privacy Rules.
- (7) With respect to some types of disclosures for purposes other than payment or health care operations, the Plan Administrator will keep a disclosure log. The disclosure log will go back for six years. Plan Participants have a right to see the disclosure log. The Plan Administrator does not have to maintain the log if disclosures are for certain Plan related purposes, such as payment of benefits or health care operations, or if a Plan Participant authorized the disclosures.
- (8) The Plan Administrator will make its internal practices, books, and records, relating to its use and disclosure of a Plan Participant's protected health information available to the Plan and to the U.S. Department of Health and Human Services upon their request.
- (9) The Plan Administrator will, if feasible, return or destroy all of protected health information in the Plan Administrator's custody or control that the Plan Administrator has received from the Plan or from any business associate when the Plan Administrator no longer needs the protected health information to administer the Plan. If it is not feasible for the Plan Administrator to return or destroy protected health information, the Plan Administrator will limit the use or disclosure of any protected health information that it cannot feasibly return or destroy to those purposes that make return or destruction of the information infeasible.

DESIGNATION OF FIREWALL DEPARTMENT

The following classes of employees or other workforce members under the control of the Plan Administrator (sometimes referred to as the "Firewall Department" for HIPAA Privacy Rules purposes) are hereby designated in accordance with HIPAA Privacy Rules firewall provisions to be given access to protected health information for the purposes set forth in this document:

Employees assigned to and working in the Human Resources Department, including but not limited to all employees whose job duties require communication and interaction with the third party administrator for the group health plan regarding any plan administration, claims or eligibility-related matters.

The above designation includes every class of employees or other workforce members under the control of the Plan Administrator who may receive protected health information. If any of these employees or workforce members use or disclose protected health information in violation of the rules that are set out in this summary, the employees or workforce members will be subject to disciplinary action and sanctions, including the possibility of termination of employment. If the Plan Administrator becomes aware of any such violations, the Plan Administrator will promptly report the violation to the Plan and will cooperate with the Plan to correct the violation, to impose appropriate sanctions, and to mitigate any harmful effects to Plan Participants.

PLAN IS NOT AN EMPLOYMENT CONTRACT

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

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME

Washington County Health Benefit Plan

PLAN NUMBER: 501

TAX ID NUMBER: 716003197

PLAN EFFECTIVE DATE: 01/01/2003

PLAN YEAR ENDS: 12/31

EMPLOYER INFORMATION

Washington County
280 North College, Suite 510
Fayetteville, Arkansas 72701
1 (479) 444-1643

PLAN ADMINISTRATOR, NAMED FIDUCIARY AND AGENT FOR SERVICE OF LEGAL PROCESS

Human Resource Administrator
Washington County
280 North College, Suite 510
Fayetteville, Arkansas 72701
1 (479) 444-1643

CLAIMS ADMINISTRATOR

BlueAdvantage Administrators of Arkansas
P.O. Box 1460
Little Rock, Arkansas 72203-1460
1 (888) 872-2531

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

BY THIS AGREEMENT, Washington County Health Benefit Plan is hereby adopted as shown.

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

By Michelle M. Gee
Washington County

Date 5-23-2017

Witness Watson

Date 23 MAY 2017