



**Active and Retiree
Health Benefit Summary Plan Description And Plan Document
7670-00-411309/7670-03-411309**

BENEFITS ADMINISTERED BY



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UNIVERSITY OF ARKANSAS SYSTEM
GROUP HEALTH BENEFIT PLAN
SUMMARY PLAN DESCRIPTION AND PLAN DOCUMENT
INTRODUCTION

The purpose of this document is to provide You and Your covered Dependents, if any, with summary information on benefits available under the UNIVERSITY OF ARKANSAS BENEFIT Plan (The "Plan") as well as information on a Covered Person's rights and obligations under the Plan. As a valued Employee of UNIVERSITY OF ARKANSAS SYSTEM, we are pleased to sponsor this Plan to provide benefits that can help meet Your health care needs. Please read this document carefully and contact Your Human Resources or Personnel office if You have questions.

The President of the UNIVERSITY OF ARKANSAS SYSTEM is named the Plan Administrator for this Plan. The Plan Administrator has designated staff of the University of Arkansas System to act on the President's behalf in plan administration and has retained the services of independent Third Party Administrators to process claims and handle other duties for this self-funded Plan. The Third Party Administrators for this Plan are UMR, Inc. (hereinafter "UMR") for medical claims, and MedImpact Healthcare Systems, Inc. for pharmacy claims. The Third Party Administrators do not assume liability for benefits payable under this Plan, as they are solely claims paying agents for the Plan Administrator.

The Plan is self-funded by participating campuses of the University of Arkansas System through monies set aside for the purpose of paying Your and Your dependent's medical care; however, Employees help cover some of the costs of covered benefits through contributions, Deductibles, out-of-pocket, and Plan Participation amounts as described in the Schedule of Benefits.

Some of the terms used in this document begin with a capital letter, even though the term normally would not be capitalized. These terms have special meaning under the Plan. Most terms will be listed in the Glossary of Terms, but some terms are defined within the provision where the term is used. Becoming familiar with the terms defined in the Glossary will help to better understand the provisions of this Plan.

Individuals covered under this Plan will be receiving an identification card to present to the provider whenever services are received. On the back of this card are phone numbers to call in case of questions or problems.

This document provides information on the benefits and limitations of the Plan and is known as a Summary Plan Description ("SPD") and Plan Document.

This document becomes effective on January 1, 2013.

PLAN INFORMATION

Plan Name	UNIVERSITY OF ARKANSAS MEDICAL BENEFIT PLAN
Name And Address Of Employer	UNIVERSITY OF ARKANSAS SYSTEM 2404 N UNIVERSITY AVE LITTLE ROCK AR 72207 ATTN: VICE PRESIDENT FOR ADMINISTRATION
Name, Address And Phone Number Of Plan Administrator	UNIVERSITY OF ARKANSAS SYSTEM 2404 N UNIVERSITY AVE LITTLE ROCK AR 72207 501-686-2500 ATTN: PRESIDENT
Named Fiduciary	BOARD OF TRUSTEES OF THE UNIVERSITY OF ARKANSAS
Employer Identification Number Assigned By The IRS	71-6003252
Type Of Benefit Plan Provided	Self-Funded Health & Welfare Plan providing Group Health Benefits
Type Of Administration	The administration of the Plan is under the supervision of the Plan Administrator. The Plan is not financed by an insurance company and benefits are not guaranteed by a contract of insurance. UMR provides administrative services such as claim payments for medical claims.
Name And Address Of Agent For Service Of Legal Process	BOARD OF TRUSTEES OF THE UNIVERSITY OF ARKANSAS 2404 N UNIVERSITY AVE LITTLE ROCK AR 72207 ATTN: PRESIDENT'S OFFICE
Funding Of The Plan	Employer and Employee Contributions Benefits are provided by a benefit plan maintained on a self-insured basis by Your employer.
Benefit Plan Year	Benefits begin on January 1 and end on the following December 31. For new Employees and Dependents, a Benefit Plan Year begins on the individual's Effective Date and runs through December 31 of the same Benefit Plan Year.
Plan's Fiscal Year	July 1 through June 30
Compliance	It is intended that this Plan meet all applicable laws. In the event of any conflict between this Plan and the applicable law, the provisions of the applicable law shall be deemed controlling, and any conflicting part of this Plan shall be deemed superseded to the extent of the conflict.

Discretionary Authority

The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion, shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all plan documents, including this SPD, and make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties, except that the Plan Administrator has delegated certain responsibilities to the Third Party Administrators for this Plan. Any interpretation, determination or other action of the Plan Administrator or the Third Party Administrators shall be subject to review only if a court of proper jurisdiction determines its action is arbitrary or capricious or otherwise a clear abuse of discretion. Any review of a final decision or action of the Plan Administrator or the Third Party Administrators shall be based only on such evidence presented to or considered by the Plan Administrator or the Third Party Administrators at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator or the Third Party Administrators make, in its sole discretion, and further, means that the Covered Person consents to the limited standard and scope of review afforded under law. Nothing herein shall waive the sovereign immunity of the State of Arkansas or of the Plan Administrator.

BENEFIT CLASS DESCRIPTION

The Covered Person's benefit class is determined by the designations shown below:

Class	Class Description	Benefit Plan
A01	ALL ACTIVE EMPLOYEES – CLASSIC PLAN	001
A02	ALL ACTIVE EMPLOYEES - POINT OF SERVICE PLAN	002
C01	ALL COBRA PARTICIPANTS – CLASSIC PLAN	001
C02	ALL COBRA PARTICIPANTS - POINT OF SERVICE PLAN	002
R01	ALL NON-MEDICARE ELIGIBLE RETIREES AND/OR SPOUSES/DEPENDENTS – CLASSIC PLAN	001
R02	ALL NON-MEDICARE RETIREES AND/OR SPOUSES, DEPENDENTS – POINT OF SERVICE PLAN	002
R05	ALL MEDICARE PRIMARY EMPLOYEES AND/OR SPOUSEES, DEPENDENTS – CLASSIC PLAN	005
R06	ALL MEDICARE PRIMARY EMPLOYEES AND/OR SPOUSEES, DEPENDENTS – POINT OF SERVICE	006
**Note: The SmartCare option is currently available only to UAMS Employees and Retirees and their eligible Dependents who receive care at UAMS or through a UAMS provider.		
A03	ALL ACTIVE EMPLOYEES - POINT OF SERVICE PLAN USING UAMS SMARTCARE OPTION	003
A04	ALL ACTIVE EMPLOYEES - POINT OF SERVICE UAMS SMARTCARE OPTION	004
C03	ALL COBRA PARTICIPANTS - CLASSIC PLAN USING UAMS SMARTCARE OPTION	003
C04	ALL COBRA PARTICIPANTS - POINT OF SERVICE PLAN USING UAMS SMARTCARE OPTION	004

Class	Class Description	Benefit Plan
R03	ALL NON-MEDICARE ELIGIBLE RETIREES AND/OR SPOUSES, DEPENDENTS – CLASSIC PLAN USING UAMS SMART CARE OPTION	003
R04	ALL NON-MEDICARE ELIGIBLE RETIREES AND/OR SPOUSES, DEPENDENTS – POINT OF SERVICE PLAN USING UAMS SMART CARE OPTION	004
R07	ALL MEDICARE PRIMARY EMPLOYEES AND/OR SPOUSEES, DEPENDENTS – CLASSIC PLAN USING UAMS SMART CARE OPTION	007
R08	ALL MEDICARE PRIMARY EMPLOYEES AND/OR SPOUSEES, DEPENDENTS – POINT OF SERVICE PLAN USING UAMS SMART CARE OPTION	008

**Note: See Provider Network section of this SPD for network description.

MEDICAL SCHEDULE OF BENEFITS

Benefit Plan(s) 001, 005 – Classic Non-SmartCare

****Note:** The SmartCare option is currently available only to UAMS Employees and Retirees and their eligible Dependents who receive care at UAMS or through a UAMS provider.

All health benefits shown on this Schedule of Benefits are subject to the following: Annual maximums, Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses section of this SPD for more details.

Benefits are subject to all provisions of this Plan including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the Utilization Management section of this SPD for a description of these services and prior authorization procedures.

Notes: Refer to the Provider Network section for clarifications and possible exceptions to the In-Network or Out-of-Network classifications.

If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, that means that it is a combined Maximum Benefit for services that the Covered Person receives from all In-Network and Out-of-Network providers and facilities.

	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible Per Calendar Year:		
• Per Person		\$750
• Per Family		\$1,500
Plan Participation Rate, Unless Otherwise Stated Below:		
• Paid By Plan After Satisfaction Of Deductible		80%
Annual Out-Of-Pocket Maximum:		
• Per Person		\$2,000
• Per Family		\$4,000
Ambulance Transportation:		
• Co-pay Per Visit (Waived If Admitted As Inpatient)		\$100
• Paid By Plan		100% (Deductible Waived)
Autism Services:		
• Maximum Benefit Per Calendar Year	\$10,000	No Benefit
• Paid By Plan After Deductible	80%	
Note: Maximum Applies To ABA Therapy Only.		
Breast Prosthesis:		
• Maximum Benefit Every Two Years	1 Replacement	No Benefit
• Paid By Plan	100% (Deductible Waived)	
Breast Pumps:		
• Paid By Plan	100% (Deductible Waived)	No Benefit

	IN-NETWORK	OUT-OF-NETWORK
Chiropractic Services: <ul style="list-style-type: none"> Maximum Visits Per Calendar Year Includes Physical, Occupational And Speech Therapy Paid By Plan After Deductible 	30 Visits 80%	No Benefit
Contraceptive Methods And Counseling Approved By The FDA: <ul style="list-style-type: none"> Paid By Plan 	100% (Deductible Waived)	No Benefit
Diabetes Treatment Not Performed In Office: <ul style="list-style-type: none"> Paid By Plan After Deductible 	80%	No Benefit
Diabetes Treatment Performed In Office: <ul style="list-style-type: none"> Co-pay Per Visit - Primary Care Physician Co-pay Per Visit - Specialist Paid By Plan 	\$25 \$40 100% (Deductible Waived)	No Benefit
Nutritional Counseling: <ul style="list-style-type: none"> Paid By Plan 	100% (Deductible Waived)	
Durable Medical Equipment: <ul style="list-style-type: none"> Paid By Plan After Deductible 	80%	No Benefit
Emergency Services / Treatment: Urgent Care: <ul style="list-style-type: none"> Co-pay Per Visit Paid By Plan Emergency Room / Emergency Physicians: <ul style="list-style-type: none"> Co-pay Per Visit (Waived If Admitted As Inpatient Within 24 Hours) Paid By Plan 	\$50 100% (Deductible Waived) \$150 100% (Deductible Waived)	
Extended Care Facility Benefits Such As Skilled Nursing, Convalescent Or Subacute Facility: <ul style="list-style-type: none"> Co-pay Per Admission (Waived If Transferred From An Acute Care Facility) Paid By Plan After Deductible <p><i>Note: Maximum Combined Inpatient Co-Pay Per Calendar Year Is \$1,200 Per Person. No More Than One Co-Pay Per 30 Days.</i></p>	\$300 80%	No Benefit
Hearing Services: Exams, Tests Not Performed In Office: <ul style="list-style-type: none"> Paid By Plan After Deductible Exam, Tests Performed In Office: <ul style="list-style-type: none"> Co-pay Per Visit - Primary Care Physician Co-pay Per Visit - Specialist Paid By Plan 	80% \$25 \$40 100% (Deductible Waived)	No Benefit No Benefit

	IN-NETWORK	OUT-OF-NETWORK
Hearing Aids: <ul style="list-style-type: none"> Maximum Benefit Per Ear Every Three Years Paid By Plan 	\$1,400 100% (Deductible Waived)	
Implantable Hearing Aids: <ul style="list-style-type: none"> Paid By Plan After Deductible 	80%	
Home Health Care Benefits: <ul style="list-style-type: none"> Maximum Visits Per Calendar Year Paid By Plan After Deductible <p><i>Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Therapist, As The Case May Be, Or Up To Four (4) Hours Of Home Health Care Services. Care Management Can Extend The Visits In Lieu Of More Expensive Level Of Care.</i></p>	40 Visits 80%	No Benefit
Hospice Care Benefits:		No Benefit
Hospice Services: <ul style="list-style-type: none"> Paid By Plan After Deductible 	80%	
Bereavement Counseling: <ul style="list-style-type: none"> Paid By Plan After Deductible 	80%	
Hospital Services:		No Benefit
Pre-admission Testing: <ul style="list-style-type: none"> Paid By Plan After Deductible 	80%	
Inpatient Services Only: <ul style="list-style-type: none"> Co-pay Per Admission Paid By Plan After Deductible <p><i>Note: Maximum Combined Inpatient Co-Pay Per Calendar Year Is \$1,200 Per Person. No More Than One Co-Pay Per 30 Days.</i></p>	\$300 80%	
Inpatient Physician Charges Only: <ul style="list-style-type: none"> Paid By Plan After Deductible 	80%	
Outpatient Services / Outpatient Physician Charges: <ul style="list-style-type: none"> Paid By Plan After Deductible 	80%	

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Lab And X-ray Charges: <ul style="list-style-type: none"> • Paid By Plan After Deductible Outpatient Lab And X-ray Charges In Relation To An In-Network Office Visit: <ul style="list-style-type: none"> • Paid By Plan Note: Lab And X-ray Charges Must Be Performed Within 14 Days Of The Office Visit. This Benefit Also Applies To Out-Of-Network Lab And X-rays In Relation To An In-Network Office Visit. Advanced Imaging Services Will Follow Normal Plan Participation Rates. Outpatient Surgery Only: <ul style="list-style-type: none"> • Co-pay Per Visit • Paid By Plan After Deductible Outpatient Surgeon Charges Only: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	80% 100% (Deductible Waived) \$150 80% 80%	
Maternity: Prenatal, Delivery And Postnatal: <ul style="list-style-type: none"> • Paid By Plan Physician Office Charges: <ul style="list-style-type: none"> • Paid By Plan Inpatient Services Only: <ul style="list-style-type: none"> • Co-pay Per Admission • Paid By Plan After Deductible Note: Maximum Combined Inpatient Co-Pay Per Calendar Year Is \$1,200 Per Person. No More Than One Co-Pay Per 30 Days.	100% (Deductible Waived) 100% (Deductible Waived) \$300 80%	No Benefit
Mental Health, Substance Abuse And Chemical Dependency Benefits: Inpatient Services Only: <ul style="list-style-type: none"> • Co-pay Per Admission • Paid By Plan After Deductible Note: Maximum Combined Inpatient Co-Pay Per Calendar Year Is \$1,200 Per Person. No More Than One Co-Pay Per 30 Days. Inpatient Physician Charges Only: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	 \$300 80% 80%	No Benefit

	IN-NETWORK	OUT-OF-NETWORK
Residential Treatment: <ul style="list-style-type: none"> • Paid By Plan After Deductible Outpatient Or Partial Hospitalization Services (Day Treatment) And Physician Charges: <ul style="list-style-type: none"> • Paid By Plan After Deductible Office Visit: <ul style="list-style-type: none"> • Co-pay Per Visit • Paid By Plan 	80% 80% \$25 100% (Deductible Waived)	 No Benefit
Morbid Obesity Treatment: <ul style="list-style-type: none"> • Paid By Plan After Deductible Note: Please Refer To The Exclusion Section For Additional Benefit Information. Weight Loss Programs: <ul style="list-style-type: none"> • Maximum Reimbursement Per Lifetime • Paid By Plan Note: Members Must Pay For The Physician Supervised Weight Loss Program Up Front And Submit A Claim To UMR For Reimbursement. UMR Will Not Reimburse The Provider Directly.	80% \$1,000 100% (Deductible Waived)	No Benefit
Nutritional Counseling: <ul style="list-style-type: none"> • Maximum Visits Per Calendar Year With Dietitian • Maximum Visits Per Calendar Year With Health Coaching • Paid By Plan 	1 Visit 3 Visits 100% (Deductible Waived)	
Nursery And Newborn Expenses: <ul style="list-style-type: none"> • Paid By Plan Note: The Deductible Is Waived For The Entire Newborn Stay Even If A Sick Child.	100% (Deductible Waived)	No Benefit
Orthotic Appliances: <ul style="list-style-type: none"> • Paid By Plan After Deductible Shoes -Custom Molded: To Age 18 <ul style="list-style-type: none"> • Maximum Benefit Per Calendar Year From Age 18 • Maximum Benefit Per Calendar Year • Paid By Plan After Deductible Shoe Inserts-Custom Molded: <ul style="list-style-type: none"> • Maximum Benefit Per Calendar Year • Paid By Plan After Deductible 	80% 2 Pairs 1 Pair 80% 2 Pairs 80%	No Benefit

	IN-NETWORK	OUT-OF-NETWORK
Physician Office Services: <ul style="list-style-type: none"> Co-pay Per Visit - Primary Care Physician Co-pay Per Visit - Specialist Paid By Plan 	\$25 \$40 100% (Deductible Waived)	No Benefit
Office Surgery: <ul style="list-style-type: none"> Co-pay Per Visit - Primary Care Physician Co-pay Per Visit - Specialist Paid By Plan 	\$25 \$40 100% (Deductible Waived)	No Benefit
Injections (All Injections Including But Not Limited To Allergy Injections, Testosterone Injections, Flu Shots, Pneumonia Shots, IV Therapy And Administration, Chemotherapy, Botox For Chronic Headaches, Hyperhidrosis (Severe Sweating), Etc.): <ul style="list-style-type: none"> Paid By Plan 	100% (Deductible Waived)	
Allergy Serum: <ul style="list-style-type: none"> Paid By Plan 	100% (Deductible Waived)	
Charges For A Radiologist, Anesthesiologist Or Pathologist While In The Physician's Office: <ul style="list-style-type: none"> Paid By Plan 	100% (Deductible Waived)	
Advanced Imaging Services (CT, PET, MRI & Nuclear Medicine): <ul style="list-style-type: none"> Paid By Plan After Deductible 	80%	
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include: From Age 3		No Benefit
Preventive / Routine Physical Exams At Appropriate Ages: <ul style="list-style-type: none"> Paid By Plan 	100% (Deductible Waived)	
Immunizations: <ul style="list-style-type: none"> Paid By Plan 	100% (Deductible Waived)	No Benefit
Preventive / Routine Diagnostic Tests, Lab And X-rays At Appropriate Ages: <ul style="list-style-type: none"> Paid By Plan 	100% (Deductible Waived)	

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Mammograms And Breast Exams: <ul style="list-style-type: none"> Maximum Exams Per Calendar Year Paid By Plan <p>Note: First Mammogram Per Calendar Year Covered At Preventive / Routine Benefits Regardless Of Diagnosis.</p>	1 Exam 100% (Deductible Waived)	
Preventive / Routine Pelvic Exams And Pap Test: <ul style="list-style-type: none"> Maximum Exams Per Calendar Year Paid By Plan 	1 Exam 100% (Deductible Waived)	
Preventive / Routine PSA Test And Prostate Exams: To Age 40 <ul style="list-style-type: none"> Maximum Exams Per Calendar Year Paid By Plan After Deductible From Age 40 <ul style="list-style-type: none"> Maximum Exams Per Calendar Year Paid By Plan 	1 Exam 80% 1 Exam 100% (Deductible Waived)	
Preventive / Routine Screenings / Services At Appropriate Ages And Gender: <ul style="list-style-type: none"> Paid By Plan 	100% (Deductible Waived)	
Preventive / Routine Colonoscopy, Sigmoidoscopy And Similar Routine Surgical Procedures Done For Preventive Reasons: To Age 40 <ul style="list-style-type: none"> Maximum Exams Per Calendar Year Paid By Plan After Deductible From Age 40 <ul style="list-style-type: none"> Maximum Exams Per Calendar Year Paid By Plan 	1 Exam 80% 1 Exam 100% (Deductible Waived)	
Preventive / Routine Counseling For Alcohol Or Substance Abuse, Tobacco Use, Obesity, Diet And Nutrition: <ul style="list-style-type: none"> Maximum Visits Per Calendar Year Paid By Plan 	1 Visit 100% (Deductible Waived)	
Preventive / Routine Bone Density Screening: <ul style="list-style-type: none"> Paid By Plan 	100% (Deductible Waived)	

	IN-NETWORK	OUT-OF-NETWORK
<p>In Addition, The Following Preventive / Routine Services Are Covered For Women:</p> <ul style="list-style-type: none"> ➤ Gestational Diabetes ➤ Papillomavirus DNA Testing* ➤ Counseling For Sexually Transmitted Infections (Provided Annually)* ➤ Counseling For Human Immune-deficiency Virus (Provided Annually)* ➤ Breastfeeding Support, Supplies And Counseling ➤ Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)* <ul style="list-style-type: none"> • Paid By Plan <p>*These Services May Also Apply To Men.</p>	100% (Deductible Waived)	No Benefit
<p>Preventive / Routine Care Benefits For Children Include: To Age 3</p> <p>Preventive / Routine Physical Exams:</p> <ul style="list-style-type: none"> • Paid By Plan <p>Immunizations:</p> <ul style="list-style-type: none"> • Paid By Plan <p>Preventive / Routine Screenings At Appropriate Ages:</p> <ul style="list-style-type: none"> • Paid By Plan <p>Preventive / Routine Diagnostic Tests, Lab And X-rays:</p> <ul style="list-style-type: none"> • Paid By Plan <p>Preventive / Routine Oral Fluoride Supplements Prescribed For Children Ages 6 Months To 5 Years Whose Primary Water Source Is Deficient In Fluoride:</p> <ul style="list-style-type: none"> • Paid By Plan <p>Preventive / Routine Hearing Exam:</p> <ul style="list-style-type: none"> • Paid By Plan 	100% (Deductible Waived) 100% (Deductible Waived) 100% (Deductible Waived) 100% (Deductible Waived) 100% (Deductible Waived) 100% (Deductible Waived)	No Benefit
<p>Sterilizations:</p> <ul style="list-style-type: none"> • Paid By Plan 	100% (Deductible Waived)	No Benefit
<p>Therapy Services: Included In Chiropractic Services Maximum</p> <ul style="list-style-type: none"> • Paid By Plan After Deductible <p>Note: Medical Necessity Will Be Reviewed After 30 Visits.</p>	80%	No Benefit

	IN-NETWORK	OUT-OF-NETWORK
Tobacco Addiction: <ul style="list-style-type: none"> Maximum Visits Per Calendar Year Paid By Plan <p>After Maximum Is Satisfied</p> <ul style="list-style-type: none"> Paid By Plan After Deductible 	2 Visits 100% (Copay Waived)	No Benefit
Upper GI Endoscopy (EGD): <ul style="list-style-type: none"> Paid By Plan After Deductible 	80%	No Benefit
Vision Care Benefits: <p>Eye Exam:</p> <ul style="list-style-type: none"> Co-pay Per Visit Maximum Exams Per Calendar Year Paid By Plan <p>Eye Refractions:</p> <ul style="list-style-type: none"> Co-pay Per Visit Maximum Exams Per Calendar Year Paid By Plan <p>Note: Only One (1) Co-Pay Applies Per Visit For Preventive And Medical As Well As Primary Care Physician Or Specialist (Combined For Eye Exams, Glaucoma Testing And Eye Refractions).</p>	\$25 1 Exam 100% (Deductible Waived) \$25 1 Exam 100% (Deductible Waived)	
All Other Covered Expenses: <ul style="list-style-type: none"> Paid By Plan After Deductible 	80%	80%

MEDICAL SCHEDULE OF BENEFITS

Benefit Plan(s) 002, 006 – Point of Service Non-SmartCare

****Note:** The SmartCare option is currently available only to UAMS Employees and Retirees and their eligible Dependents who receive care at UAMS or through a UAMS provider.

All health benefits shown on this Schedule of Benefits are subject to the following: Annual maximums, Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses section of this SPD for more details.

Benefits are subject to all provisions of this Plan including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the Utilization Management section of this SPD for a description of these services and prior authorization procedures.

Notes: Refer to the Provider Network section for clarifications and possible exceptions to the In-Network or Out-of-Network classifications.

If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, that means that it is a combined Maximum Benefit for services that the Covered Person receives from all In-Network and Out-of-Network providers and facilities.

	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible Per Calendar Year:		
• Per Person	\$750	\$1,000
• Per Family	\$1,500	\$2,000
Plan Participation Rate, Unless Otherwise Stated Below:		
• Paid By Plan After Satisfaction Of Deductible	80%	60%
Annual Out-Of-Pocket Maximum:		
• Per Person	\$2,000	\$5,000
• Per Family	\$4,000	\$10,000
Ambulance Transportation:		
• Co-pay Per Visit (Waived If Admitted As Inpatient)	\$100	\$100
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Autism Services:		
• Maximum Benefit Per Calendar Year:	\$10,000	
• Paid By Plan After Deductible	80%	60%
Note: Maximum Applies To ABA Therapy Only.		
Breast Prosthesis		
• Maximum Benefit Every Two Years	1 Replacement	No Benefit
• Paid By Plan	100% (Deductible Waived)	
Breast Pumps:		
• Paid By Plan	100% (Deductible Waived)	No Benefit

	IN-NETWORK	OUT-OF-NETWORK
Chiropractic Services: <ul style="list-style-type: none"> Maximum Visits Per Calendar Year Includes Physical, Occupational And Speech Therapy Paid By Plan After Deductible 	30 Visits 80%	60%
Contraceptive Methods And Counseling Approved By The FDA: <ul style="list-style-type: none"> Paid By Plan 	100% (Deductible Waived)	No Benefit
Diabetes Treatment Not Performed In Office: <ul style="list-style-type: none"> Paid By Plan After Deductible 	80%	No Benefit
Diabetes Treatment Performed In Office: <ul style="list-style-type: none"> Co-pay Per Visit - Primary Care Physician Co-pay Per Visit - Specialist Paid By Plan 	\$25 \$40 100% (Deductible Waived)	No Benefit
Nutritional Counseling: <ul style="list-style-type: none"> Paid By Plan 	100% (Deductible Waived)	
Durable Medical Equipment: <ul style="list-style-type: none"> Paid By Plan After Deductible 	80%	60%
Emergency Services / Treatment:		
Urgent Care: <ul style="list-style-type: none"> Co-pay Per Visit Paid By Plan 	\$50 100% (Deductible Waived)	\$100 100% (Deductible Waived)
Emergency Room / Emergency Physicians: <ul style="list-style-type: none"> Co-pay Per Visit (Waived If Admitted As Inpatient Within 24 Hours) Paid By Plan 	\$150 100% (Deductible Waived)	\$150 100% (Deductible Waived)
Extended Care Facility Benefits Such As Skilled Nursing, Convalescent Or Subacute Facility: <ul style="list-style-type: none"> Co-pay Per Admission (Waived If Transferred From An Acute Care Facility) Paid By Plan After Deductible 	\$300 80%	\$300 60%
Note: Maximum Combined Inpatient Co-Pay Per Calendar Year Is \$1,200 Per Person. No More Than One Co-Pay Per 30 Days.		
Hearing Services:		No Benefit
Exams, Tests Not Performed In Office: <ul style="list-style-type: none"> Paid By Plan After Deductible 	80%	
Exam, Tests Performed In Office: <ul style="list-style-type: none"> Co-pay Per Visit - Primary Care Physician Co-pay Per Visit - Specialist Paid By Plan 	\$25 \$40 100% (Deductible Waived)	No Benefit

	IN-NETWORK	OUT-OF-NETWORK
Hearing Aids: <ul style="list-style-type: none"> Maximum Benefit Per Ear Every Three Years Paid By Plan 	\$1,400 100% (Deductible Waived)	100% (Deductible Waived)
Implantable Hearing Aids: <ul style="list-style-type: none"> Paid By Plan After Deductible 	80%	60%
Home Health Care Benefits: <ul style="list-style-type: none"> Maximum Visits Per Calendar Year Paid By Plan After Deductible <p><i>Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Therapist, As The Case May Be, Or Up To Four (4) Hours Of Home Health Care Services. Care Management Can Extend The Visits In Lieu Of More Expensive Level Of Care.</i></p>	40 Visits 80%	60%
Hospice Care Benefits:		
Hospice Services: <ul style="list-style-type: none"> Paid By Plan After Deductible 	80%	60%
Bereavement Counseling: <ul style="list-style-type: none"> Paid By Plan After Deductible 	80%	60%
Hospital Services:		
Pre-admission Testing: <ul style="list-style-type: none"> Paid By Plan After Deductible 	80%	60%
Inpatient Services Only: <ul style="list-style-type: none"> Co-pay Per Admission (Waived If Transferred From An Acute Care Facility) Paid By Plan After Deductible <p><i>Note: Maximum Combined Inpatient Co-Pay Per Calendar Year Is \$1,200 Per Person. No More Than One Co-Pay Per 30 Days.</i></p>	\$300 80%	\$300 60%
Inpatient Physician Charges Only: <ul style="list-style-type: none"> Paid By Plan After Deductible 	80%	60%
Outpatient Services / Outpatient Physician Charges: <ul style="list-style-type: none"> Paid By Plan After Deductible 	80%	60%

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Lab And X-ray Charges: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	80%	60%
Outpatient Lab And X-ray Charges In Relation To An In-Network Office Visit: <ul style="list-style-type: none"> • Paid By Plan 	100% (Deductible Waived)	
Note: Lab And X-ray Charges Must Be Performed Within 14 Days Of The Office Visit. This Benefit Also Applies To Out-Of-Network Lab And X-rays In Relation To An In-Network Office Visit. Advanced Imaging Services Will Follow Normal Plan Participation Rates.		
Outpatient Surgery Only: <ul style="list-style-type: none"> • Co-pay Per Visit • Paid By Plan After Deductible 	\$150 80%	\$150 60%
Outpatient Surgeon Charges Only: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	80%	60%
Maternity:		
Prenatal, Delivery And Postnatal: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	100% (Deductible Waived)	60%
Physician Office Charges: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	100% (Deductible Waived)	60%
Inpatient Services Only: <ul style="list-style-type: none"> • Co-pay Per Admission (Waived If Transferred From An Acute Care Facility) • Paid By Plan After Deductible 	\$300 80%	\$300 60%
Note: Maximum Combined Inpatient Co-Pay Per Calendar Year Is \$1,200 Per Person. No More Than One Co-Pay Per 30 Days.		
Mental Health, Substance Abuse And Chemical Dependency Benefits:		
Inpatient Services Only: <ul style="list-style-type: none"> • Co-pay Per Admission • Paid By Plan After Deductible 	\$300 80%	\$300 60%
Note: Maximum Combined Inpatient Co-Pay Per Calendar Year Is \$1,200 Per Person. No More Than One Co-Pay Per 30 Days.		
Inpatient Physician Charges Only: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	80%	60%

	IN-NETWORK	OUT-OF-NETWORK
Residential Treatment: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	80%	60%
Outpatient Or Partial Hospitalization Services (Day Treatment) And Physician Charges: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	80%	60%
Office Visit: <ul style="list-style-type: none"> • Co-pay Per Visit • Paid By Plan 	\$25 100% (Deductible Waived)	No Benefit
Morbid Obesity Treatment: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	80%	60%
Note: Please Refer To The Exclusion Section For Additional Benefit Information.		
Weight Loss Programs: <ul style="list-style-type: none"> • Maximum Reimbursement Per Lifetime • Paid By Plan 	\$1,000 100% (Deductible Waived)	100% (Deductible Waived)
Note: Members Must Pay For The Physician Supervised Weight Loss Program Up Front And Submit A Claim To UMR For Reimbursement. UMR Will Not Reimburse The Provider Directly.		
Nutritional Counseling: <ul style="list-style-type: none"> • Maximum Visits Per Calendar Year With Dietitian • Maximum Visits Per Calendar Year With Health Coaching • Paid By Plan 	1 Visit 3 Visits 100% (Deductible Waived)	No Benefit
Nursery And Newborn Expenses: <ul style="list-style-type: none"> • Paid By Plan 	100% (Deductible Waived)	100% (Deductible Waived)
Note: The Deductible Is Waived For The Entire Newborn Stay Even If A Sick Child.		
Orthotic Appliances: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	80%	60%
Shoes -Custom Molded: <ul style="list-style-type: none"> • To Age 18 • Maximum Benefit Per Calendar Year • From Age 18 • Maximum Benefit Per Calendar Year • Paid By Plan After Deductible 	2 Pairs 1 Pair 80%	60%
Shoe Inserts-Custom Molded: <ul style="list-style-type: none"> • Maximum Benefit Per Calendar Year • Paid By Plan After Deductible 	2 Pairs 80%	60%

	IN-NETWORK	OUT-OF-NETWORK
Physician Office Services: <ul style="list-style-type: none"> Co-pay Per Visit - Primary Care Physician Co-pay Per Visit - Specialist Paid By Plan After Deductible 	\$25 \$40 100% (Deductible Waived)	Not Applicable Not Applicable 60%
Office Surgery: <ul style="list-style-type: none"> Co-pay Per Visit - Primary Care Physician Co-pay Per Visit - Specialist Paid By Plan After Deductible 	\$25 \$40 100% (Deductible Waived)	Not Applicable Not Applicable 60%
Injections (All Injections Including But Not Limited To Allergy Injections, Testosterone Injections, Flu Shots, Pneumonia Shots, IV Therapy And Administration, Chemotherapy, Botox For Chronic Headaches, Hyperhidrosis (Severe Sweating), Etc.): <ul style="list-style-type: none"> Paid By Plan After Deductible 	100% (Deductible Waived)	60%
Allergy Serum: <ul style="list-style-type: none"> Paid By Plan After Deductible 	100% (Deductible Waived)	60%
Charges For A Radiologist, Anesthesiologist Or Pathologist While In The Physician's Office: <ul style="list-style-type: none"> Paid By Plan After Deductible 	100% (Deductible Waived)	60%
Advanced Imaging Services (CT, PET, MRI & Nuclear Medicine): <ul style="list-style-type: none"> Paid By Plan After Deductible 	80%	60%
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include: From Age 3		
Preventive / Routine Physical Exams At Appropriate Ages: <ul style="list-style-type: none"> Paid By Plan 	100% (Deductible Waived)	No Benefit
Immunizations: <ul style="list-style-type: none"> Paid By Plan After Deductible 	100% (Deductible Waived)	60%
Preventive / Routine Diagnostic Tests, Lab And X-rays At Appropriate Ages: <ul style="list-style-type: none"> Paid By Plan After Deductible 	100% (Deductible Waived)	60%

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Mammograms And Breast Exams: <ul style="list-style-type: none"> Maximum Exams Per Calendar Year Paid By Plan <p>Note: First Mammogram Per Calendar Year Covered At Preventive / Routine Benefits Regardless Of Diagnosis.</p>	1 Exam 100% (Deductible Waived)	No Benefit
Preventive / Routine Pelvic Exams And Pap Test: <ul style="list-style-type: none"> Maximum Exams Per Calendar Year Paid By Plan 	1 Exam 100% (Deductible Waived)	No Benefit
Preventive / Routine PSA Test And Prostate Exams: To Age 40 <ul style="list-style-type: none"> Maximum Exams Per Calendar Year Paid By Plan After Deductible From Age 40 <ul style="list-style-type: none"> Maximum Exams Per Calendar Year Paid By Plan 	1 Exam 80% 1 Exam 100% (Deductible Waived)	No Benefit
Preventive / Routine Screenings / Services At Appropriate Ages And Gender: <ul style="list-style-type: none"> Paid By Plan 	100% (Deductible Waived)	No Benefit
Preventive / Routine Colonoscopy, Sigmoidoscopy And Similar Routine Surgical Procedures Done For Preventive Reasons: To Age 40 <ul style="list-style-type: none"> Maximum Exams Per Calendar Year Paid By Plan After Deductible From Age 40 <ul style="list-style-type: none"> Maximum Exams Per Calendar Year Paid By Plan After Deductible 	1 Exam 80% 1 Exam 100% (Deductible Waived)	No Benefit
Preventive / Routine Counseling For Alcohol Or Substance Abuse, Tobacco Use, Obesity, Diet And Nutrition: <ul style="list-style-type: none"> Maximum Visits Per Calendar Year Paid By Plan 	1 Visits 100% (Deductible Waived)	No Benefit
Preventive / Routine Bone Density Screening: <ul style="list-style-type: none"> Paid By Plan 	100% (Deductible Waived)	No Benefit

	IN-NETWORK	OUT-OF-NETWORK
In Addition, The Following Preventive / Routine Services Are Covered For Women: <ul style="list-style-type: none"> ➤ Gestational Diabetes ➤ Papillomavirus DNA Testing* ➤ Counseling For Sexually Transmitted Infections (Provided Annually)* ➤ Counseling For Human Immune-deficiency Virus (Provided Annually)* ➤ Breastfeeding Support, Supplies And Counseling ➤ Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)* <ul style="list-style-type: none"> • Paid By Plan After Deductible 	100% (Deductible Waived)	60%
*These Services May Also Apply To Men.		
Preventive / Routine Care Benefits For Children Include: To Age 3 Preventive / Routine Physical Exams: <ul style="list-style-type: none"> • Paid By Plan After Deductible Immunizations: <ul style="list-style-type: none"> • Paid By Plan After Deductible Preventive / Routine Screenings At Appropriate Ages: <ul style="list-style-type: none"> • Paid By Plan After Deductible Preventive / Routine Diagnostic Tests, Lab And X-rays: <ul style="list-style-type: none"> • Paid By Plan After Deductible Preventive / Routine Oral Fluoride Supplements Prescribed For Children Ages 6 Months To 5 Years Whose Primary Water Source Is Deficient In Fluoride: <ul style="list-style-type: none"> • Paid By Plan After Deductible Preventive / Routine Hearing Exam: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	100% (Deductible Waived)	60%
Sterilizations: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	100% (Deductible Waived)	60%
Temporomandibular Joint Disorder Benefits: <ul style="list-style-type: none"> • Co-pay Per Visit • Deductible Per Calendar Year • Maximum Benefit Per Lifetime • Paid By Plan 	\$200 \$1,000 80% (Deductible Waived)	\$200 \$2,000 \$10,000 60% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Therapy Services: Included In Chiropractic Services Maximum <ul style="list-style-type: none"> • Paid By Plan After Deductible Note: Medical Necessity Will Be Reviewed After 30 Visits.	80%	60%
Tobacco Addiction: <ul style="list-style-type: none"> • Maximum Visits Per Calendar Year • Paid By Plan After Maximum Is Satisfied <ul style="list-style-type: none"> • Paid By Plan After Deductible 	2 Visits 100% (Copay Waived) 80%	No Benefit
Upper GI Endoscopy (EGD): <ul style="list-style-type: none"> • Paid By Plan After Deductible 	80%	60%
Vision Care Benefits: Eye Exam: <ul style="list-style-type: none"> • Co-pay Per Visit • Maximum Exams Per Calendar Year • Paid By Plan Eye Refractions: <ul style="list-style-type: none"> • Co-pay Per Visit • Maximum Exams Per Calendar Year • Paid By Plan Note: Only One (1) Co-Pay Applies Per Visit For Preventive And Medical As Well As Primary Care Physician Or Specialist (Combined For Eye Exams, Glaucoma Testing And Eye Refractions).	\$25 100% (Deductible Waived) \$25 100% (Deductible Waived)	\$25 100% (Deductible Waived) \$25 100% (Deductible Waived)
All Other Covered Expenses: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	80%	60%

MEDICAL SCHEDULE OF BENEFITS

Benefit Plan(s) 003, 007 – Classic SmartCare

The SmartCare Option is currently available only to UAMS Employees and Retirees and their eligible Dependents who receive care at UAMS or through a UAMS provider.

All health benefits shown on this Schedule of Benefits are subject to the following: Annual maximums, Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses section of this SPD for more details.

Benefits are subject to all provisions of this Plan including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the Utilization Management section of this SPD for a description of these services and prior authorization procedures.

Notes: Refer to the Provider Network section for clarifications and possible exceptions to the In-Network or Out-of-Network classifications.

If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, that means that it is a combined Maximum Benefit for services that the Covered Person receives from all UAMS SmartCare, In-Network and Out-of-Network providers and facilities.

	UAMS SmartCare	In-Network	Out-of- Network
Annual Deductible Per Calendar Year:			No Benefit
• Per Person	\$250	\$750	
• Per Family	\$500	\$1,500	
Plan Participation Rate, Unless Otherwise Stated Below:			No Benefit
• Paid By Plan After Satisfaction Of Deductible	80%	80%	
Annual Out-Of-Pocket Maximum:			No Benefit
• Per Person	\$1,000	\$2,000	
• Per Family	\$2,000	\$4,000	
Ambulance Transportation:			
• Co-pay Per Visit (Waived If Admitted As Inpatient)	\$100	\$100	\$100
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)	100% (Deductible Waived)
Autism Services:			No Benefit
• Maximum Benefit Per Calendar Year	\$10,000		
• Paid By Plan After Deductible	80%	80%	
Note: Maximum Applies To ABA Therapy Only.			

	UAMS SmartCare	In-Network	Out-of- Network
Breast Prosthesis: <ul style="list-style-type: none"> Maximum Benefit Every Two Years Paid By Plan 	1 Replacement 100% (Deductible Waived)	100% (Deductible Waived)	No Benefit
Breast Pumps: <ul style="list-style-type: none"> Paid By Plan 	100% (Deductible Waived)	100% (Deductible Waived)	No Benefit
Chiropractic Services: <ul style="list-style-type: none"> Maximum Visits Per Calendar Year Includes Physical, Occupational And Speech Therapy Paid By Plan After Deductible 	30 Visits 80%	80%	No Benefit
Contraceptive Methods And Counseling Approved By The FDA: <ul style="list-style-type: none"> Paid By Plan 	100% (Deductible Waived)	100% (Deductible Waived)	No Benefit
Diabetes Treatment Not Performed In Office: <ul style="list-style-type: none"> Paid By Plan After Deductible 	80%	80%	No Benefit
Diabetes Treatment Performed In Office: <ul style="list-style-type: none"> Co-pay Per Visit - Primary Care Physician Co-pay Per Visit - Specialist Paid By Plan 	\$10 \$25 100% (Deductible Waived)	\$25 \$40 100% (Deductible Waived)	No Benefit
Nutritional Counseling: <ul style="list-style-type: none"> Paid By Plan 	100% (Deductible Waived)	100% (Deductible Waived)	
Durable Medical Equipment: <ul style="list-style-type: none"> Paid By Plan After Deductible 	80%	80%	No Benefit
Emergency Services / Treatment:			
Urgent Care: <ul style="list-style-type: none"> Co-pay Per Visit Paid By Plan 	\$50 100% (Deductible Waived)	\$50 100% (Deductible Waived)	\$50 100% (Deductible Waived)
Emergency Room / Emergency Physicians: <ul style="list-style-type: none"> Co-pay Per Visit (Waived If Admitted As Inpatient Within 24 Hours) Paid By Plan 	\$150 100% (Deductible Waived)	\$150 100% (Deductible Waived)	\$150 100% (Deductible Waived)

	UAMS SmartCare	In-Network	Out-of- Network
Extended Care Facility Benefits Such As Skilled Nursing, Convalescent Or Subacute Facility: <ul style="list-style-type: none"> Co-pay Per Admission (Waived If Transferred From An Acute Care Facility) Paid By Plan After Deductible <p>Note: Maximum Combined Inpatient Co-Pay Per Calendar Year Is \$1,200 Per Person. No More Than One Co-Pay Per 30 Days.</p>	\$150 80%	\$300 80%	No Benefit
Hearing Services: Exams, Tests Not Performed In Office: <ul style="list-style-type: none"> Paid By Plan After Deductible Exam, Tests Performed In Office: <ul style="list-style-type: none"> Co-pay Per Visit - Primary Care Physician Co-pay Per Visit - Specialist Paid By Plan Hearing Aids: <ul style="list-style-type: none"> Maximum Benefit Per Ear Every Three Years Paid By Plan Implantable Hearing Devices: <ul style="list-style-type: none"> Paid By Plan After Deductible 	80% \$10 \$25 100% (Deductible Waived) \$1,400 100% (Deductible Waived)	80% \$25 \$40 100% (Deductible Waived) 100% (Deductible Waived)	No Benefit
Home Health Care Benefits: <ul style="list-style-type: none"> Maximum Visits Per Calendar Year Paid By Plan After Deductible <p>Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Therapist, As The Case May Be, Or Up To Four (4) Hours Of Home Health Care Services. Care Management Can Extend The Visits In Lieu Of More Expensive Level Of Care.</p>	40 Visits 80%	80%	No Benefit
Hospice Care Benefits: Hospice Services: <ul style="list-style-type: none"> Paid By Plan After Deductible Bereavement Counseling: <ul style="list-style-type: none"> Paid By Plan After Deductible 	80% 80%	80% 80%	No Benefit
Hospital Services: Pre-Admission Testing: <ul style="list-style-type: none"> Paid By Plan After Deductible 	80%	80%	No Benefit

	UAMS SmartCare	In-Network	Out-of- Network
Inpatient Services Only: <ul style="list-style-type: none"> Co-pay Per Admission Paid By Plan After Deductible <p>Note: Maximum Combined Inpatient Co-Pay Per Calendar Year Is \$1,200 Per Person. No More Than One Co-Pay Per 30 Days.</p>	\$150 80%	\$300 80%	No Benefit
Inpatient Physician Charges Only: <ul style="list-style-type: none"> Paid By Plan After Deductible 	80%	80%	
Outpatient Services / Outpatient Physician Charges: <ul style="list-style-type: none"> Paid By Plan After Deductible 	80%	80%	
Outpatient Lab And X-ray Charges: <ul style="list-style-type: none"> Paid By Plan After Deductible 	80%	80%	
Outpatient Lab And X-ray Charges In Relation To An In-Network Office Visit: <ul style="list-style-type: none"> Paid By Plan <p>Note: Lab And X-ray Charges Must Be Performed Within 14 Days Of The Office Visit. This Benefit Also Applies To Out-Of-Network Lab And X-rays In Relation To An In-Network Office Visit. Advanced Imaging Services Will Follow Normal Plan Participation Rates.</p>	100% (Deductible Waived)	100% (Deductible Waived)	
Outpatient Surgery / Surgeon Charges: <ul style="list-style-type: none"> Co-pay Per Visit Paid By Plan After Deductible 	Not Applicable 80%	\$150 80%	No Benefit
Maternity:			
Prenatal, Delivery And Postnatal: <ul style="list-style-type: none"> Paid By Plan 	100% (Deductible Waived)	100% (Deductible Waived)	
Physician Office Charges: <ul style="list-style-type: none"> Paid By Plan 	100% (Deductible Waived)	100% (Deductible Waived)	
Inpatient Services Only: <ul style="list-style-type: none"> Co-pay Per Admission Paid By Plan After Deductible <p>Note: Maximum Combined Inpatient Co-Pay Per Calendar Year Is \$1,200 Per Person. No More Than One Co-Pay Per 30 Days.</p>	\$150 80%	\$300 80%	

	UAMS SmartCare	In-Network	Out-of- Network
Preventive / Routine Screenings / Services At Appropriate Ages And Gender: <ul style="list-style-type: none"> • Paid By Plan 	100% (Deductible Waived)	100% (Deductible Waived)	No Benefit
Preventive / Routine Colonoscopy, Sigmoidoscopy And Similar Routine Surgical Procedures Done For Preventive Reasons: To Age 40 <ul style="list-style-type: none"> • Maximum Exams Per Calendar Year • Paid By Plan After Deductible From Age 40 <ul style="list-style-type: none"> • Maximum Exams Per Calendar Year • Paid By Plan 	1 Exam 80%	1 Exam 80%	
Preventive / Routine Counseling For Alcohol Or Substance Abuse, Tobacco Use, Obesity, Diet And Nutrition: <ul style="list-style-type: none"> • Maximum Exams Per Calendar Year • Paid By Plan 	1 Exam 100% (Deductible Waived)	1 Exam 100% (Deductible Waived)	
Preventive / Routine Bone Density Screening: <ul style="list-style-type: none"> • Paid By Plan 	1 Exam 100% (Deductible Waived)	1 Exam 100% (Deductible Waived)	
In Addition, The Following Preventive / Routine Services Are Covered For Women: <ul style="list-style-type: none"> ➤ Gestational Diabetes ➤ Papillomavirus DNA Testing* ➤ Counseling For Sexually Transmitted Infections (Provided Annually)* ➤ Counseling For Human Immune-deficiency Virus (Provided Annually)* ➤ Breastfeeding Support, Supplies And Counseling ➤ Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)* • Paid By Plan 	100% (Deductible Waived)	100% (Deductible Waived)	
*These Services May Also Apply To Men.			No Benefit

	UAMS SmartCare	In-Network	Out-of- Network
Preventive / Routine Care Benefits For Children Include: To Age 3 Preventive / Routine Physical Exams: <ul style="list-style-type: none"> • Paid By Plan Immunizations: <ul style="list-style-type: none"> • Paid By Plan Preventive / Routine Screenings At Appropriate Ages: <ul style="list-style-type: none"> • Paid By Plan Preventive / Routine Diagnostic Tests, Lab And X-rays: <ul style="list-style-type: none"> • Paid By Plan Preventive / Routine Oral Fluoride Supplements Prescribed For Children Ages 6 Months To 5 Years Whose Primary Water Source Is Deficient In Fluoride: <ul style="list-style-type: none"> • Paid By Plan Preventive / Routine Hearing Exam: <ul style="list-style-type: none"> • Paid By Plan 	100% (Deductible Waived)	100% (Deductible Waived)	No Benefit
Sterilizations: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	100% (Deductible Waived)	100% (Deductible Waived)	60%
Therapy Services: Included In Chiropractic Services Maximum <ul style="list-style-type: none"> • Paid By Plan After Deductible Note: Medical Necessity Will Be Reviewed After 30 Visits.	80%	80%	No Benefit
Tobacco Addiction: <ul style="list-style-type: none"> • Maximum Visits Per Calendar Year • Paid By Plan After Maximum Is Satisfied <ul style="list-style-type: none"> • Paid By Plan After Deductible 	2 Visits 100% (Copay Waived)	100% (Copay Waived)	No Benefit
	80%	80%	

	UAMS SmartCare	In-Network	Out-of- Network
Upper GI Endoscopy (EGD): <ul style="list-style-type: none"> • Paid By Plan After Deductible 	80%	80%	No Benefit
Vision Care Benefits: Eye Exam: <ul style="list-style-type: none"> • Co-pay Per Visit • Maximum Exams Per Calendar Year • Paid By Plan Eye Refractions: <ul style="list-style-type: none"> • Co-pay Per Visit • Maximum Exams Per Calendar Year • Paid By Plan <i>Note: Only One (1) Co-Pay Applies Per Visit For Preventive And Medical As Well As Primary Care Physician Or Specialist (Combined For Eye Exams, Glaucoma Testing And Eye Refractions).</i>	\$10 100% (Deductible Waived)	\$25 1 Exam 100% (Deductible Waived)	\$25 100% (Deductible Waived)
All Other Covered Expenses: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	80%	80%	No Benefit

MEDICAL SCHEDULE OF BENEFITS

Benefit Plan(s) 004, 008 – Point of Service SmartCare

The SmartCare Option is currently available only to UAMS Employees and Retirees and their eligible Dependents who receive care at UAMS or through a UAMS provider.

All health benefits shown on this Schedule of Benefits are subject to the following: Annual maximums, Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses section of this SPD for more details.

Benefits are subject to all provisions of this Plan including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the Utilization Management section of this SPD for a description of these services and prior authorization procedures.

Notes: Refer to the Provider Network section for clarifications and possible exceptions to the In-Network or Out-of-Network classifications.

If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, that means that it is a combined Maximum Benefit for services that the Covered Person receives from all UAMS SmartCare, In-Network and Out-of-Network providers and facilities.

	UAMS SmartCare	In-Network	Out-of- Network
Annual Deductible Per Calendar Year:			
• Per Person	\$250	\$750	\$1,000
• Per Family	\$500	\$1,500	\$2,000
Plan Participation Rate, Unless Otherwise Stated Below:			
• Paid By Plan After Satisfaction Of Deductible	80%	80%	60%
Annual Out-Of-Pocket Maximum:			
• Per Person	\$1,000	\$2,000	\$5,000
• Per Family	\$2,000	\$4,000	\$10,000
Ambulance Transportation:			
• Co-pay Per Visit (Waived If Admitted As Inpatient)	\$100	\$100	\$100
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)	100% (Deductible Waived)
Autism Services:			
• Maximum Benefit Per Calendar Year		\$10,000	
• Paid By Plan After Deductible	80%	80%	60%
Note: Maximum Applies To ABA Therapy Only.			

	UAMS SmartCare	In-Network	Out-of- Network
Breast Prosthesis: <ul style="list-style-type: none"> Maximum Benefit Every Two Years Paid By Plan After Deductible 	100% (Deductible Waived)	1 Replacement 100% (Deductible Waived)	60%
Breast Pumps: <ul style="list-style-type: none"> Paid By Plan After Deductible 	100% (Deductible Waived)	100% (Deductible Waived)	60%
Chiropractic Services: <ul style="list-style-type: none"> Maximum Visits Per Calendar Year Includes Physical, Occupational And Speech Therapy Paid By Plan After Deductible 	80%	30 Visits 80%	60%
Contraceptive Methods And Counseling Approved By The FDA: <ul style="list-style-type: none"> Paid By Plan 	100% (Deductible Waived)	100% (Deductible Waived)	No Benefit
Diabetes Treatment Not Performed In Office: <ul style="list-style-type: none"> Paid By Plan After Deductible 	80%	80%	60%
Diabetes Treatment Performed In Office: <ul style="list-style-type: none"> Co-pay Per Visit - Primary Care Physician Co-pay Per Visit - Specialist Paid By Plan 	\$10 \$25 100% (Deductible Waived)	\$25 \$40 100% (Deductible Waived)	
Nutritional Counseling: <ul style="list-style-type: none"> Paid By Plan 	100% (Deductible Waived)	100% (Deductible Waived)	No Benefit
Durable Medical Equipment: <ul style="list-style-type: none"> Paid By Plan After Deductible 	80%	80%	60%
Emergency Services / Treatment:			
Urgent Care: <ul style="list-style-type: none"> Co-pay Per Visit Paid By Plan 	\$50 100% (Deductible Waived)	\$50 100% (Deductible Waived)	\$100 100% (Deductible Waived)
Emergency Room / Emergency Physicians: <ul style="list-style-type: none"> Co-pay Per Visit (Waived If Admitted As Inpatient Within 24 Hours) Paid By Plan 	\$150 100% (Deductible Waived)	\$150 100% (Deductible Waived)	\$150 100% (Deductible Waived)

	UAMS SmartCare	In-Network	Out-of- Network
Extended Care Facility Benefits Such As Skilled Nursing, Convalescent Or Subacute Facility: <ul style="list-style-type: none"> Co-pay Per Admission (Waived If Transferred From An Acute Care Facility) Paid By Plan After Deductible 	\$150 80%	\$300 80%	\$300 60%
Note: Maximum Combined Inpatient Co-Pay Per Calendar Year Is \$1,200 Per Person. No More Than One Co-Pay Per 30 Days.			
Hearing Services: Exams, Tests Not Performed In Office: <ul style="list-style-type: none"> Paid By Plan After Deductible Exam, Tests Performed In Office: <ul style="list-style-type: none"> Co-pay Per Visit - Primary Care Physician Co-pay Per Visit - Specialist Paid By Plan Hearing Aids: <ul style="list-style-type: none"> Maximum Benefit Per Ear Every Three Years Paid By Plan Implantable Hearing Devices: <ul style="list-style-type: none"> Paid By Plan After Deductible 	80% \$10 \$25 100% (Deductible Waived) 100% (Deductible Waived)	80% \$25 \$40 100% (Deductible Waived) \$1,400 100% (Deductible Waived)	80% \$25 \$40 100% (Deductible Waived) 100% (Deductible Waived)
Home Health Care Benefits: <ul style="list-style-type: none"> Maximum Visits Per Calendar Year Paid By Plan After Deductible 	80%	40 Visits 80%	60%
Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Therapist, As The Case May Be, Or Up To Four (4) Hours Of Home Health Care Services. Care Management Can Extend The Visits In Lieu Of More Expensive Level Of Care.			
Hospice Care Benefits: Hospice Services: <ul style="list-style-type: none"> Paid By Plan After Deductible Bereavement Counseling: <ul style="list-style-type: none"> Paid By Plan After Deductible 	80% 80%	80% 80%	60% 60%
Hospital Services: Pre-Admission Testing: <ul style="list-style-type: none"> Paid By Plan After Deductible 	80%	80%	60%

	UAMS SmartCare	In-Network	Out-of- Network
Inpatient Services Only: <ul style="list-style-type: none"> Co-pay Per Admission Paid By Plan After Deductible <p>Note: Maximum Combined Inpatient Co-Pay Per Calendar Year Is \$1,200 Per Person. No More Than One Co-Pay Per 30 Days.</p>	\$150 80%	\$300 80%	\$300 60%
Inpatient Physician Charges Only: <ul style="list-style-type: none"> Paid By Plan After Deductible 	80%	80%	60%
Outpatient Services / Outpatient Physician Charges: <ul style="list-style-type: none"> Paid By Plan After Deductible 	80%	80%	60%
Outpatient Lab And X-ray Charges: <ul style="list-style-type: none"> Paid By Plan After Deductible 	80%	80%	60%
Outpatient Lab And X-ray Charges In Relation To An In-Network Office Visit: <ul style="list-style-type: none"> Paid By Plan <p>Note: Lab And X-ray Charges Must Be Performed Within 14 Days Of The Office Visit. This Benefit Also Applies To Out-Of-Network Lab And X-rays In Relation To An In-Network Office Visit. Advanced Imaging Services Will Follow Normal Plan Participation Rates.</p>	100% (Deductible Waived)	100% (Deductible Waived)	
Outpatient Surgery / Surgeon Charges: <ul style="list-style-type: none"> Co-pay Per Visit Paid By Plan After Deductible 	Not Applicable 80%	\$150 80%	\$150 60%
Maternity: <p>Prenatal, Delivery And Postnatal:</p> <ul style="list-style-type: none"> Paid By Plan After Deductible <p>Physician Office Charges:</p> <ul style="list-style-type: none"> Paid By Plan After Deductible <p>Inpatient Services Only:</p> <ul style="list-style-type: none"> Co-pay Per Admission Paid By Plan After Deductible <p>Note: Maximum Combined Inpatient Co-Pay Per Calendar Year Is \$1,200 Per Person. No More Than One Co-Pay Per 30 Days.</p>	100% (Deductible Waived) 100% (Deductible Waived) \$150 80%	100% (Deductible Waived) 100% (Deductible Waived) \$300 80%	60% 60% \$300 60%

	UAMS SmartCare	In-Network	Out-of- Network
Mental Health, Substance Abuse and Chemical Dependency Benefits: Inpatient Services Only: <ul style="list-style-type: none"> Co-pay Per Admission Paid By Plan After Deductible <p><i>Note: Maximum Combined Inpatient Co-Pay Per Calendar Year Is \$1,200 Per Person. No More Than One Co-Pay Per 30 Days.</i></p> Inpatient Physician Charges Only: <ul style="list-style-type: none"> Paid By Plan After Deductible Residential Treatment: <ul style="list-style-type: none"> Paid By Plan After Deductible Outpatient Or Partial Hospitalization Services (Day Treatment) And Physician Charges: <ul style="list-style-type: none"> Paid By Plan After Deductible Office Visit: <ul style="list-style-type: none"> Co-pay Per Visit Paid By Plan 	\$150 80% 80% 80% \$10 100% (Deductible Waived)	\$300 80% 80% 80% \$25 100% (Deductible Waived)	\$300 60% 60% 60% No Benefit
Morbid Obesity Treatment: <ul style="list-style-type: none"> Paid By Plan After Deductible <p>Note: Please Refer To The Exclusion Section For Additional Benefit Information.</p> Weight Loss Programs: <ul style="list-style-type: none"> Maximum Reimbursement Per Lifetime Paid By Plan <p><i>Note: Members Must Pay For The Physician Supervised Weight Loss Program Up Front And Submit A Claim To UMR For Reimbursement. UMR Will Not Reimburse The Provider Directly.</i></p> Nutritional Counseling: <ul style="list-style-type: none"> Maximum Visits Per Calendar Year With Dietitian Maximum Visits Per Calendar Year With Health Coaching Paid By Plan 	80% 100% (Deductible Waived)	80% \$1,000 100% (Deductible Waived)	No Benefit 100% (Deductible Waived)
	1 Visit 3 Visits 100% (Deductible Waived)	100% (Deductible Waived)	No Benefit

	UAMS SmartCare	In-Network	Out-of- Network
Nursery And Newborn Expenses: <ul style="list-style-type: none"> • Paid By Plan <p><i>Note: The Deductible Is Waived For The Entire Newborn Stay Even If A Sick Child.</i></p>	100% (Deductible Waived)	100% (Deductible Waived)	100% (Deductible Waived)
Orthotic Appliances: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	80%	80%	60%
Shoes -Custom Molded: To Age 18 <ul style="list-style-type: none"> • Maximum Benefit Per Calendar Year From Age 18 • Maximum Benefit Per Calendar Year • Paid By Plan After Deductible 	80%	2 Pairs 1 Pair 80%	60%
Shoe Inserts-Custom Molded: <ul style="list-style-type: none"> • Maximum Benefit Per Calendar Year • Paid By Plan After Deductible 	80%	2 Pairs 80%	60%
Physician Office Services: <ul style="list-style-type: none"> • Co-pay Per Visit - Primary Care Physician • Co-pay Per Visit - Specialist • Paid By Plan 	\$10 \$25 100% (Deductible Waived)	\$25 \$40 100% (Deductible Waived)	Not Applicable Not Applicable 60%
Office Surgery: <ul style="list-style-type: none"> • Co-pay Per Visit - Primary Care Physician • Co-pay Per Visit - Specialist • Paid By Plan 	\$10 \$25 100% (Deductible Waived)	\$25 \$40 100% (Deductible Waived)	Not Applicable Not Applicable 60%
Injections (All Injections Including But Not Limited To Allergy Injections, Testosterone Injections, Flu Shots, Pneumonia Shots, IV Therapy And Administration, Chemotherapy, Botox For Chronic Headaches, Hyperhidrosis (Severe Sweating), Etc.): <ul style="list-style-type: none"> • Paid By Plan After Deductible 	100% (Deductible Waived)	100% (Deductible Waived)	60%
Allergy Serum: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	100% (Deductible Waived)	100% (Deductible Waived)	60%
Charges For A Radiologist, Anesthesiologist Or Pathologist While In The Physician's Office: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	100% (Deductible Waived)	100% (Deductible Waived)	60%

	UAMS SmartCare	In-Network	Out-of- Network
Advanced Imaging Services (CT, PET, MRI & Nuclear Medicine): <ul style="list-style-type: none"> • Paid By Plan After Deductible 	80%	80%	60%
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include: From Age 3 Preventive / Routine Physical Exams At Appropriate Ages: <ul style="list-style-type: none"> • Paid By Plan 	100% (Deductible Waived)	100% (Deductible Waived)	No Benefit
Immunizations: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	100% (Deductible Waived)	100% (Deductible Waived)	60%
Preventive / Routine Diagnostic Tests, Lab And X-rays At Appropriate Ages: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	100% (Deductible Waived)	100% (Deductible Waived)	60%
Preventive / Routine Mammograms And Breast Exams: <ul style="list-style-type: none"> • Maximum Exams Per Calendar Year • Paid By Plan 	100% (Deductible Waived)	100% (Deductible Waived)	No Benefit
Note: First Mammogram Per Calendar Year Covered At Preventive / Routine Benefits Regardless Of Diagnosis.	1 Exam	1 Exam	
Preventive / Routine Pelvic Exams And Pap Test: <ul style="list-style-type: none"> • Maximum Exams Per Calendar Year • Paid By Plan 	100% (Deductible Waived)	100% (Deductible Waived)	
Preventive / Routine PSA Test And Prostate Exams: To Age 40	1 Exam	1 Exam	
<ul style="list-style-type: none"> • Maximum Exams Per Calendar Year • Paid By Plan After Deductible From Age 40	80%	80%	
<ul style="list-style-type: none"> • Maximum Exams Per Calendar Year • Paid By Plan 	100% (Deductible Waived)	100% (Deductible Waived)	

	UAMS SmartCare	In-Network	Out-of- Network
Preventive / Routine Screenings / Services At Appropriate Ages And Gender: <ul style="list-style-type: none">• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)	No Benefit
Preventive / Routine Colonoscopy, Sigmoidoscopy And Similar Routine Surgical Procedures Done For Preventive Reasons: To Age 40 <ul style="list-style-type: none">• Maximum Exams Per Calendar Year• Paid By Plan After Deductible From Age 40 <ul style="list-style-type: none">• Maximum Exams Per Calendar Year• Paid By Plan After Deductible	1 Exam 80%	80%	
	100% (Deductible Waived)	1 Exam 100% (Deductible Waived)	
Preventive / Routine Counseling For Alcohol Or Substance Abuse, Tobacco Use, Obesity, Diet And Nutrition: <ul style="list-style-type: none">• Maximum Exams Per Calendar Year• Paid By Plan	1 Exam 100% (Deductible Waived)	100% (Deductible Waived)	
Preventive / Routine Bone Density Screening: <ul style="list-style-type: none">• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)	
In Addition, The Following Preventive / Routine Services Are Covered For Women: <ul style="list-style-type: none">➤ Gestational Diabetes➤ Papillomavirus DNA Testing*➤ Counseling For Sexually Transmitted Infections (Provided Annually)*➤ Counseling For Human Immune-deficiency Virus (Provided Annually)*➤ Breastfeeding Support, Supplies And Counseling➤ Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)*• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)	
*These Services May Also Apply To Men.			

	UAMS SmartCare	In-Network	Out-of- Network
Preventive / Routine Care Benefits For Children Include: To Age 3 Preventive / Routine Physical Exams: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	100% (Deductible Waived)	100% (Deductible Waived)	60%
Immunizations: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	100% (Deductible Waived)	100% (Deductible Waived)	60%
Preventive / Routine Screenings At Appropriate Ages: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	100% (Deductible Waived)	100% (Deductible Waived)	60%
Preventive / Routine Diagnostic Tests, Lab And X-rays: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	100% (Deductible Waived)	100% (Deductible Waived)	60%
Preventive / Routine Oral Fluoride Supplements Prescribed For Children Ages 6 Months To 5 Years Whose Primary Water Source Is Deficient In Fluoride: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	100% (Deductible Waived)	100% (Deductible Waived)	60%
Preventive / Routine Hearing Exam: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	100% (Deductible Waived)	100% (Deductible Waived)	60%
Sterilizations: <ul style="list-style-type: none"> • Paid By Plan 	100% (Deductible Waived)	100% (Deductible Waived)	No Benefit
Temporomandibular Joint Disorder Benefits: <ul style="list-style-type: none"> • Co-pay Per Visit • Deductible Per Calendar Year • Maximum Benefit Per Lifetime • Paid By Plan 	\$200 \$1,000 80% (Deductible Waived)	\$200 \$1,000 \$10,000 80% (Deductible Waived)	\$200 \$1,000 60% (Deductible Waived)
Therapy Services: Included In Chiropractic Services Maximum <ul style="list-style-type: none"> • Paid By Plan After Deductible 	80%	80%	60%
Note: Medical Necessity Will Be Reviewed After 30 Visits.			

	UAMS SmartCare	In-Network	Out-of- Network
Tobacco Addiction: <ul style="list-style-type: none"> Maximum Visits Per Calendar Year Paid By Plan 	2 Visits 100% (Copay Waived)	100% (Copay Waived)	No Benefit
After Maximum Is Satisfied <ul style="list-style-type: none"> Paid By Plan After Deductible 	80%	80%	
Upper GI Endoscopy (EGD): <ul style="list-style-type: none"> Paid By Plan After Deductible 	80%	80%	60%
Vision Care Benefits: Eye Exam: <ul style="list-style-type: none"> Co-pay Per Visit Maximum Exams Per Calendar Year Paid By Plan Eye Refractions: <ul style="list-style-type: none"> Co-pay Per Visit Maximum Exams Per Calendar Year Paid By Plan Note: Only One (1) Co-Pay Applies Per Visit For Preventive And Medical As Well As Primary Care Physician Or Specialist (Combined For Eye Exams, Glaucoma Testing And Eye Refractions).	\$10 100% (Deductible Waived)	\$25 1 Exam 100% (Deductible Waived)	\$25 100% (Deductible Waived)
All Other Covered Expenses: <ul style="list-style-type: none"> Paid By Plan After Deductible 	80%	80%	60%

TRANSPLANT SCHEDULE OF BENEFITS	
Benefit Plan(s) All	
Transplant Services At A Designated Transplant Facility: Transplant Services: <ul style="list-style-type: none"> • Paid By Plan After Deductible Travel And Housing: <ul style="list-style-type: none"> • Maximum Benefit Per Transplant • Paid By Plan Travel And Housing At Designated Transplant Facility For Up To One Year From Date Of Transplant.	80% \$10,000 100% (Deductible Waived)

*Note: Prior Authorization and an authorized transplant facility is required. Please contact Care Management at 866-494-4502.

OUT-OF-POCKET EXPENSES AND MAXIMUMS

Benefit Plan(s) Classic Non-SmartCare, Point of Service Non-SmartCare

****Note:** The SmartCare option is currently available only to UAMS Employees and Retirees and their eligible Dependents who receive care at UAMS or through a UAMS provider.

CO-PAYS

A Co-pay is the amount that the Covered Person must pay to the provider each time certain services are received. Co-pays do not apply toward satisfaction of Deductibles or out-of-pocket maximums. The Co-pay and out-of-pocket maximum are shown on the Schedule of Benefits.

DEDUCTIBLES

Deductible refers to an amount of money paid once a Plan Year by the Covered Person before any Covered Expenses are paid by this Plan. A Deductible applies to each Covered Person up to a family Deductible limit. When a new Plan Year begins, a new Deductible must be satisfied.

Deductible amounts are shown on the Schedule of Benefits.

Pharmacy expenses do not count toward meeting the Deductible of this Plan. The Deductible amounts that the Covered Person incurs for Covered Expenses will be used to satisfy the Deductible(s) shown on the Schedule of Benefits.

The Deductible amounts that the Covered Person incurs at an in-network provider will apply to the in-network total individual and family Deductible. The Deductible amounts that the Covered Person incurs at an out-of-network provider will apply to the in-network and out-of-network total individual and family Deductible. This does not apply to the separate Temporomandibular Joint Disorder (TMJ) Deductible **(Applies to Point of Service Non-SmartCare)**.

If You have family coverage, any combination of covered family members can help meet the maximum family Deductible, up to each person's individual Deductible amount.

All Covered Expenses which are Incurred during the last three months of a Plan Year and applied toward satisfaction of the individual and family Deductible for that year, will also be applied toward the individual and family Deductible requirement for the next Plan Year. This does not apply to the separate Temporomandibular Joint Disorder (TMJ) Deductible **(Applies to Point of Service Non-SmartCare)**.

PLAN PARTICIPATION

Plan Participation means that, after the Covered Person satisfies the Deductible, the Covered Person and the Plan each pay a percentage of the Covered Expenses until the Covered Person's (or family's, if applicable) annual out-of-pocket maximum is reached. The Plan Participation rate is shown on the Schedule of Benefits. The Covered Person will be responsible for paying copays, coinsurance and deductible up to the annual maximum out of pocket. Once the annual out-of-pocket maximum has been satisfied, the Plan will pay 100% of the Covered Expense for the remainder of the Plan Year.

Any payment for an expense that is not covered under this Plan will be the Covered Person's responsibility.

ANNUAL OUT-OF-POCKET MAXIMUMS

The annual out-of-pocket maximum is shown on the Schedule of Benefits. Amounts the Covered Person incurs for Covered Expenses, such as any Plan Participation expense, will be used to satisfy the Covered Person's (or family's, if applicable) annual out-of-pocket maximum(s). The Pharmacy Benefits Manager is MedImpact. Pharmacy expenses that the Covered Person incurs through the prescription drug benefit plan do not apply toward the out-of-pocket maximum of the medical benefit Plan.

The following will not be used to meet the out-of-pocket maximums:

- Co-pays.
- Penalties, legal fees and interest charged by a provider.
- Expenses for excluded services.
- Any charges above the limits specified elsewhere in this document.
- Co-pays and Participation amounts for Prescription products.
- Individual and family Deductibles.
- Any amounts over the Usual and Customary amount, Negotiated Rate or established fee schedule that this Plan pays.

The eligible out-of-pocket expenses that the Covered Person incurs at an in-network provider will apply to the in-network total out-of-pocket maximum. The eligible out-of-pocket expenses that the Covered Person incurs at an out-of-network provider will apply to the out-of-network total out-of-pocket maximum.

OUT-OF-POCKET EXPENSES AND MAXIMUMS

Benefit Plan(s) Classic SmartCare, Point of Service SmartCare

The SmartCare Option is currently available only to UAMS Employees and Retirees and their eligible Dependents who receive care at UAMS or through a UAMS provider.

CO-PAYS

A Co-pay is the amount that the Covered Person must pay to the provider each time certain services are received. Co-pays do not apply toward satisfaction of Deductibles or out-of-pocket maximums. The Co-pay and out-of-pocket maximum are shown on the Schedule of Benefits.

DEDUCTIBLES

Deductible refers to an amount of money paid once a Plan Year by the Covered Person before any Covered Expenses are paid by this Plan. A Deductible applies to each Covered Person up to a family Deductible limit. When a new Plan Year begins, a new Deductible must be satisfied.

Deductible amounts are shown on the Schedule of Benefits.

Pharmacy expenses do not count toward meeting the Deductible of this Plan. The Deductible amounts that the Covered Person incurs for Covered Expenses will be used to satisfy the Deductible(s) shown on the Schedule of Benefits.

The Deductible amounts that the Covered Person incurs at UAMS SmartCare or In-Network benefit levels (whether Incurred at a UAMS SmartCare or In-Network provider) will be used to satisfy the applicable benefit level's total individual and family Deductible. This does not apply to the separate Temporomandibular Joint Disorder (TMJ) Deductible **(Applies to Benefit Plan(s) Point of Service SmartCare)**.

The Deductible amounts that the Covered Person Incurs at a Out-of-Network provider will apply to the Out-of-Network total individual and family Deductible. This does not apply to the separate Temporomandibular Joint Disorder (TMJ) Deductible **(Applies to Benefit Plan(s) Point of Service SmartCare)**.

If You have family coverage, any combination of covered family members can help meet the maximum family Deductible, up to each person's individual Deductible amount.

All Covered Expenses which are Incurred during the last three months of a Plan Year and applied toward satisfaction of the individual and family Deductible for that year, will also be applied toward the individual and family Deductible requirement for the next Plan Year. This does not apply to the separate Temporomandibular Joint Disorder (TMJ) Deductible **(Applies to Benefit Plan(s) Point of Service SmartCare)**.

PLAN PARTICIPATION

Plan Participation means that, after the Covered Person satisfies the Deductible, the Covered Person and the Plan each pay a percentage of the Covered Expenses until the Covered Person's (or family's, if applicable) annual out-of-pocket maximum is reached. The Plan Participation rate is shown on the Schedule of Benefits. The Covered Person will be responsible for paying any remaining charges due to the provider after the Plan has paid its portion of the Covered Expense, subject to the Plan's maximum fee schedule, Negotiated Rate, or Usual and Customary amounts as applicable. Once the annual out-of-pocket maximum has been satisfied, the Plan will pay 100% of the Covered Expense for the remainder of the Plan Year.

Any payment for an expense that is not covered under this Plan will be the Covered Person's responsibility.

ANNUAL OUT-OF-POCKET MAXIMUMS

The annual out-of-pocket maximum is shown on the Schedule of Benefits. Amounts the Covered Person incurs for Covered Expenses, such as any Plan Participation expense, will be used to satisfy the Covered Person's (or family's, if applicable) annual out-of-pocket maximum(s). The Pharmacy Benefits Manager is MedImpact. Pharmacy expenses that the Covered Person incurs through the prescription drug benefit plan do not apply toward the out-of-pocket maximum of the medical benefit Plan.

The following will not be used to meet the out-of-pocket maximums:

- Co-pays.
- Penalties, legal fees and interest charged by a provider.
- Expenses for excluded services.
- Any charges above the limits specified elsewhere in this document.
- Co-pays and Participation amounts for Prescription products.
- Individual and family Deductibles.
- Any amounts over the Usual and Customary amount, Negotiated Rate or established fee schedule that this Plan pays.

ELIGIBILITY AND EFFECTIVE DATE

It is the responsibility of each Covered Individual to review and become familiar with the terms and conditions of eligibility. All changes that materially affect eligibility or Continuation of Benefits must be reported to the UA Campus Human Resource or Personnel representative immediately.

DEFINITIONS

The following definitions contain words and phrases that shall have the meanings as indicated in this section unless a different meaning is plainly required by the context. Any headings used are included for reference only, and do not alter any of the terms of the Plan.

1. **University of Arkansas or UA** means the University of Arkansas System.
2. **Eligible Employee** means You are an eligible Employee if You are a full time Employee of the University, unless You are an Employee of a campus not participating in the Plan. A full time Employee is any Employee who is employed half-time or greater and is on at least a nine month appointment period. However, for purposes of this Plan "Eligible Employees" shall also include Residents, Interns and house staff members at the University of Arkansas for Medical Sciences.
3. **Eligible Retiree** means an Eligible Employee who retires while covered under the Plan and on the date of retirement has age and continuous years of service with the UA equal to at least a total of seventy (70) and immediately prior to retirement has completed ten (10) or more consecutive years of continuous coverage under the Plan or who has retired under an early retirement agreement approved by the University of Arkansas System.
4. **Employee or Enrollee** means an Eligible Employee, Eligible Disabled Employee or Eligible Retiree covered under the Plan in accordance with this section.
5. **Eligible Dependent or Covered Dependent** means only the following persons not otherwise eligible for coverage under the Plan as a Covered Person:
 6. The lawful spouse of a Eligible Employee;
 7. Each Child of the Eligible Employee from birth until the date on which they attain the age of twenty-six (26) years.
8. For retirees, except for HIPAA Family Status Changes as provided herein, only dependents covered under the Plan as of the date of retirement shall be considered Eligible Dependents.
9. No person may be simultaneously covered as an Employee and as a Dependent under the Plan.
10. **Child** includes (in addition to Your natural Child) the following:
 - An adopted Child for whom a petition for adoption has been filed or the final court order has been issued;
 - A step Child for whom You are legally responsible; or
 - A person for whom You are the Legal Guardian.
 - No person not described above, including a grandchild, shall be considered a Child.
11. **Covered Person** means only Your eligible Dependent who is covered under this Plan in accordance with this section.
12. **Active Work** means the performance of full or part-time work by You for UA either at Your customary place of employment or at such other place or places as required by UA in the course of work for the full number of hours and full rate of pay in accordance with the established employment practices of UA for full or part-time Employees.

13. **Claims Administrator** means the agent retained by UA to determine the validity of claims and administer benefit payments. The Claims Administrator is UMR, Inc.
14. **HIPAA Family Status Change** means a change in Your coverage level due to marriage, birth or adoption of a Child, death or divorce, or court orders mandating medical coverage for minor Children. HIPAA Family Status Changes apply to active Employees, Retirees and former Employees on COBRA. **NOTE: You have 31 days from any of the above mentioned changes to add UA Medical Benefit Coverage for You and / or Your Dependent.**
15. **HIPAA Special Enrollment** is a 31-day medical plan enrollment period immediately following an Your or Your Eligible Dependent's loss of COBRA coverage, loss of eligibility for other medical coverage (including medical coverage attributable to the spouse's Employment), or loss of the Employer contribution for the other coverage. However, You must have previously declined the UA Medical Benefit Coverage due to having other medical coverage.
16. **Eligible Disabled Employee** is a disabled Employee with over ten years of consecutive service the UA, and who has at least 10 consecutive years of medical coverage under the UA Medical Benefit Plan, will be eligible for coverage under the UA Medical Benefit Plan upon full payment of the current premium amount made in the same manner as an Eligible Retiree.

ELIGIBLE CLASSES OF EMPLOYEES

The Eligible Classes of Employees include the following classes of Employees:

- Eligible Employees of UA;
- COBRA Qualified Beneficiaries of UA;
- Surviving Dependents of deceased Employees of UA, covered under the health plan at the time of death;
- Eligible Retirees; or
- Eligible disabled Employees previously employed and covered by the UA.

EMPLOYEE ELIGIBILITY DATE

If You are in an eligible class You are eligible for coverage on the date You enter active work for the Employer. If You are not in an eligible class, You will become eligible for coverage on the date You enter an eligible class.

EFFECTIVE DATE OF PARTICIPATION FOR ELIGIBLE EMPLOYEES

Subject to the Effective Date, You shall become effective in this Plan at 12:01 a.m. on the earliest of the following dates:

- January 1, 2013, with respect if on December 31, 2012, You were covered under the UA Plan which has been amended January 1, 2013; or
- The first day of the month coincident with or next following the date You enroll and authorize any required contributions for coverage, provided You do so within thirty-one (31) days after the Eligibility Date; or

- Please contact Your Human Resources Office to complete the forms adding coverage. **YOU MUST NOTIFY YOUR HUMAN RESOURCES OFFICE OF ANY ADDITION/CHANGE WITHIN 31 DAYS** of Your HIPAA Family Status Change or HIPAA Special Enrollment event. Your effective date will be the later of the date of the HIPAA Family Status Change or HIPAA Special Enrollment or the first day of the month following date Your written election is received by the Human Resources Office. In the case of birth of a Child or adoption, the effective date will be the date of birth or placement for adoption. **NOTE: You must enroll and authorize any required contributions for Your coverage, provided You do so within thirty-one (31) days after Your eligibility date; or**
- If You have a benefits-eligible part-time position and are changing to a benefits-eligible full-time position You will be effective on the first day of the month coincident with or next following the date the You enroll and authorize any required contributions for coverage, provided You enroll within thirty-one (31) days of this non-HIPAA enrollment event; or
- During any Open Enrollment period that may be designated by the University of Arkansas, on the effective date of the Open Enrollment following the date the You enroll and authorize any required contribution for coverage.
- If You do not enroll on Your eligibility date You will not be able to enroll in the plan unless You subsequently have a HIPAA family status change, HIPAA special enrollment event, a non-HIPAA enrollment event as defined above or the University conducts an open enrollment.
- Residents, interns, and house staff members at the University of Arkansas for Medical Sciences will be effective the first officially recognized day of their respective programs.

ELIGIBILITY DATE FOR DEPENDENT COVERAGE

- The eligibility date for Your Dependent's coverage shall be the first date on which You are eligible for coverage under this Plan and has one or more Eligible Dependents, as defined in this section.

EFFECTIVE DATE FOR COVERAGE FOR ELIGIBLE DEPENDENTS

Subject to the Effective Date, coverage for eligible Dependents shall become effective on the applicable date determined below, but in no event prior to the date the Employee becomes a Covered Person in this Plan:

- The eligibility date for Your Dependent's coverage, provided You enroll and authorize any required contributions for Dependent coverage on or before the date;
- If You have a HIPAA family status change or HIPAA special enrollment event, the later of the date of the HIPAA family status change or HIPAA special enrollment event or first day of the calendar month following the date Your written election to enroll and authorize required contributions is received by the Human Resources Office. In the case of birth or adoption of a child, coverage will be effective as of the date of birth or placement for adoption. In either case, You must make the written election to enroll within thirty-one (31) days after the HIPAA family status change or HIPAA special enrollment event.
- The first day of the calendar month following the date any Retiree has a HIPAA family status change event and enrolls and authorizes any required contributions for Dependent coverage.

- Please contact Your Human Resources Office to complete the forms adding or dropping Dependent coverage. **YOU MUST NOTIFY YOUR HUMAN RESOURCES OFFICE OF ANY CHANGE WITHIN 31 DAYS OF THE HIPAA family status change or HIPAA special enrollment event.** Dependent coverage shall be effective from the date of birth for each Dependent Child born, provided that You notify the Human Resources Office within 31 days of birth. Your effective date of enrollment for any other HIPAA family status change or HIPAA special enrollment event or the first day of the calendar month following the date Your written election is received by the Human Resources Office. **NOTE: An Employee with Employee only coverage or Employee and spouse coverage must enroll and authorize any required contributions for newborn Dependent coverage within 31 days after the date of the eligible dependents birth.**

You may select a network Primary Care Physician who will care for Your newborn Child either prior to the Child's birth or at the time You enroll the Child for coverage.

You should notify UMR, Inc. of this selection by using the appropriate selection form that is available from Your UA Campus Human Resources department or from UMR, Inc. You should also select a network Primary Care Physician for any other Dependent who becomes eligible for coverage after Your initial enrollment.

EFFECTIVE DATE OF PARTICIPATON FOR ELIGIBLE RETIREES

An eligible Retiree shall become a Covered Person in this Plan provided they elect no more than ninety (90) days prior to retirement and no more than thirty-one(31) days after retirement to continue to be covered under the Plan, enrolls for Retiree coverage within thirty-one (31) days of the date of their retirement, and makes the required contributions for coverage.

TERMINATION OF COVERAGE

When coverage under this Plan stops, You and / or Your Covered Dependents will receive a certificate that will show the period of Creditable Coverage under this Plan. Please contact Your campus Human Resources Office to determine how to receive a Certificate of Creditable Coverage.

Termination of coverage could occur if You fail to provide information necessary to comply with applicable law, including, but not limited to, Your or Your Covered Dependent's social security number or other government issued identification number.

WHEN YOUR COVERAGE TERMINATES

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

- The date the Plan ceases;
- The date the Plan ceases for the Class of Employees to which You belong; or
- The date active employment ceases, except as provided by the Plan; or
- The date ending the period for which the last contribution is made, if You are required to pay all or part of the cost of the Plan; or

- The date active employment ceases, except as provided by the Plan; or
- The date ending the period for which the last contribution is made, if You are required to pay all or part of the cost of the Plan; or
- In the event that You terminate Employment before the end of the payroll cycle, Your coverage will end on the date in accordance with the procedures established by Your campus.

BOARD POLICY

SELF-INSURED MAJOR MEDICAL PROGRAM

Effective July 1, 1990, the University of Arkansas established a self-insured major medical program. This program was revised effective November 1, 1994, for eligible employees and other eligible participants of the University of Arkansas for Medical Sciences and effective January 1, 1995, for all other eligible employees and other eligible participants of the University of Arkansas.

The extent of coverage for eligible employees and other eligible participants together with the schedule of benefits shall be governed by the terms and conditions of the University of Arkansas Medical Benefit Plan Documents which shall be approved by the President. All eligible employees and other eligible participants under the University of Arkansas Medical Benefit Plan shall be furnished a summary plan description setting forth the terms and conditions of coverage.

Active, regular, full-time or part-time appointed employees of the University of Arkansas who work twenty or more hours a week, including residents, interns and housestaff at the University of Arkansas for Medical Sciences campus, eligible retirees, eligible disabled employees and eligible dependents, as those terms are defined in University of Arkansas Medical Benefit Plan Documents, shall be eligible for coverage and to participate in the University of Arkansas Medical Benefit Plan.

The President shall contract with a company qualified to do business in the State of Arkansas to provide for managed care and third-party administrative services and for other services in connection with the University of Arkansas Medical Benefit Plan. The President shall, in consultation with the Chancellors and the Vice President for Agriculture, establish from time to time the coverage and cost of coverage at the separate campuses and the Division of Agriculture for employee only, employee and spouse, employee and child and employee and family and the percentage of such cost to be paid by the employee and the University. The cost of coverage paid by the employee may vary for eligible employees who work less than full-time. The President shall advise the Board of any changes in the cost of coverage.

HIPAA PORTABILITY RIGHTS

CERTIFICATES OF CREDITABLE COVERAGE

New Employees and covered Dependents are encouraged to get a Certificate of Creditable Coverage from the individual's prior employer or insurance company. However, not all forms of coverage are required to provide certificates. If You or Your Dependents are having difficulty obtaining this, contact Your Human Resources or Personnel office for assistance.

Covered Persons will receive a Certificate of Creditable Coverage from this Plan when the person loses coverage under this Plan, when the person loses COBRA coverage, or upon a written request to this Plan if the individual is covered under this Plan or terminated from this Plan within the previous twenty four month period. The Certificate of Creditable Coverage is evidence of Your coverage under this Plan. Covered Persons may need evidence of coverage to reduce a pre-existing condition exclusion period under another plan, to help get special enrollment in another plan, or to get certain types of individual health coverage.

Please submit written requests for a Certificate of Creditable Coverage from this Plan to:

CONEXIS
PO BOX 223726
DALLAS TX 75222

Keep these Certificates in a safe place in case You or Your Dependents obtain coverage under another health plan that has a pre-existing condition exclusion provision or become eligible for a Special Enrollment period under another plan. Proof of prior Creditable Coverage may reduce or eliminate the pre-existing condition exclusion period, may be required to enroll in another plan under Special Enrollment, or may assist individuals in obtaining an individual insurance policy in the future.

COBRA CONTINUATION OF COVERAGE

Important. Read this entire provision to understand a Covered Person's COBRA rights and obligations.

The following is a summary of the federal continuation requirements under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. This summary generally explains COBRA continuation coverage, when it may become available to You and Your family, and what You and Your Dependents need to do to protect the right to receive it. This summary provides a general notice of a Covered Person's rights under COBRA, but is not intended to satisfy all of the requirements of federal law. Your employer or the COBRA Administrator will provide additional information to You or Your Dependents as required.

The COBRA Administrator for this Plan is: Conexis

INTRODUCTION

Federal law gives certain persons, known as Qualified Beneficiaries (defined below), the right to continue their health care benefits beyond the date that they might otherwise terminate. The Qualified Beneficiary must pay the entire cost of the COBRA continuation coverage, plus an administrative fee. In general, a Qualified Beneficiary has the same rights and obligations under the Plan as an active participant.

A Qualified Beneficiary may elect to continue coverage under this Plan if such person's coverage would terminate because of a life event known as a Qualifying Event, outlined below. When a Qualifying Event causes (or will cause) a Loss of Coverage, then the Plan must offer COBRA continuation coverage. Loss of Coverage means more than losing coverage entirely. It means that a person ceases to be covered under the same terms and conditions that are in effect immediately before the Qualifying Event. In short, a Qualifying Event plus a Loss of Coverage allows a Qualified Beneficiary the right to elect coverage under COBRA.

Generally, You, Your covered spouse, and Your Dependent Children may be Qualified Beneficiaries and eligible to elect COBRA continuation coverage even if the person is already covered under another employer-sponsored group health plan or is enrolled in Medicare at the time of the COBRA election.

COBRA CONTINUATION COVERAGE FOR QUALIFIED BENEFICIARIES

The length of COBRA continuation coverage that is offered varies based on who the Qualified Beneficiary is and what **Qualifying Event** is experienced as outlined below.

An Employee will become a Qualified Beneficiary if coverage under the Plan is lost because either one of the following Qualifying Events happens:

Qualifying Event	Length of Continuation
• Your employment ends for any reason other than Your gross misconduct	up to 18 months
• Your hours of employment are reduced	up to 18 months

(There are two ways in which this 18-month period of COBRA continuation coverage can be extended. See the section below entitled "The Right to Extend Coverage" for more information.)

The spouse of an Employee will become a Qualified Beneficiary if coverage is lost under the Plan because any of the following Qualifying Events happen:

Qualifying Event	Length of Continuation
• Your spouse dies	up to 36 months
• Your spouse's hours of employment are reduced	up to 18 months
• Your spouse's employment ends for any reason other than his or her gross misconduct	up to 18 months
• Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both)	up to 36 months
• You become divorced or legally separated from Your spouse	up to 36 months

The Dependent Children of an Employee become Qualified Beneficiaries if coverage is lost under the Plan because any of the following Qualifying Events happen:

Qualifying Event	Length of Continuation
• The parent-Employee dies	up to 36 months
• The parent-Employee's employment ends for any reason other than his or her gross misconduct	up to 18 months
• The parent-Employee's hours of employment are reduced	up to 18 months
• The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both)	up to 36 months
• The parents become divorced or legally separated	up to 36 months
• The Child stops being eligible for coverage under the plan as a Dependent	up to 36 months

COBRA continuation coverage for Retired Employees and their Dependents is described below:

Qualifying Event	Length of Continuation
• If You are a Retired Employee and Your coverage is reduced or terminated due to Your Medicare entitlement, and as a result Your Dependent's coverage is also terminated, Your spouse and Dependent Children will also become Qualified Beneficiaries.	up to 36 months
• If You are a Retired Employee and Your employer files bankruptcy under Title 11 of the United States Code this may be a Qualifying Event. If the bankruptcy results in Loss of Coverage under this Plan, then the Retired Employee is a Qualified Beneficiary. The Retired Employee's spouse, surviving spouse and Dependent Children will also be Qualified Beneficiaries if bankruptcy results in their Loss of Coverage under this Plan.	
➤ Retired Employee	Lifetime
➤ Dependents	36 months

Note: A spouse or Dependent Child newly acquired (newborn or adopted) during a period of continuation coverage is eligible to be enrolled as a Dependent. The standard enrollment provision of the Plan applies to enrollees during continuation coverage. A Dependent, other than a newborn or newly adopted Child, acquired and enrolled after the original Qualifying Event, is not eligible as a Qualified Beneficiary if a subsequent Qualifying Event occurs.

COBRA NOTICE PROCEDURES

THE NOTICE(S) A COVERED PERSON MUST PROVIDE UNDER THIS SUMMARY PLAN DESCRIPTION

To be eligible to receive COBRA continuation coverage, covered Employees and their Dependents have certain obligations with respect to certain Qualifying Events (including divorce or legal separation of the Employee and spouse or a Dependent Child's loss of eligibility for coverage as a Dependent) to provide written notices to the administrator. Follow the rules described in this procedure when providing notice to the administrators, either Your employer or the COBRA Administrator.

A Qualified Beneficiary's written notice must include all of the following information: (A form to notify the COBRA Administrator is available upon request.)

- The Qualified Beneficiary's name, their current address and complete phone number,
- The group number, name of the employer that the Employee was with,
- Description of the Qualifying Event (i.e., the life event experienced), and
- The date that the Qualifying Event occurred or will occur.

Send all notices or other information required to be provided by this Summary Plan Description in writing to:

**CONEXIS
PO BOX 223726
DALLAS TX 75222
877-266-3947 Ext 6920**

For purposes of the deadlines described in this Summary Plan Description, the notice must be postmarked by the deadline. In order to protect Your family's rights, the Plan Administrator should be informed of any changes in the addresses of family members. Keep a copy of any notices sent to the Plan Administrator or COBRA Administrator.

COBRA NOTICE REQUIREMENTS AND ELECTION PROCESS

EMPLOYER OBLIGATION TO PROVIDE NOTICE OF THE QUALIFYING EVENT

Your employer will give notice to the COBRA Administrator when coverage terminates due to Qualifying Events that are the Employee's termination of employment or reduction in hours, death of the Employee, or the Employee becoming entitled to Medicare benefits due to age or disability (Part A, Part B, or both). Your employer will notify the COBRA Administrator within 30 calendar days when these events occur.

EMPLOYEE OBLIGATION TO PROVIDE NOTICE OF THE QUALIFYING EVENT

The Covered Person must give notice to the Plan Administrator in the case of other Qualifying Events that are divorce or legal separation of the Employee and a spouse, a Dependent Child ceasing to be eligible for coverage under the Plan, or a second Qualifying Event. The covered Employee or Qualified Beneficiary must provide written notice to the Plan Administrator in order to ensure rights to COBRA continuation coverage. The Covered Person must provide this notice within the 60-calendar day period that begins on the latest of:

- The date of the Qualifying Event; or
- The date on which there is a Loss of Coverage (or would lose coverage); or
- The date on which the Qualified Beneficiary is informed of this notice requirement by receiving this Summary Plan Description or the General COBRA Notice.

The Plan Administrator will notify the COBRA Administrator within 30 calendar days from the date that notice of the Qualifying Event has been provided.

The COBRA Administrator will, in turn, provide an election notice to each Qualified Beneficiary within 14 calendar days of receiving notice of a Qualifying Event from the employer, covered Employee or the Qualified Beneficiary.

MAKING AN ELECTION TO CONTINUE GROUP HEALTH COVERAGE

Each Qualified Beneficiary has the independent right to elect COBRA continuation coverage. A Qualified Beneficiary will receive a COBRA election form that must be completed to elect to continue group health coverage under this Plan. A Qualified Beneficiary may elect COBRA coverage at any time within the 60-day election period. The election period ends 60 calendar days after the later of:

- The date Plan coverage terminates due to a Qualifying Event; or
- The date the Plan Administrator provides the Qualified Beneficiary with an election notice.

A Qualified Beneficiary must notify the COBRA Administrator of their election in writing to continue group health coverage and must make the required payments when due in order to remain covered. If the Qualified Beneficiary does not choose COBRA continuation coverage within the 60-day election period, group health coverage will end on the day of the Qualifying Event.

PAYMENT OF CLAIMS AND DATE COVERAGE BEGINS

No claims will be paid under this Plan for services the Qualified Beneficiary receives on or after the date coverage is lost due to a Qualifying Event. If, however, the Qualified Beneficiary has not completed a waiver and decides to elect COBRA continuation coverage within the 60-day election period, group health coverage will be reinstated back to the date coverage was lost, provided that the Qualified Beneficiary makes the required payment when due. Any claims that were denied during the initial COBRA election period will be reprocessed once the COBRA Administrator receives the completed COBRA election form and required payment.

If a Qualified Beneficiary previously waived COBRA coverage but revokes that waiver within the 60-day election period, coverage will not be retroactive to the date of the Qualifying Event but instead will be effective on the date the waiver is revoked.

PAYMENT FOR CONTINUATION COVERAGE

Qualified Beneficiaries are required to pay the entire cost of continuation coverage, which includes both the employer and Employee contribution. This may also include a 2% additional fee to cover administrative expenses (or in the case of the 11-month extension due to disability, a 50% additional fee). Fees are subject to change at least once a year.

If Your employer offers annual open enrollment opportunities for active Employees, each Qualified Beneficiary will have the same options under COBRA (for example, the right to add or eliminate coverage for Dependents). The cost of continuation coverage will be adjusted accordingly.

The **initial payment** is due no later than 45 calendar days after the Qualified Beneficiary elects COBRA as evidenced by the postmark date on the envelope. This first payment must cover the cost of continuation coverage from the time coverage under the Plan would have otherwise terminated, up to the time the first payment is made. If the initial payment is not made within the 45-day period, then coverage will remain terminated without the possibility of reinstatement. There is no grace period for the initial payment.

The due date for **subsequent payments** is typically the first day of the month for any particular period of coverage, however the Qualified Beneficiary will receive specific payment information including due dates, when the Qualified Beneficiary becomes eligible for and elects COBRA continuation coverage.

If, for whatever reason, any Qualified Beneficiary receives any benefits under the Plan during a month for which the payment was not made on time, then the Qualified Beneficiary will be required to reimburse the Plan for the benefits received.

If the COBRA Administrator receives a check that is missing information or has discrepancies regarding the information on the check (i.e., the numeric dollar amount does not match the written dollar amount), the COBRA Administrator will provide a notice to the Qualified Beneficiary and allow him/her 14 days to send in a corrected check. If a corrected check is not received within the 14-day timeframe, then the occurrence will be treated as non-payment and the Qualified Beneficiary(s) will be terminated from the Plan in accordance with the plan language above.

Note: Payment will not be considered made if a check is returned for non-sufficient funds.

A QUALIFIED BENEFICIARY'S NOTICE OBLIGATIONS WHILE ON COBRA

Always keep the COBRA Administrator informed of the current addresses of all Covered Persons who are or who may become Qualified Beneficiaries. Failure to provide this information to the COBRA Administrator may cause You or Your Dependents to lose important rights under COBRA.

In addition, after any of the following events occur, written notice to the COBRA Administrator is required within 30 calendar days of:

- The date any Qualified Beneficiary marries. Refer to the Special Enrollment section of this SPD for additional information regarding special enrollment rights.
- The date a Child is born to, adopted by, or Placed for Adoption by a Qualified Beneficiary. Refer to the Special Enrollment section of this SPD for additional information regarding special enrollment rights.
- The date of a final determination by the Social Security Administration that a disabled Qualified Beneficiary is no longer disabled.
- The date any Qualified Beneficiary becomes covered by another group health plan.
- Additionally, if the COBRA Administrator or the Plan Administrator requests additional information from the Qualified Beneficiary, the Qualified Beneficiary must provide the requested information within 30 calendar days.

LENGTH OF CONTINUATION COVERAGE

COBRA coverage is available up to the maximum periods described below, subject to all COBRA regulations and the conditions of this Summary Plan Description:

- For Employees and Dependents. 18 months from the Qualifying Event if due to the Employee's termination of employment or reduction of work hours. (If an active Employee enrolls in Medicare before his or her termination of employment or reduction in hours, then the covered spouse and Dependent Children would be entitled to COBRA continuation coverage for up to the greater of 18 months from the Employee's termination of employment or reduction in hours, or 36 months from the earlier Medicare Enrollment Date, whether or not Medicare enrollment is a Qualifying Event.)
- For Dependents only. 36 months from the Qualifying Event if coverage is lost due to one of the following events:
 - Employee's death.
 - Employee's divorce or legal separation.
 - Former Employee becomes enrolled in Medicare.
 - A Dependent Child no longer being a Dependent as defined in the Plan.

- For Retired Employees and Dependents of Retired Employees only. If bankruptcy of the employer is the Qualifying Event that causes Loss of Coverage, the Qualified Beneficiaries can continue COBRA continuation coverage for the following maximum period, subject to all COBRA regulations. The covered Retired Employee can continue COBRA coverage for the rest of his or her life. The covered spouse, surviving spouse or Dependent Child of the covered Retired Employee can continue coverage until the earlier of:
 - The date the Qualified Beneficiary dies; or
 - The date that is 36 months after the death of the covered Retired Employee.

THE RIGHT TO EXTEND THE LENGTH OF COBRA CONTINUATION COVERAGE

While on COBRA continuation coverage, certain Qualified Beneficiaries may have the right to extend continuation coverage provided that written notice to the COBRA Administrator is given as soon as possible but no later than the **required** timeframes stated below.

Social Security Disability Determination (For Employees and Dependents): A Qualified Beneficiary may be granted an 11-month extension to the initial 18-month COBRA continuation period, for a total maximum of 29 months of COBRA in the event that the Social Security Administration determines the Qualified Beneficiary to be disabled some time before the 60th day of COBRA continuation coverage. This extension will not apply if the original COBRA continuation was for 36 months.

If the Qualified Beneficiary has non-disabled family members who are also Qualifying Beneficiaries, those non-disabled family members are also entitled to the disability extension.

The Qualified Beneficiary must give the COBRA Administrator a copy of the Social Security Administration letter of disability determination within 60 days of the later of:

- The date of the SSA disability determination;
- The date the Qualifying Event occurs;
- The date the Qualified Beneficiary loses (or would lose) coverage due to the Qualifying Event or the date that Plan coverage was lost; or
- The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the disability by receiving this Summary Plan Description or the General COBRA Notice.

Note: Premiums may be higher after the initial 18-month period for persons exercising this disability extension provision available under COBRA.

If the Social Security Administration determines the Qualified Beneficiary is no longer disabled, the Qualified Beneficiary must notify the Plan of that fact within 30 days after the Social Security Administration's determination.

Second Qualifying Events: (Dependents Only) If Your family experiences another Qualifying Event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent Children in Your family who are Qualified Beneficiaries can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second event is provided to the COBRA Administrator. This additional coverage may be available to the spouse or Dependent Children who are Qualified Beneficiaries if the Employee or former Employee dies, becomes entitled to Medicare (Part A, Part B or both) or is divorced or legally separated, or if the Dependent Child stops being eligible under the Plan as a Dependent. This extension is available only if the Qualified Beneficiaries were covered under the Plan prior to the original Qualifying Event. A Dependent acquired during COBRA continuation (other than newborns and newly adopted Children) is not eligible to continue coverage as the result of a subsequent Qualifying Event. These events will only lead to the extension when the event would have caused the spouse or Dependent Child to lose coverage under the Plan had the first qualifying event not occurred.

You or Your Dependents must provide the notice of a second Qualifying Event to the COBRA Administrator within a 60-day period that begins to run on the latest of:

- The date of the second Qualifying Event; or
- The date the Qualified Beneficiary loses (or would lose) coverage due to the second Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the second Qualifying Event by receiving this Summary Plan Description or the General COBRA Notice.

EARLY TERMINATION OF COBRA CONTINUATION

COBRA continuation coverage may terminate before the end of the above maximum coverage periods for any of the following reasons:

- The employer ceases to maintain a group health plan for any Employees. (Note that if the employer terminates the group health plan that the Qualified Beneficiary is under, but still maintains another group health plan for other similarly-situated Employees, the Qualified Beneficiary will be offered COBRA continuation coverage under the remaining group health plan, although benefits and costs may not be the same).
- The required contribution for the Qualified Beneficiary's coverage is not paid within the timeframe expressed in the COBRA regulations.
- After electing COBRA continuation coverage, the Qualified Beneficiary becomes entitled to and enrolled with Medicare.
- After electing COBRA continuation coverage, the Qualified Beneficiary becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition(s) for the beneficiary.
- The Qualified Beneficiary is found not to be disabled during the disability extension. The Plan will terminate the Qualified Beneficiary's COBRA continuation coverage one month after the Social Security Administration makes a determination that the Qualified Beneficiary is no longer disabled.
- Termination for cause, such as submitting fraudulent claims.

SPECIAL NOTICE (Read This If Thinking Of Declining COBRA Continuation Coverage)

Electing COBRA continuation coverage now may protect some of Your (or Your Dependent's) rights if You or Your Dependent need to obtain an **individual health insurance policy** soon. The Health Insurance Portability and Accountability Act (HIPAA) requires that all health insurance carriers who offer coverage in the individual market must accept any eligible individuals who apply for coverage without imposing pre-existing condition exclusions, under certain conditions. Some of those conditions pertain to COBRA continuation coverage. To take advantage of this HIPAA right, COBRA continuation coverage under this Plan must be elected and maintained (by paying the cost of coverage) for the duration of the COBRA continuation period. In the event that an individual health insurance policy is needed, You or Your Dependent must apply for coverage with an individual insurance carrier after COBRA continuation coverage is exhausted and before a 63-day break in coverage.

If You or Your Dependent will be obtaining **group health coverage** through a new employer, keep in mind that HIPAA requires employers to reduce pre-existing condition exclusion periods if there is less than a 63-day break in health coverage (Creditable Coverage).

HEALTH COVERAGE TAX CREDIT PROGRAM (HCTC)

The Trade Act of 2002 created a new health coverage tax credit for certain individuals who become eligible for trade adjustment assistance. Trade adjustment assistance is generally available to only a limited group of individuals who have lost their jobs or suffered a reduction in hours as a result of import competition or shifts of production to other countries. Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 72.5% of premiums paid for qualified health insurance, including COBRA continuation coverage. If You have questions about these new tax provisions, You may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is available at www.doleta.gov/tradeact/

Special COBRA rights apply to certain Employees who are eligible for the health coverage tax credit. These Employees are entitled to a second opportunity to elect COBRA coverage during a special second election period (if the Employee did not elect COBRA coverage already). The special second COBRA election period lasts 60 days or less, beginning on the first day of the month in which the Employee becomes an eligible HCTC recipient, but the election must also be made within six months after the initial loss of group health coverage. As a result, if the Employee finds out that he or she is eligible for this program with fewer than 60 days remaining in the six month period after initial loss of group health coverage, then this second election period will be less than 60 days. The Employee must send the COBRA Administrator a copy of the confirmation letter from HCTC or the State Workforce Agency, stating the effective date of eligibility under this program.

COBRA coverage elected during the special second election period is not retroactive. Coverage begins on the date that the special second election period begins, and the maximum COBRA coverage period will end on the same day it would have ended if COBRA coverage had been elected during the regular 60-day election period. There is no retroactive coverage for the gap period from the initial loss of coverage to the first day of the special second election period. For example, if an Employee's coverage ends on June 30 due to termination of employment, and the Employee elects COBRA coverage during a second 60-day election period that begins on November 1, the person would have no coverage from July 1 to October 31. COBRA coverage would start on November 1 and would end 14 months later because the maximum COBRA coverage period would expire 18 months from loss of coverage due to termination of employment. For purposes of pre-existing condition exclusions, the Plan will not count any days between the initial loss of group health coverage and the first day of the special second election period as part of a 63-day Significant Break in Coverage.

DEFINITIONS

Qualified Beneficiary means a person covered by this group health Plan immediately before the Qualifying Event who is the Employee, the spouse of a covered Employee or the Dependent Child of a covered Employee. This includes a Child who is born to or Placed for Adoption with a covered Employee during the Employee's COBRA coverage period if the Child is enrolled within the Plan's Special Enrollment Provision for newborns and adopted Children. This also includes a Child who was receiving benefits under this Plan pursuant to a Qualified Medical Child Support Order (QMCSO) immediately before the Qualifying Event.

Qualifying Event means Loss of Coverage due to one of the following:

- The death of the covered Employee.
- Voluntary or involuntary termination of the covered Employee's employment (other than for gross misconduct).
- A reduction in work hours of the covered Employee.

- Divorce or legal separation of the covered Employee from the Employee's spouse. (Also, if an Employee terminates coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation may be considered a Qualifying Event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Plan or the COBRA Administrator in writing within 60 calendar days after the divorce or legal separation and can establish that the coverage was originally eliminated in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation).
- The covered former Employee becomes enrolled in Medicare.
- A Dependent Child no longer being a Dependent as defined by the Plan.

Loss of Coverage means any change in the terms or conditions of coverage in effect immediately before the Qualifying Event. Loss of Coverage includes change in coverage terms, change in plans, termination of coverage, partial Loss of Coverage, increase in Employee cost, as well as other changes that affect terms or conditions of coverage. Loss of Coverage does not always occur immediately after the Qualifying Event, but it must always occur within the applicable 18- or 36-month coverage period. A Loss of Coverage that is not caused by a Qualifying Event may not trigger COBRA.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

INTRODUCTION

Employers are required to offer COBRA-like health care continuation coverage to persons in the armed service if the absence for military duty would result in loss of coverage as a result of active duty. Employees on leave for military service must be treated like they are on leave of absence and are entitled to any other rights and benefits accorded to similarly situated Employees on leave of absence or furlough. If an employer has different types of benefits available depending on the type of leave of absence, the most favorable comparable leave benefits must apply to Employees on military leave. Reinstatement following the military leave of absence cannot be subject to pre-existing condition.

COVERAGE

The maximum length of health care continuation coverage required under USERRA is the lesser of:

- 24 months beginning on the day that the Uniformed Service leave begins, or
- a period beginning on the day that the Service leave begins and ending on the day after the Employee fails to return to or reapply for employment within the time allowed by USERRA.

USERRA NOTICE AND ELECTION

An Employee or an appropriate officer of the uniformed service in which his or her service is to be performed must notify the employer that the Employee intends to leave the employment position to perform service in the uniformed services. An Employee should provide notice as far in advance as is reasonable under the circumstances. The Employee is excused from giving notice due to military necessity, or if it is otherwise impossible or unreasonable under all the circumstances.

Upon notice of intent to leave for uniformed services, Employees will be given the opportunity to elect USERRA continuation. Dependents do not have an independent right to elect USERRA coverage. Election, payment and termination of the USERRA extension will be governed by the same requirements set forth under the COBRA Section, to the extent these COBRA requirements do not conflict with USERRA.

PAYMENT

If the military leave orders are for a period of 30 days or less, the Employee is not required to pay more than the amount he or she would have paid as an active Employee. For periods of 31 days or longer, if an Employee elects to continue health coverage pursuant to USERRA, such Employee and covered Dependents will be required to pay up to 102% of the full premium for the coverage elected.

EXTENDED COVERAGE RUNS CONCURRENT

Employees and their Dependents may be eligible for both COBRA and USERRA at the same time. Election of either the COBRA or USERRA extension by an Employee on leave for military service will be deemed an election under both laws, and the coverage offering the most benefit to the Employee will generally be extended. Coverage under both laws will run concurrently. Dependents who choose to independently elect extended coverage will only be deemed eligible for COBRA extension because they are not eligible for a separate, independent right of election under USERRA.

PROVIDER NETWORK

Applies to Classic Non-SmartCare and Point of Service Non-SmartCare With UHC Options

The word "**Network**" means an outside organization that has contracted with various providers to provide health care services to Covered Persons at a Negotiated Rate. Providers who participate in a Network have agreed to accept the negotiated fees as payment in full, including any portion of the fees that the Covered Person must pay due to the Deductible, Participation amounts or other out-of-pocket expenses. The allowable charges used in the calculation of the payable benefit to participating providers will be determined by the Negotiated Rates in the network contract. A provider who does not participate in a Network may bill Covered Persons for additional fees over and above what the Plan pays.

Knowing which Network a provider belongs to will help a Covered Person to determine how much he or she will need to pay for certain services. To obtain the highest level of benefits under this Plan, Covered Persons need to see an In-Network provider, however this Plan does not limit a Covered Person's right to choose his or her own provider of medical care at his or her own expense if a medical expense is not a Covered Expense under these Plans, or is subject to a limitation or exclusion.

To find out which Network a provider belongs to, please refer to the Provider Directory, or call the toll-free number that is listed on the back of the Plan's identification card. The participation status of providers may change from time to time.

- If a provider belongs to one of the following Networks, claims for Covered Expenses will normally be processed in accordance with the **In-Network** benefit levels that are listed on the Schedule of Benefits:

Classic Non-SmartCare with UHC Options PPO

Point of Service Non-SmartCare with UHC Options PPO

- For services received from any other provider, claims for Covered Expenses will normally be processed in accordance with the **Out-of-Network** benefit levels that are listed on the Schedule of Benefits. These providers charge their normal rates for services, so Covered Persons may need to pay more. **The Covered Person is responsible for paying the balance of these claims after the Plan pays its portion, if any.**

Reimbursement for Covered Expenses received from Non-Network Physicians or health care facilities are determined based on one of the following:

- Fee(s) that are negotiated with the Physician or facility;
- 110 percent of the published rates allowed by Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market;
- 50 percent of billed charges.

The specific reimbursement formula used will vary depending upon the Physician or facility providing the service(s) and the type of service(s) received.

For Transplant Services at a Designated Transplant Facility the Preferred Provider Organization is:

OptumHealth

EXCEPTIONS TO THE PROVIDER NETWORK RATES

Some benefits may be processed at In-Network benefit levels when provided by an Out-of-Network provider. When Non-Network charges are covered in accordance with Network benefits, the charges are still subject to the Usual and Customary charge limitations

Provider Directory Information

Each covered Employee, those on COBRA, and Children or guardians of Children who are considered alternate recipients under a Qualified Medical Child Support Order, will automatically be given or electronically made available, a separate document, at no cost, that lists the participating Network providers for this Plan. The Employee should share this document with other covered individuals in Your household. If a covered spouse or Dependent wants a separate provider list, they should make a written request to the Plan Administrator. The Plan Administrator may make a reasonable charge to cover the cost of furnishing complete copies to the spouse or other covered Dependents.

TRANSITIONAL CARE

Certain eligible expenses that would have been considered at the In-Network benefit level by the prior Claims Administrator but which are not considered at the In-Network benefit level by the current Claims Administrator may be paid at the applicable In-Network benefit level if the Covered Person is currently under a treatment plan by a Physician who was a member of this Plan's previous Network but who is not a member of the Plan's current Network in the Employee or Dependent's network area. In order to ensure continuity of care for certain medical conditions already under treatment, the In-Network medical plan benefit level may continue for 90 days for conditions approved as transitional care or six months for mental health office services. Examples of medical conditions appropriate for consideration for transitional care include, but are not limited to:

- Cancer if under active treatment with chemotherapy and/or radiation therapy.
- Organ transplant patients if under active treatment (seeing a Physician on a regular basis, on a transplant waiting list, ready at any time for transplant).
- If the Covered Person is Inpatient in a Hospital on the effective date.
- Post acute Injury or Surgery within the past three months.
- Pregnancy in the second or third trimester and up to eight weeks postpartum.
- Behavioral Health – any previous treatment.

You or Your Dependent must call UMR within 30 days prior to the effective date or within 30 days after the effective date to see if You or Your Dependent are eligible for this benefit.

Routine procedures, treatment for stable chronic conditions, minor illnesses and elective surgical procedures will not be covered by transitional level benefits.

PROVIDER NETWORK

Applies to Classic UAMS and Point of Service UAMS With UHC Options and SmartCare

The word "**Network**" means an outside organization that has contracted with various providers to provide health care services to Covered Persons at a Negotiated Rate. Providers who participate in a Network have agreed to accept the negotiated fees as payment in full, including any portion of the fees that the Covered Person must pay due to the Deductible, Participation amounts or other out-of-pocket expenses. The allowable charges used in the calculation of the payable benefit to participating providers will be determined by the Negotiated Rates in the network contract. A provider who does not participate in a Network may bill Covered Persons for additional fees over and above what the Plan pays.

Knowing which Network a provider belongs to will help a Covered Person to determine how much he or she will need to pay for certain services. To obtain the highest level of benefits under this Plan, Covered Persons need to see a SmartCare or In-Network provider, however this Plan does not limit a Covered Person's right to choose his or her own provider of medical care at his or her own expense if a medical expense is not a Covered Expense under this Plan, or is subject to a limitation or exclusion.

To find out which Network a provider belongs to, please refer to the Provider Directory, or call the toll-free number that is listed on the back of the Plan's identification card. The participation status of providers may change from time to time.

- If a provider belongs to one of the following Networks, claims for Covered Expenses will normally be processed in accordance with the **SmartCare or In-Network** benefit levels that are listed on the Schedule of Benefits:

Classic UAMS with UHC Options PPO and Smartcare
Point of Service UAMS with UHC Options PPO and Smartcare

- For services received from any other provider, claims for Covered Expenses will normally be processed in accordance with the **Out-of-Network** benefit levels that are listed on the Schedule of Benefits. These providers charge their normal rates for services, so Covered Persons may need to pay more. **The Covered Person is responsible for paying the balance of these claims after the Plan pays its portion, if any.**

Reimbursement for Covered Expenses received from Non-Network Physicians or health care facilities are determined based on one of the following:

- Fee(s) that are negotiated with the Physician or facility;
- 110 percent of the published rates allowed by Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market;
- 50 percent of billed charges.

The specific reimbursement formula used will vary depending upon the Physician or facility providing the service(s) and the type of service(s) received.

For Transplant Services at a Designated Transplant Facility the Preferred Provider Organization is:

OptumHealth

EXCEPTIONS TO THE PROVIDER NETWORK RATES

Some benefits may be processed at In-Network benefit levels when provided by an Out-of-Network provider. When Non-Network charges are covered in accordance with Network benefits, the charges are still subject to the Usual and Customary charge limitations

Provider Directory Information

Each covered Employee, those on COBRA, and Children or guardians of Children who are considered alternate recipients under a Qualified Medical Child Support Order, will automatically be given or electronically made available, a separate document, at no cost, that lists the participating Network providers for this Plan. The Employee should share this document with other covered individuals in Your household. If a covered spouse or Dependent wants a separate provider list, they should make a written request to the Plan Administrator. The Plan Administrator may make a reasonable charge to cover the cost of furnishing complete copies to the spouse or other covered Dependents.

TRANSITIONAL CARE

Certain eligible expenses that would have been considered at the In-Network benefit level by the prior Claims Administrator but which are not considered at the In-Network benefit level by the current Claims Administrator may be paid at the applicable In-Network benefit level if the Covered Person is currently under a treatment plan by a Physician who was a member of this Plan's previous Network but who is not a member of the Plan's current Network in the Employee or Dependent's network area. In order to ensure continuity of care for certain medical conditions already under treatment, the In-Network medical plan benefit level may continue for 90 days for conditions approved as transitional care or six months for mental health office services. Examples of medical conditions appropriate for consideration for transitional care include, but are not limited to:

- Cancer if under active treatment with chemotherapy and/or radiation therapy.
- Organ transplant patients if under active treatment (seeing a Physician on a regular basis, on a transplant waiting list, ready at any time for transplant).
- If the Covered Person is Inpatient in a Hospital on the effective date.
- Post acute Injury or Surgery within the past three months.
- Pregnancy in the second or third trimester and up to eight weeks postpartum.
- Behavioral Health – any previous treatment.

You or Your Dependent must call UMR within 30 days prior to the effective date or within 30 days after the effective date to see if You or Your Dependent are eligible for this benefit.

Routine procedures, treatment for stable chronic conditions, minor Illnesses and elective surgical procedures will not be covered by transitional level benefits.

COVERED MEDICAL BENEFITS

This Plan provides coverage for the following covered benefits if services are authorized by a Physician and are necessary for the treatment of an Illness or Injury, subject to any limits, maximums, exclusions, or other Plan provisions shown in this SPD. The Plan does not provide coverage for services if medical evidence shows that treatment is not expected to resolve, improve, or stabilize the Covered Person's condition, or if a plateau has been reached in terms of improvement from such services.

In addition, any diagnosis change for a covered benefit after a payment denial will not be considered for benefits unless the Plan is provided with all pertinent records along with the request for change that justifies the revised diagnosis. Such records must include the history and initial assessment and must reflect the criteria listed in the most recent Diagnostic and Statistical Manual (DSM) for the new diagnosis, or, if in a foreign country, must meet diagnostic criteria established and commonly recognized by the medical community in that region.

1. **Abortions:** If a Physician states in writing that the mother's life would be in danger if the fetus were to be carried to term.
2. **Allergy Treatment** including: injections, testing and serum.
3. **Ambulance Transportation:** Medically Necessary ground and air transportation by a vehicle designed, equipped, and used only to transport the sick and injured to the nearest medically-appropriate Hospital.
4. **Anesthetics and Their Administration.**
5. **Aquatic Therapy.** (See Therapy Services below.)
6. **Autism Spectrum Disorders (ASD) Treatment (Effective 07-01-2013),** when Medically Necessary.

(ASD includes Autistic Disorder, Asperger's Syndrome, Childhood Disintegrative Disorder, Rett Syndrome and Pervasive Developmental Disorders).

ASD Treatment may include any of the following services: Diagnosis and Assessment; Psychological, Psychiatric, and Pharmaceutical (medication management) care; Speech Therapy, Occupational Therapy, and Physical Therapy; or Applied Behavioral Analysis (ABA) Therapy.

Treatment is prescribed and provided by a licensed healthcare professional practicing within the scope of their license (if ABA therapy, preferably a Board Certified Behavior Analyst, BCBA).

If ABA Therapy meets Medical Necessity, frequency and duration will be subject to current UMR guidelines, for example ABA treatment up to 20 hours per week for 6 months. Treatment plans specific to ABA Therapy with goals-progress and updates are required at least every 6 months for review of ongoing therapy to evaluate continued Medical Necessity.

Treatment is subject to all other plan provisions as applicable (such as Prescription benefit coverage, Behavioral/Mental Health coverage and/or coverage of therapy services).

Does not include services or treatment identified elsewhere in the Plan as noncovered or excluded (such as Investigational/Experimental or Unproven, custodial, nutrition-diet supplements, educational or services that should be provided through the school district).

7. **Biofeedback Services** when Medically Necessary for the treatment of a medical condition. (Refer to the Mental Health Benefits section in this SPD for biofeedback services related to treatment of a Mental Health Disorder).

8. **Breast Pumps** and related supplies.
9. **Breast Reductions** if Medically Necessary.
10. **Breastfeeding Support, Supplies and Counseling** in conjunction with each birth. Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.
11. **Cardiac Pulmonary Rehabilitation** when Medically Necessary for Activities of Daily Living (see the Glossary of Terms) and when needed as a result of an Illness or Injury.
12. **Cardiac Rehabilitation** programs, if referred by a Physician, for patients who have:
 - had a heart attack in the last 12 months; or
 - had coronary bypass surgery; or
 - a stable angina pectoris.

Covered services include:

- Phase I, cardiac rehabilitation, while the Covered Person is an Inpatient.
 - Phase II, cardiac rehabilitation, while the Covered Person is in a Physician-supervised Outpatient monitored low-intensity exercise program. Services generally will be in a Hospital rehabilitation facility and include monitoring of the Covered Person's heart rate and rhythm, blood pressure and symptoms by a health professional. Phase II generally begins within 30 days after discharge from the Hospital.
13. **Cataract or Aphakia Surgery** as well as protective lenses following such a procedure.
 14. **Chiropractic Treatment** by a Qualified chiropractor. Services for diagnosis by physical examination and plain film radiography, and when Medically Necessary for treatments for musculoskeletal conditions. Refer to "Maintenance Therapy" under the General Exclusions section of this SPD.
 15. **Circumcision** and related expenses when care and treatment meet the definition of Medical Necessity. Circumcision of newborn males is also covered as stated under nursery and newborn medical benefits.
 16. **Cleft Palate And Cleft Lip**, including Medically Necessary oral surgery and pre-graft palatal expanders.
 17. **Congenital Heart Disease:** If a Covered Person is being treated for congenital heart disease, and chooses to obtain the treatment at an OptumHealth facility, the Plan will provide the same housing and travel benefits that are outlined in the Transplant Benefits section and on the Transplant Schedule of Benefits.
 18. **Contraceptives and Counseling:** All Food and Drug Administration approved contraceptive methods, sterilization procedures and patient education and counseling. This Plan provides benefits for Prescription contraceptives, regardless of purpose. Prescription contraceptives that require a Physician to administer a hormone shot or insert a device will be processed under the Covered Medical Benefits in this SPD.
 19. **Cornea Transplants** are payable at the percentage listed under "All Other Covered Expenses" on the Schedule of Benefits.

20. **Dental Services** include:

- The care and treatment of natural teeth and gums if an Injury is sustained in an Accident (other than one occurring while eating or chewing), including implants. Treatment must be completed within 12 months of the Injury except when medical and/or dental conditions preclude completion of treatment within this time period.
- Inpatient or Outpatient Hospital charges including professional services for x-ray, lab, and anesthesia while in the Hospital if Medically Necessary.
- Removal of all teeth at an Inpatient or Outpatient Hospital or dentist's office if removal of the teeth is part of standard medical treatment that is required before the Covered Person can undergo radiation therapy for a covered medical condition.

21. **Diabetes Treatment:** Charges Incurred for the treatment of diabetes and diabetic self-management education programs and nutritional counseling.

22. **Dialysis:** Charges for dialysis treatment of acute renal failure or chronic irreversible renal insufficiency for the removal of waste materials from the body, including hemodialysis and peritoneal dialysis. Coverage also includes use of equipment or supplies, unless covered through the Prescription Benefits section. Charges are paid the same as any other Illness.

23. **Durable Medical Equipment** subject to all of the following:

- The equipment must meet the definition of Durable Medical Equipment in the Glossary of Terms. Examples include, but are not limited to crutches, wheelchairs, hospital-type beds and oxygen equipment.
- The equipment must be prescribed by a Physician.
- The equipment is subject to review under the Utilization Management Provision of this SPD, if applicable.
- The equipment will be provided on a rental basis when available; however, such equipment may be purchased at the Plan's option. Any amount paid to rent the equipment will be applied toward the purchase price. In no case will the rental cost of Durable Medical Equipment exceed the purchase price of the item.
- The Plan will pay benefits for only ONE of the following: a manual wheelchair, motorized wheelchair or motorized scooter, unless necessary due to growth of the person or changes to the person's medical condition require a different product, as determined by the Plan.
- If the equipment is purchased, benefits may be payable for subsequent repairs including batteries, except over the counter batteries, if obtained from a Durable Medical Equipment provider or replacement only if required:
 - due to the growth or development of a Dependent Child;
 - when necessary because of a change in the Covered Person's physical condition; or
 - because of deterioration caused from normal wear and tear.The repair or replacement must also be recommended by the attending Physician. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered and replacement is subject to prior approval by the Plan.
- This Plan covers insulin pumps and supplies.
- This Plan covers taxes, shipping and handling charges for Durable Medical Equipment.

24. **Emergency Room Hospital and Physician Services** including Emergency room services for stabilization or initiation of treatment of a medical Emergency condition provided on an Outpatient basis at a Hospital, as shown in the Schedule of Benefits.

25. **Emergency Room Hospital and Physician Services Provided in a Foreign Country**, including Emergency room services for stabilization or initiation of treatment of a medical Emergency condition provided on an Inpatient or Outpatient basis at a Hospital, as shown in the Schedule of Benefits.

26. **Extended Care Facility Services** for both mental and physical health diagnosis. Charges will be paid under the applicable diagnostic code. Covered Person must obtain prior authorization for services in advance. (Refer to the Utilization Management section of this SPD). The following benefits are covered:

- Room and board.
- Miscellaneous services, supplies and treatments provided by an Extended Care Facility, including Inpatient rehabilitation.

27. **Foot Care (Podiatry)** that is recommended by a Physician as a result of infection. The following charges for foot care will also be covered:

- Treatment of any condition resulting from weak, strained, flat, unstable or unbalanced feet, when surgery is performed.
- Treatment of corns, calluses and toenails when at least part of the nail root is removed or when needed to treat a metabolic or peripheral vascular disease.
- Physician office visit for diagnosis of bunions. Treatment of bunions when an open cutting operation or arthroscopy is performed.

28. **Genetic Counseling** based on Medical Necessity.

29. **Genetic Testing** when Medically Necessary (see below).

Genetic Testing MUST meet the following requirements:

The test is not considered experimental or investigational. The test is performed by a CLIA-certified laboratory. The test result will directly impact/influence the disease treatment of the covered member. In some cases, testing is accompanied by pretest and posttest counseling.

And must meet at least one of the following:

- The patient has current signs and/or symptoms (i.e., the test is being used for diagnostic purposes).
- Conventional diagnostic procedures are inconclusive.
- The patient has risk factors or a particular family history that indicate a genetic cause.
- The patient meets defined criteria that place them at high genetic risk for the condition.

Generally, genetic testing is not covered for:

- Population screening without a personal or family history, with the exception of preconception or prenatal carrier screening for certain conditions, such as cystic fibrosis, Tay-Sachs disease, sickle cell disease, and other hemoglobinopathies.
- Informational purposes alone (i.e., testing of minors for adult-onset conditions, and self-referrals or home testing).
- Test is considered Experimental or Investigational.

30. **Growth Hormones** when billed by a medical provider or facility. Prior authorization is required. Growth hormones are covered under the drug plan when obtained through a pharmacy.

31. **Hearing Services** include:

- Exams, tests, services and supplies to diagnose and treat a medical condition.
- Purchase or fitting of hearing aids.
- Implantable hearing devices.

32. **Home Health Care Services:** (Refer to Home Health Care section of this SPD).

33. **Hospice Care Services:** Treatment given at a Hospice Care Facility must be in place of a stay in a Hospital or Extended Care Facility, and can include:

- **Assessment** includes an assessment of the medical and social needs of the Terminally Ill person, and a description of the care to meet those needs.
- **Inpatient Care** in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy and part-time Home Health Care services.
- **Outpatient Care** provides or arranges for other services as related to the Terminal Illness which include: Services of a Physician; physical or occupational therapy; nutrition counseling provided by or under the supervision of a registered dietitian.
- **Bereavement Counseling:** Benefits are payable for bereavement counseling services which are received by a Covered Person's Close Relative when directly connected to the Covered Person's death and bundled with other hospice charges. Counseling services must be given by a licensed social worker, licensed pastoral counselor, psychologist or psychiatrist. The services must be furnished within six months of death.

The Covered Person must be Terminally Ill with an anticipated life expectancy of about six months. Services, however, are not limited to a maximum of six months if continued Hospice Care is deemed appropriate by the Physician, up to the maximum hospice benefits available under the Plan.

34. **Hospital Services (Includes Inpatient Services, Surgical Centers And Inpatient Birthing Centers).** The following benefits are covered:

- Semi-private room and board. For network charges, this rate is based on network repricing. For non-network charges, any charge over a semi-private room charge will be a Covered Expense only if determined by the Plan to be Medically Necessary. If the Hospital has no semi-private rooms, the Plan will allow the private room rate subject to Usual and Customary charges or the Negotiated Rate, whichever is applicable.
- Intensive care unit room and board.
- Miscellaneous and Ancillary Services.
- Blood, blood plasma and plasma expanders, when not available without charge.

35. **Hospital Services (Outpatient).**

36. **Infant Formula** administered through a tube as the sole source of nutrition for the Covered Person. Food and formula, regardless of the method, is covered for PKU.

37. **Infertility Treatment** to the extent required to treat or correct underlying causes of infertility, when such treatment is Medically Necessary and cures the condition, alleviates the symptoms, slows the harm, or maintains the current health status of the Covered Person. Diagnosis of Infertility, please see the exclusion section for additional information.

Infertility Treatment does not include Genetic Testing. (See General Exclusions for details).

38. **Laboratory Or Pathology Tests And Interpretation Charges** for covered benefits.

39. **Massage Therapy.** (See Therapy Services below)

40. **Maternity Benefits** for Covered Persons include:

- Prenatal and postnatal care.
- Hospital or Birthing Center room and board.
- Obstetrical fees for routine prenatal care.
- Vaginal delivery or Cesarean section.
- Medically Necessary diagnostic testing.
- Abdominal operation for intrauterine pregnancy or miscarriage.
- Outpatient Birthing Centers.
- Home births.
- Midwives.

Special additions for maternity management allows a nurse to act as advisor and maternal/newborn specialist. This allows one-on-one coaching and information and can:

- Discuss health history, including diet and exercise routines.
- Identify and assess potential pregnancy risk factors.
- Discuss ways to minimize risks for mother and baby.
- Answer questions and provide information on pregnancy and Child care issues.
- Contact Physician to coordinate care.
- Provide education and support related to labor and delivery.
- Identify community resources for additional information and support.

41. **Mental Health Treatment** (Refer to Mental Health section of this SPD).

42. **Modifiers or Reducing Modifiers** if Medically Necessary, apply to services and procedures performed on the same day and may be applied to surgical, radiology and other diagnostic procedures. For providers participating with a primary or secondary network, claims will be paid according to the network contract. For providers who are not participating with a network, where no discount is applied, the industry guidelines are to allow the full Usual and Customary fee allowance for the primary procedure and a percentage (%) of the Usual and Customary fee allowance for all secondary procedures. These allowances are then processed according to Plan provisions. A global package includes the services that are a necessary part of the procedure. For individual services that are part of a global package, it is customary for the individual services not to be billed separately. A separate charge will not be allowed under the Plan.

43. **Nursery And Newborn Expenses Including Circumcision** are covered for the following Children of the covered Employee or covered spouse: natural (biological) Children and newborn Children who are adopted or Placed for Adoption at the time of birth.

44. **Nutritional Counseling and Weight Management Program** includes only the following treatments if those treatments are determined to be Medically Necessary and be appropriate for an individual's Morbid Obesity condition. Refer to the Glossary of Terms for a definition of Morbid Obesity.

- Level 1 Preventive – nutritional counseling with a registered dietician. In-Network service only and accessed by contacting the network Hospital and speaking to a dietician.
- Level 2 nutritional counseling weight loss (prior authorization required) – Individuals who have BMI of 27 or greater.
- Level 3 metabolic weight loss (prior authorization required) – Individuals who have a BMI of 30 or greater are eligible for reimbursement of the cost of metabolic weight loss programs. The weight management program must be under the direction of a Physician, with documentation through a Physician attestation form.

The Covered Person must pay for the Physician's supervised weight loss program up front and then submit a claim for reimbursement. The Plan will not reimburse the provider directly.

This Plan does not cover diet supplements, exercise equipment or any other items listed in the General Exclusions of this SPD.

45. **Nutritional Supplements, Vitamins and Electrolytes** which are prescribed by a Physician and administered through enteral feedings, provided they are the sole source of nutrition. This includes supplies related to enteral feedings (for example, feeding tubes, pumps, and other materials used to administer enteral feedings) provided the feedings are prescribed by a Physician, and are the sole source of nutrition.
46. **Occupational Therapy.** (See Therapy Services below)
47. **Oral Surgery** includes:
- Excision of partially or completely impacted teeth.
 - Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examinations.
 - Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
 - Reduction of fractures and dislocations of the jaw.
 - External incision and drainage of cellulitis.
 - Incision of accessory sinuses, salivary glands or ducts.
 - Excision of exostosis of jaws and hard palate.
48. **Orthotic Appliances, Devices and Casts**, including the exam for required Prescription and fitting, when prescribed to aid in healing, provide support to an extremity, or limit motion to the musculoskeletal system after Injury. These devices can be used for acute Injury or to prevent Injury. Orthotic Appliances and Devices include custom molded shoe orthotics, supports, trusses, elastic compression stockings, custom molded shoe inserts and braces.
49. **Oxygen And Its Administration.**
50. **Pharmacological Medical Case Management** (Medication management and lab charges).
51. **Physical Therapy.** (See Therapy Services below)
52. **Physician Services** for covered benefits.
53. **Pre-Admission Testing:** The testing must be necessary and consistent with the diagnosis and treatment of the condition for which the Covered Person is being admitted to the Hospital.
54. **Prescription Medications** which are administered or dispensed as take home drugs as part of treatment while in the Hospital or at a medical facility (including claims billed on a claim form from a long-term care facility, assisted living facility or Skilled Nursing Facility) and that require a Physician's Prescription. This does not include paper (script) claims obtained at a retail pharmacy, which are covered under the Prescription benefit.

55. Preventive / Routine Care as listed under the Schedule of Benefits.

The Plan pays benefits for Preventive Care services provided on an Outpatient basis at a Physician's office, an Alternate Facility or a Hospital that encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under the applicable law:

- 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;
- 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 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
- Additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
- Well-women preventive care visit(s) for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. This well-women visit should, where appropriate, include other preventive services listed in the Health Resources and Services Administrations guidelines, as well as others referenced in the Affordable Care Act:
 - Screening for gestational diabetes;
 - Human papillomavirus (HPV) DNA testing;
 - Counseling for sexually transmitted infections;
 - Counseling and screening for human immune-deficiency virus; and
 - Screening and counseling for interpersonal and domestic violence.

Please visit the following links for additional information:

<http://www.healthcare.gov/law/resources/regulations/prevention>
or
<http://www.hrsa.gov/womensguidelines/>

56. Prosthetic Devices. The initial purchase, fitting, repair and replacement of fitted prosthetic devices (artificial body parts, including limbs, eyes and larynx) which replace body parts. Benefits may be payable for subsequent repairs or replacement only if required:

- Due to the growth or development of a Dependent Child; or
- When necessary because of a change in the Covered Person's physical condition; or
- Because of deterioration caused from normal wear and tear.

The repair or replacement must also be recommended by the attending Physician. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered and replacement is subject to prior approval by the Plan.

57. Qualifying Clinical Trials as defined below. Coverage **does not include** Phase I clinical trials (except as provided under the Clinical Trial Programs for Treatment of Pediatric Cancer). Routine patient care costs as defined below Incurred during participation in a Qualifying Clinical Trial for the treatment of:

- Cancer.
- Cardiovascular disease (cardiac/stroke).
- Surgical musculoskeletal disorders of the spine, hip, and knees.
- Other diseases or disorders for which a clinical trial meets the Qualifying Clinical Trial criteria stated below.

Clinical Trial Programs for Treatment of Pediatric Cancer: The majority of treatment for childhood cancer is provided within the context of a clinical trial. Covered services include routine patient care costs as defined below Incurred in connection with the provision of goods, services, and benefits to members who are Dependent Children in connection with Qualifying Clinical Trial programs as defined below for the treatment of Children's cancer, such as those by The National Cancer Institute (NCI)-sponsored Children's Oncology Group (COG).

For purposes of this provision, Pediatric is defined as eligible Children 0 - 18 years of age, unless treatment has been started prior to the Child's 19th birthday. Coverage **does include** Phase I clinical trials.

Qualifying Clinical Trial means, a trial in which all of the following criteria must be met:

- The trial must be sponsored and provided by a nationally recognized program or center that has been designated by any of the following:
 - **National Institutes of Health (NIH) including National Cancer Institute (NCI);**
 - **Centers for Disease Control and Prevention (CDC);**
 - **Agency for Healthcare Research and Quality (AHRQ);**
 - **Centers for Medicare and Medicaid Services (CMS);**
 - **National Comprehensive Cancer Network (NCCN);**
 - **Department of Defense (DOD); or**
 - **Veterans Administration (VA).**
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant Institutional Review Boards (IRBs) before participants are enrolled in the trial. The Plan Sponsor may, at any time, request documentation about the trial to confirm that the trial meets current standards for scientific merit and has the relevant IRB approvals; and
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a covered health service and is not otherwise excluded under the Plan.

Coverage for **routine patient care costs** for clinical trials include:

- Covered Health Services for which benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the administration of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Coverage **does not include** the Experimental or Investigational item or service that is the subject of the clinical trial.

Benefits include the reasonable and necessary items and services used to diagnose and treat complications arising from participation in a Qualifying Clinical Trial. Benefits are available only when the Covered Person is clinically eligible for participation in the clinical trial as defined by the researcher. Benefits are not available for preventive clinical trials.

58. Radiation Therapy and Chemotherapy.

59. Radiology and Interpretation Charges.

60. **Reconstructive Surgery** includes:

- Following a mastectomy (Women's Health and Cancer Rights Act)
The Covered Person must be receiving benefits in connection with a mastectomy in order to receive benefits for reconstructive treatments. Covered Expenses are reconstructive treatments which include all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and complications of mastectomies, including lymphedemas.
- Surgery to restore bodily function that has been impaired by a congenital illness or anomaly resulting in a functional defect or impairment of a Child, Accident, or from an infection or other disease of the involved part.

61. **Respiratory Therapy.** (See Therapy Services below)

62. **Second Surgical Opinion** must be given by a board-certified Specialist in the medical field relating to the surgical procedure being proposed. The Physician providing the second opinion must not be affiliated in any way with the Physician who rendered the first opinion.

63. **Sleep Disorders** if Medically Necessary.

64. **Sleep Studies.**

65. **Speech Therapy.** (See Therapy Services below)

66. **Sterilizations.**

67. **Substance Abuse Services** (Refer to Substance Abuse section of this SPD).

68. **Surgery and Assistant Surgeon Services** (See Modifiers or Reducing Modifiers above).

69. **Telemedicine – Telephone or Internet Consultations:** Telephone and internet consultations made by a Covered Person's treating Physician to another Physician.

70. **Temporomandibular Joint Disorder (TMJ) Services (Applies to Benefit Plan(s) Point Of Service, Non SmartCare and SmartCare)** includes:

- Diagnostic services.
- Surgical treatment.
- Non-surgical treatment (includes intraoral devices or any other non-surgical method to alter the occlusion and/or vertical dimension).

This does not cover orthodontic services.

71. **Therapy Services:** Therapy must be ordered by a Physician and provided as part of the Covered Person's treatment plan. Services include:

- **Occupational therapy** by a Qualified occupational therapist.
- **Physical therapy** by a Qualified physical therapist.
- **Respiratory therapy** by a Qualified respiratory therapist.
- **Aquatic therapy** by a Qualified physical therapist.
- **Massage therapy** by a Qualified chiropractor or physical therapist.
- **Speech therapy** by a Qualified speech therapist including therapy for stuttering due to a neurological disorder.

- 72. **Tobacco Addiction:** Preventive / Routine benefits as required by applicable law and diagnoses, services, treatment or supplies related to addiction to or dependency on nicotine.
- 73. **Transplant Services** (Refer to Transplant section of this SPD).
- 74. **Urgent Care Facility** as shown in the Schedule of Benefits of this SPD.
- 75. **Vision Care Services** (Refer to Vision Care section of this SPD).
- 76. **X-ray Services** for covered benefits.

HOME HEALTH CARE BENEFITS

Home Health Care services are provided for patients who are unable to leave their home, as determined by the Utilization Review Organization. Covered Persons must obtain prior authorization in advance before receiving services. Please refer to the Utilization Management section of this SPD for more details. Covered services can include:

- Home visits instead of visits to the provider's office that do not exceed the Usual and Customary charge to perform the same service in a provider's office.
- Intermittent nurse services. Benefits are paid for only one nurse at any one time, not to exceed four hours per 24-hour period.
- Nutrition counseling provided by or under the supervision of a registered dietitian.
- Physical, occupational, respiratory and speech therapy provided by or under the supervision of a licensed therapist.
- Medical supplies, drugs, or medication prescribed by a Physician, and laboratory services to the extent that the Plan would have covered them under this Plan if the Covered Person had been in a Hospital.

A Home Health Care Visit is defined as: A visit by a nurse providing intermittent nurse services (each visit includes up to a four-hour consecutive visit in a 24-hour period if Medically Necessary) or a single visit by a therapist or a registered dietitian.

EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

- Homemaker or housekeeping services.
- Supportive environment materials such as handrails, ramps, air conditioners and telephones.
- Services performed by family members or volunteer workers.
- "Meals on Wheels" or similar food service.
- Separate charges for records, reports or transportation.
- Expenses for the normal necessities of living such as food, clothing and household supplies.
- Legal and financial counseling services, unless otherwise covered under this Plan.

TRANSPLANT BENEFITS

Refer To Utilization Management section of this SPD for prior authorization requirements

DEFINITIONS

The following terms are used for the purpose of the Transplant Benefits section of this SPD. Refer to the Glossary of Terms section of this SPD for additional definitions.

Approved Transplant Services means services and supplies for certified transplants when ordered by a Physician. Such services include, but are not limited to, Hospital charges, Physician's charges, organ and tissue procurement, tissue typing and Ancillary Services.

Designated Transplant Facility means a facility which has agreed to provide Approved Transplant Services to Covered Persons pursuant to an agreement with a transplant provider network or rental network with which the Plan has a contract.

Organ and Tissue Acquisition/Procurement means the harvesting, preparation, transportation and the storage of human organ and tissue which is transplanted to a Covered Person. This includes related medical expenses of a living donor.

Stem Cell Transplant includes autologous, allogeneic and syngeneic transplant of bone marrow, peripheral and cord blood stem cells.

BENEFITS

The Plan will pay for Covered Expenses Incurred by a Covered Person at a Designated Transplant Facility for an Illness or Injury, subject to any Deductibles, Plan Participation amounts, maximums or limits shown on the Schedule of Benefits. Benefits are based on the Usual and Customary charge or the Plan's Negotiated Rate.

It will be the Covered Person's responsibility to obtain prior authorization for all transplant related services. If prior authorization is not obtained, benefits may not be payable for such services. Benefits may also be subject to reduced levels as outlined in individual Plan provisions. The approved transplant and medical criteria for such transplant must be Medically Necessary for the medical condition for which the transplant is recommended. The medical condition must not be included on individual Plan exclusions.

COVERED EXPENSES

The Plan will pay for Approved Transplant Services at a Designated Transplant Facility for Organ and Tissue Acquisition/Procurement and transplantation, if a Covered Person is the recipient.

If a Covered Person requires a transplant, including bone marrow or Stem Cell Transplant, the cost of Organ and Tissue Acquisition/Procurement from a living human or cadaver will be included as part of the Covered Person's Covered Expenses when the donor's own plan does not provide coverage for Organ and Tissue Acquisition/Procurement. This includes the cost of donor testing, blood typing and evaluation to determine if the donor is a suitable match.

The Plan will provide donor services for donor related complications during the transplant period, as per the transplant contract, if the recipient is a Covered Person under this Plan.

Benefits are payable for the following transplants:

- Kidney.
- Kidney/pancreas.
- Pancreas, if the transplant meets the criteria determined by utilization management.
- Liver.
- Heart.
- Heart/lung.
- Lung.
- Bone marrow or Stem Cell Transplant (allogeneic and autologous) for certain conditions.
- Small bowel.

SECOND OPINION

The Plan will notify the Covered Person if a second opinion is required at any time during the determination of benefits period. If a Covered Person is denied a transplant procedure by transplant facility, the Plan will allow them to go to a second Designated Transplant Facility for evaluation. If the second facility determines, for any reason, that the Covered Person is an unacceptable candidate for the transplant procedure, benefits will not be paid for further transplant related services and supplies, even if a third Designated Transplant Facility accepts the Covered Person for the procedure.

ADDITIONAL PROVISIONS (Applies to a Designated Transplant Facility Only)

TRAVEL EXPENSES (Applies to a Covered Person who is a recipient or to a covered or non-covered donor if the recipient is a Covered Person under this Plan)

If the Covered Person or non-covered living donor lives more than 50 miles from the transplant facility, the Plan will pay for travel and housing, up to the maximum listed on the Schedule of Benefits. Expenses will be paid for the Covered Person and:

- One or two parents of the Covered Person (if the Covered Person is a Dependent Child, as defined in this Plan); or
- An adult to accompany the Covered Person.

Covered travel and housing expenses include the following:

- Transportation to and from the transplant facility including:
 - Airfare.
 - Tolls and parking fees.
 - Gas/mileage.
- Lodging at or near the transplant facility including:
 - Apartment rental.
 - Hotel rental.
 - Applicable tax.

Lodging for purposes of this Plan does not include private residences.

Lodging reimbursement that is greater than \$50 per person per day, may be subject to IRS codes for taxable income.

Benefits shall be payable for up to one year from the date of the transplant while the Covered Person is receiving services at the transplant facility.

Note: This Plan will only pay travel and housing benefits for a non-covered living donor after any other coverage that the living donor has is exhausted.

TRANSPLANT EXCLUSIONS

In addition to the items listed in the General Exclusions section of this SPD, benefits will NOT be provided for any of the following:

- Expenses if a Covered Person donates an organ and/or tissue and the recipient is not a Covered Person under this Plan.
- Expenses for Organ and Tissue Acquisition/Procurement and storage of cord blood, stem cells or bone marrow, unless the Covered Person has been diagnosed with a condition for which there would be Approved Transplant Services.
- Expenses for any post-transplant complications of the donor, if the donor is not a Covered Person under this Plan.
- Transplants considered Experimental, Investigational or Unproven.
- Solid organ transplantation, autologous transplant (bone marrow or peripheral stem cell) or allogeneic transplant (bone marrow or peripheral stem cell), for conditions that are not considered to be Medically Necessary and/or are not appropriate, based on the National Comprehensive Cancer Network (NCCN) and/or Transplant Review Guidelines.
- Expenses related to, or for, the purchase of any organ.

PRESCRIPTION DRUG BENEFITS

Administered by MedImpact Healthcare Systems, Inc.

NOTE: UMR (the claims administrator) does not administer the benefits within this provision. Please contact the Benefit Manager or Your employer with any questions related to this coverage.

The University of Arkansas System uses MedImpact Healthcare Systems, Inc. as the Prescription Benefit Manager (PBM) to administer the Prescription Drug Program for individuals who are covered under the Plan.

You may obtain the Summary of Benefits for the Prescription Drug Program that details covered drugs, exclusions, pre-authorizations, and other programs by going to Your campus human resources' webpage, contacting Your campus human resources' personnel, or by contacting MedImpact Healthcare Systems, Inc. at 800-778-2949.

VISION CARE BENEFITS

NOTE: THE UNIVERSITY SYSTEM OFFERS A SEPARATE VISION BENEFIT. PLEASE SEE YOUR CAMPUS HUMAN RESOURCE PERSONNEL FOR INFORMATION ON THE VISION BENEFITS.

The Plan will pay for Covered Expenses for vision care Incurred by a Covered Person, subject to any required Deductible, Co-pay if applicable, Participation amount, maximums and limits shown on the Schedule of Benefits. Benefits are based on the Usual and Customary charge, maximum fee schedule or the Negotiated Rate.

COVERED BENEFITS

- Eye exam.
- Refraction.
- Contact lenses are generally not covered, as they are for vision correction, and vision correction is not a covered service. Services for prescribing and fitting contact lenses are not covered.
- When contact lenses are for treatment of a disease other than vision disturbance, or for replacement of the lens of the eye, they may be covered.
- Standard Intraocular lenses (IOC) implants are covered as a basic medical service.
- Hydrophilic (soft) contact lenses are covered as a prosthetic when they are prescribed for an aphakia (loss of natural lens) due to surgical removal (cataract extraction) or congenital absence, unless otherwise stated in the member's contract.
- Hydrophilic (soft) contact lenses that are part of a treatment plan (used as a moist corneal bandage in the treatment of acute or chronic pathology) are covered as a supply incidental to physician services. Examples: corneal ulcers, keratitis, bullous keratopathy, and other diseases.
- Hard plastic contact lenses are covered for a post-cataract patient only if there was no intraocular lens implanted, and is limited to soft contact lenses as noted above.
- Long term vision correction is covered for a post-cataract patient only if there was no intraocular lens implanted, and is limited to soft contact lenses as noted above. Replacement lenses for the above covered indications will be covered when there is a change in Prescription that in the opinion of a plan Physician necessitates obtaining new contacts. Contacts prescribed as a prosthetic or bandage will also be replaced when the life expectancy of the product has expired. Replacement shall not be covered for lost, damaged, misused, or abused contact lenses.

EXCLUSIONS

Benefits will NOT be provided for any of the following:

- Lenses.
 - Single.
 - Bifocal.
 - Trifocal.
 - Lenticular.
- Frames.
- Elective Contacts.
- Safety lenses and frames.
- Eye surgeries used to improve/correct eyesight for refractive disorders including lasik surgery, radial keratotomy, refractive keratoplasty or similar surgery.
- Sunglasses or subnormal vision aids.
- The fitting and/or dispensing of non-prescription glasses or vision devices whether or not prescribed by a Physician or optometrist.
- Vision therapy services (including orthoptics) or supplies.
- Correction of visual acuity or refractive errors.
- Aniseikonia.

MENTAL HEALTH BENEFITS

The Plan will pay for the following Covered Expenses for services authorized by a Physician and deemed to be Medically Necessary for the treatment of a Mental Health Disorder, subject to any Deductibles, Co-pays if applicable, Participation amounts, maximums, or limits shown on the Schedule of Benefits of this SPD. Benefits are based on the Usual and Customary amount, the maximum fee schedule, or the Negotiated Rate.

COVERED BENEFITS

Inpatient Services are payable subject to all of the following:

- The Hospital or facility must be accredited by a recognized accrediting body or licensed by the state as an acute care psychiatric, chemical dependency, or dual-diagnosis facility for the treatment of Mental Health Disorders. If outside the United States, the Hospital or facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country.
- The Covered Person must be ill in more than one area of daily living to such an extent that they are rendered dysfunctional and require the intensity of an Inpatient setting for treatment. Without such Inpatient treatment, the Covered Person's condition would deteriorate.
- The Covered Person's Mental Health Disorder must be treatable in an Inpatient facility.
- The Covered Person's Mental Health Disorder must meet diagnostic criteria as described in the most recent edition of the American Psychiatric Association Diagnostic and Statistical Manual (DSM). If outside the United States, the Covered Person's Mental Health Disorder must meet diagnostic criteria established and commonly recognized by the medical community in that region.
- The attending Physician must be a psychiatrist. If the admitting Physician is not a psychiatrist, a psychiatrist must attend to the Covered Person within 24 hours of admittance. Such psychiatrist must be United States board-eligible or board-certified. If outside the United States, Inpatient Services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located. The attending Physician must meet the requirements, if any, set out by the foreign government or regionally recognized licensing body for treatment of Mental Health Disorders.

Day Treatment (Partial Hospitalization) means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program is generally a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial and prevocational modalities. Such programs must be a less restrictive alternative to Inpatient treatment and must be affiliated with a facility outpatient day program.

Outpatient Services are payable subject to all of the following:

- Must be in person at a therapeutic medical facility; and
- Include measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident; and

- Must be provided by one of the following:
 - A United States board-eligible or board-certified psychiatrist licensed in the state where the treatment is provided.
 - A therapist with a Ph.D. or master's degree that denotes a specialty in psychiatry (Psy.D.).
 - A state-licensed psychologist.
 - A state-licensed or certified Social Worker practicing within the scope of his or her license or certification.
 - A Licensed Professional Counselor.
 - If outside the United States, Outpatient Services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located. The attending Physician must meet the requirements, if any, set out by the foreign government or regionally recognized licensing body for treatment of Mental Health Disorders.

ADDITIONAL PROVISIONS AND BENEFITS

- A medication evaluation by a psychiatrist may be required before a Physician can prescribe medication for psychiatric conditions. Periodic evaluations may be requested by the Plan.
- Any diagnosis change after a payment denial will not be considered for benefits unless the Plan is provided with all pertinent records along with the request for the change that justifies the revised diagnosis. Such records must include the history and initial assessment and must reflect the criteria listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) for the new diagnosis, or, if in a foreign country, must meet diagnostic criteria established and commonly recognized by the medical community in that region.
- Services for biofeedback are covered.

MENTAL HEALTH EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

- Inpatient charges for the period of time when full, active, Medically Necessary treatment for the Covered Person's condition is not being provided.
- Bereavement counseling, unless specifically listed as a covered benefit elsewhere in this SPD.
- Services provided for conflict between the Covered Person and society which is solely related to criminal activity.
- Conditions listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) or the International Classification of Diseases - Clinical Modification (ICD-CM) manual (most recent revision) in the following categories:
 - Personality disorders; or
 - Sexual/gender identity disorders; or
 - Behavior and impulse control disorders; or
 - "V" codes (including marriage counseling).

SUBSTANCE ABUSE AND CHEMICAL DEPENDENCY BENEFITS

The Plan will pay the following Covered Expenses for a Covered Person subject to any Deductibles, Co-pays if applicable, Participation amounts, maximums, or limits shown on the Schedule of Benefits. Benefits are based on the maximum fee schedule, the Usual and Customary amount, or the Negotiated Rate as applicable. Medicare Primary Retirees must carry both Medicare Parts A & B for full coverage.

COVERED BENEFITS

Inpatient Services are payable subject to all of the following:

- The Hospital or facility must be accredited by a recognized accrediting body or licensed by the state as an acute care psychiatric, chemical dependency or dual-diagnosis facility for the treatment of substance abuse and chemical dependency. If outside the United States, the Hospital or facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country.
- The Covered Person must have the ability to accept treatment.
- The Covered Person must be ill to such an extent that they are rendered dysfunctional and require the intensity of an Inpatient setting for treatment. Without such Inpatient treatment, the Covered Person's condition would deteriorate.
- The Covered Person's condition must be treatable in an Inpatient facility.
- The Covered Person's condition must meet diagnostic criteria as described in the most recent edition of the American Psychiatric Association Diagnostic and Statistical Manual (DSM). If outside of the United States, the Covered Person's condition must meet diagnostic criteria established and commonly recognized by the psychiatric community in that region.

Day Treatment (Partial Hospitalization) means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program is generally a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. Such programs must be a less restrictive alternative to Inpatient treatment and must be affiliated with a facility outpatient day program.

Outpatient Services are payable subject to all of the following:

- Must be in person at a therapeutic medical facility; and
- Include measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident; and
- Must be provided by one of the following:
 - A United States board-eligible or board-certified psychiatrist licensed in the state where the treatment is provided.
 - A therapist with a Ph.D. or master's degree that denotes a specialty in psychiatry (Psy.D.).
 - A state licensed psychologist.
 - A certified addiction counselor.

- A state-licensed or certified social worker practicing within the scope of his or her license or certification.
- If outside the United States, Outpatient Services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located, or a therapist with a Ph.D., or master's degree that denotes a specialty in psychiatry. The attending Physician, psychiatrist, or a counselor must meet the requirements, if any, set out by the foreign government or regionally-recognized licensing body for treatment of substance abuse and chemical dependency disorders.

ADDITIONAL PROVISIONS AND BENEFITS

- Any claim re-submitted on the basis of a change in diagnosis after a benefit denial will not be considered for benefits unless the Plan is provided with all records along with the request for change. Such records must include the history, initial assessment and all counseling or therapy notes, and must reflect the criteria listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) for the new diagnosis.

SUBSTANCE ABUSE EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

- Treatment or care considered inappropriate or substandard as determined by the Plan.
- Inpatient charges for the period of time when full, active, Medically Necessary treatment for the Covered Person's condition is not being provided.

UTILIZATION MANAGEMENT And Other Medical Management Services

Utilization Management is the process of evaluating whether services, supplies or treatment are Medically Necessary and are appropriate to help ensure cost-effective care. Utilization Management can determine Medical Necessity, shorten Hospital stays, improve the quality of care, and reduce costs to the Covered Person and the Plan. The Utilization Management procedures include certain Prior Authorization requirements.

The benefit amounts payable under the Schedule of Benefits of this SPD may be affected if the requirements described for Utilization Management are not satisfied. Covered Persons should call the phone number on the back of the Plan identification card to request Prior Authorization at least two weeks prior to a scheduled procedure in order to allow for fact gathering and independent medical review, if necessary.

Special Note: The Covered Person will not be penalized for failure to obtain Prior Authorization if a Prudent Layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would jeopardize the life or long-term health of the individual. However, Covered Persons who received care on this basis must contact the Utilization Review Organization (see below) as soon as possible within 24 hours of the first business day after receiving care or Hospital admittance. The Utilization Review Organization will then review services provided within 48 hours of being contacted.

This Plan complies with the Newborns and Mothers Health Protection Act. The Prior Authorization requirement is not required for Hospital or Birthing Center stays of 48 hours or less following a normal vaginal delivery or 96 hours or less following a Cesarean section. Prior Authorization may be required for stays beyond 48 hours following a vaginal delivery or 96 hours following a Cesarean section.

UTILIZATION REVIEW ORGANIZATION

The Utilization Review Organization is: **UMR CARE MANAGEMENT**

DEFINITIONS

The following terms are used for the purpose of the Utilization Management section of this SPD. Refer to the Glossary of Terms section of this SPD for additional definitions.

Prior Authorization is the process of determining benefit coverage prior to service being rendered to an individual member. A determination is made based on Medical Necessity criteria for services, tests or procedures that are appropriate and cost-effective for the member. This member-centric review evaluates the clinical appropriateness of requested services in terms of the type, frequency, extent and duration of stay.

Utilization Management means an assessment of the facility in which the treatment is being provided. It also includes a formal assessment of the effectiveness and appropriateness of health care services and treatment plans. Such assessment can be conducted on a prospective basis (prior to treatment), concurrent basis (during treatment), or retrospective basis (following treatment).

SERVICES REQUIRING PRIOR AUTHORIZATION

Call the Utilization Management Organization **before** receiving services for the following:

- Inpatient stay in a Hospital or Extended Care Facility.
- Organ and tissue transplants.
- Home Health Care.
- Durable Medical Equipment over \$1,500 or any Durable Medical Equipment rentals over \$500/month.

- Prosthetics over \$1,000.
- All Inpatient stays for Mental Health Disorders, substance abuse and chemical dependency and residential treatment facility.
- Inpatient stay in a Hospital or Birthing Center that is longer than 48 hours following a normal vaginal delivery or 96 hours following a Cesarean section.
- Inpatient admissions – urgent or emergent admissions including those directly from the Physician's office require Prior Authorization within 72 hours of admission.
- Nutritional counseling over 1 visit. Prior Authorization is not required for the initial visit so that the physician attestation form may be completed and faxed to UMR. Must have BMI of 27 or greater for up to 3 additional visits. Provider is to use the weight management Physician attestation form to authorize level 2.
- Physician supervised, non-surgical weight loss. Must have BMI of 30 or greater. Provider is to use the weight management Physician attestation form to authorize level 3.
- Genetic testing.
- Special radiation therapy/radio therapy such as:
 - Stereotactic radiosurgery (Gamma knife, Cyber knife).
 - Intensity modulated radiation therapy (IMRT).
 - Brachytherapy.
 - Proton beam therapy.
- Sleep apnea surgery and/or treatment of snoring, such as:
 - Uvulopalatopharyngoplasty (UPPP).
 - Laser-assisted uvulopalatopharyngoplasty (LAUP).
- Implantable stimulators including but not limited to:
 - Neuromuscular stimulators.
 - Bone growth stimulators.
 - Dorsal column stimulators.
- Outpatient spinal procedures / back procedures including but not limited to:
 - Vertebroplasty.
 - Kyphoplasty.
 - Total Disk Arthroplasty – cervical or lumbar.
 - Intervertebral disk prosthesis.
- Intrathecal pain pumps.
- Special oral formula/enteral feedings infant formula is covered for PKU only; enteral feedings are covered only if administered through a tube as the sole source of nutrition.
- Outpatient hyperbaric oxygen treatment.
- Clinical trials (Refer to Case Management).
- Non-emergent outpatient diagnostic imaging services:
 - MRI
 - MRA
 - PET
 - CT
 - CTA
 - EBCT
 - Nuclear studies
- Any surgery that could be considered potentially cosmetic including but not limited to:
 - Reconstructive surgery.
 - Eyelid surgery.
 - Varicose vein surgery.
- The following injectables require Prior Authorization; however, this is not an all inclusive list:
 - Synagis.
 - Growth hormone.
 - IVIG.
 - ESA (Erythropoiesis stimulating agents), Epogen, Procrit, and Aranesp.
- Specific Outpatient surgeries:
 - Abortions.
 - Accidental dental services / oral surgery / anesthesia and facility fees (when covered).
 - TMJ – services for diagnosis and/or treatment covered Point of Service Plans only.

Note that if a Covered Person receives Prior Authorization for one facility, but then is transferred to another facility, Prior Authorization is also needed before going to the new facility, except in the case of an Emergency (see Special Notes above).

The phone number to call for Prior Authorization is listed on the back of the Plan identification card.

Even though a Covered Person provides Prior Authorization from the Utilization Review Organization, that does not guarantee that this Plan will pay for the medical care. The Covered Person still needs to be eligible for coverage on the date services are provided. Coverage is also subject to all of the provisions described in this SPD.

Medical Director Oversight. A UMR Care Management medical director oversees the concurrent review process. Should a case have unique circumstances that raise questions for the Utilization Management specialist handling the case, the medical director will review the case to determine medical appropriateness using evidence-based clinical criteria.

Case Management Referrals. During the Prior Authorization review process, cases are analyzed for a number of criteria used to trigger case to case management for review. These triggers include ICD-9 diagnosis codes, CPT codes and length-of-stay criteria, as well as specific criteria requested by the Plan Administrator. Information is easily passed from Utilization Management to case management through our fully-integrated care management software system.

All Prior Authorization requests are used to identify the member's needs. Our goal is to intervene in the process as early as possible to determine the resources necessary to deliver clinical care in the most appropriate care setting.

Retrospective Review. Retrospective review is conducted by Plan Administrator request as long as the request is received within 30 days of the original determination. Retrospective reviews are performed according to our standard Prior Authorization policies and procedures.

Other Medical Management Services

Disease Management Program identifies those individuals who have a certain chronic disease and would benefit from this program. Nurse case managers telephonically work with Covered Persons to help them improve their chronic disease and maintain quality of life. Our unique approach to Disease Management identifies individuals with one or more of the seven targeted chronic conditions (asthma, coronary artery disease, congestive heart failure, Chronic Obstructive Pulmonary Disease (COPD), depression, diabetes and hypertension). Built within our system is a predictive modeling tool, Clinical Analytics and Clinical Intelligence Rules that takes up to two years' worth of medical and pharmacy claims data and then identifies those Covered Persons who are eligible to participate in the coaching program. If claims history is not available, Disease Management candidates are initially identified using a Health Condition Survey. The survey is a general screening questionnaire sent to all Covered Persons age 18 and over that asks a few questions about each of the conditions managed in the program. Once claims data is available, the predictive modeling tool is used to identify candidates for the program. Program participants can also be identified through referrals from the Prior Authorization process, Covered Person self-referral, NurseLine referrals, the employer or the Covered Person's Physician.

In addition to the telephonic services, UMR disease management also provides Targeted Member Messages (TMMs). The TMM provides a timely, personalized evaluation of a member's current health care recommendations. It is sent to each member's home via U.S. Mail. Members most likely to benefit from TMM/HealtheNotes are targeted to receive the report. The report provides health claims-based information and suggestions, and encourages members to take an active role in their health care and related spending choices. Members can review the informative report to help them understand their health care needs, take it with them to their medical appointments to discuss with their providers, and refer to it when making benefit plan elections.

HealtheNotes provides useful, personalized information based on the individual Plan member's health care utilization, including provider visits, prescriptions and health screenings.

The TMM/HealtheNotes is a vital educational tool in the Disease Management Program for managing a Covered Person's chronic condition(s). It assists in our efforts to significantly improve the quality of life for Covered Persons while simultaneously reducing the overall healthcare costs.

Maternity Management provides prenatal education and high-risk pregnancy identification to help mothers carry their babies to term. This program increases the number of healthy, full term-deliveries and decreases the cost of a long term hospital stay for both the mother and/or baby. Program members are contacted via telephone at least once each trimester and once postpartum. A comprehensive assessment to determine the member's risk level and educational need is done at that time. To increase participation, the program uses incentives to participate. The standard incentive is a gift card. Covered Persons who enroll via the web receive a special edition pregnancy information guide. UMR's pre-pregnancy coaching program helps women learn about risks and take action to prevent serious and costly medical complications before they become pregnant. Women with pre-existing health conditions, such as diabetes and high blood pressure, not only face risks to their babies, but also to themselves while they're pregnant. Members self-enroll in the pre-pregnancy coaching program by calling our toll-free number. They are then contacted by a nurse case manager who has extensive clinical background in obstetrics/gynecology. The nurse completes a pre-pregnancy assessment to determine risk level, if any, and provides them with education and materials based on their needs. The nurse also helps members understand their Plan's benefit information.

Case Management Services are designed to identify catastrophic and complex illnesses, transplants and trauma cases. UMR Care Management's case management specialists identify, coordinate and negotiate rates for out-of-network services (where appropriate and allowed under the Plan) and help manage related costs by finding alternatives to costly Inpatient stays. Opportunities are identified from the Prior Authorization review process, national criteria and system flags based on ICD-9 diagnosis, CPT procedure code and potential high dollar claim criteria. UMR Care Management works directly with the patient, family members, treating Physician and facility to mobilize appropriate resources for the Covered Person's care. Our philosophy is that quality care from the beginning of the serious illness helps avoid major complications in the future. The Covered Person can request that the Plan provide services and the Plan may also contact the Covered Person if the Plan believes case management services may be beneficial.

NurseLine service is a 24/7 health information line that assists Covered Persons with medical-related questions and concerns. NurseLine gives Covered Persons access to highly trained registered nurses so they can receive guidance and support when making decisions about their health and/or the health of their Dependents.

COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies whenever a Covered Person has health coverage under more than one Plan, as defined below. **It does not however, apply to prescription benefits.** The purpose of coordinating benefits is to help Covered Persons pay for Covered Expenses, but not to result in total benefits that are greater than the Covered Expenses Incurred.

The order of benefit determination rules determine which plan will pay first (Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim, and will reduce the benefits it pays so that the total payment between the Primary Plan and Secondary Plan does not exceed the Covered Expenses Incurred. Up to 100% of charges Incurred may be paid between both plans.

The Plan will coordinate benefits with the following types of medical or dental plans:

- Group health plans, whether insured or self-insured.
- Hospital indemnity benefits in excess of \$200 per day.
- Foreign health care coverage.
- Medical care components of group long-term care contracts such as skilled nursing care.
- Medical benefits under group or individual motor vehicle policies. See order of benefit determination rules (below) for details.
- Medical benefits under homeowner's insurance policies.
- Medicare or other governmental benefits, as permitted by law. See below. This does not include Medicaid.

Each contract for coverage is considered a separate plan. If a plan has two parts and COB rules apply to only one of the two parts, each of the parts is treated as a separate plan. If a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered an allowable expense and a benefit paid.

When this Plan is secondary, and when not in conflict with a network contract requiring otherwise, covered charges shall not include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the Covered Person for the difference between the provider's contracted amount and the provider's regular billed charge.

ORDER OF BENEFIT DETERMINATION RULES

The first of the following rules that apply to a Covered Person's situation is the rule to use:

- The plan that has no coordination of benefits provision is considered primary.
- When medical payments are available under motor vehicle insurance (including no-fault policies), this Plan shall always be considered secondary regardless of the individual's election under PIP (Personal Injury Protection) coverage with the auto carrier.
- Where an individual is covered under one plan as a Dependent and another plan as an Employee, member or subscriber, the plan that covers the person as an Employee, member or subscriber (that is, other than as a Dependent) is considered primary. The Primary Plan must pay benefits without regard to the possibility that another plan may cover some expenses. This Plan will deem any Employee plan beneficiary to be eligible for primary benefits from their employer's benefit plan.

- The plan that covers a person as a Dependent is generally secondary. The plan that covers a person as a Dependent is primary only when both plans agree that COBRA or state continuation coverage should always pay secondary when the person who elected COBRA is covered by another plan as a Dependent (see continuation coverage below). (Also see the section on Medicare, below, for exceptions).
- When an individual is covered under a spouse's Plan and also under his or her parent's plan, the Primary Plan is the plan of the individual's spouse. The plan of the individual's parent(s) is the Secondary Plan.
- If one or more plans cover the same person as a Dependent Child:
 - The Primary Plan is the plan of the parent whose birthday is earlier in the year if:
 - The parents are married; or
 - The parents are not separated (whether or not they have been married); or
 - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
 - If both parents have the same birthday, the plan that covered either of the parents longer is primary.
 - If the specific terms of a court decree state that one of the parents is responsible for the Child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years starting after the plan is given notice of the court decree.
 - If the parents are not married and reside separately, or are divorced or legally separated, the order of benefits is:
 - The plan of the custodial parent;
 - The plan of the spouse of the custodial parent;
 - The plan of the non-custodial parent; and then
 - The plan of the spouse of the non-custodial parent.
- Active or Inactive Employee: If an individual is covered under one plan as an active employee (or Dependent of an active employee), and is also covered under another plan as a retired or laid off employee (or Dependent of a retired or laid off employee), the plan that covers the person as an active employee (or Dependent of an active employee) will be primary. This rule does not apply if the rule in paragraph 3 (above) can determine the order of benefits. If the other plan does not have this rule, this rule is ignored.
- Continuation coverage under COBRA or state law: If a person has elected continuation of coverage under COBRA or state law and also has coverage under another plan, the continuation coverage is secondary. This is true even if the person is enrolled in another plan as a Dependent. If the two plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if one of the first four bullets above applies. (See exception in the Medicare section.)
- Longer or Shorter Length of Coverage: The plan that covered the person as an employee, member, subscriber or retiree longer is primary.
- If the above rules do not determine the Primary Plan, the Covered Expenses can be shared equally between the plans. This Plan will not pay more than it would have paid, had it been primary.

MEDICARE

If You or Your covered spouse or Dependent is also receiving benefits under Medicare, including Medicare Prescription drug coverage, federal law may require this Plan to be primary over Medicare. When this Plan is not primary, the Plan will coordinate benefits with Medicare.

The order of benefit determination rules determine which plan will pay first (Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim, and will reduce the benefits it pays so that the total payment between the Primary Plan and Secondary Plan does not exceed the Covered Expenses Incurred. Up to 100% of charges Incurred may be paid between both plans.

Physicians and other health care providers and facilities not participating in Medicare are not required to follow the Medicare fee schedules and may balance bill the Covered Person for services. In these cases, the Plan will still pay only that part it would have paid if the provider had been a Medicare provider. The Covered Person will be responsible for all remaining amounts.

ORDER OF BENEFIT DETERMINATION RULES FOR MEDICARE

This Plan complies with the Medicare Secondary Payer regulations. Examples of these regulations are as follows:

- This Plan generally pays first under the following circumstances:
 - You continue to be actively employed by the employer and You or Your covered spouse becomes eligible for and enrolls in Medicare because of age or disability.
 - You continue to be actively employed by the employer, Your covered spouse becomes eligible for and enrolls in Medicare, and is also covered under a retiree plan through Your spouse's former employer. In this case, this Plan will be primary for You and Your covered spouse, Medicare pays second, and the retiree plan would pay last.
 - For a Covered Person with End-Stage Renal Disease (ESRD), this Plan usually has primary responsibility for the claims of a Covered Person for 30 months from the date of Medicare eligibility based on ESRD. The 30-month period can also include COBRA continuation coverage or another source of coverage. At the end of the 30 months, Medicare becomes the primary payer.
- Medicare generally pays first under the following circumstances:
 - You are no longer actively employed by an employer; and
 - You or Your spouse has Medicare coverage due to age, plus You or Your spouse also have COBRA continuation coverage through the Plan; or
 - You or a covered family member has Medicare coverage based on a disability, plus You also have COBRA continuation coverage through the Plan. Medicare normally pays first, however an exception is that COBRA may pay first for Covered Persons with ESRD until the end of the 30-month period; or
 - You or Your covered spouse have retiree coverage plus Medicare coverage; or
 - Upon completion of 30 months of Medicare eligibility for an individual with ESRD, Medicare becomes the primary payer. (Note that if a person with ESRD was eligible for Medicare based on age or other disability **before** being diagnosed with ESRD and Medicare was previously paying primary, then the person can continue to receive Medicare benefits on a primary basis).

- Medicare is the secondary payer when no-fault insurance, worker's compensation, or liability insurance is available as primary payer.

Note: If a Covered Person is eligible for Medicare as the primary plan, all benefits from this Plan will be reduced by the amount Medicare would pay, regardless of whether the Covered Person is enrolled in Medicare.

TRICARE

In all instances where an eligible Employee is also a TRICARE beneficiary, TRICARE will pay secondary to this employer-provided Plan.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Plan may obtain the information it needs from or provide such information to other organizations or persons for the purpose of applying those rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. The Plan need not tell, or obtain the consent of, any person to do this. However, if the Plan needs assistance in obtaining the necessary information, each person claiming benefits under this Plan must provide the Plan any information it needs to apply those rules and determine benefits payable.

REIMBURSEMENT TO THIRD PARTY ORGANIZATION

A payment made under another plan may include an amount which should have been paid under this Plan. If it does, the Plan may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The Plan will not have to pay that amount again.

RIGHT OF RECOVERY

If the amount of the payments made by the Plan is more than it should have paid under this COB provision, the Plan may recover the excess from one or more of the persons it paid or for whom the Plan has paid; or any other person or organization that may be responsible for the benefits or services provided for the Covered Person.

RIGHT OF SUBROGATION, REIMBURSEMENT AND OFFSET

The Plan has a right to subrogation and reimbursement.

Subrogation applies when the Plan has paid Covered Expenses on Your behalf for an Illness or Injury for which a third party is considered responsible. The right to subrogation means that the Plan is substituted to and will succeed to any and all legal claims that You may be entitled to pursue against any third party for the Covered Expenses that the Plan has paid that are related to the Illness or Injury for which a third party is considered responsible.

The right to reimbursement means that if a third party causes or is alleged to have caused an Illness or Injury for which You are made whole by receiving a settlement, judgment, or other recovery from any third party, You must use those proceeds to fully return to the Plan 100% of any covered benefit you received for that Illness or Injury.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused You to suffer an Illness, Injury, or damages, or who is legally responsible for the Illness, Injury, or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Illness, Injury, or damages.
- The Plan Sponsor.
- Any person or entity who is or may be obligated to provide benefits or payments to You, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners', or otherwise), Workers' Compensation coverage, other insurance carriers, or third party administrators.
- Any person or entity that is liable for payment to You on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting the Plan's legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
 - Notifying the Plan, in writing, of any potential legal claim(s) You may have against any third party for acts that caused Covered Expenses to be paid or become payable.
 - Providing any relevant information requested by the Plan.
 - Signing and/or delivering such documents as the Plan or our agents reasonably request to secure the subrogation and reimbursement claim.
 - Responding to requests for information about any accident or Injuries.
 - Making court appearances.
 - Obtaining our consent or our agents' consent before releasing any party from liability for payment of medical expenses.
 - Complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate Your covered benefits, deny future covered benefits, take legal action against You, and/or set off from any future covered benefits the value of covered benefits we have paid relating to any Illness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to You or Your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold that should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against a third party before You receive payment from that third party. Further, our first priority right to payment is superior to any and all claims, debts, or liens asserted by any medical providers, including, but not limited to, Hospitals or Emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to You or Your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help You to pursue Your claim for damages or personal Injuries and no amount of associated costs, including attorneys' fees, will be deducted from our recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common-Fund Doctrine" or "Attorney's Fund Doctrine" will defeat this right.
- Benefits paid by the Plan may also be considered to be benefits advanced.
- If You receive any payment from any party as a result of Illness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, You will hold those funds in trust, either in a separate bank account in Your name or in Your attorney's trust account. You agree that You will serve as a trustee over those funds to the extent of the benefits the Plan has paid.
- The Plan's rights to recovery will not be reduced due to Your own negligence.
- Upon our request, You will assign to us all rights of recovery against third parties, to the extent of the Covered Expenses the Plan has paid for the Illness or Injury.
- The Plan may, at its option, take necessary and appropriate action to preserve the Plan's rights under these subrogation provisions, including, but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative, or other third party and filing suit in Your name, which does not obligate the Plan in any way to pay You part of any recovery the Plan might obtain.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

- In the case of Your wrongful death or survival claim, the provisions of this section apply to Your estate, the personal representative of Your estate, and Your heirs or beneficiaries.
- No allocation of damages, settlement funds, or any other recovery, by You, Your estate, the personal representative of Your estate, Your heirs, Your beneficiaries, or any other person or party will be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent Child who incurs an Illness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Illness or Injury, the terms of this subrogation and reimbursement clause will apply to that claim.
- If a third party causes or is alleged to have caused You to suffer an Illness or Injury while You are covered under this Plan, the provisions of this section continue to apply, even after You are no longer covered.
- The Plan and all administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

GENERAL EXCLUSIONS

Exclusions, including complications from excluded items are not considered covered benefits under this Plan and will not be considered for payment as determined by the Plan.

The Plan does not pay for Expenses Incurred for the following, unless otherwise stated below. The Plan does not apply exclusions based upon the source of the Injury to treatment listed in the Covered Medical Benefits section when the Plan has information that the Injury is due to a medical condition (including both physical and mental health conditions) or domestic violence.

1. **Abortions:** Unless a Physician states in writing that the mother's life would be in danger if the fetus were to be carried to term.
2. **Acts Of War:** Injury or Illness caused or contributed to by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.
3. **Acupuncture Treatment.**
4. **Alcohol:** Services, supplies, care or treatment to a Covered Person for an Injury or Illness which occurred as a result of that Covered Person's illegal use of alcohol for which the person has been arrested. The arresting officer's determination of intoxication will be sufficient for this exclusion. Expenses will be covered for Injured Covered Persons other than the person illegally using alcohol and expenses will be covered for Substance Abuse treatment as specified in this Plan.
5. **Alternative / Complementary Treatment** includes: Treatment, services or supplies for holistic or homeopathic medicine, hypnosis or other alternate treatment that is not accepted medical practice as determined by the Plan.
6. **Appointments Missed:** An appointment the Covered Person did not attend.
7. **Aquatic Therapy** unless provided by a Qualified physical therapist.
8. **Assistance With Activities of Daily Living.**
9. **Assistant Surgeon Services**, unless determined Medically Necessary by the Plan.
10. **Auto Excess:** Illness or bodily Injury for which there is a medical payment or expense coverage provided or payable under any automobile coverage.
11. **Before Enrollment and After Termination:** Services, supplies or treatment rendered before coverage begins under this Plan, or after coverage ends, are not covered.
12. **Blood:** Blood donor expenses.
13. **Breast Pumps** unless covered elsewhere in this SPD.
14. **Cardiac Rehabilitation** beyond Phase II including self-regulated physical activity that the Covered Person performs to maintain health that is not considered to be a treatment program.
15. **Chelation Therapy**, except in the treatment of conditions considered Medically Necessary, medically appropriate and not Experimental or Investigational for the medical condition for which the treatment is recognized.
16. **Claims** received later than twelve months from the date of service.
17. **Contraceptive Products and Counseling** unless covered elsewhere in this SPD.

18. **Cosmetic Treatment, Cosmetic Surgery**, or any portion thereof, unless the procedure is otherwise listed as a covered benefit.
19. **Court-Ordered:** Any treatment or therapy which is court-ordered, ordered as a condition of parole, probation, or custody or visitation evaluation, unless such treatment or therapy is normally covered by this Plan. This Plan does not cover the cost of classes ordered after a driving while intoxicated conviction or other classes ordered by the court.
20. **Criminal Activity:** Illness or Injury resulting from taking part in the commission of an assault or battery (or a similar crime against a person) or a felony. The Plan shall enforce this exclusion based upon reasonable information showing that this criminal activity took place.
21. **Custodial Care** as defined in the Glossary of Terms of this SPD.
22. **Dental Services:**
- The care and treatment of teeth, gums or alveolar process or for dentures, appliances or supplies used in such care or treatment, or drugs prescribed in connection with dental care. This exclusion does not apply to Hospital charges including professional charges for x-ray, lab and anesthesia, or for charges for treatment of injuries to natural teeth, including replacement of such teeth with dentures, or for setting of a jaw which was fractured or dislocated in an Accident.
 - Injuries or damage to teeth, natural or otherwise, as a result of or caused by the chewing of food or similar substances.
 - Dental implants including preparation for implants unless due to accidental Injury.
23. **Developmental Delays (Effective 01-01-2013 to 06-30-2013):** Occupational, physical, and speech therapy services related to Developmental Delays, mental retardation or behavioral therapy that are not Medically Necessary and are not considered by the Plan to be medical treatment. If another medical condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions.
24. **Duplicate Services and Charges or Inappropriate Billing** including the preparation of medical reports and itemized bills.
25. **Education:** Charges for education, special education, job training, music therapy and recreational therapy, whether or not given in a facility providing medical or psychiatric care. This exclusion does not apply to self-management education programs for diabetics.
26. **Environmental Devices:** Environmental items such as but not limited to, air conditioners, air purifiers, humidifiers, dehumidifiers, furnace filters, heaters, vaporizers, or vacuum devices.
27. **Examinations:** Examinations for employment, insurance, licensing or litigation purposes.
28. **Excess Charges:** Charges or the portion thereof which are in excess of the Usual and Customary charge, the Negotiated Rate or fee schedule.
29. **Experimental, Investigational or Unproven:** Services, supplies, medicines, treatment, facilities or equipment which the Plan determines are Experimental, Investigational or Unproven, including administrative services associated with Experimental, Investigational or Unproven treatment.
30. **Extended Care:** Any Extended Care Facility Services which exceed the appropriate level of skill required for treatment as determined by the Plan.
31. **Financial Counseling.**

32. **Fitness Programs:** General fitness programs, exercise programs, exercise equipment and health club memberships, or other utilization of services, supplies, equipment or facilities in connection with weight control or body building.
33. **Foot Care (Podiatry):** Routine foot care, unless covered elsewhere in this SPD.
34. **Foreign Coverage for Medical Care Expenses,** except for Emergency room Hospital and Physician services, including Emergency room services for stabilization or initiation of treatment of a medical Emergency condition provided on an Inpatient or Outpatient basis at a Hospital, as shown in the Schedule of Benefits.
35. **Genetic Counseling** other than based on medical Necessity unless covered elsewhere in this SPD.
36. **Genetic Testing** unless covered elsewhere in this SPD.
37. **Home Modifications:** Modifications to Your home or property such as but not limited to, escalator(s), elevators, saunas, steambaths, pools, hot tubs, whirlpools, or tanning equipment, wheelchair lifts, stair lifts or ramps.
38. **Illegal Drugs or Medications:** Services, supplies, care or treatment to a Covered Person for Injury or Illness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan.
39. **Infant Formula** not administered through tube as the sole source of nutrition for the Covered Person other than for the diagnosis of PKU.
40. **Infertility Treatment:**
- Fertility tests.
 - Surgical reversal of a sterilized state which was a result of a previous surgery.
 - Direct attempts to cause pregnancy by any means including, but not limited to hormone therapy or drugs.
 - Artificial insemination; In vitro fertilization; Gamete Intrafallopian Transfer (GIFT), or Zygote Intrafallopian Transfer (ZIFT).
 - Embryo transfer.
 - Freezing or storage of embryo, eggs, or semen.
 - Genetic testing.
- This exclusion does not apply to services required to treat or correct underlying causes of infertility where such services cure the condition, slow the harm to, alleviate the symptoms, or maintain the current health status of the Covered person.
41. **Lamaze Classes** or other child birth classes.
42. **Learning Disability:** Non-medical treatment, including but not limited to special education, remedial reading, school system testing and other rehabilitation treatment for a Learning Disability. If another medical condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions.
43. **Liposuction** regardless of purpose.
44. **Maintenance Therapy:** Such services are excluded if, based on medical evidence, treatment or continued treatment could not be expected to resolve or improve the condition, or that clinical evidence indicates that a plateau has been reached in terms of improvement from such services.
45. **Mammoplasty or Breast Augmentation** unless covered elsewhere in this SPD.

- 46. **Marriage Counseling.**
- 47. **Massage Therapy** unless provided by a Qualified chiropractor or physical therapist.
- 48. **Maximum Benefit.** Charges in excess of the Maximum Benefit allowed by the Plan.
- 49. **Military:** A military related Illness or Injury to a Covered Person on active military duty, unless payment is legally required.
- 50. **Nocturnal Enuresis Alarm** (Bed wetting).
- 51. **Non-Custom-Molded Shoe Inserts.**
- 52. **Non-Professional Care:** Medical or surgical care that is not performed according to generally accepted professional standards, or that is provided by a provider acting outside the scope of his or her license.
- 53. **Not Medically Necessary:** Services, supplies, treatment, facilities or equipment which the Plan determines are not Medically Necessary. Furthermore, this Plan excludes services, supplies, treatment, facilities or equipment which reliable scientific evidence has shown does not cure the condition, slow the degeneration/deterioration or harm attributable to the condition, alleviate the symptoms of the condition, or maintain the current health status of the Covered Person. See also Maintenance Therapy, above.
- 54. **Nursery and Newborn Expenses** for grandchildren of a covered Employee or spouse.
- 55. **Nutrition Counseling** unless covered elsewhere in this SPD.
- 56. **Nutritional Supplements, Vitamins and Electrolytes** except as listed under the Covered Benefits.
- 57. **Orthognathic, Prognathic and Maxillofacial Surgery.**
- 58. **Over-The-Counter Medication, Products, Supplies or Devices** unless covered elsewhere in this SPD.
- 59. **Palliative Foot Care.**
- 60. **Panniculectomy / Abdominoplasty** unless determined by the Plan to be Medically Necessary.
- 61. **Personal Comfort:** Services or supplies for personal comfort or convenience, such as but not limited to private room, television, telephone and guest trays.
- 62. **Pharmacy Consultations.** Charges for or relating to consultative information provided by a pharmacist regarding a prescription order, including but not limited to information relating to dosage instruction, drug interactions, side effects, and the like.
- 63. **Preventive / Routine Care Services** unless covered elsewhere in this SPD and recommended by the United States Preventative Task Force.
- 64. **Private Duty Nursing Services.**
- 65. **Reconstructive Surgery** when performed only to achieve a normal or nearly normal appearance, and not to correct an underlying medical condition or impairment, as determined by the Plan, unless covered elsewhere in this SPD.
- 66. **Return to Work / School:** Telephone or Internet consultations or completion of claim forms or forms necessary for the return to work or school.

67. **Reversal of Sterilization:** Procedures or treatments to reverse prior voluntary sterilization.
68. **Room and Board Fees** when surgery is performed other than at a Hospital or Surgical Center.
69. **Self-Administered Services** or procedures that can be done by the Covered Person without the presence of medical supervision.
70. **Self-Inflicted** unless due to a medical condition (physical or mental) or domestic violence.
71. **Services at no Charge or Cost:** Services which the Covered Person would not be obligated to pay in the absence of this Plan or which are available to the Covered Person at no cost, or which the Plan has no legal obligation to pay, except for care provided in a facility of the uniformed services as per Title 32 of the National Defense Code, or as required by law.
72. **Services** that should legally be provided by a school.
73. **Services Provided by a Close Relative.** See Glossary of Terms of this SPD for definition of Close Relative.
74. **Sex Therapy.**
75. **Sexual Function:** Diagnostic Services, non-surgical and surgical procedures and Prescription drugs (unless covered under the Prescription Benefits Section in this SPD) in connection with treatment for male or female impotence unless as a result of disease, condition or complication of surgical procedure.
76. **Sex Transformation:** Treatment, drugs, medicines, services and supplies for, leading to or maintaining, sex transformation surgery.
77. **Standby Surgeon Charges.**
78. **Subrogation.** Charges for Illness or Injuries suffered by a Covered Person due to the action or inaction of any third party if the Covered Person fails to provide information as specified in the Subrogation section. See the Subrogation section for more information.
79. **Surrogate Parenting and Gestational Carrier Services,** including any services or supplies provided in connection with a surrogate parent, including pregnancy and maternity charges Incurred by a Covered Person acting as a surrogate parent.
80. **Taxes:** Sales taxes, shipping and handling unless covered elsewhere in this SPD.
81. **Temporomandibular Joint Disorder (TMJ) Services: (Applies to Benefit Plan(s) 001, 003)**
- Diagnostic services.
 - Surgical treatment.
 - Non-surgical treatment (includes intraoral devices or any other non-surgical method to alter the occlusion and/or vertical dimension).
- This does not cover orthodontic services.
82. **Transportation:** Transportation services which are solely for the convenience of the Covered Person, the Covered Person's Close Relative, or the Covered Person's Physician.
83. **Travel:** Travel costs, whether or not recommended or prescribed by a Physician, unless authorized in advance by the Plan.
84. **Vision Care** unless covered elsewhere in this SPD. (Refer to the Vision Care Benefits section of this SPD).

85. **Vitamins, Minerals and Supplements**, even if prescribed by a Physician, except for Vitamin B-12 injections and IV iron therapy that are prescribed by a Physician for Medically Necessary purposes.
86. **Vocational Services**: Vocational and educational services rendered primarily for training or education purposes. This Plan also excludes work hardening, work conditioning and industrial rehabilitation services rendered for Injury prevention education or return-to-work programs.
87. **Weekend Admissions** to Hospital confinement (admission taking place after 3:00 p.m. on Friday or before noon on Sunday) are not eligible for reimbursement under the Plan, unless the admission is deemed an Emergency, or for care related to pregnancy that is expected to result in childbirth.
88. **Weight Control**: Treatment, services or surgery for weight control, whether or not prescribed by a Physician or associated with an Illness, except as specifically stated for preventive counseling.
89. **Wigs, Toupees, Hairpieces, Hair Implants or Transplants or Hair Weaving**, or any similar item for replacement of hair regardless of the cause of hair loss unless covered elsewhere in this SPD.
90. **Worker's Compensation**: The Plan will not cover any care or supplies for any Injury, condition or disease if payment is available to You under a Workers Compensation law or similar legislation. The Plan will not make any payments even if You do not claim the benefits You are entitled to receive under the Worker's Compensation law.

The Plan does not limit a Covered Person's right to choose his or her own medical care. If a medical expense is not a covered benefit, or is subject to a limitation or exclusion, a Covered Person still has the right and privilege to receive such medical service or supply at the Covered Person's own personal expense.

CLAIMS AND APPEAL PROCEDURES

REASONABLE AND CONSISTENT CLAIMS PROCEDURES

The Plan's claims procedures are designed to ensure and verify that claim determinations are made in accordance with the Plan documents. The Plan provisions will be applied consistently with respect to similarly situated individuals.

Pre-Determination

A Pre-Determination is a determination of benefits by the Claims Administrator, on behalf of the Plan, prior to services being provided. Although not required by the Plan, a Covered Person or provider may voluntarily request a Pre-Determination. A Pre-Determination informs individuals whether, and under which circumstances, a procedure or service is generally a covered benefit under the Plan. Covered Persons or providers may wish to request a Pre-Determination before incurring medical expenses. A Pre-Determination is not a claim and therefore cannot be appealed. A Pre-Determination that a procedure or service may be covered under the Plan does not guarantee the Plan will ultimately pay the claim. All Plan terms and conditions will still be applied when determining whether a claim is payable under the Plan.

TYPE OF CLAIMS AND DEFINITIONS

- **Pre-Service Claim needing prior authorization as required by the Plan and stated in this SPD.** This is a claim for a benefit where the Covered Person is required to get approval from the Plan **before** obtaining the medical care such as in the case of prior authorization of health care items or service that the Plan requires. If a Covered Person or provider calls the Plan just to find out if a claim will be covered, that is not a Pre-Service Claim, unless the Plan and this SPD specifically require the person to call for prior authorization (See Pre-Determination above). Giving prior authorization does not guarantee that the Plan will ultimately pay the claim.

Note that this Plan does not require prior authorization for urgent or Emergency care claims, however Covered Persons may be required to notify the Plan following stabilization. Please refer to the Utilization Management section of this SPD for more details. A condition is considered to be an urgent or Emergency care situation when a sudden and serious condition such that a Prudent Layperson could expect the patient's life would be jeopardized, the patient would suffer severe pain, or serious impairment of his or her bodily functions would result unless immediate medical care is rendered. Examples of an urgent or Emergency care situation may include, but are not limited to: chest pain; hemorrhaging; syncope; fever equal to or greater than 103° F; presence of a foreign body in the throat, eye, or internal cavity; or a severe allergic reaction.

- **Post-Service Claim** means a claim that involves payment for the cost of health care that has already been provided.
- **Concurrent Care Claim** means that an ongoing course of treatment to be provided over a period of time or for a specified number of treatments has been approved by the Plan.

PERSONAL REPRESENTATIVE

Personal Representative means a person (or provider) who can contact the Plan on the Covered Person's behalf to help with claims, appeals or other benefit issues. Minor Dependents must have the signature of a parent or Legal Guardian in order to appoint a third party as a Personal Representative.

If a Covered Person chooses to use a Personal Representative, the Covered Person must submit a written letter to the Plan stating the following: The name of the Personal Representative, the date and duration of the appointment and any other pertinent information. In addition, the Covered Person must agree to grant their Personal Representative access to their Protected Health Information. This letter must be signed by the Covered Person to be considered official.

PROCEDURES FOR SUBMITTING CLAIMS

Most providers will accept assignment and coordinate payment directly with the Plan on the Covered Person's behalf. If the provider will not accept assignment or coordinate payment directly with the Plan, then the Covered Person will need to send the claim to the Plan within the timelines discussed below in order to receive reimbursement. The address for submitting medical claims is on the back of the group health identification card.

Covered Persons who receive services in a country other than the United States are responsible for ensuring the provider is paid. If the provider will not coordinate payment directly with the Plan, the Covered Person will need to pay the claim up front and then submit the claim to the Plan for reimbursement. The Plan will reimburse Covered Persons for any covered amount in U.S. currency. The reimbursed amount will be based on the U.S. equivalency rate that is in effect on the date the Covered Person paid the claim, or on the date of service if paid date is not known.

A complete claim must be submitted in writing and should include the following information:

- Covered Person/patient ID number, name, sex, date of birth, Social Security number, address, and relationship to Employee
- Authorized signature from the Covered Person
- Diagnosis
- Date of service
- Place of service
- Procedures, services or supplies (narrative description)
- Charges for each listed service
- Number of days or units
- Patient account number (if applicable)
- Total billed charges
- Provider billing name, address, telephone number
- Provider Taxpayer Identification Number (TIN)
- Signature of provider
- Billing provider
- Any information on other insurance (if applicable)
- Whether the patient's condition is related to employment, auto accident, or other accident (if applicable)
- Assignment of benefits (if applicable)

TIMELY FILING

Covered Persons are responsible for ensuring that complete claims are submitted to the Third Party Administrator as soon as possible after services are received, but no later than twelve months from the date of service. Where Medicare or Medicaid paid as primary in error, the Plan will follow that federal agencies guidelines. A complete claim means that the Plan has all information that is necessary to process the claim. Claims received after the timely filing period will not be allowed.

INCORRECTLY FILED CLAIMS (Applies to Pre-Service Claims only)

If a Covered Person or Personal Representative attempts to, but does not properly follow the Plan's procedures for requesting prior authorization, the Plan will notify the person to explain proper procedures within five calendar days following receipt of a Pre-Service claim request. The notice will usually be oral, unless written notice is requested by the Covered Person or Personal Representative.

HOW HEALTH BENEFITS ARE CALCULATED

When UMR receives a claim for services that have been provided to a Covered Person, it will determine if the service is a covered benefit under this group health Plan. If it is not a covered benefit, the claim will be denied and the Covered Person will be responsible for paying the provider for these costs. If it is a covered benefit, UMR will establish the allowable payment amount for that service, in accordance with the provisions of this SPD.

Claims for covered benefits are paid according to an established fee schedule, a Negotiated Rate for certain services, or as a percentage of the Usual and Customary fees.

Fee Schedule: Generally, providers are paid the lesser of the billed amount or the maximum fee schedule for the particular covered service, minus any Deductible, Plan Participation rate, Co-pay or penalties that the Covered Person is responsible for paying. Where a network contract is in place, the network contract determines the Plan's allowable charge used in the calculation of the payable benefit.

Negotiated Rate: On occasion, UMR will negotiate a payment rate with a provider for a particular covered service such as transplant services, Durable Medical Equipment, Extended Care Facility treatment or other services. The Negotiated Rate is what the Plan will pay to the provider, minus any Co-pay, Deductible, Plan Participation rate or penalties that the Covered Person is responsible for paying. Where a network contract is in place, the network contract determines the Plan's Negotiated Rate.

Usual and Customary (U&C) is the amount that is usually charged by health care providers in the same geographical area (or greater area, if necessary) for the same services, treatment or materials. An industry fee file is used to determine U&C fee allowances. Refer to the U&C level being allowed by the Centers for Medicare and Medicaid Services on the Provider Network provision, see surgery and assistant surgeon under the Covered Benefits for exceptions related to multiple procedures. As it relates to charges made by a network provider, the term Usual and Customary means the Negotiated Rate as contractually agreed to by the provider and network (see above). A global package includes the services that are a necessary part of a procedure. For individual services that are part of a global package, it is customary for the individual services not to be billed separately. A separate charge will not be allowed under the Plan.

NOTIFICATION OF BENEFIT DETERMINATION

If a claim is submitted by a Covered Person or a provider on behalf of a Covered Person and the Plan does not completely cover the charges, the Covered Person will receive an Explanation of Benefits (EOB) form that will explain how much the Plan paid toward the claim, and how much of the claim is the Covered Person's responsibility due to cost-sharing obligations, non-covered benefits, penalties or other Plan provisions. Please check the information on each EOB form to make sure the services charged were actually received from the provider and that the information appears correct. For any questions or concerns about the EOB form, call the Plan at the number listed on the EOB or on the back of the group health identification card. The provider will receive a similar form on each claim that is submitted.

TIMELINES FOR INITIAL BENEFIT DETERMINATION

UMR will process claims within the following timelines, although the Covered Person may voluntarily extend these timelines:

- **Pre-Service Claim:** A decision will be made within 15 calendar days following receipt of a claim request, but the Plan can have an extra 15-day extension, when necessary for reasons beyond the control of the Plan, if written notice is given to the Covered Person within the original 15-day period.
- **Post-Service Claims:** Claims will be processed within 30 calendar days, but the Plan can have an additional 15-day extension, when necessary for reasons beyond the control of the Plan, if written notice is provided to the Covered Person within the original 30-day period.

- **Concurrent Care Claims:** If the Plan is reducing or terminating benefits before the end of the previously approved course of treatment, the Plan will notify the Covered Person prior to the coverage for the treatment ending or being reduced.
- **Emergency and/or Urgent Care Claim:** The Plan will notify a Covered Person or provider of a benefit determination (whether adverse or not) with respect to a claim involving Emergency or Urgent Care as soon as possible, taking into account the medical necessity, but not later than 72 hours after the receipt of the claim by the Plan.

A claim is considered to be filed when the claim for benefits has been submitted to UMR for formal consideration under the terms of this Plan.

CIRCUMSTANCES CAUSING LOSS OR DENIAL OF PLAN BENEFITS

Claims can be denied for any of the following reasons:

- Termination of Your employment.
- Covered Person is no longer eligible for coverage under the health Plan.
- Charges Incurred prior to the Covered Person's Effective Date or following termination of coverage.
- Covered Person reached the Maximum Benefit under this Plan.
- Amendment of group health Plan.
- Termination of the group health Plan.
- Employee, Dependent or provider did not respond to a request for additional information needed to process the claim or appeal.
- Application of Coordination of Benefits.
- Enforcement of subrogation.
- Services are not a covered benefit under this Plan.
- Services are not considered Medically Necessary.
- Failure to comply with prior authorization requirements before receiving services.
- Misuse of the Plan identification card or other fraud.
- Failure to pay premiums if required.
- Employee or Dependent is responsible for charges due to Deductible, Plan Participation obligations or penalties.
- Application of the Usual and Customary fee limits, fee schedule or Negotiated Rates.
- Incomplete or inaccurate claim submission.
- Application of utilization review.
- Experimental or Investigational procedure.
- Other reasons as stated elsewhere in this SPD.

ADVERSE BENEFIT DETERMINATION (DENIED CLAIMS)

Adverse Benefit Determination means a denial, reduction or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

If a claim is being denied in whole or in part, and the Covered Person will owe any amount to the provider, the Covered Person will receive an initial claim denial notice, usually referred to as an Explanation of Benefits (EOB) form, within the timelines described above. The EOB form will:

- Explain the specific reasons for the denial.
- Provide a specific reference to pertinent Plan provisions on which the denial was based.
- Provide a description of any material or information that is necessary for the Covered Person to perfect the claim, along with an explanation of why such material or information is necessary, if applicable.

- Provide appropriate information as to the steps the Covered Person can take to submit the claim for appeal (review).
- If an internal rule or guideline was relied upon, or if the denial was based on Medical Necessity or Experimental treatment, the Plan will notify the Covered Person of that fact. The Covered Person has the right to request a copy of the rule/guideline or clinical criteria that was relied upon, and such information will be provided free of charge.

APPEALS PROCEDURE FOR ADVERSE BENEFIT DETERMINATIONS

If a Covered Person disagrees with the denial of a claim or a rescission of coverage determination, the Covered Person or his/her Personal Representative can request that the Plan review its initial determination by submitting a written request to the Plan as described below. An appeal filed by a provider on the Covered Person's behalf is not considered an appeal under the Plan unless the provider is a Personal Representative.

First Level of Appeal: This is a **mandatory** appeal level. The Covered Person must exhaust the following internal procedures before any outside action is taken.

- Covered Persons must file the appeal within 180 days of the date they received the EOB form from the Plan showing that the claim was denied. The Plan will assume that Covered Persons received the EOB form five days after the Plan mailed the EOB form.
- Covered Persons or their Personal Representative will be allowed reasonable access to review or copy pertinent documents, at no charge.
- Covered Persons may submit written comments, documents, records and other information relating to the claim to explain why they believe the denial should be overturned. This information should be submitted at the same time the written request for a review is submitted.
- Covered Persons have the right to submit evidence that their claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The review will take into account all comments, documents, records and other information submitted that relates to the claim. This would include comments, documents, records and other information that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision and are not under the supervision of the person who originally denied the claim.
- If the benefit denial was based in whole or in part on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision, nor be supervised by the health care professional who was involved. If the Plan has obtained medical or vocational experts in connection with the claim, they will be identified upon the Covered Person's request, regardless of whether the Plan relies on their advice in making any benefit determinations.

Second Level of Appeal Plan Sponsor: This is a **mandatory** appeal level. The Covered Person must exhaust the following internal procedures before any outside legal action is taken.

- Covered Persons who are not satisfied with the decision following the first appeal have the right to appeal the denial a second time.
- Covered Persons or their Personal Representative must submit a written request for a second review within 60 calendar days following the date they received the Plan's decision regarding the first appeal. The Plan will assume that Covered Persons received the determination letter regarding the first appeal five days following the date the Plan sends the determination letter.
- Covered Persons may submit written comments, documents, records and other pertinent information to explain why they believe the denial should be overturned. This information should be submitted at the same time the written request for a second review is submitted.
- Covered Persons have the right to submit evidence that their claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.

- The second review will take into account all comments, documents, records and other information submitted that relates to the claim that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision or the first appeal, and are not under the supervision of those individuals.
- If the benefit denial was based in whole or in part on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision or first appeal, nor be supervised by the health care professional who was involved. If the Plan has obtained medical or vocational experts in connection with the claim, they will be identified upon the Covered Person's request, regardless of whether the Plan relies on their advice in making any benefit determinations.

Appeals should be sent within the prescribed time period as stated above to:

This Plan contracts with various companies to administer different parts of this Plan. Covered Persons who want to appeal a decision or a claim determination that one of these companies made, should send appeals directly to the company that made the decision being appealed. The names and addresses of the companies that the Plan contracts include:

Send Medical appeals to
 UMR
 CLAIMS APPEAL UNIT
 PO BOX 30546
 SALT LAKE CITY UT 84130-0546

TIME PERIODS FOR MAKING DECISION ON APPEALS

After reviewing a claim that has been appealed, the Plan will notify the Covered Person of its decision within the following timeframes, although Covered Persons may voluntarily extend these timelines. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, the Plan will provide it to You free of charge and sufficiently in advance of the due date of the response to the Adverse Benefit Determination.

The timelines below will only apply to the mandatory appeal level. The voluntary appeal level will not be subject to specific timelines.

- Pre-Service Claim: Within a reasonable period of time appropriate to the medical circumstances but no later than 30 calendar days after the Plan receives the request for review.
- Post-Service Claim: Within a reasonable period of time but no later than 60 calendar days after the Plan receives the request for review.
- Concurrent Care Claims: Before treatment ends or is reduced.

RIGHT TO EXTERNAL REVIEW

If, after exhausting Your internal appeals, You are not satisfied with the final determination, You may choose to participate in the external review program. This program only applies if the Adverse Benefit Determination is based on:

- Clinical reasons;
- The exclusions for Experimental or Investigational Services or Unproven Services; or
- As otherwise required by applicable law.

This external review program offers an independent review process to review the denial of a requested service or procedure or the denial of payment for a service or procedure. The process is available at no charge to You after exhausting the appeals process identified above and You receive a decision that is unfavorable, or if UMR or Your employer fail to respond to Your appeal within the timelines stated above.

You may request an independent review of the Adverse Benefit Determination. Neither You nor UMR or Your employer will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision. If You wish to pursue an external review, please send a written request to the following address:

UMR
EXTERNAL REVIEW
APPEAL UNIT
PO BOX 8048
WAUSAU WI 54402-8048

Your written request should include: (1) Your specific request for an external review; (2) the Employee's name, address, and member ID number; (3) Your designated representative's name and address, when applicable; (4) the service that was denied; and (5) any new, relevant information that was not provided during the internal appeal. You will be provided more information about the external review process at the time we receive Your request.

All requests for an independent review must be made within four (4) months of the date You receive the Adverse Benefit Determination. You, Your treating Physician or an authorized designated representative may request an independent review by contacting the toll-free number on Your ID card or by sending a written request to the address on Your ID card.

The independent review will be performed by an independent Physician, or by a Physician who is qualified to decide whether the requested service or procedure is a qualified medical care expense under the Plan. The Independent Review Organization (IRO) has been contracted by UMR and has no material affiliation or interest with UMR or Your employer. UMR will choose the IRO based on a rotating list of approved IROs.

In certain cases, the independent review may be performed by a panel of Physicians, as deemed appropriate by the IRO.

Within applicable timeframes of UMR's receipt of a request for independent review, the request will be forwarded to the IRO, together with:

- all relevant medical records;
- all other documents relied upon by UMR and/or Your employer in making a decision on the case; and
- all other information or evidence that You or Your Physician has already submitted to UMR or Your employer.

If there is any information or evidence You or Your Physician wish to submit in support of the request that was not previously provided, You may include this information with the request for an independent review, and UMR will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information to make a decision, this time period may be extended. The independent review process will be expedited if You meet the criteria for an expedited external review as defined by applicable law.

The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide You and UMR and/or Your employer with the reviewer's decision, a description of the qualifications of the reviewer and any other information deemed appropriate by the organization and/or as required by applicable law.

If the final independent decision is to approve payment or referral, the Plan will accept the decision and provide benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide benefits for the service or procedure.

You may contact the Claims Administrator at the toll-free number on Your ID card for more information regarding Your external appeal rights and the independent review process.

PHYSICAL EXAMINATION AND AUTOPSY

The Plan may require that a Covered Person have a physical examination, at the Plan's expense, as often as is necessary to settle a claim. In the case of death, the Plan may require an autopsy unless forbidden by law.

RIGHT TO REQUEST OVERPAYMENTS

The Plan reserves the right to recover any payments made by the Plan that were:

- Made in error; or
- Made after the date the person should have been terminated under this Plan; or
- Made to any Covered Person or any party on a Covered Person's behalf where the Plan Sponsor determines the payment to the Covered Person or any party is greater than the amount payable under this Plan.

The Plan has the right to recover against Covered Persons if the Plan has paid them or any other party on their behalf.

FRAUD

Fraud is a crime that can be prosecuted. Any Covered Person who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of fraud. The Plan will utilize all means necessary to support fraud detection and investigation. It is a crime for a Covered Person to file a claim containing any false, incomplete or misleading information with intent to injure, defraud or deceive the Plan. In addition, it is a fraudulent act when a Covered Person willfully and knowingly fails to notify the Plan regarding an event that affects eligibility for a Covered Person. Notification requirements are outlined in this SPD and other Plan materials. Please read them carefully and refer to all Plan materials that You receive (i.e., COBRA notices). A few examples of events that require Plan notification would be divorce, Dependent aging out of the Plan, and enrollment in other group health coverage while on COBRA (please note that the examples listed are not all inclusive).

These actions will result in denial of the Covered Person's claim or termination from the Plan, and are subject to prosecution and punishment to the full extent under state and/or federal law.

Covered Persons must:

- File accurate claims. If someone else - such as Your spouse or another family member - files claims on the Covered Person's behalf, the Covered Person should review the form before signing it;
- Review the Explanation of Benefits (EOB) form. Make certain that benefits have been paid correctly based on your knowledge of the expenses Incurred and the services rendered;
- Never allow another person to seek medical treatment under your identity. If your Plan identification card is lost, report the loss to the Plan immediately; and
- Provide complete and accurate information on claim forms and any other forms. Answer all questions to the best of your knowledge.
- Notify the Plan when an event occurs that affects a Covered Person's eligibility.

To maintain the integrity of this Plan, Covered Persons are encouraged to notify the Plan whenever a provider:

- Bills for services or treatment that have never been received; or
- Asks a Covered Person to sign a blank claim form; or
- Asks a Covered Person to undergo tests that the Covered Person feels are not needed.

Covered Persons concerned about any of the charges that appear on a bill or EOB form, or who know of or suspect any illegal activity, should call the toll-free hotline 1-800-356-5803. All calls are strictly confidential.

OTHER FEDERAL PROVISIONS

FAMILY AND MEDICAL LEAVE ACT (FMLA)

If an Employee is on a family or medical leave of absence that meets the eligibility requirements under FMLA, Your employer will continue coverage under this Plan in accordance with state and federal FMLA regulations, provided that the following conditions are met:

- Contribution is paid; and
- The Employee has written approved leave from the employer.

Coverage will be continued for up to the greater of:

- The leave period required by the federal Family and Medical Leave Act of 1993 and any amendment; or
- The leave period required by applicable state law.

An Employee can choose not to retain group health coverage during an FMLA leave. When the Employee returns to work following the FMLA leave, the Employee's coverage will usually be restored to the level the Employee would have had if the FMLA leave had not been taken, and no new pre-existing requirements will be imposed. For more information, please contact Your Human Resources or Personnel office.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS PROVISION

A Dependent Child will become covered as of the date specified in a judgment, decree or order issued by a court of competent jurisdiction or through a state administrative process.

The order must clearly identify all of the following:

- The name and last known mailing address of the participant;
- The name and last known mailing address of each alternate recipient (or official state or political designee for the alternate recipient);
- A reasonable description of the type of coverage to be provided to the Child or the manner in which such coverage is to be determined; and
- The period to which the order applies.

Please contact Your campus Human Resource Administrator for information on processing Qualified Medical Child Support.

NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering group health insurance generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or the newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, the plan or issuer may pay for a shorter stay if the attending Physician (e.g., Your Physician, nurse, or midwife, or a physician assistant) after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and insurers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce Your out-of-pocket costs, You may be required to obtain precertification. For information on precertification, contact Your plan administrator.

This group health Plan also complies with the provisions of the:

- Mental Health Parity Act.
- The Americans with Disabilities Act, as amended.
- Women's Health and Cancer Rights Act of 1998 regarding breast reconstruction following a mastectomy.
- Pediatric Vaccines regulation, whereby an employer will not reduce its coverage for pediatric vaccines below the coverage it provided as of May 1, 1993.
- Health Insurance Portability provisions of the Health Insurance Portability and Accountability Act (HIPAA).
- Medicare Secondary Payer regulations, as amended.
- TRICARE Prohibition Against Incentives and Nondiscrimination Requirements amendments.
- The Genetic Information Non-discrimination Act (GINA).

HIPAA ADMINISTRATIVE SIMPLIFICATION MEDICAL PRIVACY AND SECURITY PROVISION

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA PRIVACY AND SECURITY REGULATIONS

This Plan will Use a Covered Person's Protected Health Information (PHI) to the extent of and in accordance with the Uses and Disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, this Plan will Use and Disclose a Covered Person's PHI for purposes related to health care Treatment, Payment for health care and Health Care Operations. Additionally, this Plan will Use and Disclose a Covered Person's PHI as required by law and as permitted by authorization. This section establishes the terms under which the Plan may share a Covered Person's PHI with the Plan Sponsor, and limits the Uses and Disclosures that the Plan Sponsor may make of a Covered Person's PHI.

This Plan shall Disclose a Covered Person's PHI to the Plan Sponsor only to the extent necessary for the purposes of the administrative functions of Treatment, Payment for health care or Health Care Operations.

The Plan Sponsor shall Use and/or Disclose a Covered Person's PHI only to the extent necessary for the administrative functions of Treatment, Payment for health care or Health Care Operations which it performs on behalf of this Plan.

This Plan agrees that it will only Disclose a Covered Person's PHI to the Plan Sponsor upon receipt of a certification from the Plan Sponsor that the terms of this section have been adopted and that the Plan Sponsor agrees to abide by these terms.

The Plan Sponsor is subject to all of the following restrictions that apply to the Use and Disclosure of a Covered Person's PHI:

- The Plan Sponsor will only Use and Disclose a Covered Person's PHI (including Electronic PHI) for Plan Administrative Functions, as required by law or as permitted under the HIPAA regulations. This Plan's Notice of Privacy Practices also contains more information about permitted Uses and Disclosures of PHI under HIPAA;
- The Plan Sponsor will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- The Plan Sponsor will require each of its subcontractors or agents to whom the Plan Sponsor may provide a Covered Person's PHI to agree to the same restrictions and conditions imposed on the Plan Sponsor with regard to a Covered Person's PHI;
- The Plan Sponsor will ensure that each of its subcontractors or agents to whom the Plan Sponsor may provide Electronic PHI to agree to implement reasonable and appropriate security measures to protect Electronic PHI;
- The Plan Sponsor will not Use or Disclose PHI for employment-related actions and decisions or in connection with any other of the Plan Sponsor's benefits or Employee benefit plans;
- The Plan Sponsor will promptly report to this Plan any impermissible or improper Use or Disclosure of PHI not authorized by the Plan documents;
- The Plan Sponsor will report to the Plan any security incident with respect to Electronic PHI of which Plan Sponsor becomes aware;

- The Plan Sponsor will allow a Covered Person or this Plan to inspect and copy any PHI about the Covered Person contained in the Designated Record Set that is in the Plan Sponsor's custody or control. The HIPAA Privacy Regulations set forth the rules that the Covered Person and the Plan must follow and also sets forth exceptions;
- The Plan Sponsor will amend or correct, or make available to the Plan to amend or correct, any portion of the Covered Person's PHI contained in the Designated Record Set to the extent permitted or required under the HIPAA Privacy Regulations;
- The Plan Sponsor will keep a Disclosure log for certain types of Disclosures set forth in the HIPAA Regulations. Covered Persons have a right to see the Disclosure log. The Plan Sponsor does not have to maintain a log if Disclosures are for certain Plan-related purposes such as Payment of benefits or Health Care Operations;
- The Plan Sponsor will make its internal practices, books and records relating to the Use and Disclosure of a Covered Person's PHI available to this Plan and to the Department of Health and Human Services or its designee for the purpose of determining this Plan's compliance with HIPAA;
- The Plan Sponsor must, if feasible, return to this Plan or destroy all of a Covered Person's PHI that the Plan Sponsor received from or on behalf of this Plan when the Plan Sponsor no longer needs the Covered Person's PHI to administer this Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further Uses and Disclosures to the purposes that make the return or destruction infeasible;
- The Plan Sponsor will provide that adequate separation exists between this Plan and the Plan Sponsor so that a Covered Person's PHI (including Electronic PHI) will be used only for the purpose of plan administration; and
- The Plan Sponsor will use reasonable efforts to request only the minimum necessary type and amount of a Covered Person's PHI to carry out functions for which the information is requested.

The following Employees, classes of Employees or other workforce members under the control of the Plan Sponsor may be given access to a Covered Person's PHI for Plan Administrative Functions that the Plan Sponsor performs on behalf of the Plan as set forth in this section:

Vice President of Administration, Associate Vice President of Employee Benefits & Risk Management, Benefit Plan Analyst, Associate Director for Employee Benefits

This list includes every Employee, class of Employees or other workforce members under the control of the Plan Sponsor who may receive a Covered Person's PHI. If any of these Employees or workforce members Use or Disclose a Covered Person's PHI in violation of the terms set forth in this section, the Employees or workforce members will be subject to disciplinary action and sanctions, including the possibility of termination of employment. If the Plan Sponsor becomes aware of any such violations, the Plan Sponsor will promptly report the violation to this Plan and will cooperate with the Plan to correct the violation, to impose the appropriate sanctions and to mitigate any harmful effects to the Covered Person.

DEFINITIONS

Administrative Simplification is the section of the law that addresses electronic transactions, privacy and security. The goals are to:

- Improve efficiency and effectiveness of the health care system;
- Standardize electronic data interchange of certain administrative transactions;
- Safeguard security and privacy of Protected Health Information;
- Improve efficiency to compile/analyze data, audit, and detect fraud; and
- Improve the Medicare and Medicaid programs.

Business Associate (BA) in relationship to a Covered Entity (CE) means a BA is a person to whom the CE discloses Protected Health Information (PHI) so that a person can carry out, assist with the performance of, or perform on behalf of, a function or activity for the CE. This includes contractors or other persons who receive PHI from the CE (or from another business partner of the CE) for the purposes described in the previous sentence, including lawyers, auditors, consultants, Third Party Administrators, health care clearinghouses, data processing firms, billing firms and other Covered Entities. This excludes persons who are within the CE's workforce.

Covered Entity (CE) is one of the following: a health plan, a health care clearinghouse or a health care provider who transmits any health information in connection with a transaction covered by this law.

Designated Record Set means a set of records maintained by or for a Covered Entity that includes a Covered Persons' PHI. This includes medical records, billing records, enrollment, Payment, claims adjudication and case management record systems maintained by or for this Plan. This also includes records used to make decisions about Covered Persons. This record set must be maintained for a minimum of 6 years.

Disclose or Disclosure is the release or divulgence of information by an entity to persons or organizations outside that entity.

Electronic Protected Health Information (Electronic PHI) is Individually Identifiable Health Information that is transmitted by electronic media or maintained in electronic media. It is a subset of Protected Health Information.

Health Care Operations are general administrative and business functions necessary for the CE to remain a viable business. These activities include:

- Conducting quality assessment and improvement activities;
- Reviewing the competence or qualifications and accrediting/licensing of health care professional plans;
- Evaluating health care professional and health plan performance;
- Training future health care professionals;
- Insurance activities relating to the renewal of a contract for insurance;
- Conducting or arranging for medical review and auditing services;
- Compiling and analyzing information in anticipation of or for use in a civil or criminal legal proceeding;
- Population-based activities related to improving health or reducing health care costs, protocol development, case management and care coordination;
- Contacting of health care providers and patients with information about Treatment alternatives and related functions that do not entail direct patient care; and
- Activities related to the creation, renewal or replacement of a contract for health insurance or health benefits, as well as ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss and excess of loss insurance).

Individually Identifiable Health Information is information that is a subset of health information, including demographic information collected from a Covered Person, and that:

- Is created by or received from a Covered Entity;
- Relates to the past, present or future physical or mental health or condition of a Covered Person, the provision of health care or the past, present or future Payment for the provision of health care; and
- Identifies the Covered Person or with respect to which there is reasonable basis to believe the information can be used to identify the Covered Person.

Payment means the activities of the health plan or a Business Associate, including the actual Payment under the policy or contract; and a health care provider or its Business Associate that obtains reimbursement for the provision of health care.

Plan means the UNIVERSITY OF ARKANSAS Medical Benefit Plan.

Plan Administrative Functions means administrative functions of Payment or Health Care Operations performed by the Plan Sponsor on behalf of the Plan including quality assurance, claims processing, auditing and monitoring.

Plan Sponsor means The University of Arkansas.

Privacy Official is the individual who provides oversight of compliance with all policies and procedures related to the protection of PHI and federal and state regulations related to a Covered Person's privacy.

Protected Health Information (PHI) is Individually Identifiable Health Information transmitted or maintained by a Covered Entity in written, electronic or oral form. PHI includes Electronic PHI.

Treatment is the provision of health care by, or the coordination of health care (including health care management of the individual through risk assessment, case management and disease management) among, health care providers; the referral of a patient from one provider to another; or the coordination of health care or other services among health care providers and third parties authorized by the health plan or the individual.

Use means, with respect to Individually Identifiable Health Information, the sharing, employment, application, utilization, examination or analysis of such information within an entity that maintains such information.

NMHPA Notice:

We will pay for an in-patient hospital stay of at least 48 hours for the mother and newborn Child following a normal vaginal delivery. We will pay for an in-patient hospital stay of at least 96 hours for the mother and newborn Child following a cesarean section delivery. However, we may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, we may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour or 96-hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, we may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-authorization. For information on pre-authorization, contact your plan administrator.

WHCRA Notice:

As required by the Women's Health and Cancer Rights Act of 1998, Provide benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema), and

- b. cover services and supplies in connection with reconstructive surgery that is necessary to restore part of the body that is injured or deformed by acute trauma, infection or other pathological disease that occurred while you were an enrollee under the Plan, and
- c. cover reconstructive surgery to correct congenital malformations or anomalies resulting in a functional defect or impairment of a child covered under this Plan

PLAN AMENDMENT AND TERMINATION INFORMATION

The University fully intends to maintain this Plan indefinitely; however, the University through action by the President reserves the right to terminate, suspend or amend this Plan at any time, in whole or in part, including making modifications to the benefits or contributions required under this Plan. Amendments may be applicable to all participants or specific classes. No person or entity has any authority to make any oral change or amendments to this Plan. No agent or representative of this Plan will have the authority to legally change the Plan terms or SPD or waive any of its provisions, either purposefully or inadvertently. If a misstatement affects the existence of coverage, the true facts will be used in determining whether coverage is in force under the terms of this Plan and in what amount. The Plan Administrator will provide written notice to Covered Persons within 60 days following the adopted formal action that makes material reduction of benefits to the Plan, or may, in the alternative, furnish such notification through communications maintained by the Plan Sponsor or Plan Administrator at regular intervals no greater than 90 days.

COVERED PERSON'S RIGHTS IF PLAN IS AMENDED OR TERMINATED

If this Plan is amended, a Covered Person's rights are limited to Plan benefits in force at the time expenses are Incurred, whether or not the Covered Person has received written notification from the Plan Administrator that the Plan has been amended.

If this Plan is terminated, the rights of a Covered Person are limited to Covered Expenses Incurred before the Covered Person receives notice of termination. All claims Incurred prior to termination, but not submitted to either the Plan Sponsor or Third Party Administrator within 75 days of the Effective Date of termination of this Plan due to bankruptcy will be excluded from any benefit consideration.

The Plan will assume that the Covered Person received the written amendment or termination letter from the Plan Administrator five days after the letter is mailed.

No person will become entitled to any vested rights under this Plan.

DISTRIBUTION OF ASSETS UPON TERMINATION OF PLAN

Post tax contributions paid by COBRA beneficiaries and/or Retirees, if applicable, will be used for the exclusive purpose of providing benefits and defraying reasonable expenses related to Plan administration, and will not inure to the benefit of the employer.

NO CONTRACT OF EMPLOYMENT

This Plan is not intended to be, and may not be construed as a contract of employment between any Covered Person and the employer.

GLOSSARY OF TERMS

Accident means an unexpected, unforeseen and unintended event that causes bodily harm or damage to the body.

Activities of Daily Living (ADL) means the following, with or without assistance: bathing, dressing, toileting, and associated personal hygiene; transferring (moving in or out of a bed, chair, wheelchair, tub, or shower); mobility; eating (getting nourishment into the body by any means other than intravenous); and continence (voluntarily maintaining control of bowel and/or bladder function, or, in the event of incontinence, maintaining a reasonable level of personal hygiene).

Acupuncture means a technique used to deliver anesthesia or analgesia, to for treat conditions of the body (when clinical efficacy has been established for treatment of such conditions) by passing long, thin needles through the skin.

Adverse Benefit Determination means a denial, reduction, or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

Alternate Facility means a health care facility that is not a Hospital and that provides one or more of the following services on an Outpatient basis, as permitted by law:

- Surgical services;
- Emergency services; or
- Rehabilitative, laboratory, diagnostic, or therapeutic services.

Ambulance Transportation means professional ground or air Ambulance Transportation in an Emergency situation, or when Medically Necessary, which is:

- To the closest facility most able to provide the specialized treatment required; and
- The most appropriate mode of transportation consistent with the well being of You or Your Dependent.

Ancillary Services means services rendered in connection with Inpatient or Outpatient care in a Hospital or in connection with a medical Emergency, including the following: ambulance services, anesthesiology, assistant surgeon services, pathology, and radiology. This term also includes services of the attending Physician or primary surgeon in the event of a medical Emergency.

Birthing Center means a legally operating institution or facility which is licensed and equipped to provide immediate prenatal care, delivery services and postpartum care to the pregnant individual under the direction and supervision of one or more Physicians specializing in obstetrics or gynecology or a certified nurse midwife. It must provide for 24-hour nursing care provided by registered nurses or certified nurse midwives.

Certificate of Creditable Coverage means a certificate or other documentation that is provided to a person upon losing health care coverage. The certificate or other documentation specifies how much Creditable Coverage a person has and is used to reduce the length of a pre-existing condition exclusion period under a Plan.

Child (Children) means any of the following individuals with respect to an Employee: a natural biological Child; a step Child; a legally adopted Child or a Child legally Placed for Adoption; a Child under the Employee's or spouse's Legal Guardianship; a foster Child for whom the Employee is legally responsible; or a Child who is considered an alternate recipient under a Qualified Medical Child Support Order (even if the Child does not meet the definition of "Dependent").

Close Relative means a member of the immediate family. Immediate family includes You, Your spouse, mother, father, grandmother, grandfather, step parents, step grandparents, siblings, step siblings, half siblings, Children, step Children and grandchildren.

COBRA means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time, and applicable regulations. This law gives Covered Persons the right, under certain circumstances, to elect continuation coverage under the Plan when active coverage ends due to a Qualifying Event.

Co-pay means the amount a Covered Person must pay each time certain covered services are provided, as outlined on the Schedule of Benefits.

Cosmetic Treatment means medical or surgical procedures which are primarily used to improve, alter or enhance appearance, whether or not for psychological or emotional reasons.

Covered Expense means any expense, or portion thereof, which is Incurred as a result of receiving a covered benefit under this Plan.

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

Creditable Coverage means coverage an individual has under the following as defined by federal law and applicable regulations:

- A group health plan;
- Health insurance coverage (through a group or individual policy);
- Medicare;
- Medicaid;
- A medical care program of the uniformed services;
- A medical care program of the Indian Health Services or of a tribal organization;
- A state health benefits risk pool;
- A state Children's Health Insurance Program;
- A health plan offered under the Federal Employee Health Benefits Program;
- A public health plan, including any plan established or maintained by a state, the U.S. government, a foreign country or any political subdivision of the same; or
- A health benefit plan under Section 5(e) of the Peace Corps Act.

Creditable Coverage shall not include coverages for liability, disability income, limited scope dental or vision benefits, specified disease, supplemental benefits and other excepted benefits as defined by federal law and applicable regulations. A period of Creditable Coverage shall not be counted, with respect to enrollment under a group health plan, if there is a 63-day lapse in coverage between the end of the prior coverage and the beginning of the person's enrollment under this Plan.

Custodial Care means nonmedical care given to a Covered Person to administer medication and to assist with personal hygiene or other Activities of Daily Living rather than providing therapeutic treatment and services. Custodial Care services can be safely and adequately provided by persons who do not have the technical skills of a covered healthcare provider. Custodial Care also includes care when active medical treatment cannot be reasonably expected to reduce the disability or condition.

Deductible means the amount of Covered Expenses which must be paid by the Covered Person or the covered family before benefits are payable. The Schedule of Benefits shows the amount of the applicable Deductible (if any) and the health care benefits to which it applies.

Dependent – see Eligibility and Enrollment section of this SPD.

Developmental Delays are characterized by impairment in various areas of development such as social interaction skills, adaptive behavior and communication skills. Developmental Delays may not always have a history of birth trauma or other illness that could be causing the impairment such as a hearing problem, mental illness or other neurological symptoms or illness.

Durable Medical Equipment means equipment which meets all of the following criteria:

- Can withstand repeated use.
- Is primarily used to serve a medical purpose with respect to an illness or injury.
- Generally is not useful to a person in the absence of an illness or injury.
- Is appropriate for use in the Covered Person's home.

Effective Date means the first day of coverage under this Plan as defined in this SPD. The Covered Person's Effective Date may or may not be the same as their Enrollment Date, as Enrollment Date is defined in the Plan.

Emergency means a serious medical condition, with acute symptoms that a Prudent Layperson would seek immediate care and treatment in order to avoid jeopardy to the life and health of the person.

Employee – see the Eligibility and Enrollment section of this SPD.

Enrollment Date means:

- For anyone who applies for coverage when first eligible, the Enrollment Date is the date that coverage begins.
- For anyone who enrolls under the Special Enrollment Provision, or for Late Enrollees, the Enrollment Date is the first day coverage begins.

Essential Health Benefit means any medical expense that falls under the following categories, as defined under the Patient Protection and Affordable Care Act; ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; Prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care, etc.

Experimental, Investigational or Unproven means any drug, service, supply, care and/or treatment that, at the time provided or sought to be provided, is not recognized as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition. This includes, but is not limited to:

- Items within the research, Investigational or Experimental stage of development or performed within or restricted to use in Phase I, II, or III clinical trials (unless identified as a covered service elsewhere);
- Items that do not have strong research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (have not yet shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought). Strong research-based evidence is identified as peer-reviewed published data derived from multiple, large, human randomized controlled clinical trials OR at least one or more large controlled national multi-center population-based studies;
- Items based on anecdotal and Unproven evidence (literature consists only of case studies or uncontrolled trials), i.e., lacks scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established;
- Items which have been identified through research-based evidence to not be effective for a medical condition and/or to not have a beneficial effect on health outcomes.

Note: FDA and/or Medicare approval does not guarantee that a drug, supply, care and/or treatment is accepted medical practice, however, lack of such approval will be a consideration in determining whether a drug, service, supply, care and/or treatment is considered Experimental, Investigational or Unproven. In assessing cancer care claims, sources such as the National Comprehensive Cancer Network (NCCN) Compendium, Clinical Practice Guidelines in Oncology™ or National Cancer Institute (NCI) standard of care compendium guidelines, or similar material from other or successor organizations will be considered along with benefits provided under the Plan and any benefits required by law. Furthermore, off-label drug or device use (sought for outside FDA-approved indications) is subject to medical review for appropriateness based on prevailing peer-reviewed medical literature, published opinions and evaluations by national medical associations, consensus panels, technology evaluation bodies, and/or independent review organizations to evaluate the scientific quality of supporting evidence.

Extended Care Facility includes, but is not limited to a skilled nursing, rehabilitation, convalescent or subacute facility. It is an institution or a designated part of one that is operating pursuant to the law for such an institution and is under the full time supervision of a Physician or registered nurse. In addition, the Plan requires that the facility: Provide 24 hour-a-day service to include skilled nursing care and Medically Necessary therapies for the recovery of health or physical strength; is not a place primarily for Custodial Care; requires compensation from its patients; admits patients only upon Physician orders; has an agreement to have a Physician's services available when needed; maintains adequate medical records for all patients; has a written transfer agreement with at least one Hospital and is licensed by the state in which it operates and provides the services under which the licensure applies.

FMLA means the Family and Medical Leave Act of 1993, as amended.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and the applicable regulations. This law gives special enrollment rights, prohibits discrimination, and protects privacy of protected health information among other things.

Home Health Care means a formal program of care and intermittent treatment that is: Performed in the home; and prescribed by a Physician; and intermittent care and treatment for the recovery of health or physical strength under an established plan of care; and prescribed in place of a Hospital or an Extended Care Facility or results in a shorter Hospital or Extended Care Facility stay; and organized, administered, and supervised by a Hospital or Qualified licensed providers under the medical direction of a Physician; and appropriate when it is not reasonable to expect the Covered Person to obtain medically indicated services or supplies outside the home.

For purposes of Home Health Care, nurse services means intermittent home nursing care by professional registered nurses or by licensed practical nurses. Intermittent means occasional or segmented care, i.e., care that is not provided on a continuous, non-interrupted basis.

Home Health Care Plan means a formal, written plan made by the Covered Person's attending Physician which is evaluated on a regular basis. It must state the diagnosis, certify that the Home Health Care is in place of Hospital confinement, and specify the type and extent of Home Health Care required for the treatment of the Covered Person.

Hospice Care means a health care program providing a coordinated set of services rendered at home, in Outpatient settings, or in Inpatient settings for Covered Persons suffering from a condition that has a terminal prognosis. Non-curative supportive care is provided through an interdisciplinary group of personnel. A hospice must meet the standards of the National Hospice Organization and applicable state licensing.

Hospice Care Provider means an agency or organization that has Hospice Care available 24 hours a day, seven days a week; is certified by Medicare as a Hospice Care Agency, and, if required, is licensed as such by the jurisdiction in which it is located. The provider may offer skilled nursing services; medical social worker services; psychological and dietary counseling; services of a Physician; physical or occupational therapist; home health aide services; pharmacy services; and Durable Medical Equipment.

Hospital means:

- A facility that is a licensed institution authorized to operate as a Hospital by the state in which it is operating;
- Provides diagnostic and therapeutic facilities for the surgical or medical diagnosis, treatment, and care of injured and sick persons at the patient's expense; and
- Has a staff of licensed Physicians available at all times; and
- It is accredited by a recognized credentialing entity approved by CMS and/or a state or federal agency and is Qualified to receive payments under the Medicare program, or, if outside of the United States, is licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and
- It continuously provides on-premises, 24-hour nursing service by or under the supervision of a registered nurse; and
- Is not a place primarily for maintenance or Custodial Care.

For purposes of this Plan, Hospital also includes Surgical Centers and Birthing Centers licensed by the state in which it operates. Hospital does not include services provided in facilities operating as residential treatment centers.

Illness means a bodily disorder, disease, physical or mental sickness, functional nervous disorder, pregnancy, or complication of pregnancy. The term "Illness," when used in connection with a newborn Child, includes, but is not limited to, congenital defects and birth abnormalities, including premature birth.

Incurred means the date the service or treatment is given, the supply is received or the facility is used, without regard to when the service, treatment, supply or facility is billed, charged or paid.

Independent Contractor means someone who signs an agreement with the employer as an Independent Contractor or an entity or individual who performs services to or on behalf of the employer who is not an Employee or an officer of the employer and who retains control over how the work gets done. The employer who hires the Independent Contractor controls only the outcome of the work and not the performance of the hired service. Determination as to whether an individual or entity is an Independent Contractor shall be made consistent with Section § 530 of the Internal Revenue Code.

Infertility Treatment means services, tests, supplies, devices, or drugs which are intended to promote fertility, achieve a condition of pregnancy, or treat an Illness causing an infertility condition when such treatment is done in an attempt to bring about a pregnancy.

For purposes of this definition, Infertility Treatment includes, but is not limited to fertility tests and drugs; tests and exams done to prepare for induced conception; surgical reversal of a sterilized state which was a result of a previous surgery; sperm enhancement procedures; direct attempts to cause pregnancy by any means including, but not limited to: hormone therapy or drugs; artificial insemination; In vitro fertilization; Gamete Intrafallopian Transfer (GIFT), or Zygote Intrafallopian Transfer (ZIFT); embryo transfer; and freezing or storage of embryo, eggs, or semen.

Injury means a physical harm or disability to the body which is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. Injury does not include Illness or infection of a cut or wound.

Inpatient means a registered bed patient using and being charged for room and board at a Hospital or in a Hospital for 24 hours or more. A person is not an Inpatient on any day on which he or she is on leave or otherwise gone from the Hospital, whether or not a room and board charge is made.

Late Enrollee means a person who enrolls under this Plan other than on:

- The earliest date on which coverage can become effective under the terms of this Plan; or
- A special Enrollment Date for the person as defined by HIPAA.

Learning Disability means a group of disorders that results in significant difficulties in one or more of seven areas including: basic reading skills, reading comprehension, oral expression, listening comprehension, written expression, mathematical calculation, and mathematical reasoning. Specific Learning Disabilities are diagnosed when the individual's achievement on standardized tests in a given area is substantially below that expected for age, schooling, and level of intelligence.

Legal Guardianship / Legal Guardian means an individual recognized by a court of law as having the duty of taking care of a person and managing the individual's property and rights.

Maximum Benefit means the maximum amount or the maximum number or days or treatments that are considered a Covered Expense by the Plan.

Medically Necessary / Medical Necessity means health care services provided for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury, mental illness, substance use disorder, condition, disease or its symptoms, that are all of the following as determined by us or our designee, within our sole discretion:

- In accordance with *Generally Accepted Standards of Medical Practice*; and
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for Your Illness, Injury, mental illness, substance use disorder, disease or its symptoms; and
- Not mainly for Your convenience or that of Your doctor or other health care provider; and
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of Your Illness, Injury, disease or symptoms

The fact that a Physician has performed, prescribed, recommended, ordered, or approved a service, treatment plan, supply, medicine, equipment or facility, or that it is the only available procedure or treatment for a condition, does not, in itself, make the utilization of the service, treatment plan, supply, medicine, equipment or facility Medically Necessary.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a casual relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within our sole discretion.

UnitedHealthcare Clinical Services develops and maintains clinical policies that describe the Generally Accepted Standards of medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by UnitedHealthcare Clinical Services and revised from time to time), are available to Covered Persons by calling UMR at the telephone number on Your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.com.

Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act as amended.

Mental Health Disorder means disorders that are clinically significant psychological syndromes associated with distress, dysfunction or Illness. The syndrome must represent a dysfunctional response to a situation or event that exposes the Covered Person to an increased risk of pain, suffering, conflict, Illness or death.

Morbid Obesity means a Body Mass Index (BMI) that is greater than or equal to 30 kg/m². If there are serious (life-threatening) medical condition(s) exacerbated by, or caused by obesity not controlled despite maximum medical therapy and patient compliance with medical treatment plan, a BMI greater than or equal to 30 kg/m² is applied. Morbid Obesity for a Covered Person who is less than 19 years of age means a BMI that falls above the 95th percentile on the growth chart.

Multiple Surgical Procedures means when more than one surgical procedure is performed during the same period of anesthesia.

Negotiated Rate means the amount that providers have contracted to accept a payment in full for Covered Expenses of the Plan.

Non-Essential Health Benefit means any medical benefit that is not an Essential Health Benefit. Please refer to the "Essential Health Benefit" definition.

Orthognathic Condition means a skeletal mismatch of the jaw (such as when one jaw is too large or too small, too far forward or too far back). An Orthognathic Condition may cause overbite, underbite, or open bite. Orthognathic surgery may be performed to correct skeletal mismatches of the jaw.

Orthotic Appliances means braces, splints, casts and other appliances used to support or restrain a weak or deformed part of the body and is designed for repeated use, intended to treat or stabilize a Covered Person's Illness or Injury or improve function; and generally is not useful to a person in the absence of an Illness or Injury.

Outpatient means medical care, treatment, services or supplies in a facility in which a patient is not registered as a bed patient and room and board charges are not Incurred.

Palliative Foot Care means the cutting or removal of corns or calluses unless at least part of the nail root is removed or unless needed to treat a metabolic or peripheral vascular disease; the trimming of nails; other hygienic and preventative maintenance care or debridement, such as cleaning and soaking of the feet, and the use of skin creams to maintain the skin tone of both ambulatory and non-ambulatory Covered Persons; and any services performed in the absence of localized Illness, Injury, or symptoms involving the foot.

Physician means any of the following licensed practitioners, acting within the scope of their license in the state in which they practice, who perform services payable under this Plan: a doctor of medicine (MD), doctor of dental medicine including oral surgeons (DMD), osteopathy (DO), podiatry (DPM), dentistry (DDS), chiropractic (DC), optometry (OPT), a physician's assistant (PA), a nurse practitioner (NP), a certified nurse midwife (CNM), or a certified registered nurse anesthetist (CRNA). The term Physician also may include, at the Plan Sponsor's discretion, other licensed practitioners who are regulated by a state or federal agency, who perform services payable under this Plan, and who are acting within the scope of their license, unless specifically excluded by this Plan.

Placed or Placement for Adoption means the assumption and retention of a legal obligation for total or partial support of a Child in anticipation of adoption of such Child. The Child's placement with the person terminates upon the termination of such legal obligation.

Plan means the UNIVERSITY OF ARKANSAS Medical Benefit Plan.

Plan Participation means that the Covered Person and the Plan each pay a percentage of the Covered Expenses as listed on the Schedule of Benefits, after the Covered Person pays the Deductible(s).

Plan Sponsor means The University of Arkansas.

Prescription means any order authorized by a medical professional for a Prescription or non-prescription drug that could be a medication or supply for the person for whom prescribed. The Prescription must be compliant with applicable laws and regulations and identify the name of the medical professional and the name of the person for whom it is prescribed. It must also identify the name, strength, quantity, and directions for use of the medication or supply prescribed.

Preventive / Routine Care means a prescribed standard procedure that is ordered by a Physician to evaluate or assess the Covered Person's health and well-being, screen for possible detection of unrevealed Illness or Injury, improve the Covered Person's health, or extend the Covered Person's life expectancy. Generally, a procedure is routine if there is no personal history of the Illness or Injury for which the Covered Person is being screened, except as required by applicable law. Benefits included as Preventive/Routine Care are listed in the Schedule of Benefits and will be paid subject to any listed limits or maximums. Whether an immunization is considered Preventive/Routine is based upon the recommendations of the Center for Disease Control and Prevention. Preventive/Routine Care does not include benefits specifically excluded by this Plan, or treatment after the diagnosis of an Illness or Injury, except as required by applicable law.

Primary Care Physician means a family practitioner, general practitioner, nurse practitioner, physician's assistant, non-specializing internist (i.e., those that work out of a family practice clinic), pediatrician or obstetrician/gynecologist and geriatric. Generally, these Physicians provide a broad range of services. For instance, family practitioners treat a wide variety of conditions for all family members; general practitioners give routine medical care; internist treat routine and complex conditions in adults; and pediatricians treat Children.

Prudent Layperson means a person with average knowledge of health and medicine who is not formally educated or specialized in the field of medicine.

QMCSO means a Qualified Medical Child Support Order in accordance with applicable law.

Qualified means licensed, registered or certified by the state in which the provider practices.

Reconstructive Surgery means surgical procedures performed on abnormal structures of the body caused by congenital Illness or anomaly, Accident, or Illness. The fact that physical appearance may change or improve as a result of Reconstructive Surgery does not classify surgery as Cosmetic when a physical impairment exists and the surgery restores or improves function.

Retired Employee (Retiree) means an eligible Employee who retires while covered under the Plan and on the date of retirement has age and continuous years of service equal to at least a total of seventy (70) and immediately prior to retirement has completed ten (10) or more consecutive years of continuous coverage under the Plan or who has retired under an early retirement agreement approved by the University of Arkansas System.

Significant Break in Coverage means a period of 63 consecutive days during which a person does not have any Creditable Coverage.

SmartCare option is currently available only to UAMS Employees and Retirees and their eligible Dependents who receive care at UAMS and through a UAMS provider. Not all services at UAMS are provided by UAMS and are not eligible for SmartCare.

Specialist means a provider who treats specific medical conditions. For instance, a neurologist treats nervous disorders, a gastroenterologist treats digestive problems, and an oncologist treats cancer patients. Providers that are not considered a Specialist include, but are not limited to, family practitioners, non-specializing internists, pediatricians, or obstetricians/gynecologists.

Surgical Center means a licensed facility that is under the direction of an organized medical staff of Physicians; has facilities that are equipped and operated primarily for the purpose of performing surgical procedures; has continuous Physician services and registered professional nursing services available whenever a patient is in the facility; generally does not provide Inpatient services or other accommodations; and offers the following services whenever a patient is in the center:

- It provides drug services as needed for medical operations and procedures performed;
- It provides for the physical and emotional well-being of the patients;
- It provides Emergency services;
- It has organized administration structure and maintains statistical and medical records.

Telemedicine means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data and education using interactive audio, video, or data communications.

Temporomandibular Joint Disorder (TMJ) means a disorder of the jaw joint(s) and/or associated parts resulting in pain or inability of the jaw to function properly.

Terminal Illness or Terminally Ill means a life expectancy of about six months.

Third Party Administrator (TPA) means a service provider hired by the Plan to process claims and perform other administrative services. The TPA does not assume liability for payment of benefits under this Plan.

Totally Disabled is determined by the Plan in its sole discretion and generally means:

- That an Employee is prevented from engaging in any job or occupation for wage or profit for which the Employee is Qualified by education, training or experience; or
- That a covered Dependent has been diagnosed with a physical, psychiatric, or developmental disorder, or some combination thereof, and as a result cannot engage in Activities of Daily Living and/or substantial gainful activities that a person of like age and sex in good health can perform, preventing an individual from attaining self-sufficiency.
- Diagnosis of one or more of the following conditions is not considered proof of Total Disability. Conditions are listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) or the International Classification of Disease – Clinical Modification manual (most recent revision) (ICD-CM) in the following categories:
 - Personality disorders; or
 - Sexual/gender identity disorders; or
 - Behavior and impulse control disorders; or
 - “V” codes.

Urgent Care means the delivery of ambulatory care in a facility dedicated to the delivery of care outside of a Hospital Emergency department, usually on an unscheduled, walk-in basis. Urgent Care centers are primarily used to treat patients who have Injuries or Illnesses that require immediate care but are not serious enough to warrant a visit to an Emergency room. Often Urgent Care centers are not open on a continuous basis, unlike a Hospital Emergency room that would be open at all times.

Usual and Customary means the amount the Plan determines to be the reasonable charge for comparable services, treatment, or materials in a Geographical Area. In determining whether charges are Usual and Customary, due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual or extenuating circumstances. **Geographical Area** means a zip code area, or a greater area if the Plan determines it is needed to find an appropriate cross-section of accurate data.

You / Your means the Employee.