Arkansas
BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

MANAGED BENEFITS

PREFERRED PROVIDER ORGANIZATION

COMPREHENSIVE MAJOR MEDICAL PLAN (WITH DEDUCTIBLE)

Silver Plan

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

OTHER INSURANCE REDUCES BENEFITS - READ CAREFULLY

Attached is the Schedule of Benefits showing name of Policyholder, Policy number, premiums and the effective date.

GUARANTEED RENEWABLE
CONDITIONED UPON RESIDENCE IN ARKANSAS
PREMIUMS SUBJECT TO CHANGE

THIS POLICY CONTAINS SEVERAL SPECIFIC EXCLUSIONS. SEE SECTION 4.0

ARKANSAS BLUE CROSS AND BLUE SHIELD
601 S. GAINES STREET
LITTLE ROCK, ARKANSAS 72201

ARKANSAS BLUE CROSS AND BLUE SHIELD

PREFERRED PROVIDER ORGANIZATION
COMPREHENSIVE MAJOR MEDICAL
EXPENSE POLICY

OUTLINE OF COVERAGE

If, after examination of your Policy, you are not satisfied with any of its terms or conditions, you may return it to the Company within thirty (30) days of its delivery to you and receive a full refund of all premiums.

READ YOUR POLICY CAREFULLY - This outline of coverage provides a very brief description of the important features of your Policy. The outline is not your Policy and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

MAJOR MEDICAL EXPENSE COVERAGE or (Comprehensive Health Expense Coverage) - Policies of this category are designed to provide to persons insured, coverage for major Hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily Hospital room and board, miscellaneous Hospital services, surgical services, anesthesia services, in-Hospital medical services, and out of Hospital care, subject to any Deductibles, co-payment provisions, or other limitations which may be set forth in the Policy.

BENEFITS

DEDUCTIBLE: For individual coverage, a Covered Person must pay the cost of Covered Services equal to the individual calendar year deductible as stated in the Schedule of Benefits. For family coverage, one family member must pay the cost of Covered Services equal to the individual calendar year deductible and the remaining family members collectively pay the cost of Covered Services equal to the family calendar year deductible as stated in the Schedule of Benefits.

PRIMARY CARE PHYSICIAN (PCP) SELECTION. You are encouraged to select and maintain a patient-physician relationship with a PCP. A PCP can be helpful to you in managing your health care. The PCP selected must be an In-network Physician listed in the Preferred Provider Directory as a PCP and must be accepting new patients. You may contact Customer Service to select a PCP or change your PCP. The Provider Directory is available at WWW.ARKANSASBLUECROSS.COM. If you fail to select a PCP, the Company will recommend a PCP in your community who is working with us to make health care easier and more affordable. We hope you'll call the recommended PCP and make an appointment—you may even get a call from his/her office asking to see you. Of course, if you prefer a different PCP, please let us know by calling 1-800-238-8379. PCP changes are effective on the first day of the following month.

PREFERRED PROVIDER ORGANIZATION: Covered Benefits received from a Non-Preferred Provider, except in certain circumstances (see Section 5.0), are paid at a rate less than the same Covered Benefits received from a Preferred Provider. (See your Schedule of Benefits.)

COVERED SERVICES: SUBJECT TO PAYMENT OF YOUR COINSURANCE (CHECK YOUR SCHEDULE OF BENEFITS FOR APPROPRIATE PERCENTAGE) THE POLICY PAYMENT OF THE ARKANSAS BLUE CROSS AND BLUE SHIELD ALLOWANCE OR ALLOWABLE CHARGE;

Daily Hospital room and board
Miscellaneous Hospital services

(drug, lab, x-ray, etc.)
Surgical services
Anesthesia services
In-Hospital medical visits
Out of Hospital care

AGE LIMITATIONS: Dependent Children are covered in accordance with Policy guidelines. You are responsible for changes in coverage status (from individual to family or from family to individual).

ANNUAL LIMITATION ON COST SHARING: PLEASE CHECK YOUR SCHEDULE OF BENEFITS TO DETERMINE THE AMOUNT OF YOUR ANNUAL LIMITATION ON COST SHARING. REFER TO THE PROVISION OF SECTION 5.2 OF YOUR POLICY.

SPECIAL LIMITATIONS:

Check your Schedule of Benefits for appropriate coinsurance percentage of payment.

Physical, Occupational, Speech, and Chiropractic Therapy	Maximum of 30 combined visits per calendar year per Covered Person.
Ambulance	Maximum payment of $1,000 per trip for ground or water Ambulance Services, subject to the Deductible and Coinsurance; Maximum payment of $5,000 per trip for air Ambulance Services, subject to the Deductible and Coinsurance.
Skilled Nursing Facilities	Maximum of 60 days per calendar year per Covered Person.
Residential Treatment Centers	Maximum of 60 days per calendar year per Covered Person.
Neurologic Rehabilitation Facilities	Maximum of 60 days per lifetime per Covered Person.
Home Health Services	Maximum of 50 visits per calendar year per Covered Person.

BENEFITS AND SERVICES ARE NOT INCLUDED FOR:

- Surgical and nonsurgical treatment of obesity;
- Injuries or diseases caused by war;
- adult dental services, except for oral surgery, see Section 3.21, and adult dental services needed because of an accident, see Section 3.22;
- adult eye refractions;
- adult eyeglasses unless needed because of accidental injury, see Section 3.13.4;
- cosmetic surgery, see Section 3.23, unless needed because of accidental injury;
- Health Interventions not meeting primary coverage criteria;
- medical or Hospital service collectible under Worker's Compensation;
- services rendered in government Hospitals, unless otherwise required by applicable law; and
- inpatient services, including electrocardiograms, x-rays, and laboratory examinations, if they could have been performed safely and adequately on an outpatient basis.

Guaranteed Renewable/Conditioned upon Residence in Arkansas

This Policy and riders are guaranteed renewable so long as you reside in Arkansas. The Company may change the established premium rate, but only if the rate is changed for all policies and riders of the same form number and premium classification.

NON-DISCRIMINATION AND LANGUAGE ASSISTANCE NOTICE

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

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

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

Civil Rights Coordinator
601 Gaines Street, Little Rock, AR 72201
Phone: 1-844-662-2276; TDD: 1-844-662-2275

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

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

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

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

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-844-662-2276.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-662-2276.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-844-662-2276.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-662-2276

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-662-2276 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-662-2276.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-662-2276.

ملاحظة: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية مجانا. دعوة 1-844-662-2276 العدد.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-844-662-2276.

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-662-2276.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-844-662-2276.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-844-662-2276.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-844-662-2276.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-844-662-2276 まで、お電話にてご連絡ください。

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-662-2276.

ملاحظة: إذا كنت تتحدث باللغة الفارسية، والخدمات اللغوية المقدمة مجانا بالنسبة لك. يرجى الاتصال 1-844-662-2276.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-844-662-2276.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-844-662-2276 पर कॉल करें।

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-844-662-2276.

انتباہ: آپ اردو بولتے ہیں تو، زبان کی مدد کی خدمات بلا معاوضہ دستیاب ہیں. کال کریں 1-844-662-2276

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-844-662-2276.

LALE: Ñe kwōj kōnono Kajin Ṃajōḷ, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejjeḷọk wōṇāān. Kaalọk 1-844-662-2276

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SCHEDULE OF BENEFITS

1.0 HOW THE COVERAGE UNDER YOUR INSURANCE POLICY WORKS

1.1 Through premium payments, you have purchased a Plan of insurance benefits ("Plan") described in this Policy, which is issued by Arkansas Blue Cross and Blue Shield, ("the Company"). This Policy provides you valuable health insurance, but you should understand clearly that the Plan does NOT cover all medical services, drugs, supplies, tests or equipment ("Health Interventions" or "interventions"). A Plan covering all Health Interventions would be prohibitively expensive. For that reason, we have offered and you have purchased a more limited Plan. This Policy, together with your application and any riders or endorsements signed by the President of the Company, is the contract that describes what you have and have not purchased; in other words, what is and is not eligible for benefits under your Plan. **Accordingly, you should read this entire document carefully both now and BEFORE you obtain medical services to be sure you understand what is covered and the limitations on your coverage.**

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

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

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

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

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

1.5 **Specific Limitations in Your Plan.** Because of the high cost of some Health Interventions, as well as the difficulty in some cases of determining whether an intervention is really needed, we include coverage for such Health Interventions but place limits on the extent of coverage by limiting the number of Provider visits or treatments, or treatment received during a calendar year or other specified time period. Examples of such limitations include a limit on the number of covered visits for home health services, physical, occupational and speech therapy. Other types of limitations include requirements that an intervention be provided in a particular location or by a Provider holding a particular type of license, or in accordance with a written treatment plan or other documentation. Common benefits and limitations are outlined in detail in Section 3.0 of this document. You will note that this document refers to Coverage Policies we have developed that may address limitations of coverage for a particular service, treatment or drug. You may request a copy of our Coverage Policy with respect to a particular service, treatment or drug, or, if you have Internet access, you may review all our established Coverage Policies on our web site at WWW.ARKANSASBLUECROSS.COM

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

1.7 **Provider Network and Cost Sharing Procedures.** Your plan does not provide coverage for a Health Intervention unless it is provided by a Provider as defined in this Plan. See Subsection 9.83.

Your plan does not provide coverage for one hundred percent of the costs associated with covered Health Interventions. You are expected to pay an initial amount of covered Allowable Charges you incur each calendar year. This amount is called a "Deductible." After you have paid the Deductible, you may pay a percentage of Allowable Charges called "Coinsurance;" In addition, for certain Health Interventions you will have to pay a fixed dollar amount called a "Copayment." Once your Deductible, Coinsurance and Copayments reach a specified amount, called an "Annual Limitation on Cost Sharing," the Company will pay one hundred percent of covered Allowable Charges you incur until the end of the calendar year.

Provider networks are designed to try to hold down the costs of your Plan through discounted medical fees that the Company has negotiated with these Providers. Your Plan includes incentives in the form of lower Deductible, lower Coinsurance and a lower Copayment to encourage you to consult and seek treatment from physicians, Hospitals and other health care Providers who participate in our Provider network, called "Preferred Providers." A full explanation of the Deductible, Coinsurance and Copayment applicable to your Plan are set out in Section 5.0 and the Schedule of Benefits.

You and your physician are always free to make any decision you believe is best for you concerning whether to receive any particular service or treatment, or whether to see any practitioner or Provider (in or out of the network). However, if you go "out-of-network" for services or treatment, your coverage will be reduced or limited to the out-of-network rate. There are exceptions to the network procedures; for example Emergency Care or if, prior to your effective date of coverage, you were engaged with a Non-Preferred Provider for a scheduled procedure and you receive PRIOR approval from the Company to continue at the Preferred Provider benefit level for the scheduled procedure. Unless one of these exceptions apply, if you want to receive the full benefit of your Plan, you should check in advance to see if the Provider is a Preferred Provider. Preferred Providers are identified in our published Provider directory, or you may call Customer Service to ask about a specific Provider, or visit our web site at WWW.ARKANSASBLUECROSS.COM

1.8 **Eligibility Standards.** You must be eligible for benefits under your Plan at the time you receive a Health Intervention. Eligibility standards are set forth in Section 6.0 of this document. All premiums must be timely paid. It is important to understand the provisions of Section 6.0 that outline the circumstances under which your Policy may terminate.

1.9 **Claim Filing Procedures.** Your Plan provides procedures that you, your Provider or your Authorized Representative must follow in filing claims with the Company. Your failure to follow these procedures could result in significant delays in the processing of your claim, as well as potential denial of benefits. These procedures are set out in Section 7.0. In addition, Section 7.0 explains how you can appeal a benefit determination in the event you believe that such benefit determination does not comply with the terms of the Plan.

1.10 **Other Provisions.** Certain important matters, including financial incentives for Providers not otherwise described in this Policy, are set out in Section 8.0. Section 9.0 is a glossary of defined terms used in the Policy.

1.11 **Membership in Arkansas Blue Cross and Blue Shield.** As the owner of this Policy, the Policyholder is a Member of Arkansas Blue Cross and Blue Shield. Section 10.0 describes the meetings of Members, gives notice of the Annual Meeting of Members, and describes a Member's voting rights.

2.0 PRIMARY COVERAGE CRITERIA

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

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

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

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

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

1. **Effective defined**

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

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

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

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

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

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

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

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

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

3. **Professional Standards defined.** "Professional standards," for purposes of applying the "effectiveness" standard of the Primary Coverage Criteria to an existing Intervention, shall mean

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

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

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

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

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

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

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

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

   f. Coverage Policy - With respect to certain drugs, treatments, services, tests, equipment or supplies, the Company has developed specific Coverage Policies, which have been

put into writing, and are published on the Company's web site at WWW.ARKANSASBLUECROSS.COM. If the Company has developed a specific Coverage Policy that applies to the drug, treatment, service, test, equipment or supply that you received or seek to have covered under your Plan, the Coverage Policy shall be deemed to be determinative in evaluating whether such drug, treatment, service, test, equipment or supply meets the Primary Coverage Criteria; **however, the absence of a specific Coverage Policy with respect to any particular drug, treatment, service, test, equipment or supply shall not be construed to mean that such drug, treatment, service, test, equipment or supply meets the Primary Coverage Criteria.**

2. You may appeal a determination by the Company that an Intervention does not meet the Primary Coverage Criteria to the Appeals Coordinator. Use the procedures for appeals outlined in Sections 7.2 and 7.3.
3. Any appeal available with respect to a Primary Coverage Criteria determination shall be subject to the terms, conditions and definitions set forth in the Primary Coverage Criteria. An appeal shall also be subject to the terms, conditions and definitions set forth elsewhere in this Plan. The Appeals Coordinator or an External Review organization shall render its independent evaluation so as to comply with and achieve the intended purpose of the Primary Coverage Criteria and other provisions of this Plan.

3.0 BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN

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

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

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

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

   You are encouraged to select and maintain a patient-physician relationship with a PCP. A PCP can be helpful to you in managing your health care. The PCP selected must be an In-network Physician listed in the Preferred Provider Directory as a PCP and must be accepting new patients. You may contact Customer Service to select a PCP or change your PCP.

   Please note: Services performed by a Non-Preferred Provider are subject to the Out-of-Network Deductible and Coinsurance, not the Primary Care Physician copayment.
2. **Specialty Care Physician Office Visits.** Coverage is provided for the diagnosis and treatment of illness or injury when provided in the medical office of the Specialty Care Physician. The Covered Person is responsible for any Copayment, Deductible, and Coinsurance specified in the Schedule of Benefits.

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

3. **Physician Hospital Visits.** Coverage is provided for services of Physicians for diagnosis, treatment and consultation while the Covered Person is admitted as an inpatient in a Hospital for Covered Services. Physician Hospital Visits will be considered to have Prior Approval from the Company if the physician visit is related to a diagnosis for which an inpatient stay has received Prior Approval from the Company. For more information about pre-service claims and Prior Approval, please see Subsection 7.1.3.b.

4. **Surgical Services.** Coverage is provided for services of Physicians for surgery, either as an inpatient or outpatient, subject to Prior Approval from the Company. If coverage is provided for two (2) or more surgical operations performed during the same surgical encounter or for bilateral procedures, payment for the secondary or subsequent procedure will be made at a reduced rate. In general, overall payment for one or more procedures during the same operative setting will be no more than if the procedures had been done by one Physician. Details as to how such payments are calculated are provided to In-Network Physicians through Provider News and Coverage Policy. **Failure of the Covered Person or the Covered Person's treating Provider to submit a pre-service claim for Prior Approval will result in a denial of coverage. PLEASE NOTE: Prior Approval does not guarantee payment or assure coverage, it means only that the information furnished to the Company at the time indicates that the surgical services meets the Primary Coverage Criteria requirements set out in Subsection 2.2 and the application of the Primary Coverage Criteria set out in Subsections 2.4.1.b., e., or f. and is not subject to a Specific Plan Exclusion (see Section 4.0). All Health Interventions receiving Prior Approval must still meet all other coverage terms, conditions and limitations, and coverage for these services may still be limited or denied, if, when the claims for the services are received by us, investigation shows that a benefit exclusion or limitation applies because of a difference in the Health Interventions described in the pre-service claim and the actual Health Intervention, that the Covered Person ceased to be eligible for benefits on the date the services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in this Policy. For more information about pre-service claims and Prior Approval, please see Subsection 7.1.3.b.**

5. **Telephone and Other Electronic Consultation.** Subject to all other terms, conditions, exclusions, and limitations of this Plan set forth in this Policy,
   i. Coverage is provided for Telemedicine services performed by a Provider licensed, certified, or otherwise authorized by the laws of Arkansas to administer health care in the ordinary course of the practice of his or her profession at the same rate as if it had been performed in-person.
   ii. However, electronic consultations such as, but not limited to, telephonic, interactive audio, fax, email, or for services that are, by their nature, hands-on (e.g. surgery, interventional radiology, coronary, angiography, anesthesia, and endoscopy) are not covered.
   iii. Communications made by a Physician responsible for the direct care of a Covered Person in Case Management with involved health care Providers, however, are covered.

6. **Assistant Surgeon Services.** Not all surgeries merit coverage for an assistant surgeon. Further, the Company's payment for a covered assistant surgeon shall be limited to one Physician qualified to act as an assistant for the surgical procedure. Surgical first assistants are not covered (see Section 4.1.11).

7. **Standby Physicians.** Services of standby physicians are only covered in the event such physician is required to assist with certain high-risk services specified by the Company, and only for such time as such physician is in immediate proximity to the patient.

8. **Abortions.** Abortions are not covered, see Subsection 4.2.1. Pregnancy terminations under the direction of a Physician are covered, but only when performed in an In-Network Hospital or Outpatient Hospital setting.

3.2 **Preventive Health Services.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, the Company will pay one hundred percent (100%) of the Allowance or Allowable Charges for the routine preventive health services listed below when provided by an In-Network Primary Care Physician or an advanced practice nurse or physician's assistant who provides primary medical care

in the areas of general practice, pediatrics, family practice, internal medicine or obstetrics/gynecology, which are performed in the Primary Care Physician's office. Coverage is also provided for certain preventive health services listed below when performed in an In-Network Outpatient Hospital or Ambulatory Surgery Center setting when the service cannot be performed in an office by a Primary Care Physician.

1. evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force but not for the related treatment of disease; and
2. routine immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and
3. with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this subsection; and
5. the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention, unless state law provides a greater benefit.

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

1. **Inpatient Hospital Services.** Coverage is provided for inpatient Hospital services subject to Prior Approval and the following specific limitations:
   a. Prior Approval. All Hospital admissions are subject to Prior Approval from the Company**. Failure of the Covered Person or the Covered Person's treating Provider to submit a pre-service claim for Prior Approval will result in a denial of coverage. PLEASE NOTE: Prior Approval does not guarantee payment or assure coverage, it means only that the information furnished to the Company in the pre-service claim indicates that the Inpatient Hospital Services meet the Primary Coverage Criteria requirements set out in Subsection 2.2 and the Application of the Primary Coverage Criteria set out in Subsections 2.4.1.b., e., or f. and is not subject to a Specific Plan Exclusion (see Section 4.0). All Health Interventions receiving Prior Approval must still meet all other coverage terms, conditions and limitations, and coverage for these services may still be limited or denied, if, when the claims for the services are received by us, investigation shows that a benefit exclusion or limitation applies because of a difference in the Health Interventions described in the pre-service claim and the actual Health Intervention, that the Covered Person ceased to be eligible for benefits on the date the services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in this Policy. For more information about pre-service claims and Prior Approval, please see Subsection 7.1.3.b.**
   b. Payment for Hospital charges for inpatient admissions shall be limited to the lesser of the billed charge or the Allowance or Allowable Charge established by the Company.
   c. If you have a condition requiring that you be isolated from other patients, the Company will pay for an isolation unit equipped and staffed as such.
   d. In the event services are rendered for a covered benefit during an inpatient admission to a Hospital where the admitting diagnosis was for a non-covered benefit, the Company will pay that portion of the Hospital charge which is attributable to services rendered for the covered benefit.
   e. The services of social workers shall be included in the basic daily room and board allowance.
   f. Services rendered in a Hospital in a country outside of the United States of America shall not be paid except at the sole discretion of the Company.

2. **Outpatient Hospital Services. Certain Outpatient Hospital Services are subject to Prior Approval. For a list of those services, please visit the Company's web site at WWW.ARKANSASBLUECROSS.COM.** Coverage is provided for services, including but not limited to chemotherapy and renal dialysis, in an Outpatient Hospital, Outpatient Surgery Center, or Outpatient Radiation Therapy Center.

   a. If you use an out of state Outpatient Surgery Center, payment for all such services, including Professional Services, will be denied. See Subsection 3.4.

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

3. **Hospital Services in Connection with Dental Treatment.** Subject to Prior Approval from the Company, coverage is provided for Hospital services, including anesthesia, services in connection with treatment for a complex dental condition provided to: (i) a Covered Person under seven (7) years of age who is determined by two (2) dentists (in separate practices) to require the dental treatment without delay; (ii) a Covered Person with a diagnosis of serious mental or physical condition; or (iii) a Covered Person, certified by his or her Primary Care Physician to have a significant behavioral problem. **Failure of the Covered Person or the Covered Person's treating Provider to submit a pre-service claim for Prior Approval will result in a denial of service. PLEASE NOTE: Prior Approval does not guarantee payment or assure coverage, it means only that the information furnished to the Company in the pre-service claim indicates that the Hospital services meet the Primary Coverage Criteria requirements set out in Subsection 2.2 and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b., e., or f. and is not subject to a Specific Plan Exclusion (see Section 4.0).All Health Interventions must still meet all other coverage terms, conditions and limitations, and coverage for these services may still be limited or denied, if, when the claims for the services are received by us, investigation shows that a benefit exclusion or limitation applies because of a difference in the Health Intervention described in the pre-service claim and the actual Health Intervention, that the Covered Person ceased to be eligible for benefits on the date the services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in this Policy. For more information about pre-service claims and Prior Approval, please see Subsection 7.1.3.b.**

3.4 **Ambulatory Surgery Center. Certain services provided in an Ambulatory Surgery Center are subject to Prior Approval. For a list of those services, please visit the Company's web site at WWW.ARKANSASBLUECROSS.COM.**Subject to the Deductible, Copayment, and Coinsurance specified in the Schedule of Benefits, coverage is provided for specific surgical services received at an Ambulatory Surgery Center when performed or prescribed by a Physician and Prior Approved by the Company.

1. Covered services include diagnostic imaging and laboratory services required to augment a surgical service and performed on the same day as such surgical service.

2. Ambulatory Surgery Center services in connection with treatment for a complex dental condition are provided in accordance with Subsection 3.3.3.

3. If you use an out of state Ambulatory Surgery Center, payment for all such services, including Professional Services, will be denied.

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

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

3.6 **Advanced Diagnostic Imaging Services.** Unless the Advanced Diagnostic Imaging Services are provided in accordance with Emergency Care Services (See Subsection 3.12), computed tomography scanning ("CT SCAN"), Magnetic Resonance Angiography or Imaging ("MRI/MRA"), Nuclear Cardiology and positron emission tomography scans ("PET SCAN") (collectively referred to as "Advanced Diagnostic Imaging") require Prior Approval from the Company. **Failure of the Covered Person or the Covered Person's treating Provider to submit a pre-service claim for the Prior Approval will result in denial of coverage. PLEASE NOTE: Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished to the Company in the pre-service claim indicates that the CT SCAN, MRI/MRA, Nuclear Cardiology or PET SCAN meets the Primary Coverage Criteria requirements set out in Subsection 2.2 and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b., e., or f. and is not subject to a Specific Plan Exclusion (see Section 4.0). All Health Interventions receiving Prior Approval must still meet all other coverage terms, conditions and limitations, and coverage for these services may still be limited or denied, if, when the claims for the services are received by us, investigation shows that a benefit exclusion or limitation applies because of a difference in the Health Intervention described in the pre-service claim and the actual Health Intervention, that the Covered Person ceased to be eligible for benefits on the date the services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in this Policy. For more information about pre-service claims and Prior Approval, please see Subsection 7.1.3.b.**

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

1. **Maternity and Obstetrical Care.**

   a. Coverage is provided for Maternity and Obstetrical Care, including Routine Prenatal Care and postnatal care, use of Hospital delivery rooms and related facilities, and any special procedures as may be necessary.

   b. Routine Prenatal Care includes the coverage of one routine ultrasound only. See Subsection 4.2.98 concerning exclusion of additional routine ultrasounds.

   c. **Notification**. Coverage for Maternity and Obstetrical Care requires the Covered Person or the Covered Person's treating Provider to notify the Company of a pregnancy. You are encouraged to notify the Company within the first trimester.

2. **Midwives**. Services provided by any lay midwife are not covered. See Subsection 4.1.4. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, coverage is provided for services provided by a certified nurse midwife who has a collaborative agreement with a Physician who is within immediate proximity to the Hospital utilized by the certified nurse midwife, in case there is need for assistance during the delivery.

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

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

4. **Family Planning Services**. Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, coverage is provided for the following family planning services when authorized and provided by In-Network Physicians:
   a. Counseling and planning services for Infertility;
   b. Pregnancy terminations under the direction of a Physician are covered, but only when performed in an In-Network Hospital or In-Network Outpatient Hospital setting. Abortion is not covered. See Subsection 4.2.1.
   c. Oral Contraceptives are covered under Subsection 3.24 - Medications;
   d. Voluntary sterilizations (vasectomies and tubal ligations). Reversal of a voluntary sterilization is not covered.

5. **Allowable Charges for Infertility Testing, Artificial Insemination and In Vitro Fertilization.** Subject to all terms, conditions, exclusions, and limitations of the Plan as set forth in this Policy, and **written Prior Approval** from the Company, coverage is provided for Allowable Charges for the above-referenced services when the criteria, as defined in the applicable Coverage Policy, is established and the services are provided by an In-Network Provider. **Failure of the Covered Person's treating Provider to submit a pre-service claim for Prior Approval will result in denial of coverage. PLEASE NOTE: Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished to us at the time indicates that the requested testing, artificial insemination or in vitro fertilization procedures meet the Primary Coverage Criteria requirements set out in Subsection 2.2 and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b., e., or f. and is not subject to a Specific Plan Exclusion (see Section 4.0). All Health Interventions must still meet all other coverage terms, conditions, and limitations. Coverage for approved services may still be limited or denied if, when the claims are received by us, investigation shows that a benefit exclusion or limitation applies because of a difference in the Health Intervention described in the pre-service claim and the actual Health Intervention, that the 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 this Policy. For more information about pre-service claims and Prior Approval, please see Subsection 7.1.3.b.**
   a. **Infertility Diagnostic Testing**. Coverage is provided for certain diagnostic testing of a Covered Person, as set out in the Coverage Policy, to establish or confirm a diagnosis of infertility.
   b. **Artificial Insemination.** Coverage is provided for artificial insemination when the Covered Person has a medically documented inability to conceive due to a diagnosis of infertility listed in the Coverage Policy. .

Coverage is provided for no more than six cycles. If pregnancy does not occur in the first six cycles, a Covered Person may request Prior Approval from the Company for an additional six cycles.

c. **In-vitro Fertilization.** Coverage is provided for in-vitro fertilization when the criteria, as defined in the applicable Coverage Policy, is established. The Covered Person's oocytes must be fertilized with the sperm of the Covered Person's Spouse unless the reason for infertility is related to the absence of sperm in the Spouse or the absence of oocytes in the Covered Person; or the presence of enviable sperm in the Spouse or enviable oocytes in the Covered Person.

The in-vitro fertilization procedure must be performed by a Board Certified Reproductive Endocrinology and Infertility Physician Specialist in order to be eligible for benefits. The in-vitro fertilization benefit is limited to four complete oocyte retrievals per lifetime of the member or two live births from separate pregnancies as a result of the in vitro fertilization procedures. After a first live birth is achieved as a result of a successful in vitro fertilization cycle, up to two additional complete oocyte retrievals may be covered. All viable embryos, fresh or frozen, must be used before undergoing additional oocyte retrieval.

d. **Exclusions of Infertility and In-Vitro Fertilization Coverage.** Benefits for infertility diagnostic testing, artificial insemination and in-vitro fertilization are not available if:

i. the Covered Person or his or her Spouse has previously had a voluntary sterilization; or

ii. the infertility is related to natural age related hormone reduction (i.e. postmenopausal or 45 years of age or older); or

iii. a surrogate is used; or

iv. one of the Covered Persons has previously had three live births by any means.

e. No benefits are available for post-coital testing of cervical mucus, screening for anti-sperm antibodies, hamster testing, sperm penetration assay, assisted hatching, co-culture of embryos, cryopreservation of ovarian tissue or oocytes, cryopreservation of testicular tissues in prepubertal boys, or for storage or thawing of ovarian tissue, oocytes or testicular tissue.

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

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

3.8 **Complication of Pregnancy.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, coverage is provided for treatment of Complications of Pregnancy when performed or prescribed by a Physician, subject to the Deductible and Coinsurance amounts specified in the Schedule of Benefits. See Subsection 9.14 for the definition of Complications of Pregnancy.

3.9 **Rehabilitation and Habilitation Services.** Subject to all terms, conditions, exclusions, and limitations of the Plan as set forth in this Policy and Prior Approval from the Company, coverage is provided for Rehabilitation and Habilitation when performed or prescribed by an In-Network Physician and performed in an In-Network facility. Such therapy and developmental services include physical and occupational therapy as well as services provided for developmental delay, developmental speech or language disorder, developmental coordination disorder and mixed developmental disorder. Therapy must be

performed by an appropriate registered physical, occupational or speech-language therapist licensed by the appropriate State Licensing Board and must be furnished in accordance with a written treatment Plan established and certified by the treating Physician. Developmental Services must be provided by a provider licensed by the state or certified by an organization approved by the Company, and must be furnished in accordance with a written treatment plan established and certified by the treating Physician. This benefit is subject to the Copayment and/or Deductible and Coinsurance specified in the Schedule of Benefits. **Failure of the Covered Person's treating Provider to submit a pre-service claim for Prior Approval will result in denial of coverage. PLEASE NOTE: Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished to us at the time indicates that the Rehabilitation and Habilitation Services meet the Primary Coverage Criteria requirements set out in Subsection 2.2 and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b., e., or f. and is not subject to a Specific Plan Exclusion (see Section 4.0). All Health Interventions receiving Prior Approval must still meet all other coverage terms, conditions, and limitations. Coverage for approved services may still be limited or denied if, when the claims are received by us, investigation shows that a benefit exclusion or limitation applies because of a difference in the Health Intervention described in the pre-service claim and the actual Health Intervention, that the 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 this Policy. For more information about pre-service claims and Prior Approval, please see Subsection 7.1.3.b.**

1. **Rehabilitation Services**
    a. **Inpatient Therapy.** Coverage is provided for inpatient therapy services, including professional services, when performed or prescribed by a Physician and rendered in a Hospital. Inpatient stays for therapy are limited to sixty (60) days per Covered Person per Calendar Year.
    b. **Outpatient Therapy.** Coverage is provided for outpatient therapy services when performed or prescribed by a Physician. Coverage for outpatient visits for physical therapy, occupational therapy, speech therapy and chiropractic services is limited to an aggregate maximum of thirty (30) visits per Covered Person per Calendar Year. See Subsection 9.67 - Outpatient Therapy Visit.
    c. **Cardiac and Pulmonary Rehabilitation Therapy.** Coverage for cardiac and pulmonary rehabilitation therapy is provided in accordance with Coverage Policy. Coverage for cardiac rehabilitation therapy limited to a maximum of 36 visits per Covered Person per Calendar Year. However, coverage is not provided for cardiac or pulmonary rehabilitation therapy from Freestanding Facilities. Peripheral vascular disease rehabilitation therapy is not covered. See Subsection 4.2.79.
    d. **Cognitive Rehabilitation.** Cognitive Rehabilitation is generally not covered. See Subsections 4.2.16 and 9.11.
    e. **Radio-Frequency Thermal Therapy.** The use of radio-frequency thermal therapy for treatment of orthopedic conditions is not covered. See Subsection 4.2.81. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, coverage for radio-frequency thermal therapy is provided and included in the payment for the primary procedure of the orthopedic condition.
2. **Habilitation Services**
    a. **Outpatient Therapy.** Coverage is provided for outpatient therapy services when performed or prescribed by a Physician. Coverage for outpatient visits for physical therapy, occupational therapy, speech therapy and chiropractic services is limited to an aggregate maximum of thirty (30) visits per Covered Person per Calendar Year. See Subsection 9.67 - Outpatient Therapy Visit.
    b. **Developmental Services.** Coverage is provided for Developmental Services when performed or prescribed by a Physician and is limited to a maximum of 180 Developmental Services Visits per Covered Person per Calendar Year. See Subsection 9.26 - Developmental Service Visit.
    c. **Durable Medical Equipment.** Durable Medical Equipment required for Habilitation is covered in accordance with Subsection 3.13.

3.10 **Mental Illness and Substance Use Disorder.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy as well as the Deductible, Copayment and Coinsurance set out in the Schedule of Benefits and Prior Approval from the Company, coverage is provided for Health Interventions to treat Mental Illness and Substance Use Disorder. **Failure of the Covered Person's treating Provider to submit a pre-service claim for Prior Approval will result in denial of coverage. PLEASE NOTE: Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished to us at the time indicates that the Health Intervention to treat Mental Illness and Substance Use Disorder meets the Primary Coverage Criteria requirements set out in Subsection 2.2 and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b., e., or f. and is not subject to a Specific Plan Exclusion (see Section 4.0). All Health Interventions receiving Prior Approval must still meet all other coverage terms, conditions, and limitations. Coverage for approved services may still be limited or denied if, when the claims are received by us, investigation shows that a benefit exclusion or limitation applies because of a difference in the Health Intervention described in the pre-service claim and the actual Health Intervention, that the 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 this Policy. For more information about pre-service claims and Prior Approval, please see Subsection 7.1.3.b.**

1. **Inpatient, Partial Hospitalization Program and Intensive Outpatient Program Health Interventions.** Coverage for Inpatient Hospitalization, Partial Hospitalization Programs or Intensive Outpatient Programs for Mental Illness or Substance Use Disorder Health Interventions is subject to the following requirements.
    a. Inpatient Hospitalization requires a patient to receive Covered Services 24 hours a day as an inpatient in a Hospital.
    b. Partial Hospitalization Programs generally require the patient to receive Covered Services six to eight hours a day, five to seven days per week in a Hospital outpatient setting.
    c. Intensive Outpatient Programs generally require the patient to receive Covered Services lasting two to four hours a day, three to five days per week in a Hospital outpatient setting.
2. **Non-Hospital Health Interventions.**
    a. Coverage is provided for a Health Intervention provided during an office visit with a Psychiatrist, Psychologist or other Provider licensed to provide treatment for Mental Illness or Substance Use Disorder.
    b. Coverage is provided for a Health Intervention at a Residential Treatment Facility for Mental Illness or Substance Use Disorder.
        i. The facility is licensed by the State of Arkansas or the appropriate agency in the state where the facility is located.
        ii. The facility is accredited by The Joint Commission (TJC) or the Commission on Accreditation of Rehabilitation Facilities (CARF International).
        iii. A request for Prior Approval must be submitted to the Company prior to admission to the residential treatment facility **Failure of the Covered Person's treating Provider to submit a pre-service claim for Prior Approval will result in denial of coverage. PLEASE NOTE: Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished to us at the time indicates that the Health Intervention at the residential treatment facility meets the Primary Coverage Criteria requirements set out in Subsection 2.2 and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b., e., or f. and is not subject to a Specific Plan Exclusion (see Section 4.0). All Health Interventions receiving Prior Approval must still meet all other coverage terms, conditions, and limitations. Coverage for approved services may still be limited or denied if, when the claims are received by us, investigation shows that a benefit exclusion or limitation applies because of a difference in the Health Intervention described in the pre-service claim and the actual Health Intervention, that the 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 this Policy. For more information about pre-service claims and Prior Approval, please see Subsection 7.1.3.b.

iv. Coverage is provided for a maximum of 60 days per Covered Person per calendar year.

v. The services must be of a temporary nature and required to increase ability to function.

vi. Custodial care is not covered.

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

4. Hypnotherapy is not covered for any diagnosis or medical condition. See Subsection 4.2.51.

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

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

1. Covered Persons with autism spectrum disorder.

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

Category	Limits
Applied Behavioral Analysis Assessment:	up to six (6) hours up to twice yearly;
Applied Behavioral Analysis BCBA services:	up to eight (8) hours per week for fifty (50) weeks;
Applied Behavioral Analysis Treatment by Behavioral Technician, a Board Certified Associate Behavioral Analyst or a Board Certified Behavioral Analyst (direct or line):	up to forty (40) hours per week for fifty (50) weeks

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

3.12 **Emergency Care Services.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, coverage is provided for Emergency Care. When Emergency Care is needed the Covered Person should seek care at the nearest facility. Emergency Care is subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits. If the Covered Person is admitted as an inpatient to the same Hospital where Emergency Care was rendered, the Emergency Care Copayment is waived and all services are subject to the inpatient Deductible, Copayment and Coinsurance.

1. **After-Hours Clinic or Urgent Care Center.** Services provided in an after-hours or urgent care center are subject to the Urgent Care Center Deductible, Copayment and Coinsurance for each visit.
2. **Observation Services.** Observation services are covered when ordered by a Physician. Observation Services ordered in conjunction with an emergency room visit or outpatient visit are subject to the Emergency Care Deductible, Copayment and Coinsurance for each visit.
3. **Transfer to In-Network Hospital.** Continuing or follow-up treatment for Injury or Emergency Care is limited to care that meets Primary Coverage Criteria before you can be safely transferred, without medically harmful or injurious consequences, to an In-Network Hospital. Services are subject to all applicable Deductible, Copayment and Coinsurance.
4. **Hospital Admissions.** A Hospital admission subsequent to Emergency Care services requires the Covered Person or the Covered Person's treating Provider to notify the Company of an emergency admission to a Hospital within 24 hours or the next business day and receive approval from the Company. **PLEASE NOTE: Approval does not guarantee payment or assure coverage; it means only that the information furnished to us at the time indicates that the Hospital admission meets the Primary Coverage Criteria requirements set out in Subsection 2.2 and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b., e., or f. and is not subject to a Specific Plan Exclusion (see Section 4.0). All Health Interventions receiving approval must still meet all other coverage terms, conditions, and limitations. Coverage for approved services may still be limited or denied if, when the claims are received by us, investigation shows that a benefit exclusion or limitation applies because of a difference in the Health Intervention described in the approved claim and the actual Health Intervention, 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 this Policy.**
5. **Medical Review of Emergency Care.** Emergency Care is subject to medical review. If, based upon the signs and symptoms presented at the time of treatment as documented by attending health care personnel, the Company determines that a visit to the emergency room fails to meet the definition of Emergency Care as set out in this Policy (See Subsection 9.31 - Emergency Care), coverage shall be denied and the emergency room charges will become the Covered Person's liability.
6. **Allowable Charge**. If You need Emergency Care, the Company will cover you at the highest Allowance or Allowable Charge that federal regulations allow. You will have to pay any charges that exceed the Allowance or Allowable Charge as well as for any Deductibles, Coinsurance, Copayments and amounts that exceed any benefit maximum.

3.13 **Durable Medical Equipment.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, coverage is provided for Durable Medical Equipment (DME) when prescribed by an In-Network Physician according to the guidelines specified below. This benefit, together with the benefit for equipment under Subsection 3.19, Home Health Services, is subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits.

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

3. Durable Medical Equipment for which the cost exceeds $500 requires Prior Approval from the Company. **Failure of the Covered Person's treating Provider to submit a pre-service claim for Prior Approval will result in denial of coverage. PLEASE NOTE: Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished to us at the time indicates that the Durable Medical Equipment meets the Primary Coverage Criteria requirements set out in Subsection 2.2 and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b., e., or f. and is not subject to a Specific Plan Exclusion (see Section 4.0). All Health Interventions receiving Prior Approval must still meet all other coverage terms, conditions, and limitations. Coverage for approved services may still be limited or denied if, when the claims are received by us, investigation shows that a benefit exclusion or limitation applies because of a difference in the Health Intervention described in the pre-service claim and the actual Health Intervention, that the 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 this Policy. For more information about pre-service claims and Prior Approval, please see Subsection 7.1.3.b**
4. For adults, a single acquisition of eyeglasses or contact lenses within the first six months following cataract surgery is covered. (See Section 3.31 - Pediatric Vision Services for coverage of lenses for children.) With respect to such eyeglasses or contact lenses, tinting or anti-reflective coating and progressive lenses are not covered. The Allowance or Allowable Charge is based on the cost for basic glasses or contact lenses. Eyeglass frames are subject to a $65 maximum Allowance or Allowable Charge.
5. Replacement of DME is covered only when necessitated by normal growth or when it exceeds its useful life. Maintenance and repairs resulting from misuse or abuse of DME are the responsibility of the Covered Person.
6. When it is more cost effective, the Company in its discretion will purchase rather than lease equipment. In making such purchase, the Company may deduct previous rental payments from its purchase Allowance.
7. Coverage for Medical Supplies used in connection with Durable Medical Equipment is limited to a 90-day supply per purchase.
8. Wound Vacuum Assisted Closure (VAC) Wound VAC devices are not covered without meeting Coverage Policy and receiving Prior Approval from the Company. **Failure of the Covered Person's treating Provider to submit a pre-service claim for Prior Approval will result in denial of coverage. PLEASE NOTE: Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished to us at the time indicates that the wound VACS meet the Primary Coverage Criteria requirements set out in Subsection 2.2 and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b., e., or f. and is not subject to a Specific Plan Exclusion (see Section 4.0). All Health Interventions receiving Prior Approval must still meet all other coverage terms, conditions, and limitations. Coverage for approved services may still be limited or denied if, when the claims are received by us, investigation shows that a benefit exclusion or limitation applies because of a difference in the Health Intervention described in the pre-service claim and the actual Health Intervention, that the 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 this Policy. For more information about pre-service claims and Prior Approval, please see Subsection 7.1.3.b.**

3.14 **Medical Supplies.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, Medical Supplies (See Subsection 9.53), other than Medical Supplies that can be purchased without a prescription, are covered when prescribed by a Physician.

1. Expenses for Medical Supplies provided in a Physician's office are included in the reimbursement for the procedure or service for which the supplies are used.
2. Coverage for Medical Supplies is limited to a 90-day supply per purchase.
3. Coverage for Medical Supplies used in connection with Durable Medical Equipment, Subsection 3.13, is subject to the Deductible, Coinsurance and Copayment specified in the Schedule of Benefits.
4. Expenses for Medical Supplies provided in connection with home infusion therapy are included in the reimbursement for the procedure or service for which the supplies are used.

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

Prosthetic devices to assist hearing or talking devices are not generally covered. See Subsection 4.2.45. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, coverage is provided for:

1. cochlear implant (an implantable hearing device inserted into the modiolus of the cochlea and into cranial bone) and its associated speech processor up to a lifetime maximum benefit of one cochlear implant per ear per Covered Person; and
2. one auditory brain stem implant per lifetime for an individual twelve years of age and older with a diagnosis of Neurofibromatosis Type II (NF2) who has undergone or is undergoing removal of bilateral acoustic tumors; and
3. surgically implantable osseointegrated hearing aid for patients with single-sided deafness and normal hearing in the other ear, subject to Prior Approval. Coverage is further limited to Covered Persons with
    a. congenital or surgically induced malformations (e.g. atresia) of the external ear canal or middle ear;
    b. chronic external otitis or otitis media;
    c. tumors of the external canal and/or tympanic cavity; and
    d. sudden, permanent, unilateral hearing loss due to trauma, idiopathic sudden hearing loss, or auditory nerve tumor.
4. Prosthetic devices for which the cost exceeds $5,000 requires Prior Approval from the Company. **Failure of the Covered Person or the Covered Person's treating Provider to submit a pre-service claim for Prior Approval will result in denial of coverage. PLEASE NOTE: Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished to us at the time indicates that the Prosthetic device meets the Primary Coverage Criteria requirements set out in Subsection 2.2 and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b., e., or f. and is not subject to a Specific Plan Exclusion (see Section 4.0). All Health Interventions must still meet all other coverage terms, conditions, and limitations, and coverage for any Prosthetic devices receiving Prior Approval may still be limited or denied if, when the post service claim is received by us, investigation shows that a benefit exclusion or limitation applies because of a difference in the Health Intervention described in the pre-service claim and the actual Health Intervention, that the 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 this Policy. For more information about pre-service claims and Prior Approval, please see Subsection 7.1.3.b.**

3.16 **Diabetes Management Services.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, the Company will pay for Diabetes Self-Management Training Program up to an Allowance or Allowable Charge of $250. Such training program must be in compliance with the national standards for diabetes self-management education programs developed by the American Diabetes Association. If there is significant change in the Covered Person's symptoms or conditions which make it necessary to change the Covered Person's diabetic management process, the Company will pay for an additional Diabetes Self-Management Training Program. This benefit is payable for training in or out of the Hospital that has been prescribed by a Physician.

Foot care is generally not covered, see Subsection 4.2.40. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, coverage of foot care is provided when required for prevention of complications associated with diabetes mellitus.

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

The Company will pay for Durable Medical Equipment, Medical Supplies and services for the treatment of diabetes.

3.17 **Ambulance Services.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, coverage is provided for ground, water or air Ambulance Services to the nearest hospital in the event Emergency Care is needed. (See Subsection 9.31 Emergency Care.) The coverage for Ambulance Services is subject to the Copayment, Deductible and Coinsurance specified in the Schedule of Benefits. Payment for ground Ambulance Services may not exceed $1,000 per trip and for air Ambulance Services may not exceed $5,000 per trip

3.18 **Skilled Nursing Facility Services.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, coverage is provided for Skilled Nursing Facility services when authorized in advance by a Physician. See Subsection 9.91 for the definition of Skilled Nursing Facility. This benefit is subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits. This Skilled Nursing Facility services benefit is subject to the following conditions:

1. The admission must be within seven days of release from an inpatient Hospital stay;
2. Skilled Nursing Facility Services require Prior Approval from the Company. **Failure of the Covered Person or the Covered Person's treating Provider to submit a pre-service claim for Prior Approval will result in denial of coverage. PLEASE NOTE: Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished to us at the time indicates that the Skilled Nursing Facility services meet the Primary Coverage Criteria requirements set out in Subsection 2.2 and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b., e., or f. and is not subject to a Specific Plan Exclusion (see Section 4.0). All Health Interventions receiving Prior Approval must still meet all other coverage terms, conditions, and limitations, and coverage for any Skilled Nursing Facility services receiving Prior Approval may still be limited or denied if because of a difference in the Health Intervention described in the pre-service claim and the actual health intervention, when the post-service claim is received by us, 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 this Policy. For more information about pre-service claims and Prior Approval, please see Subsection 7.1.3.b.**
3. The Skilled Nursing Facility services are of a temporary nature and increase ability to function;
4. Custodial Care is not covered (See Subsections 4.3.7 and 9.22);
5. Coverage is provided for a maximum of sixty (60) days per Covered Person per calendar year.

3.19 **Home Health Services.** Subject to all terms, conditions, exclusions, and limitations of the Plan as set forth in this Policy, including but not limited to the exclusion of Custodial Care (see Subsections 4.3.7 and 9.22), coverage is provided for Home Health Services when Coverage Policy supports the need for in-home service and such care is prescribed or ordered by a Physician. This Home Health Services benefit is subject to the following conditions:

1. Covered Services must be provided through and billed by a licensed home health agency.
2. Covered Services provided in the home include services of a Registered Professional Nurse (R.N.), a Licensed Practical Nurse (L.P.N.) or a Licensed Psychiatric Technical Nurse (L.P.T.N.), provided the nurse is not related to you by blood or marriage or does not ordinarily reside in your home.
3. Home Health visits are subject to the Deductible, Copayment, and Coinsurance specified in the Schedule of Benefits.
4. Coverage is provided for a maximum of fifty (50) visits per Covered Person per Calendar Year. (Home infusion services are not covered by this Section 3.19, but are covered under Subsection 3.24.1.d.).
5. Prior Approval. Coverage for Home Health Services is subject to Prior Approval from the Company. **Failure of the Covered Person's treating Provider to submit a pre-service claim for Prior Approval will result in denial of coverage. PLEASE NOTE: Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished**

to us at the time indicates that the Home Health Services meet the Primary Coverage Criteria requirements set out in Subsection 2.2 and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b., e., or f. and is not subject to a Specific Plan Exclusion (see Section 4.0). All Health Interventions receiving Prior Approval must still meet all other coverage terms, conditions, and limitations. Coverage for approved services may still be limited or denied if, when the post-service claim is received by us, investigation shows that a benefit exclusion or limitation applies because of a difference in the Health Intervention described in the pre-service claim and the actual Health Intervention, that the 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 this Policy. For more information about pre-service claims and Prior Approval, please see Subsection 7.1.3.b.

3.20 **Hospice Care.** Subject to Prior Approval from the Company and all terms, conditions, exclusions, and limitations of the Plan as set forth in this Policy, and if the Covered Person has been diagnosed and certified by the attending Physician as having a terminal illness with a life expectancy of six months or less, the Company will pay the Allowance or Allowable Charge for Hospice Care. The services must be rendered by an entity licensed by the Arkansas Department of Health or other appropriate state licensing agency and accepted by the Company as a Provider. This benefit is subject to the Deductible, Copayment, and Coinsurance specified in the Schedule of Benefits. **Failure of the Covered Person's treating Provider to submit a pre- service claim for Prior Approval will result in denial of coverage. PLEASE NOTE: Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished to us at the time indicates that the Hospice Care Services meet the Primary Coverage Criteria requirements set out in Subsection 2.2 and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b., e., or f. and is not subject to a Specific Plan Exclusion (see Section 4.0). All Health Interventions receiving Prior Approval must still meet all other coverage terms, conditions, and limitations. Coverage for approved services may still be limited or denied if, when the post-service claim is received by us, investigation shows that a benefit exclusion or limitation applies because of a difference in the Health Intervention described in the pre-service claim and the actual Health Intervention, that the 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 this Policy. For more information about pre-service claims and Prior Approval, please see Subsection 7.1.3.b.**

3.21 **Oral Surgery.** Subject to all terms, conditions, exclusions, and limitations of the Plan as set forth in this Policy and subject to Prior Approval from the Company, the Company will pay only for the following non-dental oral surgical procedures:

1. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when pathological examination is required.
2. Surgical procedures required to treat an Accidental Injury (See Subsection 9.1 Accidental Injury) to jaws, cheeks, lips, tongue, roof and floor of the mouth. Injury to a tooth or teeth while eating is not considered an Accidental Injury; treatment of such injury will not be covered.
3 Excision of exostoses of jaws and hard palate.
4. External incision and drainage of abscess.
5. Incision of accessory sinuses, salivary glands or ducts.

Failure of the Covered Person's treating Provider to submit a pre-service claim for Prior Approval will result in denial of coverage. PLEASE NOTE: Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished to us at the time indicates that the oral surgery meets the Primary Coverage Criteria requirements set out in Subsection 2.2 and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b., e., or f. and is not subject to a Specific Plan Exclusion (see Section 4.0). All Health Interventions receiving Prior Approval must still meet all other coverage terms, conditions, and limitations. Coverage for approved services may still be limited or denied if, when the post-service claim is received by us, investigation shows that a benefit exclusion or limitation applies because of a difference in the Health Intervention described in the pre-service claim and the actual Health Intervention, that the 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 this Policy. For more information about pre-service claims and Prior Approval, please see Subsection 7.1.3.b.

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

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

3.23 **Reconstructive Surgery. Cosmetic Services are not covered. (See Subsections 4.3.5 and 9.18)** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, and subject to the Deductible and Coinsurance specified in the Schedule of Benefits, coverage is provided for the following reconstructive surgery procedures when prescribed or ordered by an In-Network Physician:

1. Treatment provided for the correction of defects incurred in an Accidental Injury sustained by the Covered Person
2. Surgery performed for the correction of a cleft palate or cleft lip, removal of a port-wine stain or hemangioma (on the head, neck, or face). Dental Care to correct congenital defects is not a covered benefit.
3. Subject to Prior Approval from the Company, coverage for corrective surgery and related Health Interventions for a Covered Person who is diagnosed as having a craniofacial anomaly provided the Health Interventions meet Primary Coverage Criteria to improve a functional impairment that results from the craniofacial anomaly as determined by a nationally accredited cleft-craniofacial team, approved by the American Cleft Palate-Craniofacial Association in Chapel Hill, North Carolina. A nationally accredited cleft-craniofacial team for cleft-craniofacial conditions shall evaluate Covered Persons with craniofacial anomalies and coordinate a treatment plan for each Covered Person. Coverage includes corrective surgery, dental care, vision care and the use of at least one (1) hearing aid **Failure of the Covered Person or the Covered Person's treating Provider to submit a pre-service claim for Prior Approval will result in denial of coverage. PLEASE NOTE: Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished to the Company in the pre-service claim indicates that the Health Intervention to treat a craniofacial anomaly meets the Primary Coverage Criteria requirements set out in Subsection 2.2 and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b., e., or f. and is not subject to a Specific Plan Exclusion (see Section 4.0). All Health Interventions receiving Prior Approval, must still meet all other coverage terms, conditions, and limitations, and coverage for any Health**

Intervention receiving Prior Approval may still be limited or denied if, when the post-service claim is received by the Company, investigation shows that a benefit exclusion or limitation applies because of a difference between the Health Intervention described in the pre-service claim and the actual Health Intervention, 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 this Policy. For more information about pre-service claims and Prior Approval, please see Subsection 7.1.3.b. 4. Treatment provided when it is incidental to disease or for reconstructive surgery following neoplastic (cancer) surgery.

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

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

7. Gender Reassignment Surgery for Gender Dysphoria**.** Subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, as well as Prior Approval from the Company, coverage is provided for gender reassignment surgery for Covered Persons meeting diagnostic criteria and therapeutic Provider criteria as specified in Coverage Policy. **Failure of the Covered Person's treating Provider to submit a pre-service claim for Prior Approval will result in denial of coverage. PLEASE NOTE: Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished to us at the time indicates that the gender reassignment surgery services meet the Primary Coverage Criteria requirements set out in Subsection 2.2 and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b., e., or f. and is not subject to a Specific Plan Exclusion (see Section 4.0). All Health Interventions receiving Prior Approval must still meet all other coverage terms, conditions, and limitations. Coverage for approved services may still be limited or denied if, when the post-service claim is received by us, investigation shows that a benefit exclusion or limitation applies because of a difference in the Health Intervention described in the pre-service claim and the actual Health Intervention, that the 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 this Policy. For more information about pre-service claims and Prior Approval, please see Subsection 7.1.3.b.**

3.24 **Medications.** Subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Policy, coverage is provided for Prescription Medication. (See Subsection 9.79 - Prescription Medication.) This coverage varies, depending upon the sites of service where the Medication is received by the Covered Person.

1. **Sites of Service**

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

   b. **Physician's Office.** The benefit for Medications administered in a Physician's office is covered based upon the Allowance or Allowable Charge for the Medication and subject to the Deductible, Coinsurance and Copayment specified in the Schedule of Benefits. Conditions of coverage set forth in Subsections 3.24.2.a, b., and c., are applicable to this coverage.

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

      i. **Covered Medications.** Generally, only A Medications are covered under this Subsection 3.24.1.c. however, a limited number of B Medications are covered under this Subsection 3.24.1.c. B Medications are covered under Subsections 3.24.1.a, b., and d. (See Subsection 9.79 for definitions of "A Medications" and "B Medications.")

ii. **Administration Charges.** Charges to administer or inject any Medication are not covered under this Subsection 3.24.1.c.

iii. **Conditions of Coverage.** Conditions of coverage set forth in Subsections 3.24.2.a., b., c., d., and e., are applicable to this coverage.

iv. **ID Card Presentation.** In order to receive benefits for a Prescription Medication under this Subsection 3.24.1.c., a Covered Person must present his or her Arkansas Blue Cross and Blue Shield ID card to a Participating Pharmacy at the time the Covered Person purchases the Prescription Medication. ("Participating Pharmacy" is defined in Subsection 9.69.) The pharmacist will electronically notify the Company's prescription benefits processor. The prescription benefits processor will electronically inform the pharmacist whether the Plan provides benefits for the Prescription Medication. If the prescription benefits processor indicates that the Plan does not provide benefits, the Covered Person may call the Pharmacy Help Line telephone number on the back of his or her ID card. If the Plan provides benefits, the pharmacist will charge the Covered Person the applicable Copayment for the Prescription Medication. Applicable Prescription Copayments are listed in Schedule of Benefits. The Company will only accept a post-purchase or paper claim for Prescription Medications purchased through a retail pharmacy (drug store) if such claim is submitted (1) for an Emergency Prescription, (See Subsection 9.32.), (2) for Prescription Medication purchased prior to the date the Covered Person received his or her Arkansas Blue Cross and Blue Shield ID card or (3) in accordance with Subsection 3.24.1.c.v., below.

v. **Claim Submission.** The presentation of a Prescription to a pharmacist in accordance with this Subsection 3.24.1.c., 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 has rejected benefits for the requested Prescription Medication.

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

vii. **Emergency.** When a Covered Person receives a Prescription Medication in connection with Emergency Care as defined in this Policy (See Subsection 9.31) and is unable to obtain the Medication from a Participating Pharmacy, the Covered Person should purchase the Medication at the nearest pharmacy and submit a prescription claim form for reimbursement. The claim payment will be limited to the Allowable Charge, less the applicable Prescription Copayment.

viii. **Medical Supplies.** Medical supplies such as, but not limited to, colostomy supplies, bandages and similar items are not generally covered under this Subsection 3.24.1.c; however, refer to Subsections 3.14 Medical Supplies and Subsection 3.24.1.d., below. Furthermore, subject to the terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, coverage is provided under this Subsection 3.24.1.c., for insulin and syringes purchased at the same time as insulin and which are to be used for the sole purpose of injecting insulin. Syringes not meeting this standard are not covered. In addition, certain blood glucose test meter supplies such as test strips and lancets are covered under the pharmacy benefit.

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

x. **Durable Medical Equipment.** Durable Medical Equipment, even though such device may require a prescription, such as, but not limited to, therapeutic devices, artificial appliances, blood glucose test meters, or similar devices, are not covered under this Subsection 3.24.1.c. Refer to Subsection 3.13 - Durable Medical Equipment. However, certain blood glucose test meter supplies, such as test strips and lancets, are covered under the pharmacy benefit.

xi. **Prescriptions, Excluded Providers**. Prescriptions ordered or written by any Physician or Provider who is excluded from coverage under the Plan, are not

covered. Prescriptions presented to or filled by any Pharmacy which is excluded from coverage under the Plan, are not covered. See Subsection 4.1.

xii. **Copayment Information**

Each Prescription is covered only after the Covered Person pays the applicable Copayment (listed on the Covered Person's Schedule of Benefits) to the Participating Pharmacy. Covered Persons will be charged the appropriate Copayment for each Prescription or refill. An initial fill of a Maintenance Medication Prescription is covered for one month only. A refilled Maintenance Medication Prescription may be covered for up to a 3-month supply with one Copayment applied for each month's supply. (See Subsection 9.47 - Maintenance Medication.)

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

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

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

i. **Covered Medications.** A Medications and B Medications are covered under this Subsection 3.24.1.d. (See Subsection 9.79 for definitions of "A Medications" and "B Medications.") A Medications are covered subject to the Prescription Medication Copayment as listed in the Schedule of Benefits. B Medications are covered subject to the Calendar Year Deductible and Coinsurance listed in the Schedule of Benefits.

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

iii. **Conditions of Coverage.** Conditions of coverage set forth in Subsections 3.24.2. a., b., c., d., and e., are applicable to this coverage.

iv. **Medical Supplies.** Medical Supplies used in connection with home infusion therapy are covered under this Subsection 3.24.1.d. See Subsection 3.14.

v. **Administration Charges.** Charges to administer or inject Medication by a licensed medical professional operating under his/her scope of practice are covered under this Subsection 3.24.1.d., according to the allowable fee schedule for skilled nursing under both home infusion therapy and Home Health.

2. **Conditions of Coverage**

a. **Prior Approval.** Selected Prescription Medications, as designated from time to time by the Company, are subject to Prior Approval through criteria established by the Company as detailed in Coverage Policy before coverage is allowed. A list of Medications for which Prior Approval is required is available from the Company upon request or, if you have Internet access, you may review this list on the Company's web site at WWW.ARKANSASBLUECROSS.COM. This Subsection 3.24.2.a., is applicable to Prescription Medication covered by Subsections 3.24.1.b., c., and d.

b. **Specialty Medications.** Selected Prescription Medications are designated by the Company as "Specialty Medications" due to their route of administration, approved indication, unique nature, or inordinate cost. These medications usually require defined handling and home storage demands, crucial patient education, and careful monitoring. Such medications include, but are not limited to growth hormones, blood modifiers, immunoglobulins, and medications for the treatment of hemophilia, deep vein thrombosis, hepatitis C, Crohn's disease, cystic fibrosis, multiple sclerosis and rheumatoid arthritis. Specialty Medications may be A Medications or B Medications. Coverage for Specialty

Medications is subject to Prior Approval and may only be purchased through a specialty pharmacy vendor under contract with the Company. The benefit for a Specialty Medication is subject to the calendar year Deductible and Coinsurance specified in the Schedule of Benefits. A list of Specialty Medications is available from the Company upon request or, if you have Internet access, you may review this list on the Company's web site at WWW.ARKANSASBLUECROSS.COM. This Subsection 3.24.2.b., is applicable to Prescription Medication covered by Subsections 3.24.1.b., c., and d.

c. **Formulary.** Except in limited circumstances set out in this Subsection 3.24.2.c., and elsewhere in this Policy, a Prescription Medication must be listed in the Formulary in order to be covered. (See Subsection 9.34 Formulary.) However, if a Prescription Medication in the Formulary causes or has caused adverse or harmful reactions for a particular Covered Person, or has been shown to be ineffective in the treatment of a Covered Person's particular disease or condition, such Covered Person may be able to obtain coverage for a Prescription Medication not in the Formulary by requesting Prior Approval. This Subsection 3.24.2.c., is applicable to Prescription Medication covered by Subsections 3.24.1. b., c., and d. The form to request Prior Approval or a Formulary exception is located on our web site at https://www.arkansasbluecross.com/docs/librariesprovider9/default-document-library/prior-approval-form-for-prescription-drugs.pdf.

d. **Step Therapy.** Selected Prescription Medications as designated from time to time by the Company in its discretion are subject to Step Therapy restrictions. (See Subsection 9.94 - Step Therapy.) Such Step Therapy must be completed before coverage for the selected Prescription Medication is provided. The Step Therapy requirements for a particular Prescription Medication are available from the Company upon request. This Subsection 3.24.2.d., is applicable to Prescription Medication covered by Subsections 3.24.1.c., and d.

e. **Dispensing Quantities - Limitations**

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

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

Coverage of selected Prescription Medications as designated from time to time by the Company in its discretion is subject to Dose Limitations. (See Subsection 9.29 - Dose Limitation.) The Dose Limitation for a particular Prescription Medication is available from the Company upon request.

This Subsection 3.24.2.e., is applicable to Prescription Medication covered by Subsections 3.24.1. d.

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

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

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

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

4. Notwithstanding any other provisions of this Policy, at the option of the Company, the Allowance or Allowable Charge for an organ transplant, including any charge for the procurement of the organ, Hospital services, Physician Services and associated costs, including costs of complications arising from the original procedure that occur within the Transplant Global Period, shall be limited to the lesser of (a) ninety percent (90%) of the billed charges or (b) the global payment determined as payment in full by a Blue Cross and Blue Shield Association Blue Distinction Centers Plus for Transplant participating facility.. **Please note that our payments for any transplant (whether performed within the transplant network or by a non-participating facility) are limited to a global payment that applies to all covered transplant services; we will not pay any amounts in excess of the global payment for services the facility or any physician or other health care Provider or supplier may bill or attempt to bill separately, because the global payment is deemed to include payment for all related necessary services (other than non-covered services). If you use a facility participating in the Blue Distinction Centers Plus for Transplant network, that facility has agreed to accept the global payment as payment in full, and should not bill you for any excess amount above the global payment, except for applicable Deductible, Coinsurance or non-covered services; however, a non-participating facility may bill you for all amounts it may charge above the global payment. These charges above the global payment could amount to thousands of dollars in additional out of pocket expenses to you.**

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

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

   b. Donor testing is covered only if the tested donor is found compatible.

6. Solid organ transplants of any kind are not covered for individuals with a malignancy that is presently active or in partial remission (e.g. non-metastatic resectable squamous and basal cell carcinoma of the skin are excepted.). A solid organ transplant of any kind is not covered for a Covered Person that has had a malignancy removed or treated in the 3 years prior to the proposed transplant. For purposes of this section, malignancy includes a malignancy of the brain or meninges, head or neck, bronchus or lung, thyroid, parathyroid, thymus, pleura, esophagus, heart or pericardium, liver, stomach, small or large bowel, rectum, kidney, bladder, prostate, testicle, ovary, uterus, other organs associated with the genito-urinary tract, bones, muscle, nerves, blood vessels, leukemia, lymphoma or melanoma and breast. The only exception to this non-coverage is for solid organ transplant for hepatocellular carcinoma under certain circumstances, as outlined in the Coverage Policy for hepatocellular carcinoma.

7. Coverage for high-dose or non-myeloablative chemotherapy, allogeneic or autologous stem or progenitor cell transplantation for the treatment of a medical condition is provided subject to the Company's specific Coverage Policies relative to these specific conditions.

3.26 **Medical Disorder Requiring Specialized Nutrients or Formulas.** Subject to Prior Approval from the Company and all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, coverage is provided for Medical Foods, Low Protein Modified Food Products, amino- acid-based elemental formulas, extensively hydrolyzed protein formulas, formulas with modified vitamin or mineral content and modified nutrient content formulas for the treatment of a Covered Person diagnosed with a Medical Disorder Requiring Specialized Nutrients or Formulas if

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

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

This benefit is subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits. **Failure of the Covered Person's treating Provider to submit a pre-service claim for Prior Approval will result in denial of coverage. PLEASE NOTE: Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished to us at the time indicates that the Medical Foods and Low Protein Modified Food Products meet the Primary Coverage Criteria requirements set out in Subsection 2.2 and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b., e., or f. and is not subject to a Specific Plan Exclusion (see Section 4.0). All Health Interventions receiving Prior Approval must still meet all other coverage terms, conditions, and limitations. Coverage for approved services may still be limited or denied if, when the post-service claim is received by us, investigation shows that a benefit exclusion or limitation applies because of a difference in the Health Intervention described in the pre- service claim and the actual Health Intervention, that the 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 this Policy. For more information about pre-service claims and Prior Approval, please see Subsection 7.1.3.b.**

3.27 **Prenatal Tests and Testing of Newborn Children.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, coverage is provided for prenatal tests that meet Coverage Policy and testing of newborns during the newborn hospitalization/delivery. A complete listing of this testing is available at the Arkansas Department of Health or the applicable state department of health website. Testing of newborns under twenty-nine (29) days of age includes screening for spinal muscular atrophy without cost sharing.

3.28 **Testing and Evaluation.** Subject to all other terms, conditions, exclusions and limitations of the Plan set forth in this Policy, coverage is provided for the following testing and evaluation, limited to fifteen (15) hours per Covered Person per year. This benefit is further subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits.

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

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

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

1. The Covered Person must be suffering from Severe Traumatic Brain Injury;
2. The admission must be within 7 days of release from an inpatient Hospital stay;
3. Prior Approval. All Neurologic Rehabilitation Facility services are subject to Prior Approval from the Company. **Failure of the Covered Person's treating Provider to submit a pre-service claim for Prior Approval will result in denial of coverage. PLEASE NOTE: Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished to us at the time indicates that the neurologic rehabilitation facility services meet the Primary Coverage Criteria requirements set out in Subsection 2.2 and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b., e., or f. and is not subject to a Specific Plan Exclusion (see Section 4.0). All Health Interventions receiving Prior Approval must still meet all other coverage terms, conditions, and limitations. Coverage for approved services may still be limited or denied if, when the post-service claim is received by us, investigation shows that a benefit exclusion or limitation applies because of a difference in the Health Intervention described in the pre-service claim and the actual Health Intervention, that the 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 this Policy. For more information about pre-service claims and Prior Approval, please see Subsection 7.1.3.b.

4. The Neurologic Rehabilitation Facility services are of a temporary nature with a potential to increase ability to function;
5. Custodial Care is not covered (See Subsections 4.3.7 and 9.22); and
6. Coverage is provided for a maximum of 60 days per Covered Person per lifetime.

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

1. Annual routine eye examinations with refraction are covered beginning at age six, or earlier if medically indicated, through age 18.
2. One pair of lenses in a calendar year, if prescribed by a physician.
   a. Lenses may be prescription glasses or contact lenses.
   b. Lenses may be plastic or polycarbonate lenses.
3. One frame in a calendar year if lenses are prescribed and prescription glasses selected.
4. Eye Glass repair if glasses were originally covered by this Policy.
5. Replacement of lost or broken glasses, only one time within a year, each additional pair requires Prior Approval from the Company.
6. Eye prosthesis or polishing services, subject to Prior Approval from the Company
7. Eyeglasses for children diagnosed as having the following diagnoses must have a surgical evaluation in conjunction with supplying eyeglasses:
   a. Ptosis (droopy lid);
   b. Congenital cataracts;
   c. Exotropia or vertical tropia; or
   d. Children between the ages of twelve (12) and twenty-one (21) exhibiting exotropia.
8. Vision therapy developmental testing with Prior Approval.
   a. orthoptic and pleoptic training with continuing medical direction and evaluation;
   b. sensorimotor examination with multiple measurements of ocular deviation (e.g., restrictive or paretic muscle with diplopia) with interpretation and report (separate procedure);
   c. developmental testing extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report.

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

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

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

3.34 **Health Interventions by Out-of-Area Providers. .** An Out-of-Area Provider is a Provider that is not a Contracting Provider that delivers a Health Intervention outside the State of Arkansas. Because the Company does contract with some Providers located outside the State of Arkansas, you should check our published Provider directory, visit our web site at WWW.ARKANSASBLUECROSS.COM, or call Customer Service to ask whether a specific Provider is an Out-of-Area Provider. Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, coverage is provided for a Health Intervention delivered by an Out-of-Area Provider provided such Health Intervention is Emergency Care (See Subsection 9.31) or the Covered Person or the Covered Person's treating Provider has received Prior Approval for the Health Intervention from the Company. For a Health Intervention that is not Emergency Care, **failure of the Covered Person or the Covered Person's treating Provider to submit a pre-service claim for Prior Approval will result in denial of coverage. Please note Prior Approval does not guarantee payment or assure coverage, it means only that the information furnished to the Company in the pre-service claim indicates that the Health Intervention meets the Primary Coverage Criteria requirements set out in Subsection 2.2 and the application of the Primary Coverage Criteria set out in Subsections 2.4.1.b., e., or f. and is not subject to a Specific Plan Exclusion (See Section 4.0). All Health Interventions, including the Health Interventions delivered by an Out-of-Area Provider, must still meet all other coverage terms, conditions and limitations, and coverage for these services may still be limited or denied, if, when the post-service claim for the services is received by us, investigation shows that a benefit exclusion or limitation applies because of a difference in the health intervention described in the pre-service claim and the actual health intervention, that the Covered Person ceased to be eligible for benefits on the date the services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in this Policy. For more information about pre-service claims and Prior Approval, please see Subsection 7.1.3.b.**

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

1. **Chelation Therapy.** Chelation therapy is generally not covered, see Subsection 4.2.14. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, chelation therapy for control of ventricular arrhythmias or heart block associated with digitalis toxicity, emergency treatment of hypercalcemia, extreme conditions of metal toxicity, including thalassemia intermedia with hemosiderosis, Wilson's disease (hepatolenticular degeneration), lead poisoning and hemochromatosis is covered.
2. **Clinical Trials.** Phase I, II, III or IV clinical trials or any study to determine the maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with a standard means of treatment or diagnosis of a drug, device or medical treatment or procedure are not covered. See Subsection 4.3.3. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, Routine Patient Costs for items and services furnished in connection with participation in the clinical trial are covered, provided the Covered Person is eligible to participate and has been approved for participation in accordance with the protocols of the clinical trial and the clinical trial is an Approved Clinical Trial**.** See Subsections 9**.**6 and 9.88.
3. **Contraceptive Devices.** Subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, coverage is provided for contraceptive devices when prescribed by a Physician.
4. **Dietary and Nutritional Counseling Services.** Subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, and subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits, coverage is provided for dietary and nutritional counseling services when provided in conjunction with Diabetic Self-Management Training, for services needed by Covered Persons in connection with cleft palate management and for nutritional assessment programs provided in and by a Hospital and approved by the Company.
5. **Electrotherapy stimulators.** Treatment using electrotherapy stimulators are generally not covered, see Subsection 4.2.31. However, coverage is provided for a Transcutaneous Electrical

Nerve Stimulator (TENS) to treat chronic pain due to peripheral nerve injury when that pain is unresponsive to medication.

6. **Enteral Feedings.** Enteral feedings are generally not covered, see Subsection 4.2.33. However, enteral feedings are covered when such feedings have been approved and documented by an In- Network Physician as being the Covered Person's sole source of nutrition. Enteral feedings require Prior Approval from the Company. **Failure of the Covered Person's treating Provider to submit a pre-service claim for Prior Approval will result in denial of coverage. PLEASE NOTE: Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished to us at the time indicates that the enteral feedings meet the Primary Coverage Criteria requirements set out in Subsection 2.2 and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b., e., or f. and is not subject to a Specific Plan Exclusion (see Section 4.0). All Health Interventions receiving Prior Approval must still meet all other coverage terms, conditions, and limitations. Coverage for approved services may still be limited or denied if, when the post-service claim is received by us, investigation shows that a benefit exclusion or limitation applies because of a difference in the Health Intervention described in the pre-service claim and the actual Health Intervention, that the 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 this Policy. For more information about pre-service claims and Prior Approval, please see Subsection 7.1.3.b.**

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

8. **High Frequency Chest Wall Oscillators.** Subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, and subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits, coverage is provided, to Covered Person's age two (2) or older with cystic fibrosis, for one high frequency chest wall oscillator during such Covered Person's lifetime.

9. **Inotropic Agents for Congestive Heart Failure.** Chronic, intermittent infusion of positive inotropic agents for patients with severe congestive heart failure is not covered. See Subsection 4.2.53. However, subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Policy, where the patient is on a cardiac transplant list at a Hospital where there is an ongoing cardiac transplantation program, the Plan will cover infusion of inotropic agents.

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

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

12. **Vision Enhancement.** For persons 19 years and older vision enhancements are generally not covered, see Subsection 4.2.100. However, subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, a procedure, treatment, service, equipment or supply to correct a refractive error of the eye is covered in two instances: (1) if such refractive error results from traumatic injury or corneal disease, infectious or non-infectious, and (2) the single acquisition of eyeglasses or contact lenses within the first six months following cataract surgery. The Plan does not cover the implantation of a multifocal lens; however, if a multifocal lens is implanted after a cataract extraction, the Plan will pay the Allowance or Allowed Charge for a monofocal lens. With respect to such eyeglasses or contact lenses, tinting or anti-reflective coating and progressive lenses are not covered. See Subsection 3.13.4. In addition, subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, certain vision enhancement is provided to Covered Persons under the age of 19. See Subsection 3.31 - Pediatric Vision Services.

4.0 SPECIFIC PLAN EXCLUSIONS

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

4.1 Health Care Providers.

1. Custodial Care Facility. Services or supplies furnished by an institution which is primarily a place of rest or a place for the aged are not covered. Youth homes, boarding schools, or any similar institution are not covered
2. Freestanding Cardiac Care Facility. Treatment received at a Freestanding Cardiac Care Facility is not covered.
3. Immediate Relatives. Professional services performed by a person who ordinarily resides in the Covered Person's home, including self, or is related to the Covered Person as a Spouse, parent, Child, brother or sister, grandparent and grandchild, whether the relationship is by blood or exists in law are not covered.
4. Midwives, Not Certified. Services provided by a midwife who is not a licensed certified nurse midwife in the state where he or she renders services and who does not have a collaborative agreement with a Physician are not covered.
5. Out-of-Area Provider. A Health Intervention delivered by an Out-of-Area Provider that is not Emergency Care or has not received Prior Approval from the Company is not covered (See Subsections 3.34 and 9.64.
6. Physical Therapy Aide. Services or supplies provided by a physical therapy aide are not covered.
7. Provider, Excluded. Health Interventions received from any Provider who has been excluded from participation in any federally funded program, are not covered.
8. Provider, Undefined. Services or supplies provided by an individual or entity that is not a Provider as defined in this Policy are not covered. (See Subsection 9.83 Provider.)
9. Recreational Therapist. Services or supplies provided by a recreational therapist are not covered.
10. Residents, interns, students or fellows. Services performed or provided by a Hospital resident, intern, student or fellow of any medical related discipline are not covered.
11. Surgical First Assistants. The Company does not recognize surgical first assistants as a covered provider eligible for reimbursement for Covered Services. Any services performed by a surgical first assistant will be denied.
12. Unlicensed Providers or Provider Outside Scope of Practice. Coverage is not provided for treatment, procedures or services received from any person or entity, including but not limited to Physicians, who is required to be licensed to perform the treatment, procedure or service, but (1) is not so licensed, or (2) has had his license suspended, revoked or otherwise terminated for any reason, or (3) has a license that does not, in the opinion of the Company's Medical Director, include within its scope the treatment, procedure or service provided.

4.2 **Health Interventions.**

1. Abortion. Abortion is not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, pregnancy terminations under the direction of a Physician are covered, but only when performed in an In-Network Hospital or In-Network Outpatient Hospital setting.
2. Abuse of Medications. Medications, drugs or substances used in an abusive, destructive or injurious manner are not covered, except when caused by a mental or physical illness.
3. Acupuncture. Acupuncture and services related to acupuncture are not covered.
4. Adoptive Immunotherapy. Adoptive immunotherapy, including but not limited to (lymphokine-activated killer (LAK) therapy, tumor-infiltrating lymphocyte (TIL) therapy, autolymphocyte therapy (ATL)) is not covered. However, subject to Coverage Policy and Prior Approval from the Company, chimeric antigen receptor T-cell therapy is covered in a Blue Distinction Center (BDC) approved facility.
5. Antigen immunotherapy. Antigen immunotherapy for repeat fetal loss is not covered.
6. Arthroereisis for Pes Planus (Flat Feet). This treatment is sometimes used to treat flat feet and is not covered.
7. Balloon Sinuplasty. A balloon sinuplasty device is sometimes used for treatment of sinusitis and is not covered.
8. Bereavement services. Medical social services and outpatient family counseling and/or therapy for bereavement, except if provided as Hospice Care, are not covered.
9. Biochemical Markers for Alzheimer's Disease. Measurement of cerebrospinal fluid and urinary biomarkers of Alzheimer's disease including but not limited to tau protein, amyloid beta peptides and neural thread proteins are not covered.
10. Biofeedback. Biofeedback and other forms of self-care or self-help training, and any related diagnostic testing are not covered for any diagnosis or medical condition.
11. Blood Typing. Blood Typing or DNA analysis for paternity testing is not covered.
12. Bone Growth Stimulation, electrical, as an adjunct to cervical fusion surgery. Electrical Bone Growth Stimulation used as an adjunct to cervical fusion surgery is not covered.
13. Bronchial Thermoplasty. Bronchial thermoplasty for treatment of asthma or other indications and bronchoscopy, when performed with bronchial thermoplasty, are not covered.
14. Chelation therapy**.** Services or supplies provided as, or in conjunction with, chelation therapy, are generally not covered. Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, chelation therapy for control of ventricular arrhythmias or heart block associated with digitalis toxicity, emergency treatment of hypercalcemia, extreme conditions of metal toxicity, including thalassemia intermedia with hemosiderosis, Wilson's disease (hepatolenticular degeneration), lead poisoning and hemochromatosis is covered. See Subsection 3.35.1.
15. Chemical Ecology. Diagnostic studies and treatment of multiple chemical sensitivities, environmental illness, environmental hypersensitivity disorder, total allergy syndrome or chemical ecology is not covered.
16. Cognitive Rehabilitation. Services or supplies provided as or in conjunction with, Cognitive Rehabilitation are not covered. See Subsection 9.11. However, subject to all terms, conditions, exclusions and limitation of the Plan as set forth in this Policy, coverage is provided for Neurologic Rehabilitation Facility Services for Covered Persons with Severe Traumatic Brain Injury. See Subsection 3.30.
17. Cold Therapy. Cold Therapy devices are used in place of ice packs. The use of active or passive, intermittent or continuous, with or without pneumatic compression, cold therapy is not covered. Examples of cold therapy devices include, but are not limited to, the Cryocuff device, the Polar Care Cub device, the Autochill device, and the Game Ready device.
18. Compound Medications. Compound Medications are not covered.
19. Complications of non-covered treatments. Care, services or treatment required as a result of complications from a treatment or service not covered under this Policy are not covered.
20. Compression Garments. All types of compression garments, support hose or elastic supports are not covered even when purchased with a Prescription. However, subject to all terms conditions, exclusions and limitation of the Plan as set forth in this document, coverage is

provided for compression garments specifically designed to treat severe burns or compression sleeves and gloves used to treat lymphedemas following mastectomy.

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

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

23. Cranial electrotherapy or cranial electromagnetic stimulation devices. Cranial electrotherapy is not covered. Cranial electromagnetic or cranial magnetic stimulation devices are not covered unless a specific Coverage Policy and Prior Approval from the Company are met.

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

25. Dental Care or orthodontic services. Dental Care and orthodontic services are not covered.

    1. Benefits for Accidental Injury. However, if a Covered Person has an Accidental Injury, benefits will be provided, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, for Dental Care and x-rays necessary to correct damage to a Non-Diseased Tooth or surrounding tissue caused by the Accidental Injury. The Covered Person must seek treatment within 72 hours of injury for services to be covered. Coverage is subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits with the following limitations:
        i. Only the Non-Diseased Tooth or Teeth avulsed or extracted as a direct result of the Accidental Injury and the Non-Diseased Tooth or Teeth immediately adjacent will be considered for replacement.
        ii. Orthodontic services are limited to the stabilization and re-alignment of the accident-involved teeth to their pre-accident position. Reimbursement for this service will be based on a per tooth allowance.
        iii. Injury to teeth while eating is not considered an Accidental Injury.
        iv. Double abutments are not covered.
        v. Any Health Intervention related to dental caries or tooth decay is not covered.
        vi. Removal of teeth is not covered.
    2. Benefits for dental services.
        a. Dental services in connection with radiation treatment for any malignancy of the head or neck are covered.
        b. Dental services perioperative to organ transplant when dental infection precludes listing for a transplant are covered;
        c. Dental services perioperative for hematopoietic stem cell transplant when dental infection precludes listing for a transplant are covered;
        d. Dental services perioperative to valve replacement or surgery when dental infection precludes surgery are covered.
    3. Benefits for anesthesia services. Hospital and Ambulatory Surgery Center services and anesthesia services related to dental or orthodontic procedures, including services to children, are covered in accordance with Subsection 3.3.3.

26. Dietary and Nutritional Services. Any services or supplies provided for dietary and nutritional services, including but not limited to medical nutrition therapy, unless such dietary supplies are the sole source of nutrition for the Covered Person, are not covered. Baby formula or thickening agents, whether prescribed by a Physician or acquired over the counter, is not a covered benefit. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, coverage is provided for Medical Foods and Low Protein Modified Food Products for the treatment of a Medical Disorder Requiring Specialized Nutrients or Formulas. See Subsection 3.26.

27. Digitization Computer Enhanced X-ray Analysis for Spinal Evaluation. Spinal visualization using digitization of spinal x-rays and computerized analysis of the back or spine is not covered.
28. Dynamic Orthotic Cranioplasty. Dynamic orthotic cranioplasty is not covered.
29. Dynamic spinal motion visualization techniques such as Digital Motion X-ray, Cineradiography and Videoradiography. The use of digital motion x-ray for the evaluation of musculoskeletal conditions is not covered.
30. EKG, Signal Averaged. Signal averaged electrocardiography utilized to stratify risk for arrhythmias following myocardial infarction, in patients with cardiomyopathy, in patients with syncope, as an assessment of success after surgery for arrhythmia, in detection of acute rejection of heart transplants, as an assessment of efficiency of antiarrhythmic drug therapy and in the assessment of successful pharmacological, mechanical or surgical interventions to restore coronary blood flow is not covered.
31. Electrotherapy and electromagnetic stimulators. All treatment using electrotherapy and electromagnetic stimulators, including services and supplies used in connection with such stimulators, and complications resulting from such treatment are not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, coverage is provided for a Transcutaneous Electrical Nerve Stimulator (TENS) to treat chronic pain due to peripheral nerve injury when that pain is unresponsive to medication. Coverage is also provided for neuromuscular electrical stimulation (NMES) for treatment of disuse atrophy where nerve supply to the muscle is intact, including but not limited to atrophy secondary to prolonged splinting or casting of the affected extremity, contracture due to scarring of soft tissue as in burn lesions and hip replacement surgery until orthotic training begins.
32. Enhanced External Counterpulsation. Enhanced external counterpulsation (EECP) is generally not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, coverage is provided for one course of enhanced external counterpulsation for the treatment of disabling angina in patients who are NYHA Class III or IV, or equivalent classification; who have experienced inadequate control of anginal symptoms with a medication regimen that consists of optimal dosages of platelet inhibitors, beta-blockers, calcium channel blockers, long-acting nitrates, lipid-lowering drugs and antihypertensives when these drugs are appropriate and there is no contraindication to any of these drugs; and who are not amenable to surgical cardiac intervention such as angioplasty or coronary artery bypass grafting. Repeat courses of EECP are not covered.
33. Enteral Feedings. Enteral feedings are generally not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, enteral feedings are covered when such feedings have been approved and documented by an In-Network Physician as the Covered Person's sole source of nutrition with Prior Approval from the Company.
34. Environmental Intervention. Services or supplies used in adjusting a Covered Person's home, place of employment or other environment so that it meets the Covered Person's physical or psychological condition are not covered.
35. Epiduroscopy/spinal myeloscopy. This service is used in the diagnosis and treatment of spinal pain and is not covered.
36. Excessive Use. Excessive use of Medications is not covered. For purposes of this exclusion, each Covered Person agrees that the Company shall be entitled to deny coverage of medications on grounds of excessive use when the Company's medical director, in his sole discretion, determines (1.) that a Covered Person has exceeded the dosage level, frequency or duration of medications recommended as safe or reasonable by major peer-reviewed medical journals specified by the United States Department of Health and Human Services pursuant to section 1861(t)(2)(B) of the Social Security Act, 42 U.S.C. §1395(x)(t)(2)(B), as amended, standard reference compendia or by the Pharmacy & Therapeutics Committee; or (2.) that a 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 Company to communicate with any 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.
37. Exercise programs. Exercise programs for treatment of any condition are not covered.

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

39. Family Planning. The following family planning services are not covered.

    a. reversal of sterilization

    b. surrogate mothers providing services for a Covered Person.

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

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

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

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

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

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

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

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

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

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

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

        ii. chronic external otitis or otitis media;

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

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

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

47. High dose Chemotherapy, Autologous Transplants, Allogeneic Transplants or Non-myeloablative Allogeneic Stem Cell Transplantation. High dose Chemotherapy, Autologous Transplants, Allogeneic Transplants or Non-myeloablative Allogeneic Stem Cell Transplantation are not covered except in accordance with the Company's specific Coverage Policies. See Subsection 3.25.

48. Hippo Therapy. Hippo therapy is not covered.

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

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

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

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

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

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

55. Intraoperative Neurophysiologic Monitoring (IONM). IONM is used to monitor the integrity of neural pathways during high-risk neurosurgical cranial/spinal, orthopedic spinal, vascular, and major thyroid procedures is not covered unless the physician performing this service is a licensed physician other than the operating surgeon. The physician must: a) either be physically present in the operative suite or b) monitor remotely with attention directed exclusively to one patient (one-on-one, cannot be billed for simultaneous monitoring).in the operating suite. When intraoperative monitoring is remotely performed it is not covered.

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

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

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

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

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

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

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

63. Medical Supplies. Medical Supplies that can be purchased without a prescription or over the counter, whether or not a prescription was obtained, are not covered; for example, medication coated dressings, tape and gauze are not covered even with a Physician Prescription. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, Medical Supplies necessary for the management of diabetes mellitus or for home health services are covered. See Subsection 3.14 Medical Supplies, Subsection 3.16 Diabetes Management Services and Section 3.19 Home Health Services. Expenses for Medical Supplies provided in a Physician's office are included in the reimbursement for the procedure or service for which the supplies are used.

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

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

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

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

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

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

    i. the Prescription Medication has been recognized as safe and effective for treatment of that specific type of cancer in any of the following standard reference compendia, unless the use is identified as "not indicated" or otherwise inappropriate or not recommended, in one or more of these standard reference compendia: (A) The American Hospital Formulary Service Drug Information; (B) The National Comprehensive Cancer Network Drugs and Biologics Compendium; (C) The Elsevier Gold Standard's Clinical Pharmacology; or

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

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

70. Oral, Implantable and Injectable Contraceptives. Oral, implantable and injectable contraceptive drugs, and Prescription barrier methods that are not on the Formulary are not covered.
71. Orthoptic, Pleoptic or Vision Therapy. Orthoptic, pleoptic or vision therapy services are generally not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set out in this Policy, coverage is provided in the following instances: 1.) office-based orthoptic training in the treatment of convergence insufficiency when supported by the Coverage Policy on Orthoptic Training for the Treatment of Vision and Learning Disabilities or 2.) vision therapy developmental testing provided in accordance with Pediatric Vision Services. See Subsection 3.31.
72. Out-of-Network Infertility. Testing, counseling and planning services for infertility are not covered when provided by Out-of-Network Providers.
73. Out-of-Network Reconstructive Surgery. Services rendered for any Reconstructive Surgery, including reduction mammoplasty, are not covered when rendered by an Out-of-Network Provider.
74. Out-of-Network Therapy. Services rendered Out-of-Network for physical, occupational and speech therapy, chiropractic services and cardiac rehabilitation therapy are not covered.
75. Over the Counter Medications. Over-the-counter Medications (except insulin) are not covered without a Prescription from a Physician.
76. Pain Pump, Disposable. Disposable pain pumps following surgery are not covered.
77. Percutaneous discectomy and Radio-frequency Thermocoagulation. Any method of percutaneous discectomy, including, but not limited to, automated or manual percutaneous discectomy, laser discectomy, radiofrequency nucleotomy or nucleolysis, and coblation therapy, is not covered. Radio-frequency Thermocoagulation or Intradiscal electrothermal therapy for discogenic or other forms of back pain are not covered.
78. Percutaneous Sacroplasty. Percutaneous sacroplasty is not covered.
79. Peripheral Vascular Disease Rehabilitation Therapy. Peripheral vascular disease rehabilitation therapy is not covered.
80. Prolotherapy. Prolotherapy or Sclerotherapy for the stimulation of tendon or ligament tissue or for pain relief in a localized area of musculoskeletal origin is not covered.
81. Radio-frequency Thermal Therapy for Treatment of Orthopedic Conditions. The use of radio-frequency thermal therapy for treatment of orthopedic conditions is not covered.
82. Rest cures. Services or supplies for rest cures are not covered.
83. Seasonal Affective Disorder (SAD). Use of photo therapy or light therapy to treat seasonal affective disorder or depression is not covered.
84. Sensory Stimulation for Coma Patients. Sensory stimulation, whether visual, auditory, olfactory, gustatory, cutaneous or kinesthetic, for coma patients is not covered.
85. Sexual Enhancement Medications. Medications used for the treatment of sexual enhancement, including but not limited to medications for erectile dysfunction, are not covered regardless of the reason(s) for the sexual dysfunction.
86. Short stature syndrome. Any services related to the treatment of short stature syndrome, except for laboratory documented growth hormone deficiency, are not covered.
87. Sleep Apnea, Portable Studies. Studies for the diagnosis, assessment or management of obstructive sleep apnea are generally not covered. However, subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, coverage is provided for portable (at home) sleep studies when all of the following seven channel monitoring information is included: EEG, heart rate, Chin EMG, ECG, airflow, effort and oxygen saturations, channels to identify awake versus asleep and apnea events. Devices used are considered portable comprehensive polysomnography devices monitoring a minimum of seven channels.
88. Smoking cessation/Caffeine addiction. Treatment of caffeine or nicotine addiction, smoking cessation Prescription Medication products not on our Formulary, including, but not limited to, nicotine gum and nicotine patches without a written Prescription are not covered.
89. Snoring. Devices, procedures or supplies to treat snoring are not covered.
90. Spinal Manipulation under general anesthesia. This type of manipulation is sometimes used for treatment of arthrofibrosis of the knee or shoulder and is intended to overcome the patient's protective reflex mechanism. Spinal manipulation under anesthesia is not covered.

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

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

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

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

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

96. Transplant procedures. The following transplant procedures and services are not covered:

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

    b. Organ transplants not authorized by Coverage Policy are not covered.

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

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

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

100. Vision enhancement. For Covered Persons age 19 or older, any procedure, treatment, service, equipment or supply used to enhance vision by changing the refractive error of the eye is not covered. Examples of non-covered visual enhancement services include, but are not limited to, the refraction for and the provision of eyeglasses and contact lenses, intraocular lenses, and Refractive Keratoplasty, with the exception of excessive, visually debilitating residual astigmatism following anterior segment surgery, i.e. corneal transplantation, cataract extraction, etc. Laser Assisted Insitu Keratomileusis (LASIK) and all other related refractive procedures are not covered. However, subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, a procedure, treatment, service, equipment or supply to correct a refractive error of the eye is covered in two instances: (1) if such refractive error results from traumatic injury or corneal disease, infectious or non-infectious, and (2) the single acquisition of eyeglasses or contact lenses within the first six months following cataract surgery. With respect to such eyeglasses or contact lenses, tinting or anti-reflective coating and progressive lenses are not covered. Eyeglass frames are subject to a $65 maximum Allowance or Allowable Charge. See Subsection 3.13.4. In addition, subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, certain vision enhancement is provided to Covered Persons under the age of 19. See Subsection 3.31 - Pediatric Vision Services.

101. Vitamins or Baby Formula. Vitamins or food/nutrient supplements, except those that are Prescription Medications not available over the counter, are not covered. Baby formula and thickening agents, even if prescribed by a Physician, is not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, coverage is provided for Medical Foods and Low Protein Modified Food Products for the treatment of Medical Disorder Requiring Specialized Nutrients or Formulas. See Subsection 3.26.

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

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

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

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

106. Wound Vacuum Assisted Closure (VACs). Wound VAC are not covered without meeting Coverage Policy and receiving Prior Approval from the Company.

4.3 **Miscellaneous Fees and Services.**

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

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

3. Clinical Trials. Phase I, II, III or IV clinical trials or any study to determine the maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with a standard means of treatment or diagnosis of a drug, device or medical treatment or procedure are not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, routine patient costs for items and services furnished in connection with participation in the trial are covered. See Subsection 3.35.2.

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

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

6. Court ordered or third party recommended treatment. Services required or recommended by third parties, including physicals and/or vaccines/immunizations for employment, overseas travel, camp, marriage licensing, insurance, and services ordered by a court or arranged by law enforcement officials, unless otherwise covered by the Plan, are not covered.

7. Custodial Care. Services or supplies for custodial, convalescent, domiciliary or supportive care and non-medical services to assist a Covered Person with activities of daily living are not covered. (See Subsection 9.22 - Custodial Care.)

8. Donor services. Services or supplies incident to organ and tissue transplant, or other procedures when the Covered Person acts as the donor are not covered except for Autologous services.

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

   a. Allowance or Allowable Charges for the organ removal as well as any complications resulting from the organ removal are only covered for the period beginning on the day before the transplant to the date of discharge or 39 days, whichever is less.

   b. Services for testing of a donor who is found to be incompatible are not covered.

9. Education Programs. Education programs, including but not limited to physical education programs in a group setting, health club memberships, athletic training, back schools, Work Hardening and Work Integration (Community) training, are not covered. However, subject to all

terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, coverage is provided for Diabetes Self-Management Training. See Subsection 3.16.

10. Excess charges. The part of an expense for care and treatment of an illness or Accidental Injury that is in excess of the Allowance or Allowable Charge is not covered.
11. Postage or Delivery Charges. Charges for shipping, packaging, handling or delivering Medications are not separately covered.
12. Prescription Medications used in connection with Health Interventions Not Covered by Plan. Prescription Medications used or intended to be used in connection with or arising from a treatment, service, condition, sickness, disease, injury, or bodily malfunction that is not covered under this Policy, or for which this Policy's benefits have been exhausted, are not covered.
13. Services Received Outside the United States. Services or supplies received outside of the United States of America shall not be covered except at the sole discretion of the Company.
14. Telephone and Other Electronic Consultation. Subject to all other terms, conditions, exclusions, and limitations of this Plan set forth in this Policy,
    i. Coverage is provided for Telemedicine services performed by a Provider licensed, certified, or otherwise authorized by the laws of Arkansas to administer health care in the ordinary course of the practice of his or her profession at the same rate as if it had been performed in-person.
    ii. However, electronic consultations such as, but not limited to, telephonic, interactive audio, fax, email, or for services that are, by their nature, hands-on (e.g. surgery, interventional radiology, coronary, angiography, anesthesia, and endoscopy) are not covered.
    iii. Communications made by a Physician responsible for the direct care of a Covered Person in Case Management with involved health care Providers, however, are covered.
15. Travel or accommodations. Travel or transportation as a treatment or to receive consultation or treatment, except Ambulance Services covered under Subsection 3.17, are not covered. Accommodations, while receiving treatment or consultation or for any other purpose, are not covered.
16. War. Services or supplies provided for treatment of disease or injuries sustained while serving in the military forces of any nation are not covered.
17. Workers Compensation. Treatment of any compensable injury, as defined by the Workers' Compensation Law is not covered, regardless of whether or not the Covered Person filed a claim for workers' compensation benefits in a timely manner. See Subsection 5.3 Other Plans and Benefit Programs.

5.0 PROVIDER NETWORK AND COST SHARING PROCEDURES

The plan may afford you significant savings if you obtain coverage from Providers who are Providers in our Preferred Provider Organization ("Preferred Providers") or other health care Providers who have contracted with the Company ("Contracting Providers"). This Section explains how you can maximize your benefits under the Plan by using Preferred Providers and Contracting Providers, see Subsection 5.1. Under your plan, you are responsible for part of the costs associated with Covered Services, supplies, equipment and treatment. Your responsibilities are explained in this Section, see Subsection 5.2. Finally, this Section explains how costs of benefits that are covered by another benefit plan are covered by the Plan, see Subsection 5.3.

5.1 Network Procedures

1. **Standard Benefits.** Subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Policy, coverage is provided for Health Interventions you receive from a Provider as defined by the Plan. See Subsection 9.83.
2. **Preferred Provider Organization (PPO).** This coverage is most effective and advantageous for you when the services of Preferred Providers are used. Claims associated with services provided by Preferred Providers may have a more advantageous Deductible, Coinsurance and Copayment than claims for services of Non-Preferred Providers. For the definitions and explanation of the terms "Deductible," "Coinsurance," and "Copayment" please refer to Section 9.0 Glossary of Terms and Subsection 5.2.

   The PPO or In-Network Deductible, Coinsurance and Copayment set forth in the Schedule of Benefits are applied to Allowable Charges for services and supplies you receive from a Preferred

Provider, unless the Schedule of Benefits or this Policy shows a different Deductible, Coinsurance or Copayment for the particular service.

3. **Non-PPO Benefits.** Reimbursement for services by Non-preferred Providers generally will be less than payment for the same services when provided by a Preferred Provider and could result in substantial additional out-of-pocket expense. The Non-PPO or Out-of-Network Deductible, Coinsurance, and Copayment set forth in the Schedule of Benefits are applied to Allowable Charges for services and supplies you receive from a Non-Preferred Provider including services and supplies you receive from an Out-of-Area Provider that delivered Emergency Care or a Health Intervention that has received Prior Approval, unless:

   a. **Plan Provision.** The Schedule of Benefits or this Policy provides a different Deductible, Coinsurance or Copayment for the particular service or supply that is the subject of the claim;

   b. **Emergency Services.** The intervention is for Emergency Care (see Subsection 9.31), in which case the In-Network Deductible, Coinsurance and Copayment apply;

   c. **Provider Leaves PPO.** You notify the Company that your Non-Preferred Provider was formerly a Preferred Provider when your ongoing treatment for an acute condition began and that you request PPO benefits for the continuation of such ongoing treatment. If the Company approves PPO coverage for the ongoing treatment, In-Network Deductible, Coinsurance and Copayment will apply to claims for services and supplies rendered by the Non-Preferred Provider for such condition after the Company's approval until the end of the current episode of treatment or until the end of ninety (90) days, whichever occurs first;

   d. **Provider Leaves PPO, Pregnancy.** You notify the Company that your Non-Preferred Provider was formerly a Preferred Provider when you began receiving obstetrical care for a pregnancy covered under the terms of the Plan, that you were in the third trimester of your pregnancy on the date that the Provider left the PPO, and that you request PPO benefits for continuation of such obstetrical care from this Non-Preferred Provider. If the Company approves PPO coverage for the requested Obstetrical Care, In-Network Deductible, Coinsurance and Copayment will apply to services and supplies received from this Non-Preferred Provider after the Company's approval and will continue to apply to claims for services and supplies rendered by the Non-Preferred Provider until the completion of the pregnancy, including two (2) months of postnatal visits.

   e. **Company Approval.** You notify the Company prior to receiving a Health Intervention and the Company has determined that the required Covered Services or supplies associated with such Health Intervention are not available from a Preferred Provider and has provided you a written approval of in-network coverage for such services or supplies, In-Network Deductible, Coinsurance and Copayment will apply to the claims for the services that you receive from the Non-Preferred Provider.

A pre-service claim for Prior Authorization submitted to the Company of requests for payment of out-of-network services or supplies at in-network benefit level should be made by writing Arkansas Blue Cross and Blue Shield, Attention: Medical Audit and Review Services, Post Office Box 3688, Little Rock, Arkansas 72203, and should be received at least 15 working days prior to your receipt of such services or supplies. See Section 7.0 for procedures related to urgent care requests.

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

4. **No Balance Billing from Preferred Providers and Contracting Providers.** Preferred Providers and Contracting Providers are Physicians or Hospitals who are paid directly by the Company and have agreed to accept the Company's payment for Covered Services as payment in full except for your Deductible, Coinsurance, Copayment and any specific benefit limitation, e.g. Home Health visits are limited to 50 per year (Subsection 3.19), if applicable. **A Covered Person is responsible for billed charges in excess of the Company's payment when Physicians or Hospitals who are neither a Preferred Provider nor a Contracting Provider render services. These excess charges could amount to thousands of dollars in additional out of pocket expenses to the Covered Person.**

5. **Preferred Provider Directory.** The determination of whether a Physician or Hospital is a Preferred Provider, Non-Preferred Provider, Contracting Provider or Non-Contracting Provider is the responsibility of the Company. The Company can provide a list of Preferred Providers and Contracting Providers. You may also obtain a list of Preferred Providers and Contracting Providers on the Company's web site WWW.ARKANSASBLUECROSS.COM. A Provider's status may change. You can verify the Provider's status by calling Customer Service.

   BlueCard PPO Program. Your plan includes the BlueCard PPO benefit. This benefit allows you to receive PPO in-network benefits from a Provider, as defined in Subsection 9.85, located outside of Arkansas, provided such Provider is in the PPO network of the local Blue Cross or Blue Shield Company and benefits are Prior Approved in accordance with Subsection 3.34. You may obtain a list of the PPO Providers in an out- of- Arkansas location or verify the status of an out of state Provider by calling (800) 810-2583.

6. **Provider Status may Change.** It is possible that you might not be able to obtain services from a particular Preferred Provider. The network of Providers is subject to change. You might find that a particular PPO Provider may not be accepting new patients. If a Provider leaves the Network or is otherwise not available to you, you must choose another PPO Provider to get In-Network benefits.

7. **NOTICE: Certain Services may not be In-Network Benefits.** Additional costs, including balance billing, may be incurred for a covered Health Intervention, e.g. anesthesia, radiology, or laboratory tests, provided by a non-PPO Provider in a PPO Hospital. These additional charges may not count toward the In-network Annual Limitation on Cost Sharing. **Do not assume that a PPO Provider's agreement includes all covered benefits or that all services provided at a PPO Hospital are provided by PPO Provider** Some PPO Providers contract with the Company to provide only certain covered benefits, but not all covered benefits. Some Providers choose to be a PPO Provider for only some of our products. Refer to the Provider directory, ask your Provider or contact Customer Service for assistance. **Your Provider may not be In-Network for all services.**

8. **Relation of the Company to Providers.** The decision about whether to use a Preferred Provider or a Contracting Provider is the sole responsibility of a Covered Person. Neither Preferred Providers nor Contracting Providers are Policyholders or agents of the Company. The Company makes no representations or guarantees regarding the qualification or experience of any Provider with respect to any service. The evaluation of such factors and the decision about whether to use any Provider is the sole responsibility of the Covered Person.

9. **Scope of Provider Payment - Global Payment**. The Company's payment to a Provider for their services as described in a Current Procedural Terminology ("CPT") or Healthcare Common Procedure Coding System ("HCPCS") code and reimbursed in accordance with the Resource-Based Relative Value System ("RBRVS") used by the Centers for Medicare & Medicaid Services ("CMS") is an all-inclusive, global payment that covers all elements of the service as described in the particular code billed. This means that whatever staffing, overhead costs, equipment, drugs, machinery, tools, technology, supplies, or materials of any kind that may be required in order for the billing Provider to perform the service or treatment described in the CPT or HCPCS code billed, the Company's payment to the billing Provider of the Allowance or Allowable Charge for that CPT or HCPCS code constitutes the entire payment and the limit of benefits under this Policy with respect to the CPT or HCPCS code billed. A Provider who bills for a particular CPT or HCPCS code is deemed to represent that the billing Provider has performed and is responsible for provision of all services or treatments described in the CPT or HCPCS code, and is entitled to bill

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

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

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

Company will not be responsible for paying multiple providers or multiple billings for the professional component, nor will the Company be responsible for paying multiple providers or multiple billings for the technical component. Benefits under this Policy will be limited in such circumstances to one global payment (Allowance) for the professional component and one global payment (Allowance) for the technical component.

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

1. **Deductible.** For those covered Health Interventions specified in the Schedule of Benefits as subject to a Deductible, each calendar year before the Plan makes a Coinsurance payment, a Policyholder must pay the cost of a Covered Service equal to the annual Deductible limitation specified in the Schedule of Benefits. If Plan provides family coverage and the Schedule of Benefits specifies a dollar amount for the family annual Deductible, all family members will accumulate Allowable Charges equal to the dollar amount specified for the family annual Deductible, however no single family member may accrue more Allowable Charges than specified in the individual annual Deductible. Once the family members accumulate Allowable Charges equal to the dollar amount specified for family annual Deductible, no further Deductible will be required for the balance of the year. Deductible payments count toward the Annual Limitation on Cost Sharing
2. **Coinsurance.** Once the Deductible is satisfied, the Policyholder is responsible for Coinsurance, which is a percentage of the Allowance or Allowable Charges paid, for claims incurred until the payment equals the Annual Limitation on Cost Sharing specified in the Schedule of Benefits.
3. **Copayments.** In order to receive certain Health Interventions from an In-Network Provider, a Covered Person may have to pay a Copayment, which is expressed as either a dollar amount or a percentage of the Allowance or Allowable Charge in the Schedule of Benefits. Copayments count toward the Annual Limitation on Cost Sharing specified in the Schedule of Benefits.
4. **Annual Limitation on Cost Sharing.** A Covered Person with individual coverage must incur Allowable Charges for services and supplies from In-Network Providers equal to or exceeding the In-Network Individual Annual Limitation on Cost Sharing specified in the Schedule of Benefits. If the Plan provides family coverage (coverage other than individual coverage), all the Covered Persons in the family will meet the Family Annual Limitation on Cost Sharing once one member of the family incurs Allowable Charges for services and supplies from In-Network Providers that equal or exceed the In-Network Individual Annual Limitation on Cost Sharing specified in the Schedule of Benefits and one or more of the remaining family members incur Allowable Charges that results in the family total Allowable Charges equal to or exceeding the In-Network Family Annual Limitation on Cost Sharing specified in the Schedule of Benefits. After the Annual Limitation on Cost Sharing is satisfied, subject to the provisions of Subsection 5.2.5 of this Policy, the Policyholder will have no further responsibility with respect to Allowances or Allowable Charges incurred during the balance of the calendar year.
5. **Allowable Charges Not Applicable to Annual Limitation on Cost Sharing.** No Allowance or Allowable Charges paid for services or supplies from Non-Preferred Providers shall accumulate to or be impacted by the satisfaction of the Annual Deductible Limitation or the Annual Limitation on Cost Sharing, unless the Company determines that the Non-Preferred Provider should be treated as a Preferred Provider in accordance with one of the provisions listed in Subsection 5.1.3.

5.3 **Other Plans and Benefit Programs**

1. **Coordination of Benefits.** Coordination of Benefits (COB) applies when a Covered Person has coverage under more than one Health Benefit Plan. The Company may annually request that a Covered Person verify the existence of other coverage.
   a. **Definitions.** For purposes of this Subsection 5.3 only, the following words and phrases shall have the following meanings:
      i. "Allowable Expenses" means any necessary, reasonable and customary item of expense at least a portion of which is covered under at least one of the Health Benefit Plans covering the person for whom claim is made. When a Health Benefit Plan provides benefits in the form of coverage for services, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

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

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

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

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

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

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

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

(2) That portion of any such Policy, contract or other arrangement which reserves the right to take the benefits of other Health Benefit Plans into consideration in determining its benefits and that portion which does not.

b. The Company shall have the right to coordinate benefits between this Plan and any other Health Benefit Plan covering a Covered Person.

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

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

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

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

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

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

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

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

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

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

(3) When the parents are divorced and the parent with custody of the child has remarried, if there is no court decree fixing financial responsibility on one parent for the medical, dental or other health care expense with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the step-parent, and the benefits of a plan which covers that child as a dependent of the step-parent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

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

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

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

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

2. **Medicare, Military or Government Benefits.** If you are a Medicare beneficiary, your Medicare benefits will be considered primary to this Policy. In other words, because Medicare is primary, when you submit a claim, the Company will subtract the amount of Medicare benefits you receive in determining the benefits due under this Policy. Services and benefits for treatment of military service-connected disabilities to which a Covered Person is legally entitled from a military or government benefit plan shall in all cases be provided before the benefits of this Policy.

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

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

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

In the event that the Company pays any claim by the Covered Person for benefits under this Policy, and subsequently learns that the Covered Person has filed a claim for workers' compensation benefits as to such claim, or that the Covered Person has settled a workers' compensation claim with any workers' compensation carrier, or has otherwise received any amount toward payment of such a claim under the Workers' Compensation Law, state or federal workers' compensation, employer's liability or occupational disease law, or motor vehicle no-fault law, the Covered Person agrees to reimburse the Company to the full extent of its payments on such claim.

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

6.0 ELIGIBILITY STANDARDS

Even if a Health Intervention you receive would be covered under the other coverage standards set out in this Policy, you must be eligible under the Policy and the Policy must be in force at the time you receive such

Intervention in order to receive benefits. This section sets out the standards for eligibility under the Policy Subsection 6.1; describes the Open Enrollment Period in which individuals covered by this Policy may change their coverage, Subsection 6.2; describes Special Enrollment Periods in which individual covered by this Policy and persons related to them may acquire coverage, Subsection 6.3; and the policies governing termination of coverage under this Policy; Subsection 6.4.

6.1 **Eligibility for Coverage.** In order to be covered by the Policy, you must meet the eligibility requirements for a Policyholder, an individual insured under a "Child Only" Policy or the Policyholder's Dependent.

1. **Policyholder Eligibility.** An eligible Policyholder is:
   a. a Qualified Individual enrolled through the Exchange and current on all Premiums or
   b. an individual between the ages of 18 and 65, who resides in the State of Arkansas, who is not eligible for Medicare, and who has completed and submitted to the Company an application for coverage.
2. **Individual Insured under a "Child Only" Policy** is an individual under the age of 18, who resides in the State of Arkansas and whose parent or legal guardian has completed and submitted to the Company an application for coverage.
3. **Dependent Coverage.** Eligible Dependents are those individuals who are the Policyholder's:
   a. Spouse;
   b. Child less than 26 years of age;
   c. unmarried Child who is incapable of self-support because of mental retardation or physical disability, provided such Child is or was under the limiting age of dependency stated in Subsection b. above at the time of application for coverage under the Policy.
4. **Proof of Mental Retardation or Physical Disability.** In order for Dependent coverage to be provided due to mental retardation or physical disability, proof of the Child's dependency and retardation or disability must be furnished to the Company, or to the Exchange if the Policyholder is a Qualified Individual, prior to the Child's attainment of the applicable limiting age referenced in section 6.1.3.b., above. Such proof must at least demonstrate that the Child is unable to obtain or continue a job or position in the course of commerce and that his or her parent(s) are providing 50% or more of his financial support (i.e.e.g. are declaring the Child as a dependent on their federal income tax return or providing a child's birth certificate.) Initial and subsequent evaluation for continued retardation or physical disability and dependency may be required by the Company, at the Company's expense, or the Exchange if the Policyholder is a Qualified Individual, but not more frequently than once per year. A Policyholder who first becomes eligible under the Plan may enroll a retarded or disabled Dependent Child provided the retardation or disability commenced before the limiting age.

6.2 **Open Enrollment Period.** During this period the Policyholder may change his or her coverage and that of Covered Dependents, as well as apply for coverage for other dependents by submitting the appropriate applications or change forms to the Company or to the Exchange. Coverage approved during the Open Enrollment Period will become effective on January 1st of the following calendar year.

6.3 **Special Enrollment Periods.** A Special Enrollment Period is a specified period of time during which time the Policyholder may obtain coverage for a Dependents after initial coverage is obtained by the Policyholder and not during an Open Enrollment Period

1. **Length of Special Enrollment Periods**. Unless otherwise specified, a Special Enrollment Period shall be 60 days from the date of the triggering event.
2. **Triggering Events.**
   a. A Dependent of the Policyholder loses Minimum Essential Coverage under another health plan for reasons other than failure to pay premiums or justified rescission.
   b. The Policyholder gains a Dependent through marriage, birth, adoption or placement for adoption. Note that the Special Enrollment Period for a new born child is 90 days.
   c. A Dependent of the Policyholder that is a Qualified Individual who was not previously a citizen, national or lawfully present becomes a Qualified Individual by gaining the applicable status.
   d. A Dependent of the Policyholder who was formerly not a permanent resident becomes a permanent resident of Arkansas.
3. **Special Enrollment Effective Date**

a. If eligible for coverage as a result of a Special Enrollment Triggering Event and the individual elects coverage between the 1st and the 15th day of the month, his or her coverage will become effective on the first of the following month.

b. If eligible for coverage as a result of a Special Enrollment Triggering Event and the individual elects coverage between the 16th and the last day of the month, his or her coverage will become effective on the first of the second following month.

c. In the case of birth, adoption or placement for adoption, the coverage will become effective on the date of birth, adoption or placement for adoption.

d. In the case of marriage or loss of Minimum Essential Coverage, the coverage will become effective on the first of the following month.

6.4 **Term, Renewal and Termination of the Policy.** This Policy shall be in effect until terminated by its terms.

1. **At the Option of the Policyholder.** The Policyholder may terminate this Policy at his or her option on the date the Policyholder specifies by giving the Company at least fourteen (14) days' notice.

2. **Termination by the Exchange.** If the Policyholder is a Qualified Individual, his or her coverage may be terminated on a date specified by the Exchange.

3. **Death of Policyholder.** This Policy shall terminate upon the death of the Policyholder. In such event, the Company shall return all unearned premiums beyond the date of death to your estate or other appropriate party. Contact Customer Service to set up a new Policy for family Covered Persons currently covered on this Policy.

4. **Change of Residence.** If the Policyholder moves permanently to another state, this Policy shall terminate at the end of the period for which premiums have been paid.

5. **Guaranteed Renewable, Premiums May Change.** Unless you change residence from Arkansas (See Subsection 6.4.4), this Policy and any amendments or riders to it are guaranteed renewable. This means that the Policy shall remain in force, so long as the Policyholder complies with its terms and so long as the premiums are paid in a timely manner. Your premium rate may change upon renewal if your age increases, if you relocate into a different rating area or the Company changes the established premium rate for all policies and riders of the same form number and premium classification as this Policy.

6. **Payment of Premiums**. Premium payment due dates are the first day of the month. The premium payment mode is monthly. Premium payments are due in advance of the premium due date regardless of the premium payment mode selected, subject to the Grace Period provision below. "Pay," "Paid" or "Payment," when used herein reference to premium, premium due dates or the Grace Period shall mean that the full amount of all funds due are actually received by the Company at its principal offices in Little Rock, Arkansas. Placing a check into the U.S. mail or with any courier service shall not constitute payment under this Policy unless or until the check is actually received by the Company at its principal office. Nor shall any invalid or dishonored check constitute payment.

7. **Grace Period.**

a. For a Policyholder who is a Qualified Individual receiving advance payments of premium tax credits, a grace period of three consecutive months will be granted for the payment of premiums becoming payable after the first premium payment. During the grace period the Policy shall continue in force. The Company shall pay appropriate claims for services rendered during the first month of the grace period and shall suspend payment of claims for services rendered during the second and third month of the grace period. If all outstanding premiums are not paid within the three month period after they become due and payable, this Policy shall terminate as of the last day of the first month of the grace period.

b. For a Policyholder who is not Qualified Individual receiving advance payments of premium tax credits, a grace period of one month will be granted for the payment of premiums becoming payable after the first premium payment. During the grace period the Policy shall continue in force. If premiums are not paid within one month after they become due and payable, this Policy shall terminate as of the date on which the premiums were due and payable.

8. **Reinstatement.** If any renewal premium is not paid within the grace period, a subsequent acceptance of premium by the Company or by any agent authorized by the Company to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Policy; provided, however, that if the Company or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by the Company or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the Company has previously notified the Covered Person in writing of its disapproval of such application. The reinstated Policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten (10) days after such date. In all other respects, the Covered Person and Company shall have the same rights hereunder as they had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

9. **Termination of a Covered Person's Coverage For Cause.**

   a. The Company may terminate coverage under this Policy upon thirty (30) days' written notice for:

      i. intentional misrepresentation of material fact (subject to the provision entitled "Time Limit on Certain Defenses," Subsection 8.3,) or fraud in obtaining coverage; or

      ii. intentional misrepresentation of material fact or fraud in the filing of a claim for services, supplies, or in the use of services or facilities.

   b. For purposes of this termination for cause provision, intentional misrepresentation of material fact occurs if (i) information is withheld or if incorrect information is provided and (ii) the Company would not have issued this Policy, would have charged a higher premium, would have required the Policy to be amended, or would not have paid a claim in the manner it was paid had the Company known the facts concealed or misrepresented.

   c. Termination for cause shall be effective upon the later of (i) thirty (30) days after a written notice of termination for cause is posted in the U.S. Mail, addressed to the Policyholder at his or her last known address as provided by Policyholder to Company; or (ii) the date stated in the termination notice letter to Policyholder.

   d. A Covered Person may appeal a termination for cause action. Such an appeal must be submitted in writing, addressed to the Appeals Coordinator of Arkansas Blue Cross and Blue Shield, 601 S. Gaines Street, Little Rock, Arkansas 72203. In order for the appeal to be considered the Appeals Coordinator must receive the appeal prior to the later of (i) thirty (30) days after a written notice of termination for cause is posted in the U.S. Mail, addressed to the Policyholder at his or her last known address as provided by Policyholder to Company; or (ii) the termination effective date stated in the termination notice letter to Policyholder.

10. **Termination of Benefits.** Upon termination of this Policy all benefits, except for Health Interventions that incurred prior to termination, shall cease.

7.0 CLAIM PROCESSING AND APPEALS

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

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

7.1 **Claim Processing.**

1. **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, test, 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 Company.

2. **Who May Submit a Claim.** A Covered Person, a Provider with an assignment of the claim that is approved by the Company or the Covered Person's Authorized Representative may submit a claim. See Subsection 7.4 below concerning the Authorized Representative.

3. **Classifications of Claims.** There are two 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 Company.

   a. **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, test, 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 Company. Examples of post-service claims are claims involving physician office visits, maternity care, outpatient services, and most prescription drugs obtained through a managed pharmacy benefit.

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

   Post-Service Claims may be submitted electronically in accordance with the Company's electronic claim filing procedures, or such claims may be mailed to Arkansas Blue Cross and Blue Shield Claims Division, Post Office Box 2181, Little Rock, Arkansas 72203.

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

   If the Company requires information reasonably necessary to determine whether or to what extent benefits are covered under the Plan, as specified in Subsection 7.1.4. below, the Company will suspend the claim and request the needed information. If you or your treating Provider supplies the Company the required information within ninety (90) days of the claim suspension, the Company will notify you of its claim determination and will forward any payment resulting from the claim determination within 15 days of the Company's receipt of the required information. If the Company does not receive the required information within the 90-day period, 15 days later, the suspended claim becomes a denied claim, subject to appeal. See Subsection 7.2 Claim Appeals to the Plan.

   b. **Pre-Service Claims.** The terms of the Plan condition receipt of certain benefits on Prior Approval by the Company, whereby the Company gives approval in advance of the Covered Person obtaining a requested medical service, drug, supply, test, or equipment that such medical service, drug, supply, test, or equipment meets Primary Coverage Criteria. Plan benefits requiring the submission of pre-service claims are: Services of Physicians for surgery (Subsection 3.1.4); Inpatient Hospital (Subsection 3.3.1); Certain Outpatient Hospital Services (3.3.2); Hospital services with anesthesia for complex dental conditions (Subsection 3.3.3); Certain services performed at an Ambulatory Surgery Center (Subsection 3.4); Advanced Diagnostic Imaging (Subsection 3.6); Allowable charges for infertility testing, artificial insemination and in-vitro fertilization (Subsection 3.7.5); Rehabilitation and Habilitation Services (Subsection 3.9); Mental Illness and Substance Use Disorder, residential treatment centers, and Repetitive Transcranial Magnetic Stimulation (rTMS) (Subsection 3.10); Applied behavioral analysis (Subsection 3.11); Durable medical equipment for which costs exceed $500 (Subsection 3.13.3); Wound Vacuum Assisted Closure (VAC) (Subsection 3.13.8); Surgically implantable osseointegrated hearing aids (Subsection 3.15.3); Prosthetic devices for which cost

exceed $5,000 (Subsection 3.15.4); Skilled Nursing Facility (Subsection 3.18); Home Health Services (Subsection 3.19); Hospice Care (Subsection 3.20); Oral Surgery (Subsection 3.21); Corrective surgery for craniofacial anomalies (Subsection 3.23.3); Reduction mammoplasty (Subsection 3.23.6); Certain Prescription Medications (Subsection 3.24); Most organ transplants (Subsection 3.25); Medical Disorder Requiring Specialized Nutrients or Formulas (Subsection 3.26); Admission to neurologic rehabilitation facilities (Subsection 3.30); Some pediatric vision services (Subsection 3.31); Health Interventions by Out-of-Area Providers (Subsection 3.34); Enteral feedings (Subsection 3.35.6); and Gastric pacemakers (Subsection 3.35.7). **Please note Prior Approval does not guarantee payment or assure coverage, it means only that the information furnished to the Company in the pre-service claim indicates that the Health Intervention meets the Primary Coverage Criteria requirements set out in Subsection 2.2 and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b., e., or f. and is not subject to a Specific Plan Exclusion (see Section 4.0). All Health Interventions must still meet all other coverage terms, conditions and limitations, and coverage for these services may still be limited or denied, if, when the post-service claim for the services is received by us, investigation shows that a benefit exclusion or limitation applies because of a difference in the Health Intervention described in the pre-service claim and the actual Health Intervention, that the Covered Person ceased to be eligible for benefits on the date the services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in this Policy.**

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

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

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

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

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

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

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

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

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

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

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

If the Company requires information reasonably necessary to determine whether the requested medical service, drug, supply, test or equipment meets the Primary Coverage Criteria under the Plan, the Company will notify your physician within 24 hours of receiving the claim and request the needed information. If you or your treating Provider supplies the Company the required information within 48 hours, the Company will notify you of its claim determination within 1 business day after the Company receives such information. If the Company does not receive the required information within the 48-hour period, the claim will be denied, subject to appeal. See Subsection 7.3 Claim Appeals to the Plan.

If the urgent care claim is a request to extend previously approved benefit for ongoing treatment, the Company 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 Company at the time indicates that the Health Intervention that is the subject of the claim involving urgent care meets the Primary Coverage Criteria and is not subject to a Specific Plan Exclusion (see Section 4.0). A Health Intervention receiving Prior Approval as a claim involving urgent care, must still meet all other coverage terms, conditions, and limitations. Coverage for any such claim may still be limited or denied if, when the claimed Intervention is completed and the Company receives the post-service claim(s), investigation shows that a benefit exclusion or limitation applies because of a difference in the Health Intervention described in the prior approved claim and the actual Health Intervention, that the 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 this Evidence of Coverage applies to limit or exclude the claim.

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

e. **Claims involving Ongoing Care or Concurrent Review.** The Company'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 Company shall give an explanation of the reduction or termination of a benefit to the Covered Person, as specified in Subsection 7.1.6, with sufficient time prior to the termination or reduction to allow for an appeal under Subsection 7.2.7.d., to be completed before the termination or reduction takes place but no later than 24 hours after receipt of the claim.

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

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

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

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

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

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

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

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

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

vii. payment from the policyholder of premiums that were delinquent at the time the claimed services were rendered.

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

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

a. The specific reason or reasons for the determination with information sufficient to identify the claim involved (including the date of service, the health care provider, the claim

amount and a way that the Covered Person may learn the diagnosis and treatment codes and their descriptions);

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

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

d. A description of the Plan's appeal process, see Subsection 7.2 below. If the claim involves urgent care, a description of the expedited appeals process, see Subsection 7.2.7.c., below;

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

7. **Informal Claim Review.** If you have questions about an Explanation of Benefit Determination, you may contact Customer Service (Telephone toll free (800) 800-4298, or write Arkansas Blue Cross and Blue Shield, Customer Service, Post Office Box 2181, Little Rock, Arkansas 72203) and ask that the determination be reviewed. Customer Service will respond in like manner with answers to your request. This informal review is not an Appeal (see Subsection 7.2 below) nor a substitute for an appeal. Nor must you ask for an informal review in order to request an appeal.

8. **Informal Coverage Information.** From time to time you or your Provider may want an indication whether a service, supply, prescription drug, equipment, or treatment is an eligible benefit of the Plan. You may make an Informal Coverage Information to Arkansas Blue Cross and Blue Shield Customer Service Division, Post Office Box 2181 Little Rock, Arkansas 72203, or by Telephone toll free (800) 800-4298.

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

b. **The Company's response to an Informal Coverage Information is not a guarantee of payment. The Company's ultimate determination of a claim will be based upon the relevant facts as applied to the terms, conditions, limitations and exclusions of the Plan.** An Informal Coverage Information is not a claim. The Company's response to an Informal Coverage Information is not a claim determination. The Company's response is based upon the information available to the Company at the time of the inquiry and such information may not be current or accurate. The Company reserves the right to make a final determination of the post-service claim resulting from a Health Intervention that may have been the subject of an Informal Coverage Information after the intervention has been completed and all relevant facts are known.

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

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

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

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

1. **Legal Actions**. No Court suit shall be brought to recover on this Policy before sixty (60) days after a claim has been submitted in accordance with the terms of this Policy. No legal action shall be brought after the expiration of three (3) years from the time that a claim is required to be submitted.

2. **Who May Request a Review.** A Covered Person or the Covered Person's Authorized Representative may file an appeal to request a review of a claim denial. See Subsection 7.4 concerning the Authorized Representative.

3. **Where and When (Deadline) to Submit an Appeal.** If a claim for benefits is denied either in whole or in part, you will receive a notice explaining the reason or reasons for the denial. See Subsection 7.1.6, above. You may request a review of a denial of benefits for any claim or portion of a claim by sending a request marked "Internal Review Request" to the Appeals Coordinator of Arkansas Blue Cross and Blue Shield, 601 S. Gaines Street, Little Rock, Arkansas 72203. Your request must be made within one hundred eighty (180) days after you have been notified of the denial of benefits.

4. **Appeals Subject to Direct External Review.** The Company may waive internal review of any claim determination. If the Company waives internal review, the Company shall defer the claim for external review in accordance with Section 7.3 below.

5. **Documentation.**

   a. **Written Appeals.** You must submit your appeal in writing. However, an appeal related to a claim involving urgent care may initially be submitted orally. Although the Appeals Coordinator will immediately commence consideration of an oral appeal, the Appeals Coordinator requires written confirmation of the appeal.

   b. **Appellant's Right to Information.** The Company shall provide you free of charge and sufficiently in advance of the date of the final internal adverse benefit determination to give you a reasonable opportunity to respond, reasonable access to, and copies of, all documents, records or other information that:

      i. were relied upon in making the benefit determination;

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

      iii. demonstrate compliance with the terms of the Plan.; or

      iv. constitute a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the your diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

   c. **Appellant's Right to Submit Information.** You may submit with your request for review any additional written comments, issues, documents, records and other information relating to your claim.

   d. **Appeals Coordinator Right to Information.** You and the treating health care professional are required to provide the Appeals Coordinator, upon request, access to information necessary to determine the appeal. Such information should be provided not later than five (5) days after the date on which the Appeals Coordinator's request for information is received, or, in the case of a claim involving urgent care or concurrent review, at such earlier time as may be necessary to comply with the applicable timelines. See Subsections 7.2.7.c. and d. Your failure to provide access to such information shall not remove the obligation of the Appeals Coordinator to make a determination on the appeal, but the Appeals Coordinator's determination may be affected if such requested information is not provided.

6. **Conduct of Review.**

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

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

   c. **Review of Medical Judgment.** When reviewing a claim in which the determination was based in whole or in part on medical judgment, including determinations with regard to the application of the Primary Coverage Criteria or a Coverage Policy, the Appeals Coordinator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health

care professional shall not be an individual that was consulted in the initial claim determination, nor the subordinate of such individual. The Appeals Coordinator shall, upon request, provide the identity of health care professional(s) consulted in conducting the review, without regard to whether the health care professional's advice was relied upon in making the benefit determination.

7. **Timing of Appeal Determination.**

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

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

   c. **Claims Involving Urgent Care.** If you request an expedited review, and a health care professional certifies that determination as a general pre-service claim would seriously jeopardize your life or health or your ability to regain maximum function, the Appeals Coordinator shall make a determination on review in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 72 hours after the time the Appeals Coordinator receives the request for review. See Subsection 7.2.9., below.

   d. **Concurrent Care Determination.** The Appeals Coordinator shall administer an appeal involving concurrent care in accordance with Subsections 7.2.7.a., b., or c., depending upon whether the claim is a post-service claim, a pre-service claim or a claim involving urgent care.

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

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

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

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

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

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

9. **Expedited Appeal Procedure.** An appeal of a claim involving urgent care or of a claim involving ongoing care is conducted in accordance with this Subsection 7.2.9. Note that submission to the Appeals Coordinator may be done electronically, FAX No. (501) 378-3366, e-mail: APPEALSCOORDINATOR@ARKBLUECROSS.COM. In accordance with Subsection 7.2.5.a., an expedited appeal may be submitted by telephone, (501) 378-2025, followed by a written confirmation. Please refer to Subsection 7.2.5.d., with respect to submission of information concerning a claim involving urgent care or concurrent review to the Appeals Coordinator. In accordance with Subsection 7.2.7.c., the Appeals Coordinator will notify you and your treating health care professional of the determination of your expedited appeal in accordance with the medical exigencies of the case and soon as possible, but in no case later than 72 hours after the Appeals Coordinator receives the expedited appeal.

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

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

   a. **Waiver of Internal Review.** If we have waived internal review, your appeal shall be to external review in accordance with this Section 7.3.

   b. **Application of Primary Coverage.** If your claim has not been the subject of a prior external review and if we have denied your claim in whole or in part because the

intervention did not meet the Primary Coverage Criteria (other than under the conditions outlined in Subsections 2.4.1.a., b., c. or d.) or because of the application of a Coverage Policy, you may request an independent medical review by an Independent Review Organization in accordance with the provisions of this Subsection 7.3 provided:

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

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

iii. You have not requested or agreed to a delay in the Plan's internal review process and the Appeals Coordinator has not given you notification of the determination involving a post-service claim appeal within sixty (60) days following receipt of your appeal to the Plan; or

iv. Your claim meets the requirements for expedited external review, (see Subsection 7.3.12) and you have simultaneously submitted an appeal to the Plan.

2. **Where and When to Submit External Review Appeal.** You may request external review by submitting a request for external review to the Arkansas Insurance Commissioner, 1200 West Third Street, Little Rock, Arkansas 72201 or by calling (800) 282-9134. Your request must be made within four (4) months after you were notified that the claim denial was upheld in whole or in part as a result of the Plan's internal review process. If Subsection 7.3.1.b.ii. or 7.3.1.b.iii. apply, your request may be made at the end of the thirty (30) day period or sixty (60) day period. If Subsection 7.3.1.b.iv., applies, you must file your request for external review at the same time you file your appeal to the Plan.

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

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

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

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

4. **Documentation**

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

b. **Authorization to Release Information.** In filing your request for external review, you must include the following authorization: "I, [Covered Person's name], authorize Arkansas Blue Cross and Blue Shield and my healthcare Provider(s) to release all medical information or records pertinent to this claim to the Independent Review Organization that is designated by Arkansas Blue Cross. I further authorize such Independent Review Organization to release such medical information to any

Independent Medical Reviewer(s) selected by the Independent Review Organization to conduct the review."

5. **Referral of Review Request to an Independent Review Organization.** Upon receipt of the documentation set out in Subsection 7.3.4, the Arkansas Insurance Commissioner shall immediately refer the request for external review, along with the Company's initial determination of the claim and the Appeals Coordinator's internal review determination (if applicable) to an Independent Review Organization.

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

7. **Rejection of Request for Review by the Independent Review Organization.** The Independent Review Organization shall reject a request for review and notify you, your Authorized Representative and the Appeals Coordinator in writing within five (5) business days (or within 72 hours for an Expedited Appeal) of its determination, if it determines that the appeal does meet the standards for an appeal for external review. See Subsections 7.3.1.

8. **Rejection of the Review for Failure to Submit Requested Information.** The Independent Review Organization may reject a request for review if:
   a. you have not provided the authorization for release of medical records or information pertinent to the claim required by Subsection 7.3.4.b; or
   b. you or your health care professional have not provided information requested by the Independent Review Organization in accordance with Subsection 7.3.6.

9. **Independent Medical Review Determination.** If the Independent Review Organization does not reject the request for review in accordance with Subsections 7.3.7 or 7.3.8, it shall assign the request for review to an Independent Medical Reviewer. Such Independent Medical Reviewer shall make a determination after reviewing the documentation submitted by you, your health care professional and the Company. The Independent Medical Reviewer shall consider the terms of this Policy to assure that the reviewer's decision is not contrary to the terms of the Plan. In making the determination the reviewer need not give deference to the determinations made by the Company or the recommendations of the treating health care professional (if any).

10. **Timing of Appeal Determination.**
    a. **Standard Review.** The Independent Medical Reviewer shall complete a review on an appeal within a reasonable period of time, but in no case later than forty five (45) days after the Independent Review Organization received the appeal.
    b. **Expedited Review.** If you request an expedited review, and a health care professional certifies that the time for a standard review would seriously jeopardize your life or health or your ability to regain maximum function, the Independent Medical Reviewer shall make a determination on review in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 72 hours after the time the Independent Review Organization received the request for review.

11. **Notification of Determination of Independent Medical Review.**
    a. **Recipients of Notice.** Upon receipt of the determination of the Independent Medical Reviewer, the Independent Review Organization shall provide written notification of the determination to you, your health care Provider, the Company and the Arkansas Insurance Commissioner.
    b. **The Notification shall include**.
       i. A general description of the reason for the request for external review;
       ii. The date the Independent Review Organization was notified by the Company to conduct the review;
       iii. The date the external review was conducted;
       iv. The date of the Independent Medical Reviewer's determination;
       v. The principal reason(s) for the determination;
       vi. The rationale for the determination; and

vii. References to the evidence or documentation, including practice guidelines, considered in the determination.

12. **Expedited External Review.**

a. **Requirement for Expedited Review.** You may submit a pre-service claim denial or a denial of a claim involving concurrent care for an expedited external review provided your health care professional certifies that the time to complete a standard review would seriously jeopardize your life or health or your ability to regain maximum function.

b. **Expedited External Review without prior Appeal to Plan (internal review).** You may request an expedited review at the same time you submit a request for an appeal to the Plan (internal review) if your health care professional certifies that the time to complete the Plan's expedited appeal process would seriously jeopardize your life or health or your ability to regain maximum function. If you make such a request, the Independent Review Organization may determine and notify you in accordance with Subsections 7.3.10.b. and 7.3.11 whether you will be required to complete the internal review process.

c. **Same procedures as standard external review.** Unless otherwise specified, the provisions of this Section 7.3 applicable to independent medical review of claims apply to expedited external review of claims.

13. **Other Rights under Plan.** Your decision to submit an appeal to external review will have no effect on your other rights and benefits under the Plan.

14. **Arkansas Insurance Commissioner.** You may contact the Arkansas Insurance Commissioner for assistance. The mailing address is Arkansas Insurance Department, Attention External Review Assistance, 1200 West Third Street, Little Rock, Arkansas 72201. The telephone number is (501) 371-2640 or toll free (800) 282-9134. The e-mail address is insurance.consumers@arkansas.gov.

15. **Binding on the Plan.** The determination of an Independent Review Organization and an Independent Medical Reviewer is binding on both the Plan and you, except to the extent that other remedies are available under applicable federal or state law.

7.4 **Authorized Representative**

1. **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.

2. **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 "You" or "Covered Person" in this document refer to the Authorized Representative.

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

a. An individual designated by the Covered Person in writing in a form approved by the Company;

b. 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 Company;

c. A person holding the Covered Person's durable power of attorney;

d. 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

e. If the Covered Person is a minor, the Covered Person's parent or legal guardian, unless the Company 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.

4. **Communication with Authorized Representative.**

a. 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 Company shall send all correspondence, notices and

benefit determinations in connection with the Covered Person's claim to the Authorized Representative.

b. 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 Company shall send all correspondence, notices and benefit determinations in connection with the Covered Person's claim to the Authorized Representative.

c. If the Authorized Representative represents the Covered Person in connection with the submission of a post-service claim, the Company will send all correspondence, notices and benefit determinations in connection with the Covered Person's claim to the Covered Person, but the Company will provide copies of such correspondence to the Authorized Representative upon request.

5. **Term of the Authorized Representative.** The authority of an Authorized Representative shall continue until

a. the claim(s) or appeal(s) for which the Authorized Representative was designated has been fully adjudicated; or

b. the Covered Person is legally competent to represent himself or herself and notifies the Company that the Authorized Representative is no longer required.

8.0 OTHER PROVISIONS

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

8.1 **Entire Contract.**

a. This Policy, any amendments thereto, and the Application, Change Request Form and the Schedule of Benefits constitute the entire agreement between the parties. No part of this Policy shall be changed or waived in any way except by written amendment signed by the President of the Company and approved by the Arkansas Insurance Department. No Agent has the authority to change any of its terms.

b. You hereby expressly acknowledge your understanding that this Policy constitutes a contract solely between you and Arkansas Blue Cross and Blue Shield, that Arkansas Blue Cross and Blue Shield is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Arkansas Blue Cross and Blue Shield to the use the Blue Cross and Blue Shield Service Marks in the State of Arkansas, and that Arkansas Blue Cross and Blue Shield is not contracting as the agent of the Association. You further acknowledge and agree that you have not entered into this Contract based upon representations by any person other than Arkansas Blue Cross and Blue Shield and that no person, entity, or organization other than Arkansas Blue Cross and Blue Shield shall be held accountable or liable to you for any of the obligations created under this Policy.

8.2 **Assignment of Benefits.** No assignment of benefits under this Policy shall be valid until approved and accepted by the Company. The Company reserves the right to make payment of benefits, in its sole discretion, directly to the Provider of service.

8.3 **Time Limit on Certain Defenses.** Except for fraudulent misstatements made by you in the application for this Policy, no misstatement shall be used to void any of the terms of the Policy after three (3) years.

8.4 **Right of Rescission.** Subject to the provision entitled "Time Limit on Certain Defenses," Subsection 8.3, the Policyholder's act of fraud or intentional misrepresentation of material fact may be used by the Company as the basis for rescinding this Policy. The Company must provide the Policyholder 30 days' advance written notice of its intent to rescind the Policy.

8.5 **Premium Refunds.** Premium refunds are available under this Policy when:

1. You have provided a written notice to Arkansas Blue Cross and Blue Shield that you want your coverage cancelled on a particular premium due date and this document is received by Arkansas Blue Cross and Blue Shield in advance of the premium due date on which you want your coverage cancelled. Premiums will only be refunded for any period beyond the end of the Policy Month in which the notice was received; or

2. Upon a Covered Person's death, premiums will be refunded for any period beyond the date of death.

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

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

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

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

3. If a Covered Person is no longer covered by the Company at the time of any such recovery, regardless of the amount or of the time of such recovery, the Company shall be entitled to retain such recovery for its own use.

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

8.7 **Notice of Provider/Physician Incentives That Could Affect Your Access to Healthcare**

1. General Description and Purpose of Incentive Programs: The Company contracts with physicians and other types of health care providers who agree to perform services for Arkansas Blue Cross and Blue Shield Covered Persons, often at a discount from their usual charges. In contracting with providers, including physicians, the Company sometimes offers financial incentives to encourage providers to practice medicine in a cost-effective manner, and to improve the quality of health care services. These incentive arrangements sometimes offered by the Company may take a variety of forms but the main goals of the incentive arrangements are designed to do one or both of two things: (1) give the provider (including physicians) a financial incentive to control the overall cost of treatment; and (2) give the provider (including physicians) a financial incentive to pay increased attention to well-established quality standards and thereby hopefully improve the overall quality of care being provided. The financial incentives sometimes offered by the Company to providers (including physicians) sometimes involve a financial reward if specified goals are met; at other times, the financial incentives may include a financial penalty if the provider (including physicians) fails to achieve specified goals. In other cases, the financial incentive program that the Company offers to providers (including physicians) may include both the opportunity for financial rewards, as well as the possibility of financial penalties, depending on how the provider performs.

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

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

if the provider's overall cost of care for Covered Persons is higher than a pre-determined target budget, the provider may forfeit some or all of the withhold fund.

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

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

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

3. Incentive Arrangements Subject to Change. The incentive arrangements described here concern the provider contracts that are either in place and regularly used by the Company at the time this Policy was issued, or are being contemplated for use in the future. Because of the rapid pace of change in health care financing in today's marketplace, physician provider negotiating positions, regulatory changes, or other developments, the precise content of the Company's provider reimbursement and incentive plans may change significantly in the future. See subsection 4, below, for ways in which you can obtain additional or updated information regarding the Company's provider incentive programs.

4. For Further Information. If you have any concerns about how the various incentive programs offered to the Company's-participating providers may affect your access to health care services, you should discuss such concerns with your physician or other treating health care professional. You may ask your Physician's health care provider's administrative staff about compensation methods, including incentives, which apply to the services provided by their Physician, your health care provider. In addition, you may or request information from the Company by writing to submit written questions to Arkansas Blue Cross and Blue Shield, Customer Service Division, Post Office Box 2181 Little Rock, Arkansas 72203.

9.0 GLOSSARY OF TERMS

These are terms used in this Policy.

9.1 **Accidental Injury** is defined as bodily injury sustained by a Covered Person while the insurance is in force, and which is the direct cause of the loss, independent of disease or bodily infirmity. Injury to a tooth or teeth while eating is not considered an Accidental Injury.

9.2 **Allowance or Allowable Charge,** when used in connection with Covered Services or supplies delivered in Arkansas, will be the amount deemed by the Company, in its sole discretion, to be reasonable. The Arkansas Blue Cross and Blue Shield customary allowance is the basic Allowance or Allowable Charge. However, the Allowance or Allowable Charge may vary, given the facts of the case and the opinion of the Company's medical director.

See Subsection 3.25.4 with respect to the Allowance or Allowable Charge for transplants. See Subsection 3.3.2 with respect to the Allowance or Allowable Charge for Outpatient Surgery Centers. **Please note that all benefits under this Policy are subject to and shall be paid only by reference to the Allowance or Allowable Charge as determined at the discretion of Arkansas Blue Cross and Blue Shield. This means that regardless of how much your health care Provider may bill for a given service, the benefits under this Policy will be limited by the Allowance or Allowable Charge we establish. If you use an Arkansas Blue Cross and Blue Shield-participating Provider, that Provider is obligated to accept our established rate as payment in full, and should only bill you for your Deductible, Coinsurance and any non-covered services; however, if you use a non-participating Provider, you will be responsible for all amounts billed in excess of the Arkansas Blue Cross and Blue Shield Allowance or Allowable Charge.**

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

For example, a physician who performs certain surgical procedures in the physician's office might choose to engage an equipment and supply company to set up the surgical table, furnish an assisting nurse, and also furnish certain surgical instruments, devices or supplies used by the physician. When the physician bills the Company for the physician's performance of the surgical procedure described in a specific CPT or HCPCS code, the Company will make a single, global payment to the physician for Covered Services described in the CPT or HCPCS code, and will not be obligated to pay for any charges of the equipment and supply company. In such circumstances, any charge or claim of payment due the equipment and supply company shall be the exclusive responsibility of the physician (or other provider) who engaged the equipment and supply company, and permitted or facilitated such company's access to the physician's patient. In any event, as noted above, no benefits are available under this Policy for any services, drugs, materials or supplies of the equipment and supply company. It is the Company's policy (and this Policy is specifically intended to adopt the same) that no benefits shall be paid for "unbundled services" in excess of the Company's Allowance or Allowable Charge for any service as described in the applicable CPT or HCPCS code. This means, for example, that if a physician and another category of provider (such as a durable medical equipment supplier, a laboratory, a nurse practitioner, a nurse, a physician's assistant or any other category of provider) agree together to divide up, split or "unbundle" the components of any

CPT or HCPCS code, and attempt to bill separately for the various components each allegedly provides for the patient, benefits under this Policy shall nevertheless be limited to one Allowance per CPT or HCPCS code; in such circumstances, your benefits under this Policy will pay only one Allowance or Allowable Charge for any Covered Service described in any single CPT or HCPCS code, and the various providers involved in any such "unbundling" action or agreement must resolve among themselves any division of that single Allowance or Allowable Charge between or among them. You can protect yourself from the possibility of billing in excess of the Allowance or Allowable Charge in these circumstances by always inquiring in advance to be sure that each provider involved in your care or treatment is a Preferred Provider.

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

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

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

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

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

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

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

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

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

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

9.10 **Child** means a Policyholder's natural Child, legally adopted Child or Stepchild. "Child" also means a Child for whom the Policyholder has been appointed the legal guardian.

9.11 **Cognitive Rehabilitation** means a treatment modality designed specifically for the remediation of disorders of perception, memory and language in brain-injured persons. Services or supplies provided as or in conjunction with, Cognitive Rehabilitation are not covered. See Subsection 4.2.16.

9.12 **Coinsurance** means the obligation of a Covered Person to pay a certain portion of an Allowance or Allowable Charge. Coinsurance is expressed as a percentage in the Schedule of Benefits. The Schedule of Benefits sets forth the Coinsurance for services or supplies received from a Preferred Provider and the Coinsurance for services and supplies from Non-Preferred Provider.

9.13 **Company** means Arkansas Blue Cross and Blue Shield.

9.14 **Complication of Pregnancy** means

1. Hospital confinement required to treat conditions, such as the following, in a pregnant female: acute nephritis, nephrosis, cardiac decompensation, HELLP syndrome, uterine rupture, amniotic fluid embolism, chorioamnionitis, fatty liver in pregnancy, septic abortion, placenta accrete, gestational hypertension, puerperal sepsis, peripartum cardiomyopathy, cholestasis in pregnancy, thrombocytopenia in pregnancy, placenta previa, placental abruption, acute cholecystitis and pancreatitis in pregnancy, postpartum hemorrhage, septic pelvic thrombophlebitis, retained placenta, venous air embolus associated with pregnancy, miscarriage or an emergency c-section required because of (a) fetal or maternal distress during labor, or (b) severe pre-eclampsia, or (c) arrest of descent or dilatation, or (d) obstruction of the birth canal by fibroids or ovarian tumors, or (e) necessary because of the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that, in the absence of immediate medical attention, will result in placing the life of the mother or fetus in jeopardy. For purposes of this subsection, a c-section delivery is not considered to be an emergency c-section if it is merely for the convenience of the patient and/or doctor or solely due to a previous c-section.
2. Treatment, diagnosis or care for conditions, including the following, in a pregnant female when the condition was caused by, necessary because of, or aggravated by the pregnancy: hyperthyroidism, hepatitis B or C, HIV, Human papilloma virus, abnormal PAP, syphilis, chlamydia, herpes, urinary tract infections, thromboembolism, appendicitis, hypothyroidism, pulmonary embolism, sickle cell disease, tuberculosis, migraine headaches, depression, acute myocarditis, asthma, maternal cytomegalovirus, urolithiasis, DVT prophylaxis, ovarian dermoid tumors, biliary atresia and/or cirrhosis, first trimester adnexal mass, hydatidiform mole or ectopic pregnancy.
3. Management of a difficult pregnancy is not a Complication of Pregnancy.

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

9.16 **Contracting Provider** means a Provider who has signed a Contract with this Company to provide the

services covered by this Policy to Covered Persons. The Company will pay the Contracting Provider directly.

9.17 **Copayment** means the amount required to be paid to a Preferred Provider by or on behalf of a Covered Person in connection with Covered Services.

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

9.19 **Coverage Policy** means a statement developed by the Company that sets forth the medical criteria for coverage under an Arkansas Blue Cross and Blue Shield Policy. Some limitations of benefits related to coverage, of a drug, treatment, service equipment or supply are also outlined in the Coverage Policy. A copy of a Coverage Policy is available from the Company, at no cost, upon request, or a Coverage Policy can be reviewed on the Company's web site at WWW.ARKANSASBLUECROSS.COM.

9.20 **Covered Person** means the Policyholder or Dependent who is insured under this Policy.

9.21 **Covered Services** means services for which a Covered Person is entitled to benefits under the terms of this Policy.

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

9.23 **Deductible** means the amount of out of pocket expense a Covered Person must incur for Covered Services each calendar year before any Coinsurance expenses are paid by the Company under the Plan. This amount is calculated from the Allowance or Allowable Charges, not the billed charges. Once the Deductible has been met, subject to all other terms, conditions, limitations and exclusions in the Plan, Coinsurance payments for Covered Services begin.

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

9.25 **Dependent** means any Covered Person of the Policyholder's family who meets the eligibility requirements of Section 6.0, who is enrolled in the Plan, and for whom the Company has received premium.

9.26 **Developmental Service Visit** means one hour of Developmental Services provided by a licensed or certified provider. A Developmental Service Visit may include services provided by more than one provider.

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

9.28 **Diabetes Self-Management Training** means instruction, including medical nutrition therapy relating to diet, caloric intake and diabetes management (excluding programs the primary purpose of which is weight

reduction) which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a means of avoiding frequent Hospitalizations and complications when the instruction is provided in accordance with a program in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

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

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

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

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

9.33 **Exchange** means a governmental agency or non-profit entity, which meets the applicable standards of the federal Affordable Care Act of 2010 and implementing rules, that makes Qualified Health Plans available to Qualified Individuals.

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

Prescription Medications on the Formulary are classified into various cost tier designs based on the benefit. Prescription Medication tiers are classified as Preventive Medications, Generic Medications, Brand Name Medications, and Specialty Medications. The list of Prescription Medications that make up the Formulary and the tier classification of a Prescription Medication on the Formulary are subject to change by the Company and the Pharmacy and Therapeutics Committee. In recommending whether to place a Prescription Medication on the Formulary or to place a Prescription Medication in a tier classification in the Formulary, the Pharmacy and Therapeutics Committee compares a Prescription Medication's safety, effectiveness, cost efficiency and uniqueness with other Prescription Medications in the same category. **Prescription Medications including new Prescription Medications approved by the FDA are not covered under this Policy unless or until the Company places the medication on the Formulary.**

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

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

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

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

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

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

9.40 **Homeopathic** means healing the underlying cause of disease not simply eliminating the symptoms caused by the disease. Some forms of homeopathic treatment may include, but are not limited to diet therapy, environment services, minimum doses of natural medications. Homeopathic treatments are not covered. See Subsection 4.2.66.

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

9.42 **Hospital** means an acute general care Hospital and a Rehabilitation Hospital licensed as such by the appropriate state agency. It does not include any of the following, unless required by applicable law or approved by the Board of Directors of the Company: 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.

9.43 **In-Network Provider** means a Preferred Provider or a Contracting Provider who has signed a contract with the Company to provide the Covered Services by this Policy to Covered Persons. The Company pays an In-Network Provider directly.

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

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

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

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

9.48 **Maintenance Therapy** means any therapy where there is no expectation based upon a reasonable degree of medical probability that treatment will result in significant, measurable improvement in the condition in a reasonable, predictable period of time for treatment.

9.49 **Maternity Care and Obstetrical Care** means Health Interventions necessary because of or related to the following conditions: premature rupture of membranes; false labor; occasional spotting in pregnancy; pre-term labor; pre-term birth; physician prescribed rest during the pregnancy; morning sickness; hyperemesis gravidarum; celphalopelvic disproportion; intrauterine growth retardation; analysis for fetal down syndrome, trisomy 18 or neural tube defect; congenital diaphragmatic hernia; hydrops fetalis; group B strep prophylaxis in pregnancy; isoimmunization in pregnancy; antepartum fetal surveillance; management of hyperemesis; cervical incompetence; fetal urethral obstruction; twin or greater gestation with prior uterine atony; macrosomia; incompetent cervix; forceps deliver; fetal fibronectin; cytotec for induction of labor; sudden onset of polyhydramnios; prophylactic cesarean delivery of HIV positive mother; Klippel-Trenaunay Syndrome; caudal regression syndrome; Hospitalization to postpone delivery until the fetus is further developed; biophysical profiles; fetal monitoring; non-routine ultrasounds; vaginal delivery; antepartum and postpartum care; or services related to c-sections scheduled because of (a) multiple

gestation, (b) previous c-section delivery, (c) patient or physician convenience, (d) cephalopelvic disproportion or (e) abnormal presentations such as breech, shoulder dystonia, transverse and compound.

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

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

9.52 **Medical Literature** means articles from major peer-reviewed medical journals specified by the United States Department of Health and Human Services pursuant to section 1861(t)(2)(B) of the Social Security Act, 42 U.S.C. §1395(x)(t)(2)(B), as amended.

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

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

9.55 **Member** means the Policyholder. See Section 10.0.

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

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

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

2. An employer sponsored health benefit plan;

3. Comprehensive health coverage in the individual market;

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

9.58 **Naturopathic** means a system of therapeutics in which neither surgical or medicine agents are used, dependence placed only on natural (non-medicinal) focus. Naturopathic treatments are not covered. See Subsection 4.2.66.

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

1. be operated pursuant to law;

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

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

9.60 **Non-Contracting Provider** means a Provider who has declined to sign a contract with this Company to provide to Covered Persons services covered by this Policy. Non-Contracting Providers are free to bill and collect from you charges for Covered Services which are in excess of the Company's Allowance or Allowable Charge.

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

9.62 **Non Preferred Provider** means a Provider that does not participate in the Preferred Provider Organization.

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

9.64 **Out-of-Network Provider** means a Non-Contracting Provider who does not have a contract with the Company to provide Covered Services by this Policy to Covered Persons. Out-of-Network Providers are free to bill and collect from you charges for Covered Services which are in excess of the Company's Allowance or Allowable Charge.

9.65 **Outpatient Hospital** means a portion of a Hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under the supervision of, a Physician to patients treated on an outpatient basis for a variety of medical conditions and not kept overnight or otherwise admitted as inpatients to the Hospital.

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

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

9.68 **Partial Day Treatment Program** means treatment for a Covered Person who is not at imminent risk of significant harm to self or others but requires a structured and monitored environment with access to the full spectrum of Health Interventions. Physicians normally prescribe services for at least 4 hours, but not more than 8 hours in any 24-hour period.

9.69 **Participating Pharmacy** means a licensed pharmacy that has contracted directly or indirectly with the Company to provide pharmacy services to Covered Persons subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Policy.

9.70 **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.

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

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

9.73 **Plan** means a health insurance plan. The terms of the Plan are set forth in this Policy.

9.74 **Policy** means this document, the Schedule of Benefits, the application and any endorsements or riders signed by the President of the Company.

9.75 **Policyholder** means the person with whom the Company has agreed to provide benefits and whose name appears on the Schedule of Benefits. Policyholder also means Covered Person.

9.76 **Preferred Provider** means a Contracting Provider who has agreed to participate in the Preferred Provider Organization and meets all applicable credentialing and contractual standards associated with the Preferred Provider Organization.

9.77 **Preferred Provider Organization** means a panel of Providers (Hospitals and Physicians) who have agreed to accept reimbursement for their services covered under this Plan at reduced charges.

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

9.79 **Prescription Medication** or **Medication** means any pharmaceutical that has been approved by the FDA and can be obtained only through a Prescription. The Company has classified selected Prescription Medications, primarily Medications intended for self-administration as "A Medications." The Company has classified Intra-muscular injections, Intravenous injections and other pharmaceuticals that are primarily intended for professional administration as "B Medications." You can determine whether a Medication is an A Medication or a B Medication by contacting Customer Service.

9.80 **Primary Care Physician** means a Preferred Provider Physician who provides primary medical care in one of these medical specialties: General Practice, Pediatrics, Family Practice, Obstetrics/Gynecology (when providing Preventive Health Services) or Internal Medicine. This also includes advanced practice nurses or physician's assistants who provide primary medical care in these medical specialties and are performed in the Primary Care Physician's office.

9.81 **Prior Approval** means the process initiated by which the Company as a result of a pre-service claim (see Subsection 7.1.3.b.) to determine in advance of the Covered Person obtaining a requested medical service, Medication, supply, test, or equipment if such medical service, Medication, supply, test, or equipment meets Primary Coverage Criteria requirements set out in Subsection 2.4.1.b, e., or f., and is not subject to a Specific Plan Exclusion (see Subsection 4.0). Ongoing therapy of a prior authorized Medication may require periodic assessments that could include an efficacy measure intended to demonstrate positive outcomes for continuation of therapy. **PLEASE NOTE: Prior Approval does not mean that the service, supply or treatment will be covered regardless of other terms, conditions or limitations outlined in this Policy, but means only that the information furnished to the Company in the pre-service claim indicates that the requested medical service, Medication, supply, test or equipment meet the Primary Coverage Criteria requirements set out in Subsection 2.2 and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b., e., or f. and is not subject to a Specific Plan Exclusion (see Section 4.0). All Health Interventions receiving Prior Approval must still meet all other coverage terms, conditions and limitations, and coverage for these services may still be limited or denied, if, when the post-service claim for the services is received by the Company, investigation shows that a benefit exclusion or limitation applies because of a difference in the Health Intervention described in the pre-service claim and the actual Health Intervention, that the Covered Person ceased to be eligible for benefits on the date the services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in this Policy. For more information about Prior Approval, please see Subsection 7.3.1.b.**

Plan benefits requiring the submission of pre-service claims are: Services of Physicians for surgery (Subsection 3.1.4); Inpatient Hospital (Subsection 3.3.1); Certain Outpatient Hospital Services (3.3.2); Hospital services with anesthesia for complex dental conditions (Subsection 3.3.3); Certain services performed at an Ambulatory Surgery Center (Subsection 3.4); Advanced Diagnostic Imaging (Subsection 3.6); Allowable charges for infertility testing, artificial insemination and in-vitro fertilization (Subsection 3.7.5); Rehabilitation and Habilitation Services (Subsection 3.9); Mental Illness and Substance Use Disorder, residential treatment centers, and Repetitive Transcranial Magnetic Stimulation (rTMS) (Subsection 3.10); Applied behavioral analysis (Subsection 3.11); Durable medical equipment for which costs exceed $500 (Subsection 3.13.3); Wound Vacuum Assisted Closure (VAC) (Subsection 3.13.8); Surgically implantable osseointegrated hearing aids (Subsection 3.15.3); Prosthetic devices for which cost exceed $5,000 (Subsection 3.15.4); Skilled Nursing Facility (Subsection 3.18); Home Health Services (Subsection 3.19); Hospice Care (Subsection 3.20); Oral Surgery (Subsection 3.21); Corrective surgery for craniofacial anomalies (Subsection 3.23.3); Reduction mammoplasty (Subsection 3.23.6); Certain Prescription Medications (Subsection 3.24); Most organ transplants (Subsection 3.25); Medical Disorder Requiring Specialized Nutrients or Formulas (Subsection 3.26); Admission to neurologic rehabilitation facilities (Subsection 3.30); Some pediatric vision services (Subsection 3.31); Enteral feedings (Subsection 3.35.6); and Gastric pacemakers (Subsection 3.35.7).

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

9.83 **Provider** means an advance practice nurse; an athletic trainer; an audiologist; a certified orthotist; a chiropractor; a community mental health center or clinic; a dentist, a Hospital; a licensed ambulatory

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

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

9.85 **Qualified Health Plan** or **QHP** means a health plan that has in effect a certification issued by the Exchange.

9.86 **Qualified Individual** means an individual enrolled through the Exchange and determined by the Exchange to be a citizen or national of the United States or an alien lawfully present in the United States residing in the service area of the Exchange, and is current on his or her premiums.

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

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

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

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

9.89 **Routine Prenatal Care** means outpatient antepartum care and laboratory testing that has been approved as routine based on a Coverage Policy established by the Company. A copy of the Routine Prenatal Care Coverage Policy is available from the Company, at no cost, upon request, or may be reviewed on the Company's web site at WWW.ARKANSASBLUECROSS.COM.

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

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

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

However, a Skilled Nursing Facility does not include:

1. any home, facility or part thereof used primarily for rest;

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

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

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

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

9.95 **Stepchild** means a natural or adopted Child of the Spouse of the Policyholder.

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

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

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

9.99 **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.

9.100 **We, Our and Us** mean the Company.

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

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

9.103 **You and Your** mean a Covered Person.

10.0 POLICY PROVISIONS RELATIVE TO MEMBERSHIP, MEETINGS AND VOTING

As the owner of this Policy, the Policyholder is a Member of Arkansas Blue Cross and Blue Shield. This Section 10.0 describes the meetings of Members, gives notice of the Annual Meeting of Members, and describes a Member's voting rights.

10.1 **Membership** By virtue of ownership of this Policy, the Policyholder is a member of Arkansas Blue Cross and Blue Shield. This Policy is a non-participating policy. This means that the Policyholder does not receive distribution of any premium, revenues, savings or assets of the Company.

10.2 **Annual Meeting.** An annual meeting of the Members shall be held each and every calendar year in the State of Arkansas for the purpose of electing directors, receive and consider reports as to the business and affairs of the Company, and transacting such other business as may properly come before the meeting. The meeting shall be held between January 1 and April 1 of each year at such place, date and time as shall be fixed by the Board of Directors or the Chief Executive Officer. The Board of Directors may, from time to time, provide that the place, date and time of the annual meeting shall be set forth in the Policy of Members as set out in Section 10.3 below.

[THE ANNUAL MEETING OF THE MEMBERS SHALL BE HELD EACH YEAR AT THE HOME OFFICE, LOCATED AT 601 GAINES STREET, LITTLE ROCK, ARKANSAS, ON

THE THIRD MONDAY IN MARCH AT 1:00 P.M. (PROVIDED, IF SUCH DAY SHALL BE A LEGAL HOLIDAY, THEN AT THE SAME TIME AND PLACE ON THE NEXT SUCCEEDING DAY WHICH IS NOT A LEGAL HOLIDAY)].

10.3 **Special Meetings.** A special meeting of Members for any purpose may be called by the Board of Directors or Chief Executive Officer, and shall be called by the Chief Executive Officer or the Secretary at the request of Members holding one-third (1/3) of the voting power entitled to vote thereat. Such request shall state the purpose or purposes of the meeting and no other business outside the scope of the stated purpose or purposes shall be transacted. Unless ordered by the Board of Directors, the time and place of each special meeting of Members shall be determined by the Chief Executive Officer.

10.4 **Notice of Meetings.** So long as each insurance Policy issued by the Company sets forth the place, date and hour of the annual meeting of Members, no notice of any annual meeting shall be required to be given to any Member, regardless of the number or nature of proposals to be considered and voted upon at the annual meeting. If notice of the annual meeting is not set forth in each insurance Policy, written or printed notice of the annual meeting and every special meeting of the Members, stating the place, date, time and the purpose or purposes of such meeting shall be given to the Members entitled to vote at such meeting not less than ten (10), nor more than sixty (60), days before the date of the meeting. All such notices shall be given, either personally or by mail, by or at the direction of the Chief Executive Officer or Secretary unless ordered by the Board of Directors. Notices which shall be mailed shall be deemed to be "given" when deposited in the United States Mail addressed to the Member at the Member's address as it appears on the records of the Company, with postage prepaid [first class mail, if the notice is mailed thirty (30) days or less before the date of the meeting], and any notice transmitted other than by mail shall be deemed to have been "given" when delivered to the Member.

10.5 **Quorum.** Except as otherwise provided by applicable law, a majority of the Members of the Company (present in person or by proxy) shall be necessary to constitute a quorum for the transaction of business at any annual or special meeting of the Members of the Company.

10.6 **Voting Rights.** Each Member shall be entitled to one vote for each Policy held by him upon each matter coming to a vote at meetings of Members. Such vote may be exercised in person or by written proxy.

10.7 **Vote Required.** A majority of the voting power represented at any meeting of Members shall be necessary and sufficient to approve any given matter. There shall be no cumulative voting.

10.8 **Proxy.** By accepting this Policy the Policyholder appoints the Board of Directors ("Board") of the Company to act on the Policyholder's behalf at all meetings of Members of the Company. This appointment shall include such persons as the Board may designate by resolution to act on its behalf. This proxy gives the Board, or its designee, full power to vote for the Policyholder on all matters that may be voted upon at any meeting. This proxy, unless revoked, shall remain in effect during the term of this Policy. The Policyholder may revoke this proxy in writing by advising the Company of such revocation at least five (5) days prior to any meeting. The Policyholder may also revoke its proxy by attending and voting in person at any Members' meeting.

Curtis Barnett, President and Chief Executive Officer

ARKANSAS BLUE CROSS AND BLUE SHIELD
601 S. Gaines Street
Little Rock, Arkansas 72201

ARKANSAS CONSUMERS INFORMATION NOTICE

For additional information regarding your Arkansas Blue Cross and Blue Shield benefits, please feel free to contact us at:

Arkansas Blue Cross and Blue Shield
Customer Service
Post Office Box 2181
Little Rock, Arkansas 72203
Telephone toll free (800) 800-4298

If we at Arkansas Blue Cross and Blue Shield fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201
Telephone (501) 371-2640 or toll free (800) 852-5494
insurance.consumers@arkansas.gov.

LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are Covered Persons of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a Covered Person insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other Covered Person insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the Covered Person insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
C/o The Liquidation Division
1023 West Capitol, Suite 2
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a Covered Person insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit Hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contract holders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC")(whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the Covered Person insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliated benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 in life and annuity benefits and $500,000 in health insurance benefits - no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. Within this overall limits, the Association will not pay more than $300,000 in disability and long-term care benefits, $500,000 in health insurance benefits $300,000 in present value of annuity benefits, or $300,000 in life insurance death benefits or net cash surrender values - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverage. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.