ARKANSAS HEALTH AND WELLNESS SOLUTIONS
AMBETTER OF ARKANSAS

[Home Office: One Allied Drive, Building One, Suite 1400, Little Rock, AR, 72202]

Major Medical Expense Insurance Policy

In this *policy, "you"* or *"your"* will refer to the *covered person* named on the Schedule of Benefits, and *"we," "our,"* or *"us"* will refer to Arkansas Health & Wellness Solutions.

AGREEMENT AND CONSIDERATION

We issued this *policy* in consideration of the application and the payment of the first premium. *We* will pay benefits to *you*, the *covered person*, for covered benefits as outlined in this *policy*. Benefits are subject to *policy* definitions, provisions, limitations and exclusions.

GUARANTEED RENEWABLE

You may keep this *policy* in force by timely payment of the required premiums. However, *we* may refuse renewal if: (1) *we* refuse to renew all policies issued on this form, with the same type and level of benefits, to residents of the state where *you* then live; or (2) there is fraud or an intentional material misrepresentation made by or with the knowledge of a *covered person* in filing a claim for *policy* benefits.

Annually, *we* may change the rate table used for this *policy* form. Each premium will be based on the rate table in effect on that premium's due date. The policy plan, and age of *covered persons,* type and level of benefits, and place of residence on the premium due date are some of the factors used in determining *your* premium rates. We have the right to change premiums.

At least thirty-one (31) days' notice of any plan to take an action or make a change permitted by this clause will be delivered to *you* at *your* last address as shown in *our* records. *We* will make no change in *your* premium solely because of claims made under this *policy* or a change in a *covered person's* health. While this *policy* is in force, *we* will not restrict coverage already in force.

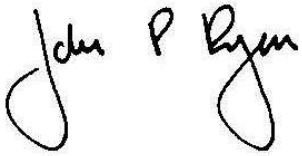
As a cost containment feature, this policy contains prior authorization requirements. This contract may require a referral from a primary care physician for care from a specialist provider. Benefits may be reduced or not covered if the requirements are not met. Please refer to the Schedule of Benefits and the Prior Authorization Section.

You are required to enroll each year in order to receive any subsidies for which *you* may be eligible.

Celtic Insurance Company,

Anand Shukla
SVP, Individual Health

Arkansas Health & Wellness,



John Ryan
CEO and Plan President

Member Services Department: [1-877-617-0390]
TDD/TTY [1-877-617-0392] **Log on to:** [www.ambetterofarkansas.com]

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INTRODUCTION

Welcome to Ambetter of Arkansas! This *contract* has been prepared by *us* to help explain *your* coverage. Please refer to this *contract* whenever *you* require medical services. It describes:

- How to access medical care.
- What health services are covered by *us*.
- What portion of the health care costs *you* will be required to pay.

This *contract*, the Schedule of Benefits, the application as submitted to the exchange and any amendments or riders attached shall constitute the entire contract under which *covered services* and supplies are provided or paid for by *us*.

This *contract* should be read and re-read in its entirety. Since many of the provisions of this *contract* are interrelated, you should read the entire *contract* to get a full understanding of your coverage. Many words used in the *contract* have special meanings, are *italicized* and are defined for you. Refer to these definitions in the Definitions section for the best understanding of what is being stated. This *contract* also contains exclusions, so please be sure to read this *contract* carefully.

How to Contact Us
Arkansas Health & Wellness Solutions
Ambetter of Arkansas
One Allied Drive
Building One, Ste. 1400
Little Rock, AR 72202

Normal Business Hours of Operation 8:00 a.m. to 5:00 p.m. CST

Member Services 1- 877-617-0390
TDD/TTY line 1-877-617-0392
Fax 1-877-617-0393
Emergency **911**
24/7 Nurse Advice Line 1- 877-617-0390

Interpreter Services
Ambetter of Arkansas has a free service to help *our members* who speak languages other than English. This service is very important because *you* and your *physician* must be able to talk about *your* medical or behavioral health concerns in a way *you* both can understand. *Our* interpreter services are provided at no cost to *you*. We have representatives that speak Spanish and also have medical interpreters to assist with other languages. *Members* who are blind or visually impaired and need help with interpretation can call Member Services for an oral interpretation.

To arrange for interpretation services, call Member Services at 1- 877-617-0390 (TDD/TTY 1-877-617-0392).

MEMBER RIGHTS AND RESPONSIBILITIES

We are committed to:

1. Recognizing and respecting *you* as a *member*.
2. Encouraging open discussions between you, *your physician* and *medical practitioners*.
3. Providing information to help *you* become an informed health care consumer.
4. Providing access to *covered services* and *our network providers*.
5. Sharing *our* expectations of *you* as a *member*.
6. Providing coverage regardless of age, ethnicity or race, religion, gender, sexual orientation, national origin, physical or mental disability, and/or expected health or genetic status.

You have the right to:

1. Participate with *your physician* and *medical practitioners* in making decisions about *your* health care. This includes working on any treatment plans and making care decisions. *You* should know any possible risks, problems related to recovery, and the likelihood of success. *You* shall not have any treatment without consent freely given by *you* or your legally authorized surrogate decision-maker. *You* will be informed of *your* care options.
2. Know who is approving and who is performing the procedures or treatment. All likely treatment and the nature of the problem should be explained clearly.
3. Receive the benefits for which *you* have coverage.
4. Be treated with respect and dignity.
5. Privacy of *your* personal health information, consistent with state and federal laws, and *our* policies.
6. Receive information or make recommendations, including changes, about *our* organization and services, *our* network of *physicians* and *medical practitioners*, and *your* rights and responsibilities.
7. Candidly discuss with *your physician* and *medical practitioners* appropriate and *medically necessary* care for *your* condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from your *primary care physician* about what might be wrong (to the level known), treatment and any known likely results. Your *primary care physician* can tell you about treatments that may or may not be covered by the plan, regardless of the cost. *You* have a right to know about any costs *you* will need to pay. This should be told to *you* in words *you* can understand. When it is not appropriate to give *you* information for medical reasons, the information can be given to a legally authorized person. *Your physician* will ask for your approval for treatment unless there is an *emergency* and your life and health are in serious danger.
8. Make recommendations regarding member's rights, responsibilities and policies.
9. Voice complaints or *grievances* about: *our* organization, any benefit or coverage decisions *we* (or *our* designated administrators) make, *your* coverage, or care provided.
10. Refuse treatment for any condition, *illness* or disease without jeopardizing future treatment, and be informed by *your physician*(s) of the medical consequences.
11. See *your* medical records.

12. Be kept informed of *covered* and non-covered *services*, program changes, how to access services, *primary care physician* assignment, providers, advance directive information, referrals and authorizations, benefit denials, member rights and responsibilities, and *our* other rules and guidelines. *We* will notify *you* at least 60 days before the *effective date* of the modifications. Such notices shall include:
    a. Any changes in clinical review criteria; or
    b. A statement of the effect of such changes on the personal liability of the *member* for the cost of any such changes.
13. A current list of *network providers*.
14. Select a health plan or switch health plans, within the guidelines, without any threats or harassment.
15. Adequate access to qualified *medical practitioners* and treatment or services regardless of age, race, creed, sex, sexual preference, national origin or religion.
16. Access *medically necessary* urgent and *emergency* services 24 hours a day and seven days a week.
17. Receive information in a different format in compliance with the Americans with Disabilities Act, if *you* have a disability.
18. Refuse treatment to the extent the law allows. *You* are responsible for *your* actions if treatment is refused or if the *primary care physician*'s instructions are not followed. *You* should discuss all concerns about treatment with your *primary care physician*. *Your primary care physician* can discuss different treatment plans with *you*, if there is more than one plan that may help *you*. *You* will make the final decision.
19. Select *your primary care physician* within the *network*. *You* also have the right to change your *primary care physician* or request information on *network providers* close to your home or work.
20. Know the name and job title of people giving you care. *You* also have the right to know which *physician* is your *primary care physician*.
21. An interpreter when *you* do not speak or understand the language of the area.
22. A second opinion by a *network provider*, at no cost to *you*, or non- *network provider*, in which *you* will be responsible for up to 40 percent of the out-of-network cost, if *you* believe your *network provider* is not authorizing the requested care, or if *you* want more information about *your* treatment.
23. Make advance directives for healthcare decisions. This includes planning treatment before *you* need it.
24. Advance directives are forms *you* can complete to protect *your* rights for medical care. It can help your *primary care physician* and other providers understand *your* wishes about your health. Advance directives will not take away *your* right to make *your* own decisions and will work only when *you* are unable to speak for yourself. Examples of advance directives include:
    a. Living Will;
    b. Health Care Power of Attorney; and
    c. "Do Not Resuscitate" Orders. Members also have the right to refuse to make advance

directives. *You* should not be discriminated against for not having an advance directive.

You have the responsibility to:

1. Read this *contract* in its entirety.
2. Treat all health care professionals and staff with courtesy and respect.
3. Give accurate and complete information about present conditions, past illnesses, hospitalizations, medications, and other matters about *your* health. *You* should make it known whether *you* clearly understand *your* care and what is expected of *you*. *You* need to ask questions of your *physician* until *you* understand the care *you* are receiving.
4. Review and understand the information *you* receive about *us*. *You* need to know the proper use of *covered services*.
5. Show *your* I.D. card and keep scheduled appointments with *your physician*, and call the *physician*'s office during office hours whenever possible if *you* have a delay or cancellation.
6. Know the name of *your* assigned *primary care physician*. *You* should establish a relationship with *your physician*. *You* may change *your primary care physician* verbally or in writing by contacting *our* Member Services Department.
7. Read and understand to the best of *your* ability all materials concerning *your* health benefits or ask for help if *you* need it.
8. Understand *your* health problems and participate, along with *your* health care professionals and *physicians* in developing mutually agreed upon treatment goals to the degree possible.
9. Supply, to the extent possible, information that *we* and/or *your* health care professionals and *physicians* need in order to provide care.
10. Follow the treatment plans and instructions for care that *you* have agreed on with *your* health care professionals and *physician*.
11. Tell *your* health care professional and *physician* if *you* do not understand *your* treatment plan or what is expected of *you*. *You* should work with your *primary care physician* to develop treatment goals. If *you* do not follow the treatment plan, *you* have the right to be advised of the likely results of *your* decision.
12. Follow all health benefit plan guidelines, provisions, policies and procedures.
13. Use any emergency room only when *you* think you have a medical *emergency*. For all other care, *you* should call *your primary care physician*.
14. When *you* enroll in this coverage, give all information about any other medical coverage *you* have. If, at any time, *you* get other medical coverage besides this coverage, *you* must tell *us*.
15. Pay *your* monthly premium, all *deductible amounts, copayment amounts*, or *cost-sharing percentages* at the time of service.
16. Inform the entity in which *you* enrolled for this policy if *you* have any changes to *your* name, address, or family members covered under this *contract.*

Your Provider Directory
A listing of *network providers* is available online at www.ambetterofarkansas.com. *We* have plan *physicians*, *hospitals*, and other *medical practitioners* who have agreed to provide *you* healthcare services. You can find any of our *network providers* by visiting our website and selecting the "Find a Provider" function. There *you* will have the ability to narrow *your* search by provider specialty, zip code, gender, whether or not they are currently accepting new patients, and languages spoken. *Your* search will produce a list of providers based on *your* search criteria and will give *you* other information such as address, phone number, office hours, and qualifications.

At any time, you can request a printed copy of the provider directory at no charge by calling Member Services at 1- 877-617-0390. In order to obtain benefits, *you* must designate a *network primary care physician* for each *member. We* can also help *you* pick a *primary care physician* (PCP). We can make your choice of *primary care physician* effective on the next business day.

Call the *primary care physician*'s office if you want to make an appointment. If *you* need help, call Member Services at 1- 877-617-0390. *We* will help *you* make the appointment.

Your Member ID Card
When *you* enroll, *we* will mail you a member ID card within 5 business days of *our* receipt of *your* completed enrollment materials. This card is proof that *you* are enrolled in an Ambetter plan and is valid once your binder payment has been paid and enrollment processing is complete. *You* need to keep this card with *you* at all times. Please show this card every time *you* go for any service under the *contract*. The ID card will show *your* name, *member* ID#, the phone number for Behavioral Health services, and *copayment amounts* required at the time of service. If *you* do not get your ID card within a few weeks after *you* enroll, please call Member Services at 1- 877-617-0390. *We* will send *you* another card.

Our Website
Our website helps *you* get the answers to many of *your* frequently asked questions. *Our* website has resources and features that make it easy to get quality care. *Our* website can be accessed at www.ambetterofarkansas.com. It also gives *you* information on *your* benefits and services such as:

1. Finding a *provider*.
2. Programs to help *you* get and stay healthy.
3. A secure online member account for *you* to check the status of *your* claims.
4. Online form submission.
5. Member Rights and Responsibilities.
6. Notice of Privacy.
7. Current events and news with your Ambetter plan.
8. Deductible and Co-payment Accumulators.
9. Making your payment.

Quality Improvement
We are committed to providing quality healthcare for *you* and *your* family. *Our* primary goal is to improve *your* health and help *you* with any illness or disability. *Our* program is consistent with National Committee

on Quality Assurance (NCQA) standards and Institute of Medicine (IOM) priorities. To help promote safe, reliable, and quality healthcare, *our* programs include:

1. Conducting a thorough check on *physicians* when they become part of the *provider network*.
2. Monitoring *member* access to all types of healthcare services.
3. Providing programs and educational items about general healthcare and specific diseases.
4. Sending reminders to *members* to get annual tests such as a physical exam, cervical cancer screening, breast cancer screening, and immunizations.
5. Monitoring the quality of care and developing action plans to improve the healthcare *you* are receiving.
6. A Quality Improvement Committee which includes *network providers* to help us develop and monitor our program activities.
7. Investigating any *member* concerns regarding care received.

For example, if *you* have a concern about the care *you* received from your *network physician* or service provided by *us*, please contact the Member Services Department.

We believe that getting *member* input can help make the content and quality of *our* programs better. *We* conduct a *member* survey each year that asks questions about *your* experience with the healthcare and services *you* are receiving.

DEFINITIONS

In this policy, italicized words are defined. Words not italicized will be given their ordinary meaning.

Wherever used in this policy:

Abortion means the use or prescription of any instrument, medicine, drug, or any other substance or device intentionally to terminate the pregnancy of a woman known to be pregnant with an intention other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, or to remove a dead unborn child who died as the result of natural causes, accidental trauma, or a criminal assault on the pregnant woman or her unborn child.

Acute rehabilitation means two or more different types of therapy provided by one or more rehabilitation medical practitioners and performed for three or more hours per day, five (5) to seven (7) days per week, while the covered person is confined as an inpatient in a hospital, *rehabilitation facility*, or *skilled nursing facility*.

Advance premium tax credit means the tax credit provided by the Affordable Care Act to help you afford health coverage purchased through the Exchange. Advance payments of the tax credit can be used right away to lower your monthly premium costs. If you qualify, you may choose how much advance credit payments to apply to your premiums each month, up to a maximum amount. If the amount of advance credit payments you get for the year is less than the tax credit you're due, you'll get the difference as a refundable credit when you file your federal income tax return. If your advance payments for the year are more than the amount of your credit, you must repay the excess advance payments with your tax return.

Adverse benefit determination means:

1. Any claim denial, reduction, or termination of, or a failure to provide, or make payment in whole or in part for a benefit, including:
    a. Deductible credits; coinsurance; copayment amounts; network provider reductions or exclusions, or other cost sharing requirements;
    b. Any instance where the plan pays less than the total expenses submitted resulting in claimant responsibility;
    c. A benefit resulting from the application of any utilization review;
    d. A covered benefit that is otherwise denied as not medically necessary or appropriate;
    e. A covered benefit that is otherwise denied as experimental or investigational;
2. Any denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's eligibility to participate in the plan, including any decision to deny coverage at the time of application; and
3. Any *rescission* of coverage whether or not the *rescission* has an adverse effect on any particular benefit at that time.

Regarding the independent review procedures, this includes the denial of a request for a referral for out-of-network services when the claimant requests health care services from a provider that does not participate

in the provider network because the clinical expertise of the provider may be medically necessary for treatment of the claimant's medical condition and that expertise is not available in the provider network.

Allogeneic bone marrow transplant or ***BMT*** means a procedure in which bone marrow from a related or non-related donor is infused into the transplant recipient and includes peripheral blood stem cell transplants.

Applied Behavioral Analysis means the design, implementation, and evaluation of environmental modifications by a board-certified behavior analyst using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Autism spectrum disorder means any of the pervasive developmental disorders as defined by the most recent edition of the "Diagnostic and Statistical Manual of Mental Disorders", including: autistic disorder; Asperger's disorder; and pervasive developmental disorder not otherwise specified.

Autologous bone marrow transplant or ***ABMT*** means a procedure in which the bone marrow infused is derived from the same person who is the transplant recipient and includes peripheral blood stem cell transplants.

Bereavement counseling means counseling of members of a deceased person's *immediate family* that is designed to aid them in adjusting to the person's death.

Calendar Year is the period beginning on the initial effective date of this *policy* and ending December 31 of that year. For each following year it is the period from January 1 through December 31.

Case Management is a program in which a registered nurse, known as a case manager, assists a *member* through a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options and health care benefits available to a *member*. Case management is instituted at the sole option of us when mutually agreed to by the *member* and the *member's physician*.

Communications made by a *physician* responsible for the direct care of a member in case management with involved health care providers are covered.

Coinsurance is the percentage of *covered expenses* that must be paid by *you* after the *deductible.* This percentage is shown on the Schedule of Benefits.

Coinsurance percentage means the percentage of *covered expenses* that are payable by *us*.

Complaint means any expression of dissatisfaction expressed to the insurer by the claimant, or a claimant's authorized representative, about an insurer or its providers with whom the insurer has a direct or indirect contract.

Complications of pregnancy means:

1. Conditions whose diagnoses are distinct from pregnancy, but are adversely affected by pregnancy or are caused by pregnancy and not, from a medical viewpoint, associated with a normal pregnancy. This includes: ectopic pregnancy, spontaneous abortion, eclampsia, missed abortion, and similar medical and surgical conditions of comparable severity; but it does not include: false labor, preeclampsia, edema, prolonged labor, physician prescribed rest during the period of pregnancy, morning sickness, and conditions of comparable severity associated with management of a difficult pregnancy, and not constituting a medically classifiable distinct complication of pregnancy; and
2. An *emergency* caesarean section or a *non-elective caesarean section*.

Continuous loss means that *covered expenses* are continuously and routinely being incurred for the active treatment of an *illness* or *injury*. The first *covered expense* for the *illness* or *injury* must have been incurred before insurance of the *covered person* ceased under this *policy*. Whether or not *covered expenses* are being incurred for the active treatment of the covered *illness* or *injury* will be determined by *us* based on generally accepted current medical practice.

Copayment amount means the amount of *covered expenses* that must be paid by a *covered person* for each service that is subject to a *copayment amount* (as shown in the Schedule of Benefits), before benefits are payable for remaining *covered expenses* for that service under the *policy*.

Cosmetic treatment means treatments, procedures, or services that change or improve appearance without significantly improving physiological function and without regard to any asserted improvement to the psychological consequences or socially avoidant behavior resulting from an *injury*, *illness*, or congenital anomaly.

Cost-sharing reductions means reductions in cost sharing for an eligible individual enrolled in a silver level plan in the Exchange or for an individual who is an American Indian and/or Alaskan Native enrolled in a *QHP* in the Exchange.

Covered expense means an expense that is:

1. Incurred while *your* or *your dependent's* insurance is in force under this *policy*;
2. Covered by a specific benefit provision of this *policy*; and
3. Not excluded anywhere in this *policy*.

Covered person means *you*, *your* lawful *spouse* and each *eligible child*:

1. Named in the application; or
2. Whom *we* agree in writing to add as a *covered person*.

Craniofacial anomaly means a congenital or acquired musculoskeletal disorder that primarily affects the cranial facial tissue.

Craniofacial corrective surgery means the use of surgery to alter the form and function of the cranial facial tissues due to a congenital or acquired musculoskeletal disorder.

Custodial care is treatment designed to assist a *covered person* with activities of daily living and which can be provided by a layperson and not necessarily aimed at curing or assisting in recovery from a sickness or bodily injury.

Custodial care includes but is not limited to the following:

1. Personal care such as assistance in walking, getting in and out of bed, dressing, bathing, feeding and use of toilet;
2. Preparation and administration of special diets;
3. Supervision of the administration of medication by a caregiver;
4. Supervision of self-administration of medication; or
5. Programs and therapies involving or described as, but not limited to, convalescent care, rest care, sanatoria care, educational care or recreational care.

Such treatment is custodial regardless of who orders, prescribes or provides the treatment.

Deductible amount means the amount of *covered expenses subject to deductible*, shown in the *Schedule of Benefits*, that must actually be paid during any calendar year before any benefits are payable. The family *deductible amount* is two times the individual *deductible amount*. For family coverage, the family deductible amount can be met with the combination of any one or more covered persons' eligible expenses.

Dental expenses means *surgery* or services provided to diagnose, prevent, or correct any ailments or defects of the teeth and supporting tissue and any related supplies or oral appliances. Expenses for such treatment are considered *dental expenses* regardless of the reason for the services.

Dependent means *your* lawful *spouse* and/or an *eligible child*.

Durable medical equipment means items that are used to serve a specific diagnostic or therapeutic purpose in the treatment of an *illness* or *injury*, can withstand repeated use, are generally not useful to a person in the absence of *illness* or *injury*, and are appropriate for use in the patient's home.

Effective date means the applicable date a *covered person* becomes insured for *covered services*.

Eligible child means the child of a covered person, if that child is less than 26 years of age. As used in this definition, "child" means:

1. A natural child;
2. A legally adopted child;
3. A child placed with *you* for adoption; or
4. A child for whom legal guardianship has been awarded to *you* or *your spouse*.

It is *your* responsibility to notify the Exchange if *your* child ceases to be an *eligible child*. *You* must reimburse *us* for any benefits that *we* pay for a child at a time when the child did not qualify as an *eligible child*.

Eligible expense means a *covered expense* as determined below.

1. For *network providers*: When a *covered expense* is received from a *network provider*, the *eligible expense* is the contracted fee with that provider.
2. For *non-network providers*:
    a. When a *covered expense* (excluding Transplant Benefits) is received from a *non-network provider* as a result of an *emergency*, the *eligible expense* is the negotiated fee, if any, that the provider has agreed to accept as payment in full (*you* will not be billed for the difference between the negotiated fee and the providers charge). However, if the provider has not agreed to accept a negotiated fee as payment in full, the eligible expense is the greatest of the following:
        i. the amount that would be paid under Medicare,
        ii. the amount for the covered service calculated using the same method we generally use to determine payments for out-of-network services, or
        iii. the contracted amount paid to in-network providers for the covered service. If there is more than one contracted amount with in-network providers for the covered service, the amount is the median of these amounts.
    b. When a *covered expense* (excluding Transplant Benefits) is received from a *non-network provider* as approved or authorized by us, or because the service or supply is not of a type provided by any *network provider*, the *eligible expense* is the lesser of (1) the negotiated fee, if any, that has been mutually agreed upon by us and the provider; or the providers billed charge.
    c. Except as provided under (2)(a) and (2)(b) above, when a *covered expense* (excluding Transplant Benefits) is received from a *non-network provider*, the *eligible expense* is determined based on the lowest amount of the following:
        i. the negotiated fee that has been agreed upon by *us* and the provider (*you* may be billed for the difference between the negotiated fee and the provider's charge);
        ii. 100% of the fee Medicare allows for the same or similar services provided in the same geographical area;
        iii. The fee established by *us* by comparing rates from one or more regional or national databases or schedules for the same or similar services from a geographical area determined by *us*;
        iv. The fee charged by the provider for the services; or
        v. A fee schedule that *we* develop.
3. Transplant benefits are covered as an *eligible expense* when received by a *network provider* or by a *non-network provider*, when authorized by *us.*

Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain which requires immediate (no later than 48 hours after onset) medical or surgical care and such that an average person who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the *covered person* or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Essential health benefits provided within this Certificate are not subject to lifetime or annual dollar maximums. Certain non-essential health benefits, however, are subject to either a lifetime and/or annual dollar maximum. Essential Health Benefits are defined by federal law and refer to benefits in at least the following categories: 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.

Expedited grievance means a *grievance* where any of the following applies:

1. The duration of the standard resolution process will result in serious jeopardy to the life or health of the *claimant* or the ability of the claimant to regain maximum function;
2. In the opinion of a physician with knowledge of the claimant's medical condition, the claimant is subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *grievance*; and
3. A physician with knowledge of the claimant's medical condition determines that the *grievance* shall be treated as an *expedited grievance*.

Experimental *or* ***investigational treatment*** means medical, surgical, diagnostic, or other health care services, treatments, procedures, technologies, supplies, devices, drug therapies, or medications that, after consultation with a medical professional, *we* determine to be:

1. Under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (*FDA*) regulation, regardless of whether the trial is subject to *FDA* oversight;
2. An *unproven service;*
3. Subject to *FDA* approval, and:
    a. It does not have *FDA* approval;
    b. It has *FDA* approval only under its Treatment Investigational New Drug regulation or a similar regulation;
    c. It has *FDA* approval, but is being used for an indication or at a dosage that is not an accepted off-label use. An accepted off-label use of a *FDA*-approved drug is a use that is determined by *us* to be:
        i. Included in authoritative compendia as identified from time to time by the Secretary of Health and Human Services;
        ii. Safe and effective for the proposed use based on supportive clinical evidence in peer-reviewed medical publications; or
        iii. Not an *unproven service;* or
    d. It has *FDA* approval, but is being used for a use, or to treat a condition, that is not listed on the Premarket Approval issued by the *FDA* or has not been determined through peer reviewed medical literature to treat the medical condition of the *covered person.*
4. Experimental or investigational according to the provider's research protocols.

Items (3) and (4) above do not apply to phase III or IV *FDA* clinical trials. . Benefits are available for routine care costs that are incurred in the course of a clinical trial if the services provided are otherwise Covered Services under this Contract.

Gastric pacemaker means a medical device that uses an external programmer and implanted electrical

leads to the stomach; and transmits low-frequency, high-energy electrical stimulation to the stomach to entrain and pace the gastric slow waves to treat gastroparesis.

Gastroparesis means a neuromuscular stomach disorder in which food empties from the stomach more slowly than normal.

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.

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 medical professionals in determining whether a health care service, supply, or drug is *medically necessary* and is a *covered expense* under the *policy*. The decision to apply physician specialty society recommendations, the choice of medical professional, and the determination of when to use any such opinion, will be determined by *us*.

Grievance means any dissatisfaction with an insurer offering a health benefit plan or administration of a health benefit plan by the insurer that is expressed in writing in any form to the insurer by, or on behalf of, a claimant including any of the following:

1. Provision of services;
2. Determination to reform or rescind a policy;
3. Determination of a diagnosis or level of service required for evidence-based treatment of autism spectrum disorders; and
4. Claims practices.

Habilitative or Habilitation means ongoing, *medically necessary*, therapies provided to patients with developmental disabilities and similar conditions who need habilitation therapies to achieve functions and skills never before learned or acquired, due to a disabling condition, including services and devices that improve, maintain, and lessen the deterioration of a patient's functional status over a lifetime and on a treatment continuum.

These therapies include physical, occupational and speech therapies, developmental services and durable medical equipment for developmental delay, developmental disability, developmental speech or language disorder, developmental coordination disorder and mixed developmental disorder.

Home health aide services means those services provided by a home health aide employed by a *home health care agency* and supervised by a registered nurse, which are directed toward the personal care of a *covered person.*

Home health care means care or treatment of an *illness* or *injury* at the *covered person's* home that is:

1. Provided by a *home health care agency*; and
2. Prescribed and supervised by a *physician*.

Home health care agency means a public or private agency, or one of its subdivisions, that:

1. Operates pursuant to law as a *home health care agency*;
2. Is regularly engaged in providing *home health care* under the regular supervision of a registered nurse;
3. Maintains a daily medical record on each patient; and
4. Provides each patient with a planned program of observation and treatment by a *physician,* in accordance with existing *generally accepted standards of medical practice* for the *injury* or *illness* requiring the *home health care.*

Hospice means an institution that:
1. Provides a *hospice care program*;
2. Is separated from or operated as a separate unit of a *hospital, hospital*-related institution, *home health care agency,* mental health facility, *skilled nursing facility,* or any other licensed health care institution;
3. Provides care for the *terminally ill;* and
4. Is licensed by the state in which it operates.

Hospice care program means a coordinated, interdisciplinary program prescribed and supervised by a *physician* to meet the special physical, psychological, and social needs of a *terminally ill covered person* and those of his or her *immediate family.*

Hospital means an institution that:
1. Operates as a *hospital* pursuant to law;
2. Operates primarily for the reception, care, and treatment of sick or injured persons as *inpatients*;
3. Provides 24-hour nursing service by registered nurses on duty or call;
4. Has staff of one or more *physicians* available at all times;
5. Provides organized facilities and equipment for diagnosis and treatment of acute medical, surgical, or mental conditions either on its premises or in facilities available to it on a prearranged basis; and
6. Is not primarily a long-term care facility; a *skilled nursing facility*, nursing, rest, *custodial care*, or convalescent home; a halfway house, transitional facility, or *residential treatment facility;* a place for the aged, drug addicts, alcoholics, or runaways; a facility for wilderness or outdoor programs; or a similar establishment.

While confined in a separate identifiable *hospital* unit, section, or ward used primarily as a nursing, rest, *custodial care* or convalescent home, *rehabilitation facility*, *skilled nursing facility,* or *residential treatment facility,* halfway house, or transitional facility, a *covered person* will be deemed not to be confined in a *hospital* for purposes of this *policy*.

Illness means a sickness, disease, or disorder of a *covered person*. *Illness* does not include learning disabilities, attitudinal disorders, or disciplinary problems. All *illnesses* that exist at the same time and that are due to the same or related causes are deemed to be one *illness*. Further, if an *illness* is due to causes that are the same as, or related to, the causes of a prior *illness*, the *illness* will be deemed a continuation or recurrence of the prior *illness* and not a separate *illness*.

Immediate family means the parents, *spouse*, children, or siblings of any *covered person*, or any person residing with a *covered person*.

Injury means accidental bodily damage sustained by a *covered person* and inflicted on the body by an external force. All *injuries* due to the same accident are deemed to be one *injury*.

Inpatient means that medical services, supplies, or treatment are received by a person who is an overnight resident patient of a *hospital* or other facility, using and being charged for room and board.

Intensive care unit means a unit or area of a *hospital* that meets the required standards of the Joint Commission.

Intensive day rehabilitation means two or more different types of therapy provided by one or more *rehabilitation medical practitioners* and performed for three (3) or more hours per day, five (5) to seven (7) days per week.

Loss means an event for which benefits are payable under this *policy*. A *loss* must occur while the *covered person* is insured under this *policy*.

Listed transplant means one of the following procedures and no others:

1. Heart transplants;
2. Lung transplants;
3. Heart/lung transplants;
4. Kidney transplants;
5. Liver transplants;
6. Bone marrow transplants for the following conditions:
    a. *BMT* or *ABMT* for Non-Hodgkin's Lymphoma;
    b. *BMT* or *ABMT* for Hodgkin's Lymphoma;
    c. *BMT* for Severe Aplastic Anemia;
    d. *BMT* or *ABMT* for Acute Lymphocytic and Nonlymphocytic Leukemia;
    e. *BMT* for Chronic Myelogenous Leukemia;
    f. *ABMT* for Testicular Cancer;
    g. *BMT* for Severe Combined Immunodeficiency;
    h. *BMT* or *ABMT* for Stage III or IV Neuroblastoma;
    i. *BMT* for Myelodysplastic Syndrome;
    j. *BMT* for Wiskott-Aldrich Syndrome;
    k. *BMT* for Thalassemia Major;
    l. *BMT* or *ABMT* for Multiple Myeloma;
    m. *ABMT* for pediatric Ewing's sarcoma and related primitive neuroectodermal tumors, Wilm's tumor, rhabomyosarcoma, medulloblastoma, astrocytoma and glioma;
    n. *BMT* for Fanconi's anemia;
    o. *BMT* for malignant histiocytic disorders; and
    p. *BMT* for juvenile.

Loss of Minimum essential coverage means in the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions are satisfied at the time the coverage is terminated as a result of loss of eligibility regardless of whether the individual is eligible for or elects COBRA

continuation coverage. Loss of eligibility does not include a loss due to the failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan. Loss of eligibility for coverage includes, but is not limited to:

1. Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status such as attaining the maximum age to be eligible as a dependent child under the plan, death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
2. In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area whether or not within the choice of the individual;
3. In the case of coverage offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area whether or not within the choice of the individual, and no other benefit package is available to the individual;
4. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals as described in § 54.9802-1(d) that includes the individual;
5. In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions are satisfied at the time employer contributions towards the employee's or dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or dependent, and
6. In the case of an employee or dependent who has coverage that is COBRA continuation coverage, the conditions are satisfied at the time the COBRA continuation coverage is exhausted. An individual who satisfies the conditions for special enrollment, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions.

Managed drug limitations means limits in coverage based upon time period, amount or dose of a drug, or other specified predetermined criteria.

Maximum out-of-pocket amount is the sum of the deductible amount, prescription drug deductible amount (if applicable), *copayment amount* and *coinsurance percentage* of covered services, as shown in the Schedule of Benefits. After the *maximum out-of-pocket amount* is met for an individual, Ambetter pays 100% of eligible expenses for that individual. The family *maximum out-of-pocket amount* is two times the individual maximum out-of-pocket amount. For family coverage, the family maximum out-of-pocket amount can be met with the combination of any one or more covered persons' eligible expenses. A covered person's maximum out-of-pocket will not exceed the individual maximum out-of-pocket amount.

Maximum therapeutic benefit means the point in the course of treatment where no further improvement in a *covered person's* medical condition can be expected, even though there may be fluctuations in levels of pain and function.

Medical practitioner includes, but is not limited to, a *physician*, nurse anesthetist, physician's assistant, physical therapist, licensed mental health and substance use practitioners, nurse practitioners, audiologists, chiropractors, dentists, pharmacists, nurse anesthetists, optometrists, podiatrists,

psychologists or midwife. The following are examples of providers that are NOT *medical practitioners*, by definition of the *policy:* acupuncturist, speech therapist, occupational therapist, rolfer, registered nurse, hypnotist, respiratory therapist, X-ray technician, *emergency* medical technician, social worker, family counselor, marriage counselor, child counselor, naturopath, perfusionist, massage therapist or sociologist. With regard to medical services provided to a *covered person*, a *medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

Medically necessary or ***medical necessity*** means any medical service, supply or treatment authorized by a *physician* to diagnose and treat a *covered person*'s *illness or injury* which:

1. Is consistent with the symptoms or diagnosis;
2. Is provided according to *generally accepted standards of medical practice* ;
3. Is not *custodial care*;
4. Is not solely for the convenience of the *physician* or the *covered person*;
5. Is not *experimental or investigational*;
6. Is provided in the most cost effective care facility or setting;
7. Does not exceed the scope, duration, or intensity of that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment; and
8. When specifically applied to a *hospital* confinement, it means that the diagnosis and treatment of *your* medical symptoms or conditions cannot be safely provided as an outpatient.

Charges incurred for treatment not *medically necessary* are not *eligible expenses*.

Medically stabilized means that the person is no longer experiencing further deterioration as a result of a prior *injury* or *illness* and there are no acute changes in physical findings, laboratory results, or radiologic results that necessitate acute medical care. Acute medical care does not include *acute rehabilitation*.

Medicare opt-out practitioner means a *medical practitioner* who:

1. Has filed an affidavit with the Department of Health and Human Services stating that he, she, or it will not submit any claims to Medicare during a two-year period; and
2. Has been designated by the Secretary of that Department as a *Medicare opt-out practitioner*.

Medicare participating practitioner means a *medical practitioner* who is eligible to receive reimbursement from Medicare for treating Medicare-eligible individuals.

Member or Covered Person means an individual covered by the health plan including any enrollee, subscriber or policy holder.

Mental disorder is a behavioral, emotional or cognitive pattern of functioning in an individual that is associated with distress, suffering, or impairment in one or more areas of life – such as school, work, or social and family interactions.

Necessary medical supplies mean medical supplies that are:

1. Necessary to the care or treatment of an *injury* or *illness*;
2. Not reusable or *durable medical equipment*; and

3. Not able to be used by others.

Necessary medical supplies do not include first aid supplies, cotton balls, rubbing alcohol, or like items routinely found in the home.

Network means a group of *medical practitioners* and providers who have contracts that include an agreed upon price for health care expenses.

Network eligible expense means the *eligible expense* for services or supplies that are provided by a *network provider*. For facility services, this is the *eligible expense* that is provided at and billed by a *network* facility for the services of either a *network* or non-*network provider*. *Network eligible expense* includes benefits for *emergency* health services even if provided by a non-*network provider*.

Network provider means a *medical practitioner* or provider who is identified in the most current published list for the *network* shown on *your* identification card.

Neurologic Rehabilitation Facility means an institution licensed as such by the appropriate state agency. A neurological rehabilitation facility must:

1. be operated pursuant to law;
2. be accredited by the Joint Commission and the Commission on Accreditation of Rehabilitation Facilities;
3. be primarily engaged in providing, in addition to room and board accommodations, rehabilitation services for *severe traumatic brain injury* under the supervision of a duly licensed physician; and
4. maintain a daily progress record for each patient.

Non-elective caesarean section means:

1. A caesarean section where vaginal delivery is not a medically viable option; or
2. A repeat caesarean section.

Non-network provider means a *medical practitioner* who is NOT identified in the most current list for the *network* shown on *your* identification card. Services received from a *non-network provider* are covered at a reduced amount from those services received from a *network provider*. Please refer to your Schedule of Benefits.

Other plan means any plan or policy that provides insurance, reimbursement, or service benefits for *hospital*, surgical, or medical expenses. This includes payment under group or individual insurance policies, automobile no-fault or medical pay, homeowner insurance medical pay, premises medical pay, nonprofit health service plans, health maintenance organization subscriber contracts, self-insured group plans, prepayment plans, and Medicare when the *covered person* is enrolled in Medicare. *Other plan* will not include Medicaid.

Out-of-pocket expenses mean those expenses that a *covered person* is required to pay that: (A) qualify as *covered expenses*; and (B) are not paid or payable if a claim were made under any *other plan*.

Outpatient surgical facility means any facility with a medical staff of *physicians* that operates pursuant to law for the purpose of performing *surgical procedures*, and that does not provide accommodations for patients to stay overnight. This does not include facilities such as: acute-care clinics, *urgent care centers*, ambulatory-care clinics, free-standing emergency facilities, and *physician* offices.

Period of extended loss means a period of consecutive days:
1. Beginning with the first day on which a *covered person* is a *hospital inpatient;* and
2. Ending with the 30th consecutive day for which he or she is not a *hospital inpatient.*

Physician means a licensed medical practitioner who is practicing within the scope of his or her licensed authority in treating a bodily injury or sickness and is required to be covered by state law. A *physician* does **NOT** include someone who is related to a *covered person* by blood, marriage or adoption or who is normally a member of the *covered person's* household.

Policy when *italicized,* means this *policy* issued and delivered to *you*. It includes the attached pages, the applications, and any amendments.

Post-service claim means any claim for benefits for medical care or treatment that is not a *pre-service claim*.

Skilled nursing facility means an institution, or a distinct part of an institution, that:
1. Is licensed as a *hospital*, *skilled nursing facility*, or *rehabilitation facility* by the state in which it operates;
2. Is regularly engaged in providing 24-hour skilled nursing care under the regular supervision of a *physician* and the direct supervision of a registered nurse;
3. Maintains a daily record on each patient;
4. Has an effective utilization review plan;
5. Provides each patient with a planned program of observation prescribed by a *physician;* and
6. Provides each patient with active treatment of an *illness* or *injury*, in accordance with existing standards of medical practice for that condition.

Skilled nursing facility does not include a facility primarily for rest, the aged, treatment of *substance use, custodial care,* nursing care, or for care of *mental disorders* or the mentally incompetent.

Qualified health plan or ***QHP*** means a health plan that has in effect a certification that it meets the standards described in subpart C of part 156 issued or recognized by each Exchange through which such plan is offered in accordance with the process described in subpart K of part 155.

Qualified Individual means, with respect to an Exchange, an individual who has been determined eligible to enroll through the Exchange in a *qualified health plan* in the individual market.

Pre-service claim means any claim for benefits for medical care or treatment that requires the approval of the plan in advance of the claimant obtaining the medical care.

Pregnancy means the physical condition of being pregnant, but does not include *complications of pregnancy*.

Prescription drug means any medicinal substance whose label is required to bear the legend "RX only."

Prescription order means the request for each separate drug or medication by a *physician* or each authorized refill or such requests.

Primary care physician means a *physician* who is a family practitioner, general practitioner, pediatrician, internist, obstetrician or gynecologist.

Proof of loss means information required by *us* to decide if a claim is payable and the amount that is payable. It includes, but is not limited to, claim forms, medical bills or records, other plan information, and *network* re-pricing information. *Proof of loss* must include a copy of all Explanation of Benefit forms from any other carrier, including Medicare.

Reconstructive surgery means *surgery* performed on an abnormal body structure caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease in order to improve function or to improve the patient's appearance, to the extent possible.

Rehabilitation means care for restoration including by education or training of one's prior ability to function at a level of *maximum therapeutic benefit*. This type of care must be *acute rehabilitation*, *sub-acute rehabilitation*, or *intensive day rehabilitation*, and it includes *rehabilitation therapy.* An *inpatient* hospitalization will be deemed to be for *rehabilitation* at the time the patient has been *medically stabilized* and begins to receive *rehabilitation therapy.*

Rehabilitation facility means an institution or a separate identifiable *hospital* unit, section, or ward that:

1. Is licensed by the state as a *rehabilitation facility*; and
2. Operates primarily to provide 24-hour primary care or *rehabilitation* of sick or injured persons as *inpatients*.

Rehabilitation facility does not include a facility primarily for rest, the aged, long term care, assisted living, *custodial care,* nursing care, or for care of the mentally incompetent.

Rehabilitation medical practitioner means a *physician*, physical therapist, speech therapist, occupational therapist, or respiratory therapist. A *rehabilitation medical practitioner* must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

Rehabilitation therapy means physical therapy, occupational therapy, speech therapy, or respiratory therapy.

Rescission of a policy means a determination by an insurer to withdraw the coverage back to the initial date of coverage.

Residence means the physical location where *you* live. If *you* live in more than one location, and *you* file a United States income tax return, the physical address, not a P.O. Box, shown on *your* United States income tax return as *your* residence will be deemed to be *your* place of residence. If *you* do not file a United States income tax return, the *residence* where *you* spend the greatest amount of time will be deemed to be *your* place of *residence*.

Residential treatment facility means a facility that provides, with or without charge sleeping accommodations, and:

1. Is not a *hospital, skilled nursing facility,* or *rehabilitation facility;* or
2. Is a unit whose beds are not licensed at a level equal to or more acute than skilled nursing.

Respite care means home health care services provided temporarily to a *covered person* in order to provide relief to the *covered person's immediate family* or other caregiver.

Service area means a geographical area, made up of counties, where we have been authorized by the State of Arkansas to sell and market our health plans. This is where the majority of our Network Providers are located where you will receive all of your health care services and supplies. You can receive precise service area boundaries from our website or our Member Services department.

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

Specialist physician means a *physician* who is not a *primary care physician.*

Spouse means *your* lawful wife or husband.

Sub-acute rehabilitation means one or more different types of therapy provided by one or more *rehabilitation medical practitioners* and performed for one-half (1/2) hour to two (2) hours per day, five (5) to seven (7) days per week, while the *covered person* is confined as an *inpatient* in a *hospital*, *rehabilitation facility*, or *skilled nursing facility*.

Substance use means alcohol, drug or chemical abuse, overuse, or dependency.

Surgery or ***surgical procedure*** means:

1. An invasive diagnostic procedure; or
2. The treatment of a *covered person's illness* or *injury* by manual or instrumental operations, performed by a *physician* while the *covered person is under general or local anesthesia.*

Surveillance tests for ovarian cancer means annual screening using:

1. CA-125 serum tumor marker testing;
2. Transvaginal ultrasound; or
3. Pelvic examination.

Terminal illness counseling means counseling of the *immediate family* of a *terminally ill* person for the purpose of teaching the *immediate family* to care for and adjust to the *illness* and impending death of the *terminally ill* person.

Terminally ill means a *physician* has given a prognosis that a *covered person* has six (6) months or less to live.

Third party means a person or other entity that is or may be obligated or liable to the *covered person* for payment of any of the *covered person's* expenses for *illness* or *injury*. The term *"third party"* includes, but is not limited to, an individual person; a for-profit or non-profit business entity or organization; a government agency or program; and an insurance company. However, the term *"third party"* will not include any insurance company with a policy under which the *covered person* is entitled to benefits as a named insured person or an insured *dependent* of a named insured person except in those jurisdictions where statutes or common law does not specifically prohibit *our* right to recover from these sources.

Tobacco use or ***use of tobacco*** means use of tobacco by individuals who may legally use tobacco under federal and state law on average four or more times per week and within the six months immediately preceding the date application for this *policy* was completed by the *covered person*, including all tobacco products but excluding religious and ceremonial uses of tobacco.

Unproven service(s) means services, including medications, that are determined not to be effective for treatment of the medical condition, and/or not to have a beneficial effect on health outcomes, due to insufficient and inadequate clinical evidence from *well-conducted randomized controlled trials* or *well-conducted cohort studies* in the prevailing published peer-reviewed medical literature.

1. *"Well-conducted randomized controlled trials"* means that two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received; and
2. *"Well-conducted cohort studies"* means patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

Urgent care center means a facility, not including a *hospital emergency* room or a *physician's* office, that provides treatment or services that are required:

1. To prevent serious deterioration of a *covered person's* health; and
2. As a result of an unforeseen *illness, injury,* or the onset of acute or severe symptoms.

DEPENDENT COVERAGE

Dependent Eligibility
Your dependents become eligible for insurance on the latter of:

1. The date *you* became insured under this *policy;* or
2. The date of a newborns birth; or
3. The date that an adopted child is placed with the subscriber for the purposes of adoption or the subscriber assumes total or partial financial support of the child.

Effective Date for Initial Dependents
The *effective date* for *your* initial *dependents,* if any, is shown on the Schedule of Benefits. Only *dependents* included in the application for this *policy* will be covered on *your effective date*.

Coverage for a Newborn Child
An *eligible child* born to a *covered person* will automatically be covered from the time of birth provided that (1) notice of the newborn is given to us by the Marketplace within 90 days from birth, and premium billed for this 90-day period, is timely paid under the terms of this policy and its grace period after such notice. If such notice and premium payment is made, the newborn child will be covered from the time of its birth for *loss* due to *injury* and *illness*, including *loss* from complications of birth, premature birth, medically diagnosed congenital defect(s), and birth abnormalities. *Covered expense* shall also include routine nursery care and pediatric charges for a well newborn child for up to five (5) full days in a hospital nursery or until the mother is discharged from the hospital following the birth of the child, whichever is the lesser period of time.

If notice is not provided within 90 days after birth, or premium for such 90-day period is not timely paid after such notice under the terms of this policy and its grace period, coverage for the newborn will not be effective and the newborn cannot be enrolled until the next open enrollment period.

Coverage for an Adopted Child
An adopted child of a *covered person* shall be covered from the date of the filing of a petition for adoption if (1) the *covered person* applies for coverage within sixty (60) days after the filing of the petition for adoption and where the issuer is notified by the Marketplace and (2) premium billed for this 60-day period is timely paid under the terms of this policy and its grace period after such application. However, the coverage shall begin from the moment of birth if (1) the petition for adoption and application for coverage is filed within sixty (60) days after the birth of the child, and (2) premium billed for this 60-day period is timely paid under the terms of this policy and its grace period after such application. The child will be covered for *loss* due to *injury* and *illness*, including *medically necessary* care and treatment of conditions existing prior to the date of *placement.*

Unless an application is received within 60 days of petition of adoption, and premium is timely paid for the first 60 days under the terms of this policy and its grace period, coverage for the adopted child will not be effective and the adopted child cannot be enrolled until the next open enrollment period. Coverage for an adopted child shall terminate upon the dismissal or denial of a petition for adoption.

Adding Other Dependents
If *you* apply in writing for insurance on a *dependent* and *you* pay the required premiums, then the *effective date* will be shown in the written notice to *you* that the *dependent* is insured.

ONGOING ELIGIBILITY

For All Covered Persons
A *covered person's* eligibility for insurance under this *policy* will cease on the earlier of:

1. The date that a *covered person* has failed to pay premiums or contributions in accordance with the terms of this contract or the date that we have not received timely premium payments in accordance with the terms of this contract;
2. The date the member has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact (e.g., the date that a member accepts any direct or indirect contributions or reimbursement by or on behalf of an employer, for any portion of the premium for coverage under this contract;
3. The date a *member's* employer and a *member* treat this *contract* as part of an employer-provided health plan for any purpose, including tax purposes; or
4. The date *we* receive a request from *you* to terminate this *policy,* or any later date stated in *your* request, or if *you* are enrolled through an Exchange, the date of termination that the Exchange provides us upon your request of cancellation to the Exchange;
5. The date *we* decline to renew this *policy,* as stated in the Discontinuance provision;
6. The date of *a covered person's* death;
7. The date a *covered person's* eligibility for insurance under this *policy* ceases due to losing network access as the result of a permanent move.

For Dependents
A *dependent* will cease to be a *covered person* at the end of the premium period in which he or she ceases to be *your dependent* due to divorce or if a child ceases to be an *eligible child*. For *eligible children*, the Exchange will send a termination letter with an Effective Date the last day of the dependent's 26th birth month.

All enrolled *dependent members* will continue to be covered until the age limit listed in the definition of *eligible child*.

A *covered person* will not cease to be a *dependent eligible child* solely because of age if the *eligible child* is:

1. Not capable of self-sustaining employment due to mental handicap or physical handicap that began before the age limit was reached; and
2. Mainly dependent on *you* for support.

Open Enrollment
There will be an open enrollment period for coverage on the Exchange. The open enrollment period begins November 1, 2015 and extends through January 31, 2016. *Qualified Individuals* who enroll on or before to December 15, 2015 will have an effective date of coverage on January 1, 2016. *Qualified Individuals* that enroll between the first (1st) and fifteenth (15th) day of any subsequent month during the initial open enrollment period will have a coverage effective date of the first day of the following month. *Qualified Individuals* that enroll between the sixteenth and last day of the month between December 2015 and January 31, 2016, will have a coverage effective date of the first day of the second following month.

Special and Limited Enrollment
A q*ualified individual* has sixty (60) days to report a qualifying event to the Exchange and could be granted a 60 day Special Enrollment Period as a result of one of the following events:

- A q*ualified individual* or *dependent loses minimum essential coverage*;
- A *qualified individual* gains a dependent or becomes a *dependent* through marriage, birth, adoption or placement for adoption;
- An individual who was not previously a citizen, national, or lawfully present individual gains such status;
- A *qualified* individual's enrollment or non-enrollment in a q*ualified* health plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS, or its instrumentalities as evaluated and determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or agent;
- An enrollee adequately demonstrates to the Exchange that the *qualified* health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
- An *individual* is determined newly eligible or newly ineligible for *advance payments of the premium tax credit* or has a chance in eligibility for *cost-sharing reductions*, regardless of whether such individual is already enrolled in a *Qualified Health Plan*;
- A *qualified individual* or enrollee gains access to new *Qualified Health Plans* as a result of a permanent move;
- Qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended;
- An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a *Qualified Health Plan* or change from one *Qualified Health Plan* to another one time per month; or
- A *qualified individual* or enrollee demonstrates to the Exchange, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Exchange may provide.

In the case of birth, adoption or placement for adoption, the coverage is effective on the date of birth, adoption or placement for adoption.

In the case of marriage, or in the case where *qualified individual* loses minimum essential coverage, the effective date is the first day of the following month.

The Exchange may provide a coverage *effective date* for a *qualified individual* earlier than specified in the paragraphs above, provided that either:

1. The *qualified individual* has not been determined eligible for *advance payments of the premium tax credit* or *cost-sharing reductions*; or
2. The *qualified individual* pays the entire premium for the first partial month of coverage as well as all cost sharing, thereby waiving the benefit of *advance payments of the premium tax credit* and *cost-sharing reduction* payments until the first of the next month.

PREMIUMS

Premium Payment
Each premium is to be paid on or before its due date. The initial premium must be paid prior to the coverage *effective date.*

Grace Period
When a member is receiving a premium subsidy:
After the first premium is paid, a grace period of 3 months from the premium due date is given for the payment of premium. Coverage will remain in force during the grace period. If full payment of premium is not received within the grace period, coverage will be terminated as of the last day of the first month during the grace period, if advance premium tax credits are received.

We will continue to pay all appropriate claims for *covered services* rendered to the *member* during the first month of the grace period, and may pend claims for *covered services* rendered to the *member* in the second and third month of the grace period. *We* will notify HHS of the non-payment of premiums, the *member*, as well as providers of the possibility of denied claims when the *member* is in the second and third month of the grace period. *We* will continue to collect advance premium tax credits on behalf of the *member* from the Department of the Treasury, and will return the advance premium tax credits on behalf of the *member* for the second and third month of the grace period if the *member* exhausts their grace period as described above. A member is not eligible to re-enroll once terminated, unless a member has a special enrollment circumstance, such as a marriage or birth in the family or during annual open enrollment periods.

When a member is not receiving a premium subsidy:
Premium payments are due in advance, on a calendar month basis. Monthly payments are due on or before the first day of each month for coverage effective during such month. There is a one (1) month grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the Contract will stay in force; however, claims may pend for *covered services* rendered to the *member* during the grace period. *We* will notify HHS, as necessary, of the non-payment of premiums, the *member*, as well as providers of the possibility of denied claims when the *member* is in the grace period.

Misstatement of Age
If a *covered person's* age has been misstated, the premiums may be adjusted based on the premium that should have been paid, based on the correct age.

Change or Misstatement of Residence
If *you* change *your residence*, *you* must notify the Exchange of *your* new *residence* within sixty (60) days of the change. As a result your premium may change and you may be eligible for a Special Enrollment Period. See the section on Special Enrollment Periods for more information.

Misstatement of Tobacco Use
The *covered person's* answer to the tobacco question listed on the covered person's application for coverage is material to *our* determination of premium. If a *covered person's use of tobacco* has been misstated on the

covered person's application for coverage under this *policy, we* have the right to charge corrected premiums for the policy back to the original effective date.

Billing/Administrative Fees
Upon prior written notice, *we* may impose an administrative fee for credit card payments. This does not obligate *us* to accept credit card payments. *We* may charge a $20 fee for any check or automatic payment deduction that is returned unpaid.

MAJOR MEDICAL EXPENSE BENEFITS

Deductible
The *deductible amount* means the amount of *eligible expenses* that must be paid by all *covered persons* before any benefits are payable. The *deductible amoun*t does not include any *copayment amount*.

Coinsurance Percentage
We will pay the applicable *coinsurance percentage* in excess of the applicable deductible amount(s) and *copayment amount*(s) for a service or supply that:

1. Qualifies as a *covered expense* under one or more benefit provisions; and
2. Is received while the *covered person's* insurance is in force under the *policy* if the charge for the service or supply qualifies as an *eligible expense*.

When the annual out-of-pocket maximum has been met, additional *eligible expenses* will be payable at 100%.

The amount payable will be subject to:

1. Any specific benefit limits stated in the *policy*;
2. A determination of *eligible expenses*; and
3. Any reduction for expenses incurred at a *non-network provider*. Please refer to the information on the Schedule of Benefits.

The applicable *deductible amount(s), coinsurance percentage,* and *copayment amounts* are shown on the Schedule of Benefits.

Note: The bill *you* receive for services or supplies from a *non-network provider* may be significantly higher than the *eligible expenses* for those services or supplies. In addition to the *deductible amount*, *copayment amount*, and *coinsurance percentage*, *you* are responsible for the difference between the *eligible expense* and the amount the provider bills *you* for the services or supplies. Any amount *you* are obligated to pay to the provider in excess of the *eligible expense* will not apply to *your deductible amount* or *maximum out-of-pocket*.

Primary Care Physician
You may select any *network primary care physician* who is accepting new patients. You may obtain a list of *network primary care physicians* at *our* website or by contacting our Member Services department. *Your network primary care physician* will be responsible for coordinating all covered health services and making referrals for services from other *network providers. You* do not need a referral from *your network primary care physician* for obstetrical or gynecological treatment and may seek care directly from a *network* obstetrician or gynecologist.

You may change *your network primary care physician* by submitting a written request, online at *our* website, or by contacting *our* office at the number shown on *your* identification card. The change to *your network primary care physician* of record will be effective no later than 30 days from the date *we* receive *your* request.

Service Area
Arkansas Health & Wellness Solutions operates in a service area which covers the entire state. However, our service area is subject to change upon advance written notice. If you move from one county to another within the service area your premium may change. Please refer to the Premium section for more information. If you move out of Arkansas you are no longer eligible for coverage under this contract and may be eligible for enrollment into another Qualified Health Plan during a Special Enrollment Period.

Coverage Under Other Policy Provisions
Charges for services and supplies that qualify as *covered expenses* under one benefit provision will not qualify as *covered expenses* under any other benefit provision of this *policy.*

Ambulance Service Benefits
Covered expenses will include ground, air or water ambulance services for local transportation:

1. To the nearest *hospital* that can provide services appropriate to the *covered person's illness* or *injury*; or
2. To the nearest neonatal special care unit for newborn infants for treatment of *illnesses*, *injuries*, congenital birth defects, or complications of premature birth that require that level of care.

Exclusions:
No benefits will be paid for:

1. Expenses incurred for ambulance services covered by a local governmental or municipal body, unless otherwise required by law;
2. Non-*emergency* air ambulance; or
3. Ambulance services provided for a *covered person's* comfort or convenience.

Chelation Therapy
Covered expenses for chelation therapy for control of ventricular arrhythmias or heart block associated with digitalis toxicity, emergency treatment of hypercalcemia, extreme conditions of metal toxicity, including thalassemia intermedia with hemosiderosis, Wilson's disease (hepatolenticular degeneration), lead poisoning and hemochromatosis is covered.

Craniofacial Corrective Surgery and Related Expenses
Covered expenses shall include *craniofacial corrective surgery* and related medical care for a person of any age who is diagnosed as having a *craniofacial anomaly*, provided that the surgery and treatment are *medically necessary* to improve a functional impairment that results from the *craniofacial anomaly* as determined by a nationally accredited cleft-craniofacial team.

A nationally accredited cleft-craniofacial team for cleft-craniofacial conditions shall:

1. Evaluate a *covered persons* with *craniofacial anomalies*; and
2. Coordinate a treatment plan for each person.

Covered expenses may include *medically necessary* dental care, vision care, and the use of at least one (1) hearing aid, if related to the *craniofacial corrective surgery* and included in the treatment plan described above.

Durable Medical Equipment (DME), Devices and Supplies
The following are Covered Services when Medically Necessary:

Orthopedic Appliances: Orthopedic appliances, which are attached to an impaired body segment for the purpose of protecting the segment or assisting in restoration or improvement of its function.

Excluded: arch supports, including custom shoe modifications or inserts and their fittings except for therapeutic shoes, modifications and shoe inserts for severe diabetic foot disease, and orthopedic shoes that are not attached to an appliance.

Ostomy Supplies: Ostomy supplies for the removal of bodily secretions or waste through an artificial opening. Quantities that are greater than CMS guidelines may require Prior Authorization by us.

Durable Medical Equipment: Durable Medical Equipment is equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, is useful only in the presence of an illness or injury and used in the Member's home. Durable Medical Equipment includes: standard hospital beds, standard non-motorized wheelchairs, wheelchair cushion, standard walkers, crutches, canes, glucose monitors, external insulin pumps, oxygen, and oxygen equipment. All Durable Medical Equipment must receive prior authorization. We will determine if equipment is made available on a rental or purchase basis. At our option, we may authorize the purchase of the equipment in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a provider we authorize before the purchase.

Prosthetic Devices: Prosthetic devices are items which replace all or part of an external body part, or function thereof. When authorized in advance, repair, adjustment or replacement of appliances and equipment is covered.

Excluded: take-home dressings and supplies following hospitalization; any other supplies, dressings, appliances, devices or services which are not specifically listed as covered above**;** replacement or repair of appliances, devices and supplies due to loss, breakage from willful damage, neglect or wrongful use, or due to personal preference.

Diabetic Supplies: including insulin syringes, lancets, urine testing reagants, blood glucose monitoring reagants and insulin.

Electrotherapy stimulators
Covered expenses include using Transcutaneous Electrical Nerve Stimulator (TENS) to treat chronic pain due to peripheral nerve injury when that pain is unresponsive to medication.

Enteral Feedings
Coverage for enteral feedings when such have been approved and documented by a *network provider* as being the *member's* sole source of nutrition. Enteral feedings require prior authorization by *case management*.

Diabetes Care
For *medically necessary* services and supplies used in the treatment of diabetes*. Covered expenses* include, but are not limited to, exams including podiatric exams; routine foot care such as trimming of nails and corns; laboratory and radiological diagnostic testing; self-management equipment, and supplies such as urine and/or ketone strips, blood glucose monitor supplies, glucose strips for the device, and syringes or needles; orthotics and diabetic shoes; urinary protein/microalbumin and lipid profiles; educational health and nutritional counseling for self-management, eye examinations, and prescription medication.

High Frequency Chest Wall Oscillators
Covered expenses for a *member* age 17 or older with cystic fibrosis, is provided for one high frequency chest wall oscillator during such *member's* lifetime.

Inotropic Agents for Congestive Heart Failure
Covered expenses for infusion of inotropic agents where the *member* is on a cardiac transplant list at a *hospital* where there is an ongoing cardiac transplantation program.

Mental Health and Substance Use Disorder Benefits
Cenpatico Behavioral Health, LLC (Cenpatico) oversees the delivery and oversight of covered behavioral health and substance use disorder services for Arkansas Health & Wellness Solutions. If you need mental health and/or substance use disorder treatment, you do not need a referral from your PCP in order to initiate treatment. Any services beyond outpatient diagnosis, treatment, crisis stabilization, medication management, psychological and neuropsychological testing services may be provided by an outpatient hospital or other covered facility. An eligible facility will be licensed by Arkansas or the state in which it operates and be accredited by the Joint Commission, CARF International, or Council on Accreditation (COA) for the specific mental health or substance use treatment modality it is providing (for example, outpatient, intensive outpatient, partial hospitalization, or residential treatment).

Deductibles, copayment or coinsurance amounts and treatment limits for covered mental health and substance use disorder benefits will be applied in the same manner as physical health service benefits.

Covered services for mental health and substance use disorder are included on a non-discriminatory basis for all *Members* for the diagnosis and treatment of mental, emotional, and substance use disorders, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, autism spectrum disorders, and family and marital counseling. Diagnoses known as "V Codes" are eligible expenses only when billed as supporting diagnoses.

When making coverage determinations, Cenpatico utilizes established level of care guidelines and medical necessity criteria that are based on currently accepted standards of practice and take into account legal and regulatory requirements. Cenpatico utilizes "Interqual" criteria for mental health determinations and "ASAM" criteria for substance use determinations. Services should always be provided in the least

restrictive clinically appropriate setting. Any determination that requested services are not medically necessary will be made by a qualified licensed mental health professional.

Covered Inpatient, Intermediate and Outpatient mental health and/or substance use disorder services are as follows:

Inpatient

1. Inpatient treatment;
2. Diagnostic testing;
3. Inpatient detoxification treatment;
4. Observation;
5. Crisis Stabilization;
6. Electroconvulsive Therapy (ECT); and
7. Residential Treatment for Mental Health and Substance Use Disorders.

Intermediate

1. Partial Hospitalization Program (PHP).

Outpatient

1. Traditional outpatient services, including individual and group therapy services;
2. Diagnostic testing;
3. Medication management services;
4. Biofeedback;
5. Psychological Testing;
6. Applied Behavioral Analysis and Autism Spectrum disorders; and
7. Telemedicine.

Expenses for these services are covered, if medically necessary and may be subject to prior authorization. Please see the Schedule of Benefits for more information regarding services that require prior authorization and specific benefit, day or visit limits, if any.

Rehabilitation Expense Benefits

Covered expenses include expenses incurred for *rehabilitation* services, subject to the following limitations:

1. *Covered expenses* available to a *covered person* while confined primarily to receive *rehabilitation* are limited to those specified in this provision;
2. *Rehabilitation* services or confinement in a *rehabilitation facility* must begin within 14 days of a *hospital* stay of at least 3 consecutive days and be for treatment of, or *rehabilitation* related to, the same *illness* or *injury* that resulted in the *hospital* stay;
3. *Covered expenses* for *provider facility* services are limited to charges made by a *hospital* or *rehabilitation facility* for:
    a. Daily room and board and nursing services;
    b. Diagnostic testing; and
    c. Drugs and medicines that are prescribed by a *physician*, must be filled by a licensed pharmacist, and are approved by the U.S. Food and Drug Administration; and

4. *Covered expenses* for non-*provider facility* services are limited to charges incurred for the professional services of *rehabilitation medical practitioners.*
5. Outpatient physical therapy, occupational therapy, speech therapy and aural therapy for rehabilitative purposes.
6. Inpatient physical therapy, occupational therapy, speech therapy and aural therapy for rehabilitative purposes.
7. Cardiac rehabilitation, limited to 36 visits per *member* per year.

Outpatient Physical therapy, Speech therapy and Occupation therapy are limited to 30 days per *covered person* per year. Inpatient Physical therapy, Speech therapy and Occupation therapy are listed to 60 days per *covered person* per year. See the Schedule of Benefits for benefit levels or additional limits.

Care ceases to be *rehabilitation* upon *our* determination of any of the following:
1. The *covered person* has reached *maximum therapeutic benefit*;
2. Further treatment cannot restore bodily function beyond the level the *covered person* already possesses;
3. There is no measurable progress toward documented goals; and
4. Care is primarily *custodial care*.

Exclusion:
No benefits will be paid under these Rehabilitation Expense Benefits for charges for services or confinement related to treatment or therapy for *mental disorders* or *substance use*.

Definition:
As used in this provision, *"provider facility"* means a *hospital, rehabilitation facility*, or *skilled nursing facility*.

Neurological Rehabilitation Facility Services
Covered expenses for *neurologic rehabilitation facility* services are limited to:
1. The *member* must be suffering from *severe traumatic brain injury*;
2. The admission must be within 7 days of release from a *hospital*;
3. Prior authorization must be given with written approval of the admission to the *neurologic rehabilitation facility* prior to the *member* receiving *neurologic rehabilitation facility* services; and
4. The *neurologic rehabilitation facility* services are of a temporary nature with a potential to increase ability to function.

Exclusions and Limitations:
No benefits will be paid under this benefit subsection for expenses incurred:
1. Custodial Care is not covered; and
2. Coverage is provided for a maximum of 60 days per *member* per lifetime.

Skilled Nursing Facility Expense Benefits
Covered expenses include expenses incurred for services or confinement in a *skilled nursing facility*, subject to the following limitations:

1. Services or confinement in a *skilled nursing facility* must begin within 14 days of a *hospital* stay of at least 3 consecutive days and be for treatment of, the same *illness* or *injury* that resulted in the *hospital* stay;
2. *Covered expenses* for *provider facility* services are limited to charges made by a *hospital* or *skilled nursing facility* for:
    a. Daily room and board and nursing services;
    b. Diagnostic testing; and
    c. Drugs and medicines that are prescribed by a *physician*, must be filled by a licensed pharmacist, and are approved by the U.S. Food and Drug Administration.

Skilled Nursing Facility charges are limited to 60 days per *covered person* per year. See the Schedule of Benefits for benefit levels or additional limits.

Exclusion:
No benefits will be paid under this Skilled nursing facility Expense Benefit for charges for services or confinement related to treatment or therapy for *mental disorders* or *substance use*.

Definition:
As used in this provision, *"provider facility"* means a *hospital* or *skilled nursing facility*.

Habilitation Expense Benefits
Covered expenses include expenses incurred for *habilitation* services, subject to the following limitations:
1. *Covered expenses* for *habilitation* services, including physical, occupational and speech therapies, developmental services and durable medical equipment for developmental delay, developmental disability, developmental speech or language disorder, developmental coordination disorder and mixed developmental disorder; and
2. The *habilitation services* must be received on an outpatient basis.

Outpatient Physical therapy, Speech therapy and Occupation therapy are limited to 30 days per *covered person* per year. Inpatient Physical therapy, Speech therapy and Occupation therapy are listed to 60 days per *covered person* per year. See the Schedule of Benefits for benefit levels or additional limits. Please note there are separate limits for developmental services provided as part of the habilitation benefits listed above.

Exclusion:
No benefits will be paid under these Habilitation Expense Benefits for charges for services or confinement related to treatment or therapy for *mental disorders* or *substance use*.

Definition:
As used in this provision, *"provider facility"* means a *hospital*.

Home Health Care Expense Benefits
Covered expenses for *home health care* are limited to the following charges:
1. *Home health aide services*;

2. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care and developmental services associated with developmental delays, developmental speech or language disorder, developmental coordination disorder and mixed developmental disorder.*
3. I.V. medication and pain medication;
4. Hemodialysis, and for the processing and administration of blood or blood components;
5. *Necessary medical supplies*; and
6. Rental of *medically necessary durable medical equipment*.

Charges listed under (4) of this "Home Health Care Expense Benefits" section are *covered expenses* to the extent they would have been *covered expenses* during an *inpatient hospital* stay.

At *our* option, *we* may authorize the purchase of the equipment in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a provider *we* authorize before the purchase.

An agency that is approved to provide *home health care* to those receiving Medicare benefits will be deemed to be a *home health care agency*.

Limitations:
Covered expenses for *home health aide services* will be limited to:
1. Seven visits per week; and
2. A calendar year maximum of fifty (50) visits.

Each eight-hour period of *home health aide services* will be counted as one visit.

Exclusion:
No benefits will be payable for charges related to *respite care, custodial care,* or educational care.

Hospice Care Expense Benefits
This provision only applies to a *terminally ill covered person* receiving *medically necessary* care under a *hospice care program*.

The list of *covered expenses* in the Miscellaneous Medical Expense Benefits provision is expanded to include:
1. Room and board in a *hospice* while the *covered person* is an *inpatient;*
2. Occupational therapy;
3. Speech-language therapy;
4. The rental of medical equipment while the *terminally ill covered person* is in a *hospice care program* to the extent that these items would have been covered under the *policy* if the *covered person* had been confined in a *hospital;*
5. Medical, palliative, and supportive care, and the procedures necessary for pain control and acute and chronic symptom management;
6. Counseling the *covered person* regarding his or her *terminal illness;*
7. *Terminal illness counseling* of members of the *covered person's immediate family;* and
8. *Bereavement counseling*.

Exclusions and Limitations:
Any exclusion or limitation contained in the *policy* regarding:

1. An *injury* or *illness* arising out of, or in the course of, employment for wage or profit;
2. Medical necessity of services or supplies, to the extent such services or supplies are provided as part of a *hospice care program;* or
3. Expenses for other persons, to the extent those expenses are described above, will not be applied to this provision.

Benefits for *hospice inpatient* or outpatient care are available to a *terminally ill covered person* for one continuous period up to one hundred eighty (180) days in a *covered person's* lifetime.

Respite Care Expense Benefits
Respite care is covered on an inpatien*t or outpatient basis to allow* temporary relief to family members from the duties of caring for a Covered Person. Respite days that are applied toward the Deductible are considered benefits provided and shall apply against any Maximum Benefit limit for these services. Coverage is limited to 14 days per year. See your Schedule of Benefits for additional coverage limits.

In Vitro Fertilization
Benefits for in vitro fertilization procedures are covered when:

a) The patient is the policyholder or the spouse of the policyholder and a covered dependent under the policy, and the covered person's oocytes are fertilized with the sperm of the patient's spouse, and the patient and the patient's spouse have a history of unexplained infertility of at least two (2) years' duration; or
b) the infertility is associated with one or more of the following medical conditions:
    - Endometriosis;
    - Exposure in utero to Diethylstilbestrol, commonly known as DES;
    - Blockage of or removal of one or both fallopian tubes (lateral or bilateral salpingectomy) not a result of voluntary sterilization; or
    - Abnormal male factors contributing to the infertility.

In vitro fertilization procedures must be performed at a medical facility, licensed or certified by the Arkansas Department of Health, which conform to the American College of Obstetricians and Gynecologists' guidelines for in vitro fertilization clinics, or those performed at a facility certified by the Arkansas Department of Health which meet the American Fertility Society's minimal standards for programs of in vitro fertilization and the patient has been unable to obtain successful pregnancy through any less costly applicable infertility treatment for which coverage is available under the policy.

Benefits for in vitro fertilization shall be the same as the benefits provided under maternity benefit provisions and are subject to the same deductibles, co-insurance and out-of-pocket limitations that apply to maternity benefits. Cryopreservation, the procedure whereby embryos are frozen for late implantation, shall be included as an in vitro fertilization procedure.

Low Protein Modified Food Products
Covered expenses shall include medically necessary medical foods and low protein modified food products

for the therapeutic treatment of a *covered person* inflicted with phenylketonuria (PKU), galactosemia, organic acidemias, and disorders of amino acid metabolism. Products must be administered under the direction of a licensed physician.

Miscellaneous Medical and Surgical Expense Benefits
Medical *covered expenses* are limited to charges:

1. Made by a *hospital* for:
    a. Daily room and board.
        i. *Hospital* admissions are subject to pre-admission notification. Please call the number listed on *your* identification card to notify *us* of the admission.
        ii. Services rendered in a *Hospital* in a country outside of the United States of America shall not be paid except at *our* sole discretion;
        iii. Admissions to a long term acute care *hospital* or to a long term acute care division of a *hospital* are subject to pre-admission notification.
    b. Daily room and board and nursing services while confined in an *intensive care unit*.
    c. *Inpatient* use of an operating, treatment, or recovery room;
    d. Outpatient use of an operating, treatment, or recovery room for *surgery;*
    e. Services and supplies, including drugs and medicines, that are routinely provided by the *hospital* to persons for use only while they are *inpatients;*
    f. For a condition requiring that *you* be isolated from other patients, *we* will pay for an isolation unit equipped and staffed as such; *and*
    g. *Emergency* treatment of an *injury* or *illness*, even if confinement is not required. When *emergency* treatment is needed the *covered person* should seek care at the nearest facility. *Emergency* treatment received within forty-eight (48) hours of the *emergency* is subject to the deductible, copayment and coinsurance specified in the Schedule of Benefits. If the *covered person* is admitted as an inpatient to the same hospital where *emergency* treatment was rendered, the *emergency* treatment copayment is waived and all services are subject to the inpatient deductible, copayment and coinsurance.

1. **After-Hours Clinic or Urgent Care Center.** Services provided in an after-hours urgent care center are subject to the *urgent care* deductible, copayment and coinsurance for each visit.
2. **Observation Services.** Observation services are covered when ordered by a *network physician*. 3. **Transfer to Network Hospital.** Continuing or follow-up treatment for *injury* or *emergency* treatment is limited to care that meets primary coverage criteria before you can be safely transferred, without medically harmful or injurious consequences, to an *network hospital* in the service area. Services are subject to all applicable deductible, copayment and coinsurance.
4. **Emergency Hospital Admissions.** *You* are responsible for notifying Arkansas Health & Wellness Solutions of an *emergency* admission to a *network hospital* in the service area or a *hospital* outside the service area within 24 hours or the next business day. Failure to notify Arkansas Health & Wellness Solutions may result in the *covered person* paying a greater portion of the medical bill.
5. **Medical Review of Emergency Care.** *Emergency* treatment is subject to medical review. If, based upon the signs and symptoms presented at the time of treatment as documented by attending health care personnel, Arkansas Health & Wellness

Solutions determines that a visit to the *emergency* room fails to meet the definition of *emergency* treatment, coverage shall be denied and the emergency room charges will become the covered person's responsibility.

2. For *surgery* in a *physician's* office or at an *outpatient surgical facility,* including services and supplies;
3. Made by an assistant surgeon, limited to 20 percent of the *eligible expense* for the *surgical procedure;*
4. Services of standby physicians are only covered in the event such physician is required to assist with certain high-risk services specified by Arkansas Health & Wellness Solutions, and only for such time as such physician is in immediate proximity to the patient;
5. For the professional services of a *medical practitioner*, including *surgery;*
6. For dressings, crutches, orthopedic splints, braces, casts, or other *necessary medical supplies.*
7. For diagnostic testing using radiologic, ultrasonographic, or laboratory services. Psychometric, behavioral and educational testing are not included This includes advanced diagnostic imaging such as computed tomography scanning (CT SCAN‖), Magnetic Resonance Angiography or Imaging (MRI/MRA‖), Nuclear Cardiology and positron emission tomography scans (PET SCAN‖) referred to as ―advanced diagnostic imaging. This will require prior authorization from *us*;
8. For chemotherapy and radiation therapy or treatment on an inpatient or outpatient basis;
9. For hemodialysis, and the charges by a *hospital* for processing and administration of blood or blood components;
10. For renal dialysis;
11. For the cost and administration of an anesthetic;
12. For oxygen and its administration;
13. For *dental expenses* when a *covered person* suffers an *injury,* after the *covered person's effective date* of coverage, that results in:
    a. Damage to his or her natural teeth; and
    b. Expenses are incurred within six months of the accident or as part of a treatment plan that was prescribed by a *physician* and began within six months of the accident. *Injury* to the natural teeth will not include any injury as a result of chewing;
14. For reconstructive breast surgery charges as a result of a partial or total mastectomy. Coverage includes surgery and reconstruction of the diseased and non-diseased breast and prosthetic devices necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedemas;
15. Testing of newborn children, including testing for Down's syndrome, hypothyroidism, sickle-cell anemia, phenylketonuria/galactosemia, PKU and other disorders of metabolism;
16. For the following types of tissue transplants:
    a. Cornea transplants;
    b. Artery or vein grafts;
    c. Heart valve grafts;
    d. Prosthetic tissue replacement, including joint replacements; and
    e. Implantable prosthetic lenses, in connection with cataracts;
17. Coverage for anesthesia and hospital or ambulatory surgical facility charges for services performed in connection with dental procedures in a hospital or ambulatory surgical facility, if the provider certifies that because of the patient's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures; and the patient is a

child under seven (7) years of age who is determined by (2) licensed dentists to require dental treatment in a hospital or ambulatory surgical center for a significantly complex dental condition; a person with a diagnosed serious mental or physical condition; or a person with a significant behavioral problem;

18. Coverage for gastric pacemakers for *covered persons* diagnosed with *gastroparesis*, eligible charges and limits are based on medical necessity and require prior authorization;
19. Infertility counseling and planning services when provided by a *network provider*, and testing to diagnose infertility;
20. Cochlear implants;
21. Hearing Aids- limited to one pair per year;
22. One auditory brain stem implant per lifetime for an individual twelve years of age and older with a diagnosis of Neurofibromatosis Type II (NF2) who has undergone or is undergoing removal of bilateral acoustic tumors;
23. Implantable osseointegrated hearing aid for patients with single-sided deafness and normal hearing in the other ear. Coverage is further limited to *members* with:
    a. congenital or surgically induced malformations (e.g. atresia) of the external ear canal or middle ear;
    b. chronic external otitis or otitis media, subject to Prior Approval;
    c. tumors of the external canal and/or tympanic cavity; and
    d. sudden, permanent, unilateral hearing loss due to trauma, idiopathic sudden hearing loss, or auditory nerve tumor; and
24. Testing and evaluation limited to fifteen (15) hours per *member* per year:
    a. Psychological testing, including but not limited to, assessment of personality, emotionality and intellectual abilities;
    b. For children under the age of six (6), childhood developmental testing, including but not limited to assessment of motor, language, social, adaptive or cognitive function by standardized developmental instruments;
    c. Neurobehavioral status examination, including, but not limited to assessment of thinking, reasoning and judgment;
    d. Neuropsychological testing, including, but not limited to Halstead-Reitan, Luria and WAIS-R.
25. *Medically necessary services* made by a *physician* in an *urgent care center*, including facility costs and supplies;
26. Radiology services, including X-ray, MRI, CAT scan, PET scan, and ultrasound imaging;
27. New Intervention (one that is not commonly recognized as a *generally accepted standard of medical practice*) when it is shown through scientific evidence that the intervention will achieve its intended purpose and will prevent, cure, alleviate or enable diagnosis or detection of a medical condition without exposing the *member* to risks that outweigh the potential benefits. New interventions in the process of phase I, II or III trials are not covered;
28. Nutritional and Dietary counseling services for *members* in connection with cleft palate management and for nutritional assessment programs provided in and by a *hospital*; and
29. Allergy Testing.

Miscellaneous Outpatient Medical Services and Supplies Expense Benefits
Covered expenses for miscellaneous outpatient medical services and supplies are limited to charges:

1. For artificial eyes and polishing of such, for larynx, breast prosthesis, or basic artificial limbs but not the replacement thereof, unless required by a physical change in the *covered person* and the item cannot be modified. If more than one prosthetic device can meet a *covered person's* functional needs, only the charge for the most cost effective prosthetic device will be considered a *covered expense.* Coverage provided for eligible charges shall be no less than eighty (80%) of Medicare allowable as defined by the Centers for Medicare & Medicaid Services, Healthcare Common Procedure Coding System;
2. For one pair of foot orthotics per year per *covered person*;
3. For *medically necessary* genetic blood tests;
4. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV);
5. For two mastectomy bras per year if the *covered person* has undergone a covered mastectomy;
6. For rental of *medically necessary durable medical equipment*;
7. For the rental of one Continuous Passive Motion (CPM) machine per *covered person* following a covered joint surgery;
8. For the cost of one wig per *covered person* necessitated by hair loss due to cancer treatments or traumatic burns. See the Schedule of Benefits for benefit levels or additional limits;
9. For a procedure, treatment, service, equipment or supply to correct a refractive error of the eye is covered in two instances: (1) if such refractive error results from traumatic injury or corneal disease, infectious or non-infectious, and (2) For one pair of eyeglasses or contact lenses per *covered person* following a covered cataract surgery. See the Schedule of Benefits for benefit levels or additional limits; and
10. For the cost of a monofocal lens, if the multifocal lens is implanted after a cataract extraction.

Outpatient Prescription Drug Expense Benefits
Covered expenses in this benefit subsection are limited to charges from a licensed *pharmacy* for:

1. A *prescription drug*.
2. Prescribed, self-administered anticancer medication.
3. Contraceptive devices prescribed by a *physician*.
4. Any drug that, under the applicable state law, may be dispensed only upon the written prescription of a *physician.*
5. Off-label drugs that are:
    a. Recognized for treatment of the indication in at least one (1) *standard reference compendium*; or
    b. The drug is recommended for a particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.

As used in this section, *Standard Reference Compendia* means (a) The American Hospital Formulary Service Drug Information (b) The American Medical Association Drug Evaluation or (c) The United States Pharmacopoeia-Drug Information.

Covered expenses shall include coverage for prescribed drugs or devices approved by the United States Food and Drug Administration for use as a contraceptive.

See the Schedule of Benefits for benefit levels or additional limits.

The appropriate drug choice for a *covered person* is a determination that is best made by the *covered person* and his or her *physician.*

Notice and Proof of Loss:
In order to obtain payment for *covered expenses* incurred at a *pharmacy* for *prescription orders,* a notice of claim and *proof of loss* must be submitted directly to *us.*

Exclusions and Limitations:
No benefits will be paid under this benefit subsection for expenses incurred:

1. For *prescription drugs* for the treatment of erectile dysfunction or any enhancement of sexual performance;
2. For immunization agents otherwise not required under the Affordable Care Act;
3. For medication that is to be taken by the *covered person,* in whole or in part, at the place where it is dispensed;
4. For medication received while the *covered person* is a patient at an institution that has a facility for dispensing pharmaceuticals;
5. For a refill dispensed more than 12 months from the date of a *physician's* order;
6. Due to a *covered person's* addiction to, or dependency on foods;
7. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs;
8. For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are covered on the formulary or when the over-the-counter drug is used for preventive care. This exclusion does not apply to prescribed FDA approved contraceptive methods;
9. For drugs labeled "Caution - limited by federal law to investigational use" or for investigational or experimental drugs;
10. For a *prescription drug* that contains an active ingredient(s) that is/are:
    a. Available in and *therapeutically equivalent* to another covered *prescription drug;* or
    b. A modified version of and *therapeutically equivalent* to another covered *prescription drug.* Such determinations may be made up to six times during a calendar year, and *we* may decide at any time to reinstate benefits for a *prescription drug* that was previously excluded under this paragraph;
11. For more than a 34-day supply when dispensed in any one prescription or refill, a 90-day supply when dispensed by mail order; and
12. For *prescription drugs* for any *covered person* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date.

Prescription Drug Exception Process
Standard exception request
A *member*, a *member's* designee or a *member's* prescribing *physician* may request a standard review of a decision that a drug is not covered by the plan. The request can be made in writing or via telephone. Within 72 hours of the request being received, we will provide the *member*, the *member's* designee or the

member's prescribing *physician* with our coverage determination. Should the standard exception request be granted, we will provide coverage of the non-formulary drug for the duration of the prescription, including refills.

Expedited exception request
A *member*, a *member's* designee or a *member's* prescribing *physician* may request an expedited review based on exigent circumstances. Exigent circumstances exist when a *member* is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a non-formulary drug. Within 24 hours of the request being received, we will provide the *member*, the *member's* designee or the *member's* prescribing *physician* with our coverage determination. Should the standard exception request be granted, we will provide coverage of the non-formulary drug for the duration of the exigency.

External exception request review
If *we* deny a request for a standard exception or for an expedited exception, the *member*, the *member's* designee or the *member's* prescribing *physician* may request that the original exception request and subsequent denial of such request be reviewed by an independent review organization. *We* will make our determination on the external exception request and notify the *member*, the *member's* designee or the *member's* prescribing *physician* of *our* coverage determination no later than 72 hours following receipt of the request, if the original request was a standard exception, and no later than 24 hours following its receipt of the request, if the original request was an expedited exception.

If *we* grant an external exception review of a standard exception request, *we* will provide coverage of the non-formulary drug for the duration of the prescription. If *we* grant an external exception review of an expedited exception request, *we* will provide coverage of the non-formulary drug for the duration of the exigency.

Pediatric Vision Expense Benefits
Covered expenses in this benefit subsection include the following for an *eligible child* under the age of 19 who is a *member*:

1. Routine vision screening, including dilation refraction every calendar year;
2. Vision therapy developmental testing;
3. One pair of prescription lenses (single vision, lined bifocal, lined trifocal, or lenticular in plastic) or initial supply of standard contacts every calendar year, including standard polycarbonate lenses, scratch resistant and anti-reflective coating. Standard progressive lenses if medically necessary;
4. One pair of frames every calendar year;
5. Low vision optical devices including low vision services, and an aid allowance with follow-up care when pre-authorized;
6. If you elect to see a non-network provider for routine exam and eyewear services, see your Schedule of Benefits for maximum allowances for these benefits. You will be financially responsible for any differences above the maximum benefit. Out of network benefits cannot be utilized in conjunction with in network benefits;
7. Office-based orthoptic and pleoptic training in the treatment of convergence insufficiency with continuing medical direction and evaluation;

8. Eyeglasses for children diagnosed as having the following diagnoses must have a surgical evaluation in conjunction with supplying eyeglasses;
9. Ptosis (droopy lid);
10. Congenital cataracts;
11. Exotropia or vertical tropia;
12. Children between the ages of 12 an 18 exhibiting exotropia;
13. Sensorimotor examination with multiple measurements of ocular deviatrion (e.g. restrictive or paretic muscle with diplopia with interpretation and report; and
14. Eye prosthesis and polishing services.

Covered expenses do not include:

1. Two pair of glasses as a substitute for bifocals;
2. Replacement of lost or stolen eyewear; or
3. Any vision services, treatment or material not specifically listed as a covered service.

Preventive Care Expense Benefits

Covered expenses are expanded to include the charges incurred by a *covered person* for the following preventive health services if appropriate for that *covered person* in accordance with the following recommendations and guidelines:

1. Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force;
2. 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 an individual;
3. Evidence-informed preventive care and screenings for infants, children, and adolescents, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration;
4. Additional preventive care and screenings not included in (1) above, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration for women;
5. Complications resulting from the smallpox vaccine; and
6. Covers without cost sharing:
    a. Screening for *tobacco use*; and
    b. For those who *use tobacco* products, at least two (2) cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:
        i. Four (4) tobacco cessation counseling sessions of at least ten (10) minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and
        ii. All Food and Drug Administration (FDA) approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization.

Benefits for preventive health services listed in this provision, except under the administration of reasonable medical management techniques discussed in the next paragraph, are exempt from any

deductibles or coinsurance provisions, and *copayment amounts* under the *policy* when the services are provided by a *network provider.*

Benefits for *covered expenses* for preventive care expense benefits may include the use of reasonable medical management techniques authorized by federal law to promote the use of high value preventive services from *network providers*. Reasonable medical management techniques may result in the application of deductibles or coinsurance provisions, or *copayment amounts* to services when a *covered person* chooses not to use a high value service that is otherwise exempt from deductibles or coinsurance provisions, and *copayment amounts*, when received from a *network provider*.

As new recommendations and guidelines are issued, those services will be considered *covered expenses* when required by the United States Secretary of Health and Human Services, but not earlier than one year after the recommendation or guideline is issued.

Colorectal Cancer
Covered expenses shall include colorectal cancer examinations and laboratory tests for covered persons who are fifty (50) years of age or older; covered persons who are less than fifty (50) years of age and at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines as they existed on January 1, 2005; and covered persons experiencing the following symptoms of colorectal cancer as determined by a physician licensed under the Arkansas Medical Practices Act: Bleeding from the rectum or blood in the stool; or a change in bowel habits, such as diarrhea, constipation, or narrowing of the stool, that lasts more than five (5) days.

Colorectal screening shall involve an examination of the colon, including the following examinations or laboratory tests, or both: (i) An annual fecal occult blood test utilizing the take-home multiple sample method, or an annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every five (5) years; (ii) A double-contrast barium enema every five (5) years; or (iii) A colonoscopy every ten (10) years; and any additional medically recognized screening tests for colorectal cancer required by the Director of the Division of Health of the Department of Health and Human Services, determined in consultation with appropriate health care organizations.

A *covered person* shall determine the choice of screening strategies in consultation with a health care provider. Screenings shall be limited to the following guidelines: (1) If the initial colonoscopy is normal, follow-up is recommended in ten (10) years; (2) For individuals with one (1) or more neoplastic polyps or adenomatous polyps, assuming that the initial colonoscopy was complete to the cecum and adequate preparation and removal of all visualized polyps, follow-up is recommended in three (3) years; if single tubular adenoma of less than one centimeter (1 cm) is found, follow-up is recommended in five (5) years; and for patients with large sessile adenomas greater than three centimeters (3 cm), especially if removed in piecemeal fashion, follow-up is recommended in six (6) months or until complete polyp removal is verified by colonoscopy.

Mammography Screening
Covered expenses for a female *covered person* shall be paid at the following frequency schedule: Age 35 through 39, one exam; Age 40 and older, every one (1) to two (2) years based on the recommendation of a physician. Annual mammograms without regard to age are covered for women with a family history of

breast cancer.

Prostate Cancer Screening
Covered expenses shall include coverage for prostate cancer screenings for a covered male 40 years of age or older in accordance with the National Comprehensive Cancer Network guidelines. If recommended by a Physician, *covered expenses* shall include a prostate specific antigen blood test.

Maternity Care
Coverage for maternity care: outpatient and inpatient pre- and post-partum care including exams, prenatal diagnosis of genetic disorder, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment, childbirth classes, and hospital stays for delivery or other *medically necessary* reasons less any applicable *deductible*, or *coinsurance*. An inpatient stay is covered for at least forty-eight (48) hours following a vaginal delivery, and for at least ninety-six (96) hours following a caesarean delivery. Other maternity benefits include *complications of pregnancy,* parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests, including one obstetrical ultrasound.

Newborns' and Mothers' Health Protection Act Statement Of Rights
If expenses for *hospital* confinement in connection with childbirth are otherwise included as *covered expenses*, *we* will not limit the number of days for these expenses to less than that stated in this provision.

Under federal law, health insurance issuers generally may not restrict benefits otherwise provided for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery or less than ninety-six (96) hours following a delivery by cesarean section. However, *we* may provide benefits for *covered expenses* incurred 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.

The level of benefits and out-of-pocket costs for any later part of the 48-hour or 96-hour stay will not be less favorable to the mother or newborn than any earlier part of the stay. *We* do not 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.

Note: This provision does not amend the *policy* to restrict any terms, limits, or conditions that may otherwise apply to *covered expenses* for childbirth.

Temporomandibular Joint Disorder and Craniomandibular Disorder Expense Benefits
Covered service expenses expanded to include the charges incurred for diagnosis and treatment services, both surgical and nonsurgical for temporomandibular joint disorder (TMJ) and craniomandibular disorder. These expenses shall be the same as that for treatment to any other joint in the body. Coverage shall apply if the treatment is administered or prescribed by a *physician* or dentist.

Transplant Service Expense Benefits
Covered expenses for transplant expenses:

If *we* determine that a *covered person* is an appropriate candidate for a *listed transplant,* Medical Benefits *covered expenses* will be provided for:

1. Pre-transplant evaluation;
2. Pre-transplant harvesting;
3. Pre-transplant stabilization, meaning an *inpatient* stay to medically stabilize a *covered person* to prepare for a later transplant, whether or not the transplant occurs;
4. High dose chemotherapy;
5. Peripheral stem cell collection;
6. Post-transplant follow-up; and
7. For donor testing is the donor is found compatible.

Transplant Donor Expenses:
We will cover the medical expenses incurred by a live donor as if they were medical expenses of the *covered person* if:

1. They would otherwise be considered *covered expenses* under the *policy;*
2. The *covered person* received an organ or bone marrow of the live donor; and
3. The transplant was a *listed transplant.*

A *covered person* may obtain services in connection with a *listed transplant* from any *physician*. *We* will pay a maximum of $10,000 per lifetime for the following services:

a. Transportation for the *covered person,* any live donor, and the *immediate family* to accompany the *covered person.* Reimbursement for miles traveled will be made at the current IRS standard mileage rate for medical purposes.
b. Lodging for any live donor and the *immediate family* accompanying the *covered person* while the *covered person* is confined*. We* will pay the costs directly for transportation and lodging, however, *you* must make the arrangements.

Exclusions:
No benefits will be paid under these Transplant Expense Benefits for charges:

1. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no *listed transplant* occurs;
2. For animal to human transplants;
3. For artificial or mechanical devices designed to replace a human organ temporarily or permanently;
4. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision;
5. To keep a donor alive for the transplant operation;
6. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ; and
7. Related to transplants not included under this provision as a *listed transplant.*

Limitations on Transplant Expenses Benefits:
In addition to the exclusions and limitations specified elsewhere in this section *Covered expenses* for *listed transplants* will be limited to two transplants during any 10- year period for each *covered person*.

Trans-telephonic Home Spirometry
Coverage for *eligible service expenses* for trans-telephonic home or ambulatory spirometry for *members* who have had a lung transplant.

Clinical Trial Coverage
Clinical Trial Coverage includes routine patient care costs incurred as the result of an approved phase I, II, III or phase IV clinical trial and the clinical trial is undertaken for the purposes of prevention, early detection, or treatment of cancer or other life-threatening disease or condition. Coverage will include routine patient care costs incurred for (1) drugs and devices that have been approved for sale by the Food and Drug Administration (FDA), regardless of whether approved by the FDA for use in treating the patient's particular condition, (2) reasonable and *medically necessary* services needed to administer the drug or use the device under evaluation in the clinical trial and (3) all items and services that are otherwise generally available to a qualified individual that are provided in the clinical trial except:

- The investigational item or service itself:
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and
- Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

Clinical trials must meet the following requirements:

- Phase I and II of a clinical trial is sanctioned by the National Institutes of Health (NIH) or National Cancer Institute (NCI) and conducted at academic or National Cancer Institute Center; and
- The insured is enrolled in the clinical trial. This section shall not apply to insureds who are only following the protocol of phase I or II of a clinical trial, but not actually enrolled.

"Clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, funded or approved by:

- One of the National Institutes of Health (NIH);
- The Centers for Disease Control and Prevention;
- The Agency for Health Care Research and Quality;
- The Centers for Medicare & Medicaid Services;
- A cooperative group or center of any of the entities listed above or the Department of Defense or the Department of Veteran Affairs;
- An NIH Cooperative Group or Center;
- The FDA in the form of an investigational new drug application;
- The federal Departments of Veterans' Affairs, Defense, or Energy;
- An institutional review board in this state that has an appropriate assurance approved by the Department of Health and Human Services assuring compliance with and implementation of regulations for the protection of human subjects;
  The study or investigation is a drug trial that is exempt from having such an investigational new drug application; or

- A qualified non-governmental research entity that meets the criteria for NIH Center support grant eligibility.

In a clinical trial, the treating facility and personnel must have the expertise and training to provide the treatment and treat a sufficient volume of patients. A qualified individual must be eligible to participate in the clinical trial, and either (a) have a referral from a doctor stating that the clinical trial would be appropriate based upon the individual having cancer or a life-threatening disease or condition; or (b) the individual must provide medical and scientific information establishing that their participation in the clinical trial would be appropriate based on the individual having cancer or a life-threatening disease or condition.

Providers participating in clinical trials shall obtain a patient's informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards. Such documents shall be made available to Arkansas Health & Wellness Solutions upon request.

Wellness Program Benefits

Benefits may be available from time to time to *members* for participating in certain wellness programs that *we* may make available in connection with this Contract. The benefits available to *members* for participating in the wellness programs are described on the Schedule of Benefits. You may obtain information regarding the particular wellness programs available at any given time by visiting *our* website at www.ambetterofarkansas.com or by contacting Member Services by telephone at 1-877-617-0390. The wellness programs and benefits available at any given time are made part of this *contract* by this reference and are subject to change from time to time by *us* through an update to wellness program information available on *our* website or by contacting *us*.

PRIOR AUTHORIZATION

Prior Authorization Required
Some *covered expenses* require prior authorization. In general, *network providers* must obtain authorization from *us* prior to providing a service or supply to a *covered person.* However, there are some *network eligible expenses* for which *you* must obtain the prior authorization.

For services or supplies that require prior authorization, as shown on the Schedule of Benefits, *you* must obtain authorization from *us* before the *covered person:*

1. Receives a service or supply from a *non-network provider;* or
2. Is admitted into a *network* facility by a *non-network provider.*

How to Obtain Prior Authorization
To obtain prior authorization or to confirm that a *network provider* has obtained prior authorization, contact *us* by telephone at the telephone number listed on *your* health insurance identification card before the service or supply is provided to the *covered person.*

Failure to Obtain Prior Authorization
Failure to comply with the prior authorization requirements will result in benefits being reduced. Please see the *policy* Schedule of Benefits for specific details.

Network providers cannot bill *you* for services for which they fail to obtain prior authorization as required.

Benefits will not be reduced for failure to comply with prior authorization requirements prior to an *emergency.* However, *you* must contact *us* as soon as reasonably possible after the *emergency* occurs.

Prior Authorization Does Not Guarantee Benefits
Our authorization does not guarantee either payment of benefits or the amount of benefits. Eligibility for, and payment of, benefits are subject to all terms and conditions of the *policy.*

Requests for Predeterminations
You may request a predetermination of coverage. *We* will provide one if circumstances allow *us* to do so. However, *we* are not required to make a predetermination of either coverage or benefits for any particular treatment or medical expense. Any predetermination *we* may make will be reviewed after the medical expense is incurred and a claim is filed. A review that shows one or more of the following may cause *us* to reverse the predetermination:

1. The predetermination was based on incomplete or inaccurate information initially received by *us;*
2. The medical expense has already been paid by someone else; and
3. Another party is responsible for payment of the medical expense.

We will make all benefit determinations after a *loss* in good faith. All benefit determinations are subject to *our* receipt of proper *proof of loss.*

GENERAL LIMITATIONS AND EXCLUSIONS

No benefits will be paid for:

1. Any service or supply that would be provided without cost to *you* or *your* covered *dependent* in the absence of insurance covering the charge;
2. Expenses/surcharges imposed on *you* or *your* covered *dependent* by a provider, including a *hospital*, but that are actually the responsibility of the provider to pay;
3. Any services performed by a member of a *covered person's immediate family; and*
4. Any services not identified and included as *covered expenses* under the *policy*. *You* will be fully responsible for payment for any services that are not *covered expenses.*

Even if not specifically excluded by this *policy,* no benefit will be paid for a service or supply unless it is:

1. Administered or ordered by a *physician;* and
2. *Medically necessary* to the diagnosis or treatment of an *injury* or *illness,* or covered under the Preventive Care Expense Benefits provision.

Covered expenses will not include, and no benefits will be paid for any charges that are incurred:

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *policy*, except as expressly provided for under the Benefits After Coverage Terminates clause in this *policy's* Termination section;
2. For any portion of the charges that are in excess of the *eligible expense;*
3. For weight modification, or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass *surgery,* bariatric surgery and weight loss programs, except as specifically covered in the Preventive Services section of the *contract*.
4. For breast reduction or augmentation;
5. For modification of the physical body in order to improve the psychological, mental, or emotional well-being of the *covered person,* such as sex-change *surgery*;
6. For the reversal of sterilization and the reversal of vasectomies;
7. For an elective *abortion* for any reason other than:
    a. To prevent the death of the mother upon whom the *abortion* is performed. However, an *abortion* shall not be deemed an elective *abortion* to prevent the death of the mother based on a claim or diagnosis that without the *abortion* the mother will engage in conduct that will result in her death; or
    b. In a *pregnancy* resulting from rape or incest.
8. For treatment of malocclusions, disorders of the temporomandibular joint, or craniomandibular disorders, except as described in *covered expenses* of the Medical Benefits provision;
9. For expenses for television, telephone, or expenses for other persons;
10. For telephone consultations or for failure to keep a scheduled appointment;
11. For *hospital* room and board and nursing services for the first Friday or Saturday of an *inpatient* stay that begins on one of those days, unless it is an *emergency*, or *medically necessary inpatient surgery* is scheduled for the day after the date of admission;
12. For stand-by availability of a *medical practitioner* when no treatment is rendered;
13. For *dental expenses,* including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under Medical Benefits;

14. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *policy* or is performed to correct a birth defect in a child who has been a *covered person* from its birth until the date *surgery* is performed;
15. For diagnosis or treatment of attitudinal disorders, or disciplinary problems*.*
16. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Expense Benefits;
17. For high dose chemotherapy prior to, in conjunction with, or supported by *ABMT/BMT*, except as specifically provided under the Transplant Expense Benefits;
18. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism;
19. While confined primarily to receive *rehabilitation, custodial care,* educational care, or nursing services, unless expressly provided for by the *policy*;
20. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *policy*;
21. For alternative or complementary medicine using non-orthodox therapeutic practices that do not follow conventional medicine. These include, but are not limited to, wilderness therapy, outdoor therapy, boot camp, equine therapy, and similar programs;
22. For eyeglasses, contact lenses, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as specifically provided under the *policy*;
23. For *experimental or investigational treatment(s)* or *unproven services.* The fact that an *experimental or investigational treatment* or *unproven service* is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be an *experimental or investigational treatment* or *unproven service* for the treatment of that particular condition;
24. For treatment received outside the United States, except for a medical *emergency* while traveling for up to a maximum of ninety (90) consecutive days. If travel extends beyond ninety (90) consecutive days, no coverage is provided for medical *emergencies* for the entire period of travel including the first ninety (90) days;
25. As a result of an *injury* or *illness* arising out of, or in the course of, employment for wage or profit, if the *covered person* is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If *you* enter into a settlement that waives a *covered person's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *covered person's w*orkers' compensation claim, this exclusion will still apply unless that denial is appealed to the proper governmental agency and the denial is upheld by that agency;
26. As a result of:
    a. Intentionally self-inflicted bodily harm , unless the injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions);
    b. An *injury* or *illness* caused by any act of declared or undeclared war;
    c. The *covered person* taking part in a riot; or
    d. The *covered person's* commission of a felony, whether or not charged;
27. For or related to *durable medical equipment* or for its fitting, implantation, adjustment, or removal, or for complications there from, except as expressly provided for under the Medical Benefits;
28. For any *illness* or *injury* incurred as a result of the *covered person* being intoxicated, as defined by applicable state law in the state in which the *loss* occurred, or under the influence of a controlled

substance unless administered or prescribed by a *physician*, except as expressly provided for under the Mental Health and Substance Use Expense Benefits provision;
29. For or related to surrogate parenting;
30. For or related to treatment of hyperhidrosis (excessive sweating);
31. For fetal reduction surgery;
32. Except as specifically identified as a *covered expense* under the *policy*, expenses for alternative treatments, including acupressure, acupuncture, aroma therapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health;
33. As a result of any *injury* sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: professional or semi-professional sports; intercollegiate sports not including intramural sports; parachute jumping; hang-gliding; racing or speed testing any motorized vehicle or conveyance; racing or speed testing any non-motorized vehicle or conveyance, if the *covered person* is paid to participate or to instruct; scuba/skin diving when diving 60 or more feet in depth; skydiving; bungee jumping; rodeo sports; horseback riding, if the *covered person* is paid to participate or to instruct; rock or mountain climbing, if the *covered person* is paid to participate or to instruct; or skiing, if the *covered person* is paid to participate or to instruct;
34. As a result of any *injury* sustained while operating, riding in, or descending from any type of aircraft if the *covered person* is a pilot, officer, or member of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft;
35. For prescription drugs for any *covered person* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. Prescription drug coverage may not be reinstated at a later date;
36. For the following miscellaneous items: artificial insemination except where required by federal or state law; biofeedback; care or complications resulting from non-*covered expenses*; chelating agents; domiciliary care; food and food supplements; routine foot care, foot orthotics or corrective shoes; health club memberships, unless otherwise covered; home test kits; care or services provided to a non-*member* biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; private duty nursing; rehabilitation services for the enhancement of job, athletic or recreational performance; routine or elective care outside the service area; sclerotherapy for varicose veins; treatment of spider veins; transportation expenses, unless specifically described in this *policy*; and
37. Services or supplies eligible for payment under either federal or state programs (except Medicaid). This exclusion applies whether or not *you* assert *your* rights to obtain this coverage or payment of these services.

Limitation on Benefits for Services Provided By Medicare Opt-Out Practitioners

Benefits for *covered expenses* incurred by a Medicare-eligible individual for services and supplies provided by a *Medicare opt-out practitioner* will be determined as if the services and supplies had been provided by a *Medicare participating practitioner*. Benefits will be determined as if Medicare had, in fact, paid the benefits it would have paid if the services and supplies had been provided by a *Medicare participating practitioner*.

TERMINATION

Termination of Policy
All insurance will cease on termination of this *policy.* This *policy* will terminate on the earliest of:

1. The date that a member has failed to pay premiums or contributions in accordance with the terms of this contract (including, but not limited to, the Grace Period provision) or the date that we have not received timely premium payments in accordance with the terms of this contract.
2. The date *we* receive a request from *you* to terminate this *policy,* or any later date stated in *your* request, or if you are enrolled through an Exchange, the date of termination that the Exchange provides us upon your request of cancellation to the Exchange;
3. The date *we* decline to renew this *policy,* as stated in the Discontinuance provision;
4. The date of *your* death, if this *policy* is an Individual Plan;
5. The date a *covered person's* eligibility for insurance under this *policy* ceases due to losing network access as the result of a permanent move;
6. The date the member has performed an act or practice that constitutes fraud or made an intentional misrepresentation of a material fact (e.g., the date that a member accepts any direct or indirect contributions or reimbursement by or on behalf of an employer, for any portion of the premium for coverage under this contract;
7. The date a *member's* employer and a *member* treat this *contract* as part of an employer-provided health plan for any purpose, including tax purposes; or
8. The date a *covered person's* eligibility for insurance under this *policy* ceases due to any of the reasons stated in the Ongoing Eligibility section in this *policy*.

We will refund any premium paid and not earned due to *policy* termination.

Discontinuance
90-Day Notice:
If *we* discontinue offering and refuse to renew all policies issued on this form, with the same type and level of benefits, for all residents of the state where *you* reside, *we* will provide a written notice to *you* at least ninety (90) days prior to the date that *we* discontinue coverage. *You* will be offered an option to purchase any other coverage in the individual market *we* offer in *your* state at the time of discontinuance of this *policy*. This option to purchase other coverage will be on a guaranteed issue basis without regard to health status.

180-Day Notice:
If *we* discontinue offering and refuse to renew all individual policies/certificates in the individual market in the state where *you* reside, *we* will provide a written notice to *you* and the Commissioner of Insurance at least one hundred eighty (180) days prior to the date that *we* stop offering and terminate all existing individual policies in the individual market in the state where *you* reside.

Benefits After Coverage Terminates
Benefits for *covered expenses* incurred after a *covered person* ceases to be insured are provided for certain *illnesses* and *injuries.* However, no benefits are provided if this *policy* is terminated because of:

1. A request by *you*;

2. Fraud or an intentional material misrepresentation on *your* part; or
3. *Your* failure to pay premiums.

The *illness* or *injury* must cause a *period of extended loss,* as defined below. The *period of extended loss* must begin before insurance of the *covered person* ceases under this *policy*. No benefits are provided for *covered expenses* incurred after the *period of extended loss* ends.

In addition to the above, if this *policy* is terminated because *we* refuse to renew all policies issued on this form, with the same type and level of benefits, to residents of the state where *you* live, termination of this *policy* will not prejudice a claim for a *continuous loss* that begins before insurance of the *covered person* ceases under this *policy.* In this event, benefits will be extended for that *illness* or *injury* causing the *continuous loss,* but not beyond the earlier of:

1. The date the *continuous loss* ends; or
2. Twelve (12) months after the date renewal is declined.

REIMBURSEMENT

If a *covered person's illness* or *injury* is caused by the acts or omissions of a *third party*, *we* will not cover a *loss* to the extent that it is paid as part of a settlement or judgment by any *third party*.

However, if payment by or for the *third party* has not been made by the time *we* receive acceptable *proof of loss, we* will pay regular *policy* benefits for the *covered person's loss*. *We* will have the right to be reimbursed to the extent of benefits *we* paid for the *illness* or *injury* if the *covered person* subsequently receives any payment from any *third party*. The *covered person* or the guardian, legal representatives, estate, or heirs of the *covered person* shall promptly reimburse *us* from the settlement, judgment, or any payment received from any *third party*.

As a condition for *our* payment, the *covered person* or anyone acting on his or her behalf including, but not limited to, the guardian, legal representatives, estate, or heirs agrees:

1. To fully cooperate with *us* in order to obtain information about the *loss* and its cause;
2. To immediately inform *us* in writing of any claim made or lawsuit filed on behalf of a *covered person* in connection with the *loss*;
3. To include the amount of benefits paid by *us* on behalf of a *covered person* in any claim made against any *third party*;
4. That *we*:
    a. Will have a lien on all money received by a *covered person* in connection with the *loss* equal to the amount *we* have paid;
    b. May give notice of that lien to any *third party* or *third party's* agent or representative;
    c. Will have the right to intervene in any suit or legal action to protect *our* rights;
    d. Are subrogated to all of the rights of the *covered person* against any *third party* to the extent of the benefits paid on the *covered person's* behalf; and
    e. May assert that subrogation right independently of the *covered person*;
5. To take no action that prejudices *our* reimbursement and subrogation rights;
6. To sign, date, and deliver to *us* any documents *we* request that protect *our* reimbursement and subrogation rights;
7. To not settle any claim or lawsuit against a *third party* without providing *us* with written notice of the intent to do so;
8. To reimburse *us* from any money received from any *third party*, to the extent of benefits *we* paid for the *illness* or *injury*, whether obtained by settlement, judgment, or otherwise, and whether or not the *third party's* payment is expressly designated as a payment for medical expenses; and
9. That *we* may reduce other benefits under the *policy* by the amounts a *covered person* has agreed to reimburse *us*.

Furthermore, as a condition of *our* payment, *we* may require the *covered person* or the *covered person's* guardian, if the *covered person* is a minor or legally incompetent, to execute a written reimbursement agreement. However, the terms of this provision remain in effect regardless of whether or not an agreement is actually signed.

Our right of subrogation and reimbursement only exists to the extent the *covered person* has been made whole. Any costs associated with subrogation shall be shared in the same proportion as each participant shared in the recovery amount.

COORDINATION OF BENEFITS

We coordinate benefits with other payers when a member is covered by two or more group health benefit plans. Coordination of Benefits (COB) is the industry standard practice used to share the cost of care between two or more carriers when a member is covered by more than one health benefit plan.

It is a contractual provision of a majority of health benefit contracts. *We* comply with Federal and state regulations for COB and follows COB guidelines published by National Association of Insurance Commissioners (NAIC).

Under COB, the benefits of one plan are determined to be primary and are first applied to the cost of care. After considering what has been covered by the primary plan, the secondary plan may cover the cost of care up to the fully allowed expense according to the plan's payment guidelines. *Our* Claims COB and Recovery Unit procedures are designed to avoid payment in excess of allowable expense while also making sure claims are processed both accurately and timely.

"Allowable expense" is the necessary, reasonable, and customary item of expense for health care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

"The term "Plan" includes:

1. Group health insurance benefits and group blanket or group remittance health benefits coverage, whether uninsured arrangements of group coverage, insured, self-insured, or self-funded. This includes group HMO insurance and other prepayment, group practice and individual practice plans, and blanket contracts, except as excluded below.
2. Plan includes medical benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.
3. Plan includes hospital, medical, and surgical benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid or any other or any other federal government plan as permitted by law.
4. Plan does not include blanket school accident coverage or coverage's issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.
5. Plan does not include Individual or Family: Insurance contracts, direct payment subscriber contracts, coverage through health maintenance organizations (HMO's) or coverage under other prepayment, group practice and individual practice plans.
6. Plan whose benefits are by law excess to any private benefits coverage.

"Primary plan" is one whose benefits must be determined without taking the existence of any other plan into consideration. A plan is primary if either:

1. the plan has no order of benefits rules or its rules differ from those required by regulation; or

2. all plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for example, two plans which have no order of benefit determination rules).

"Secondary plan" is one which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which their benefits are determined in relation to each other.

Order of Benefit Determination Rules

The first of the rules listed below in paragraphs 1-6 that applies will determine which plan will be primary:

1. The Primary plan pays or provides its benefits as if the Secondary plan or plans did not exist. A Plan may consider benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

2. If the other plan does not contain a coordination of benefits provision that is consistent with this provision is always primary. There are two exceptions:
    a. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder, and
    b. Any noncontributory group or blanket insurance coverage which is in force on January 1, 1987 which provides excess major medical benefits intended to supplement any basic benefits on a covered person may continue to be excess to such basic benefits.

The first of the following rules that describes which Plan pays its benefits before another Plan is the rule to use.

3. If the person receiving benefits is the *member* and is only covered as *an eligible dependent* under the other plan, this *contract* will be primary.

4. Subject to State Statues: Social Security Act of 1965, as amended makes Medicare secondary to the plan covering the person as a dependent of an active employee, the order of benefit determination is:
    a. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year (excluding year of birth) shall be primary.
    b. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.

5. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's health care expenses:
    a. The plan of the parent who has custody will be primary;

b. If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third;
c. If a court decree between the parents says which parent is responsible for the child's health care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.

6. If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.

7. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

Effects of Coordination
When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed *our* maximum available benefit for each Covered Service. Also, the amount *we* pay will not be more than the amount *we* would pay if *we* were primary. As each claim is submitted, *we* will determine our obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

Right to Receive and Release Needed Information
Certain fact about heath care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other Plans. We may get the facts we need from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other Plans covering the person claiming benefits. We need not tell or get the consent of, any person to do this.

CLAIMS

Notice of Claim
We must receive notice of claim within 30 days of the date the *loss* began or as soon as reasonably possible. Notice given by or on behalf of the insured to Arkansas Health & Wellness Solutions, Ambetter of Arkansas, One Allied Drive, Building One, Suite 1400, Little Rock, AR, 72202 , , with information sufficient to identify the insured, shall be deemed notice to *us.*

Claim Forms
Upon receipt of a notice of claim, *we* will furnish *you* with forms for filing proofs of loss. If *we* do not provide *you* with such forms within fifteen (15) days after *you* have given *us* notice, *you* shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time required for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

Proof of Loss
You or *your* covered *dependent* must give *us* written *proof of loss* within one hundred eighty (180) days of the *loss* or as soon as is reasonably possible.

Cooperation Provision
Each *covered person*, or other person acting on his or her behalf, must cooperate fully with *us* to assist *us* in determining *our* rights and obligations under the *policy* and, as often as may be reasonably necessary:

1. Sign, date and deliver to *us* authorizations to obtain any medical or other information, records or documents *we* deem relevant from any person or entity;
2. Obtain and furnish to *us*, or *our* representatives, any medical or other information, records or documents *we* deem relevant;
3. Answer, under oath or otherwise, any questions *we* deem relevant, which *we* or *our* representatives may ask; and
4. Furnish any other information, aid or assistance that *we* may require, including without limitation, assistance in communicating with any person or entity including requesting any person or entity to promptly provide to *us*, or *our* representative, any information, records or documents requested by *us*.

If any *covered person*, or other person acting on his or her behalf, fails to provide any of the items or information requested or to take any action requested, the claim(s) will be closed and no further action will be taken by *us* unless and until the item or information requested is received or the requested action is taken, subject to the terms and conditions of the *policy*.

In addition, failure on the part of any *covered person*, or other person acting on his or her behalf, to provide any of the items or information requested or to take any action requested may result in the denial of the claim at issue to the *member.*

Time for Payment of Claims
Benefits will be paid as soon as *we* receive proper *proof of loss*.

Payment of Claims
Except as set forth in this provision, all benefits are payable to *you.* Any accrued benefits unpaid at *your* death, or *your dependent's* death may, at *our* option, be paid either to the beneficiary or to the estate. If any benefit is payable to *your* or *your dependent's* estate, or to a beneficiary who is a minor or is otherwise not competent to give valid release, *we* may pay up to $1,000 to any relative who, in *our* opinion, is entitled to it.

We may pay all or any part of the benefits provided by this *policy* for *hospital,* surgical, nursing, or medical services, directly to the *hospital* or other person rendering such services.

Any payment made by *us* in good faith under this provision shall fully discharge *our* obligation to the extent of the payment. *We* reserve the right to deduct any overpayment made under this *policy* from any future benefits under this *policy*.

Foreign Claims Incurred For Emergency Care
Claims incurred outside of the United States for *emergency* care and treatment of a *covered person* must be submitted in English or with an English translation. Foreign claims must include the applicable medical records in English to show proper *proof of loss*.

Assignment
We will reimburse a *hospital* or health care provider if:
1. *Your* health insurance benefits are assigned by *you* in writing; and
2. *We* approve the assignment.

Any assignment to a *hospital* or person providing the treatment, whether with or without *our* approval, shall not confer upon such *hospital* or person, any right or privilege granted to *you* under the *policy* except for the right to receive benefits, if any, that *we* have determined to be due and payable.

Medicaid Reimbursement
The amount payable under this *policy* will not be changed or limited for reason of a *covered person* being eligible for coverage under the Medicaid program of the state in which he or she lives.

We will pay the benefits of this *policy* to the state if:
1. A *covered person* is eligible for coverage under his or her state's Medicaid program; and
2. *We* receive proper *proof of loss* and notice that payment has been made for *covered expenses* under that program.

Our payment to the state will be limited to the amount payable under this *policy* for the *covered expenses* for which reimbursement is due. Payment under this provision will be made in good faith. It will satisfy *our* responsibility to the extent of that payment.

Insurance With Other Insurers
If *you* are eligible to receive *benefits* under this policy and any basic hospital, medical-surgical, major medical plan, then the policy with the earliest effective date is the primary policy of coverage and the other

policy is the secondary policy. *You* must obtain *benefits* from *your* primary policy before *you* can obtain *benefits* from the secondary policy. This policy does not pay *benefits* for any *benefits you* receive under any primary policy.

Insurance With Medicare
If a person is also a Medicare beneficiary, Medicare is always the primary plan. This means that benefits paid for *eligible expenses* by *your* plan will be reduced by the amount that Medicare pays.

Custodial Parent
This provision applies if the parents of a covered *eligible child* are divorced or legally separated and both the custodial parent and the non-custodial parent are subject to the same court or administrative order establishing custody. The custodial parent, who is not a *covered person*, will have the rights stated below if *we* receive a copy of the order establishing custody.

Upon request by the custodial parent, *we* will:
1. Provide the custodial parent with information regarding the terms, conditions, benefits, exclusions and limitations of the *policy*;
2. Accept claim forms and requests for claim payment from the custodial parent; and
3. Make claim payments directly to the custodial parent for claims submitted by the custodial parent. Payment of claims to the custodial parent, which are made under this provision, will fully discharge *our* obligations.

A custodial parent may, with *our* approval, assign claim payments to the *hospital* or *medical practitioner* providing treatment to an *eligible child*.

Physical Examination
We shall have the right and opportunity to examine a *covered person* while a claim is pending or while a dispute over the claim is pending. These examinations are made at *our* expense and as often as *we* may reasonably require.

Legal Actions
No suit may be brought by *you* on a claim sooner than sixty (60) days after the required *proof of loss* is given. No suit may be brought more than three years after the date *proof of loss* is required.

No action at law or in equity may be brought against *us* under the *policy* for any reason unless the *covered person* first completes all the steps in the complaint/grievance procedures made available to resolve disputes in *your* state under the *policy*. After completing that complaint/grievance procedures process, if *you* want to bring legal action against *us* on that dispute, *you* must do so within three years of the date *we* notified *you* of the final decision on *your* complaint/grievance.

INTERNAL CLAIMS AND APPEALS PROCEDURES AND EXTERNAL REVIEW

Overview

If *you* need help: *If you do not understand your rights or if you need assistance understanding your rights or you do not understand some or all of the information in the following provisions, you may contact Arkansas Health & Wellness Solutions, Ambetter of Arkansas, at the Member Services Department, Post Office Box 26440 Little Rock, Arkansas 72221, by telephone at 1-877-617-0390, by fax at 1-877-941-8076 or www.ambetterofarkansas.com..*

Internal Claims and Appeals Procedures: When a health insurance plan denies a claim for a treatment or service (a claim for plan benefits, *you* have already received (post-service claim denial) or denies *your* request to authorize treatment or service (pre-service claim denial), *you*, or someone *you* have authorized to speak on *your* behalf (an authorized representative), can request an appeal of the plan's decision. If the plan rescinds *your* coverage or denies *your* application for coverage, *you* may also appeal the plan's decision. When the plan receives *your appeal*, it is required to review its own decision. When the plan makes a claim decision, it is required to notify *you* (provide notice of an *adverse benefit determination*):

- The reasons for the plan's decision;
- *Your* right to file appeal the claim decision
- *Your* right to request an *external review*; and
- The availability of a Consumer Assistance Program at The Arkansas Department of Insurance.

- If *you* do not speak English, *you* may be entitled to receive appeals' information in *your* native language upon request.
- When *you* request an *internal appeal*, the plan must give *you* its decision as soon as possible, but no later than:
  - 72 hours after receiving *your* request when *you* are appealing the denial of a claim for urgent care. (If *your* appeal concerns urgent care, *you* may be able to have the internal appeal and external reviews take place at the same time.)
  - 30 days for appeals of denials of non-urgent care *you* have not yet received.
  - 60 days for appeals of denials of services *you* have already received (post-service denials).
  - No extensions of the maximum time limits are permitted unless *you* consent.

Continuing Coverage: *The plan cannot terminate your benefits until all of the appeals have been exhausted.* ***However, if the plan's decision is ultimately upheld, you may be responsible for paying any***

outstanding claims or reimbursing the plan for claims' payments it made during the time of the appeals.

Cost and Minimums for Appeals: There is no cost to *you* to file an appeal and there is no minimum amount required to be in dispute.

Defined terms: Any terms appearing in *italics* are defined at the end of these provisions.

Emergency medical services: If the plan denies a claim for an emergency medical service, *your* appeal will be handled as an *urgent appeal. The plan will advise you at the time it denies the claim that you can file an expedited internal appeal. If you have filed for an expedited internal appeal, you may also file for an expedited external review (see "Simultaneous urgent claim, expedited internal review and external review").*

***Your* rights to file an appeal of denial of health benefits:** *You or your authorized representative, such as your health care provider, may file the appeal for you, in writing, either by mail or by facsimile (fax). For an urgent request, you may also file an appeal by telephone:*

Arkansas Health & Wellness Solutions, Ambetter of Arkansas, at the Appeals Unit, Post Office Box 26440, Little Rock, Arkansas 72221, by telephone at 1-877-617-0390, by fax at 1-877-941-8076 or www.ambetterofarkansas.

Please include in *your* written appeal or be prepared to tell us the following:

- Name, address and telephone number of the insured person;
- The insured's health plan identification number;
- Name of health care provider, address and telephone number;
- Date the health care benefit was provided (if a post-claim denial appeal)
- Name, address and telephone number of an *authorized representative* (if appeal is filed by a person other than the insured); and
- A copy of the notice of *adverse benefit determination.*

Rescission of coverage: If the plan rescinds *your* coverage, *you* may file an appeal according to the following procedures. The plan cannot terminate *your* benefits until all of the appeals have been exhausted. Since a rescission means that no coverage ever existed, if the plan's decision to rescind is upheld, *you* will be responsible for payment of all claims for *your* health care services.

Time Limits for filing an internal claim or appeal: *You* must file the internal appeal within 180 days of the receipt of the notice of claim denial (an adverse benefit determination). Failure to file within this time limit may result in the company's declining to consider the appeal.

In general, the health plan may unilaterally extend the time for providing a decision on both pre-service and post-service claims for 15 days after the expiration of the initial period, if the plan determines that such

an extension is necessary for reasons beyond the control of the plan. There is no provision for extensions in the case of claims involving urgent care.

Time Limits for an External Appeal: *You* have 180 days to file for an *external review* after receipt of the plan's *final adverse benefit determination*.

***Your* Rights to a Full and fair review**. The plan must allow *you* to review the claim file and to present evidence and testimony as part of the internal claims and appeals process.

- The plan must provide *you*, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan (or at the direction of the plan) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to give *you* a reasonable opportunity to respond prior to that date; and

- Before the plan can issue a *final internal adverse benefit determination* based on a new or additional rationale, *you* must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of *final internal adverse benefit determination* is required to be provided to give *you* a reasonable opportunity to respond prior to that date.

- The adverse determination must be written in a manner understood by *you*, or if applicable, *your* authorized representative and must include all of the following:

    - The titles and qualifying credentials of the person or persons participating in the first level review process (the reviewers);
    - Information sufficient to identify the claim involved, including the date of service, the health care provider; and
    - A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.

- As a general matter, the plan may deny claims at any point in the administrative process on the basis that it does not have *sufficient information*; such a decision; however, will allow *you* to advance to the next stage of the claims process.

Other Resources to help *you*

Department of Insurance: For questions about *your* rights or for assistance *you* may also contact the Consumer Services Division at The Arkansas Department of Insurance (800) 852-5494.

Department of Labor: If this is a health plan provided through *your* employer or under a retiree health benefit plan through *your* former employer, *your* rights are also protected by ERISA. For information about *your* rights under ERISA, *you* may contact the **Employee Benefits Security Administration** (EBSA), an agency of the Department of Labor, at (866) 444-3272.

Language services are available from the health benefit plan and from The Arkansas Department of Insurance.

Your rights to appeal and the instructions for filing an appeal are described in the provisions following this Overview.

INTERNAL CLAIMS AND APPEALS

Non-urgent, pre-service claim denial

For a non-urgent *pre-service claim,* the plan will notify *you* of its decision as soon as possible but no later than 15 days after receipt of the claim.

If the plan needs more time, it will contact *you*, in writing, telling *you* the reasons why it needs more time and the date when it expects to have a decision for *you*, which should be no later than 15 days.

If the plan needs additional information from *you* before it can make its decision, it will provide a notice to *you*, describing the information needed. *You* will have 45 days from the date of the plan's notice to provide the information. If *you* do not provide the additional information, the plan can deny *your* claim. In which case, *you* may file an appeal.

Urgent Pre-service Care claim denial

If your claim for benefits is urgent, you or your authorized representative, or your health care provider (physician) may contact us with the claim, orally or in writing.

If the claim for benefits is one *involving urgent care*, we will notify *you* of our decision as soon as possible, but no later than 72 hours after we receive *your* claim provided *you* have given us information sufficient to make a decision.

If *you* have not given us sufficient information, we will contact *you* as soon as possible but no more than 24 hours after we receive *your* claim to let *you* know the specific information we will need to make a decision. *You* must give us the specific information requested as soon as *you* can but no later than 48 hours after we have asked *you* for the information.

We will notify *you* of our decision as soon as possible but no later than 48 hours after we have received the needed information or the end of the 48 hours *you* had to provide the additional information.

To assure *you* receive notice of our decision, we will contact *you* by telephone or facsimile (fax) or by another method meant to provide the decision to *you* quickly.

In determining whether a claim involves urgent care, the plan must apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. **However, if a physician with knowledge of *your* medical condition determines that a claim involves urgent care, or an emergency, the claim must be treated as an urgent care claim.**

Simultaneous *urgent claim and expedited* internal review:

In the case of a claim involving urgent care, *you* or *your* authorized representative may also request an expedited internal review. A request for expedited internal review may be submitted orally or in writing

by the claimant; and all necessary information, including the plan's benefit determination on review, shall be transmitted between the plan and the claimant by telephone, facsimile, or other expeditious method.

The physician, if the physician certifies, in writing, that *you* has a medical condition where the time frame for completion of an expedited review of an internal appeal involving an adverse benefit determination would seriously jeopardize the life or health of *you* or jeopardize *your* ability to regain maximum function, *you* may file a request for an expedited external review to be conducted simultaneously with the expedited internal appeal.

Simultaneous urgent claim, expedited internal review and external review:
You, or *your* authorized representative, may request an expedited external review if both the following apply

1. *You* have filed a request for an expedited internal review; and
2. After a final adverse benefit determination, if either of the following applies:

    a. *Your* treating physician certifies that the adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of *you*, or would jeopardize *your* ability to regain maximum function, if treated after the time frame of a standard external review;

    b. The final adverse benefit determination concerns an admission, availability of care, continued stay, or health care service for which *you* received emergency services, but has not yet been discharged from a facility.

Concurrent care decisions
Reduction or termination of ongoing plan of treatment: If we have approved an ongoing plan or course of treatment that will continue over a period of time or a certain number of treatments and we notify *you* that we have decided to reduce or terminate the treatment, we will give *you* notice of that decision allowing sufficient time to appeal the determination and to receive a decision from us before any interruption of care occurs.

Request to extend ongoing treatment: If *you* have received approval for an ongoing treatment and wish *to extend the treatment* beyond what has already been approved, we will consider *your* appeal as a request for urgent care. If *you* request an extension of treatment at least 24 hours before the end of the treatment period, we must notify *you* soon as possible but no later than 24 hours after receipt of the claim.

An appeal of this decision is conducted according to the urgent care appeals procedures.

Concurrent urgent care and extension of treatment: Under the concurrent care provisions , any request that involves both urgent care and the extension of a course of treatment beyond the period of time or number of treatments previously approved by the plan must be decided as soon as possible, taking into account the medical urgencies, and notification must be provided to the claimant within 24 hours after receipt of the claim, provided the request is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Non-urgent request to extend course of treatment or number of treatments: If a request to extend a course of treatment beyond the period of time or number of treatments previously approved by the plan does not involve urgent care, the request may be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim, e.g., as a pre-service claim or a post-service claim.

If the request is not made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request must be treated as a claim involving urgent care and decided in accordance with the urgent care claim timeframes, e.g., as soon as possible, taking into account the medical emergencies, but not later than 72 hours after receipt.

Post-service appeal of a claim denial (retrospective)

If *your* appeal is for a *post-service claim denial*, we will notify *you* of our decision as soon as possible but no later than 30 days after we have received *your* appeal. If we need more time, we will contact *you*, telling *you* about the reasons why we need more time and the date when we expect to have a decision for *you*, which should be no later than 15 days, provided that the we determine that such an extension is necessary due to matters beyond our control, and we notify you prior to the expiration of the initial 30 days period. If the reason we need more time to make a decision is because *you* have not given us necessary information, *you* will have 45 days from the date we notify *you* to give us the information. We will describe the information needed to make our decision in the notice we send *you*. This is also known as a "retrospective review." The plan will notify *you* of its determination as soon as possible but no later than 5 days after the benefit determination is made.

The plan will let *you* know before the end of the first 30-day period, explaining the reason for the delay, requesting any additional information needed, and advising *you* when a final decision is expected. If more information is requested, *you* have at least 45 days to supply it. The claim then must be decided no later than 15 days after *you* supply the additional information or the period given by the plan to do so ends, whichever comes first. The plan must get *your* consent if it wants more time after its first extension. The plan must give *you* notice that *your* claim has been denied in whole or in part (paying less than 100% of the claim) before the end of the time allotted for the decision.

EXTERNAL REVIEW

Right to External Review

Under certain circumstances, *you* have a right to request an external review of our adverse benefit decision by an independent review organization or by the superintendent of insurance, or both.

If *you* have filed internal claims and appeals according with the procedures of this plan, and the plan has denied or refused to change its decision, or if the plan has failed, because of its actions or its failure to act, to provide *you* with a *final determination* of *your* appeal within the time permitted, or if the plan waives, in writing, the requirement to exhaust the internal claims and appeals procedures, *you* may make a request for an *external revie*w of an *adverse benefit determination*.

All requests for an *external review* must be made within 180 days of the date of the notice of the plan's *final adverse benefit determination*. Standard requests for an external review must be provided in writing; requests for expedited external reviews, including experimental/investigational, may be submitted orally

or electronically. When an oral or electronic request for review is made, written confirmation of the request must be submitted to the plan no later than 5 days after the initial request was made.

You may file the request for an _external review_ by contacting the plan

Arkansas Health and Wellness Solutions, Ambetter of Arkansas, at the Appeals Unit, Post Office Box 26440 Little Rock, Arkansas 72221, by telephone at 1-877-617-0390, by fax at 1-877-941-8076 or www.ambetterofarkansas.com.

Non-urgent request for an external review
Unless the request is for an expedited external review, the plan will initiate an external review within 5 days after it receives *your* written request if *your* request is complete. The plan will provide *you* with notice that it has initiated the external review that includes:
(a) The name and contact information for the assigned independent review organization or the superintendent of insurance, as applicable, for the purpose of submitting additional information; and
(b) Except for when an expedited request is made, a statement that *you* may, with 10 business days after the date of receipt of the notice, submit, in writing, additional information for either the independent review organization or the superintendent of insurance to consider when conducting the external review.

If _your_ request is not complete, the plan will notify *you* in writing and include information about what is needed to make the request complete.

If the plan denies _your_ request for an external review on the basis that the adverse benefit determination is not eligible for an external review, the plan will notify *you*, in writing, the reasons for the denial and that *you* have a right to appeal the decision to the superintendent of insurance.

If the plan denies _your_ request for an _external review_ because _you_ have failed to exhaust the Internal Claims and Appeals Procedure, *you* may request a written explanation, which the plan will provide to *you* within 10 days of receipt of *your* request, explaining the specific reasons for its assertion that *you* were not eligible for an *external review* because *you* did not comply with the required procedures.

Request for external review to Arkansas Department of Insurance: If the plan denies *your* request for an *external review*, *you* may file a request for the Arkansas Department of Insurance to review the plan's decision by contacting Consumer Services Division at 800-686-1526 between 8:00 a.m. and 5:00 p.m., eastern standard time or by sending a written request addressed to: Consumer Services, The Arkansas Department of Insurance, Consumer Services Division, 1200 West Third Street, Little Rock, AR 72201-1904. Information about external reviews is also available on the Department's website: www.insurance.arkansas.gov.

If the Arkansas Department of Insurance upholds the plan's decision: If *you* file a request for an external review with the Arkansas Department of Insurance, and if the superintendent upholds the plan's decision to deny the *external review* because *you* did not follow the plan's internal claims and appeals procedures, *you* must resubmit *your* appeal according to the plan's internal claims and appeals procedures within 10 days of the date of *your* receipt of the superintendent's decision. The clock will begin running on

all of the required time periods described in the internal claims and appeals procedures when *you* receive this notice from the superintendent.

If the plan's failure to comply with its obligations under the *internal claims and appeals procedures* was considered (i) *de minimis*, (ii) not likely to cause prejudice or harm to *you* (claimant), (iii) because we had a good reason or our failure was caused by matters beyond our control (iv) in the context of an ongoing good-faith exchange of information between the plan and *you* (claimant) or *your authorized representative* and (v) not part of a pattern or practice of our not following the internal claims and appeals procedures, then *you* will not be deemed to have exhausted the internal claims and appeals requirements. *You* may request an explanation of the basis for the plan's asserting that its actions meet this standard.

Expedited external review : *You* may have an expedited external review if *your* treating *physician* certifies that the *adverse benefit determin*ation involves a *medical condition* that could seriously jeopardize the life or health of *you* (claimant), or would jeopardize *your* ability to regain maximum function if treated after the time frame for a *standard external review*; or the *final adverse benefit determination* concerns an admission, availability of care, continued stay, or health care service for which *you* received emergency services, but have not yet been discharged from a facility.
The request may be made orally or electronically by *you* or *your* health care provider.

Expedited external review for experimental and/or investigational treatment: *You* may request an external review of an adverse benefit determination based on the conclusion that a requested health care service is experimental or investigational, except when the requested health care service is explicitly listed as an excluded benefit under the terms of the health benefit plan.
To be eligible for an external review under this provision, *your* treating physician shall certify that one of the following situations is applicable:
(1) Standard health care services have not been effective in improving *your* condition;
(2) Standard health care services are not medically appropriate for *you*; or
(3) There is no available standard health care service covered by the health plan issuer that is more beneficial than requested health care service.

The request for an expedited external review under this provision may be requested orally or by electronically. For Expedited/Urgent requests, *your* health care provider can orally make the request on *your* behalf.

If the request for an *expedited external review* is complete and eligible, the plan will immediately provide or transmit all necessary documents and information considered in making the adverse benefit determination in question to the assigned independent review organization (IRO) by telephone, facsimile or other available expeditious method.

If the request is not complete, we will notify you immediately, including what is needed to make the request complete.

Independent Review Organization: An *external review* is conducted by an independent review organization (IRO) selected on a random basis as determined in accordance with Arkansas law. The IRO

will provide *you* with a written notice of its decision to either uphold or reverse the plan's *adverse benefit determination* within 30 days of receipt of a *standard external review (not urgent)*.

If an *expedited external review* (urgent) was requested, the IRO will provide a determination as soon as possible or within 72 hours of receipt of the expedited request. The IRO's decision is binding on the company. If the IRO reverses the health benefit plan's decision, the plan will immediately provide coverage for the health care service or services in question.

If the superintendent or IRO requires additional information from *you* or *your* health care provider, the plan will tell *you* what is needed to make the request complete.

If the plan reverses its decision: If the plan decides to reverse its adverse determination before or during the external review, the plan will notify *you*, the IRO, and the superintendent of insurance within one business day of the decision.

After receipt of health care services: No expedited review is available for adverse benefit determinations made after receipt of the health care service or services in question.

Emergency medical services: If plan denies coverage for an emergency medical service, the plan will also advise at the time of denial that *you* request an expedited internal and *external review* of the plan's decision.

Review by the superintendent of insurance: If the plan has made an adverse benefit determination based on a contractual issue (e.g., whether a service or services are covered under *your* contract of insurance), *you* may request an external review by the superintendent of insurance.

If the IRO and Superintendent uphold the plan's decision, *you* may have a right to file a lawsuit in any court having jurisdiction.

Definitions

Adverse benefit determination means any of the following:

A. a decision by a health plan issuer:
   1. To deny, reduce, or terminate a requested health care service or payment in whole or in part, including all of the following:
      a. A determination that the health care service does not meet the health plan issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, including experimental or investigational treatments;
      b. A determination of an individual's eligibility for individual health insurance coverage, including coverage offered to individuals through a nonemployer group, to participate in a plan or health insurance coverage;
      c. A determination that a health care service is not a covered benefit;
      d. The imposition of an exclusion, including an exclusion for pre-existing conditions, source of injury, network, or any other limitation on benefits that would otherwise be covered.

2. Not to issue individual health insurance coverage to an applicant, including coverage offered to individuals through a nonemployer group;
3. To rescind coverage on a health benefit plan.

B. a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in par) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary.

An "adverse benefit determination" also includes a rescission of the participant or beneficiary.

Ambulatory review means utilization review of health care services performed or provided in an outpatient setting.

Authorized representative means an individual who represents *you* in an internal appeal or external review process of an adverse benefit determination who is any of the following:
(1) A person to whom a covered individual has given express, written consent to represent that individual in an internal appeals process or external review process of an adverse benefit determination;
(2) A person authorized by law to provide substituted consent for a covered individual;
(3) A family member but only when *you* are unable to provide consent.

Claim involving urgent care means any claim for Medicare care or treatment with respect to the application of the time periods for making non-urgent care determinations

- Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or,

- In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment is the subject of the claim.

The determination whether a claim is a "claim involving urgent care" will be determined by the plan; or, by a physician with knowledge of the claimant's medical condition.

You means a policyholder, subscriber, enrollee, member, or individual covered by a health benefit plan. "*You*" does include *your* authorized representative with regard to an internal appeal or external review in accordance with division (C) of this section. "*You*" does not include *your* representative in any other context.

de minimis means something not important; something so minor that it can be ignored.

Emergency medical condition means a medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain that a prudent layperson with an average knowledge of health and

medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

1. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part.

Emergency services means the following:

1. A medical screening examination, as required by federal law, that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department, to evaluate an emergency medical condition;
2. Such further medical examination and treatment that are required by federal law to stabilize an emergency medical condition and are within the capabilities of the staff and facilities available at the hospital, including any trauma and burn center of the hospital.

As used when referring to *emergency services* or *emergency medical condition*, "Stabilize" means the provision of such medical treatment as may be necessary to assure, within reasonable medical probability, that no material deterioration of an individual's medical condition is likely to result from or occur during a transfer, if the medical condition could result in any of the following:

a. 1) Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
   2) Serious impairment to bodily functions;
   3) Serious dysfunction of any bodily organ or part.
b. In the case of a woman having contractions, "stabilize" means such medical treatment as may be necessary to deliver, including the placenta.

Transfer has the same meaning as in section 1867 of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 1395dd, as amended.

Final adverse benefit determination means an adverse benefit determination that is upheld at the completion of a health plan issuer's internal appeals process.

Health care professional means a physician, psychologist, nurse practitioner, or other health care practitioner licensed, accredited, or certified to perform health care services consistent with state law.

Health care provider or *provider* means a health care professional or facility.

Independent review organization (IRO) means an entity that is accredited by a nationally recognized private accrediting organization to conduct independent external reviews of adverse benefit determinations and by the superintendent of insurance in accordance with Arkansas law.

Language assistance means translation services provided if requested. Contact customer service at 1-877-617-0390 if oral or written services are needed.

1. The plan or issuer must provide oral language services (such as a telephone customer assistance hotline) that include answering questions in any applicable non-English language

and providing assistance with filing claims and appeals (including external review) in any applicable non-English language;
2. The plan or issuer must provide, upon request, a notice in any applicable non-English language; and
3. The plan or issuer must include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the plan or issuer.

Applicable non-English language. With respect to an address in any United States county to which a notice is sent, a non-English language is an applicable non-English language if ten percent or more of the population residing in the county is literate only in the same non-English language, as determined in guidance published by the Secretary.

Medical care means the diagnosis, cure, mitigation, treatment, or prevention of disease or for the purpose of affecting any structure or function of the body and for transportation primarily for and essential to the provision of such care.

Post-service claim means any claim for a benefit under a group health plan that is not a "pre-service claim."

Pre-service claim means any claim for a benefit under a group health plan, with respect to which the terms of the plan condition receipt of the benefit, in completely or in part, on approval of the benefit in advance of obtaining medical care.

Physician means a provider who holds a certificate under Arkansas law authorizing the practice of medicine and surgery or osteopathic medicine and surgery or a comparable license or certificate from another state.

Rescission means a cancellation or discontinuance of coverage that has a retroactive effect. "Rescission" does not include a cancellation or discontinuance of coverage that has only a prospective effect or a cancellation or discontinuance of coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage

Urgent care claims: If *your* claim involves *urgent care*, we will notify *you* as soon as possible but no later than 72 hour after we have received the appeal for a denied claim for urgent care.

Utilization review means a process used to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Areas of review may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review.

GENERAL PROVISIONS

Entire Contract
This *policy,* with the application and any rider-amendments is the entire contract between *you* and *us.* No change in this *policy* will be valid unless it is approved by one of *our* officers and noted on or attached to this *policy.* No agent may:

1. Change this *policy*;
2. Waive any of the provisions of this *policy*;
3. Extend the time for payment of premiums; or
4. Waive any of *our* rights or requirements.

All riders or endorsements added to the *policy* after the date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the *policy* shall require signed acceptance by the insured. After date of *policy* issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the *policy* term must be agreed to in writing signed by the insured, except if the increased benefits or coverage is required by law.

Non-Waiver
If *we* or *you* fail to enforce or to insist on strict compliance with any of the terms, conditions, limitations or exclusions of the *policy* that will not be considered a waiver of any rights under the *policy*. A past failure to strictly enforce the *policy* will not be a waiver of any rights in the future, even in the same situation or set of facts.

Rescissions
No misrepresentation of fact made regarding a *covered person* during the application process that relates to insurability will be used to void/rescind the insurance coverage or deny a claim unless:

1. The misrepresented fact is contained in a written application, including amendments, signed by a *covered person;*
2. A copy of the application, and any amendments, has been furnished to the *covered person(s),* or to their beneficiary; and
3. The misrepresentation of fact was intentionally made and material to *our* determination to issue coverage to any *covered person.* A *covered person's* coverage will be voided/rescinded and claims denied if that person performs an act or practice that constitutes fraud. "Rescind" has a retroactive effect and means the coverage was never in effect.

Repayment for Fraud, Misrepresentation or False Information
During the first two years a *covered person* is insured under the *policy*, if a *covered person* commits fraud, misrepresentation or knowingly provides false information relating to the eligibility of any *covered person* under this *policy* or in filing a claim for *policy* benefits, *we* have the right to demand that *covered person* pay back to *us* all benefits that *we* paid during the time the *covered person* was insured under the *policy*.

Conformity with State Laws
Any part of this *policy* in conflict with the laws of the state in which your policy was issued on this *policy's effective date* or on any premium due date is changed to conform to the minimum requirements of that state's laws.

Conditions Prior To Legal Action
On occasion, *we* may have a disagreement related to coverage, benefits, premiums, or other provisions under this *policy*. Litigation is an expensive and time-consuming way to resolve these disagreements and should be the last resort in a resolution process. Therefore, with a view to avoiding litigation, *you* must give written notice to *us* of *your* intent to sue *us* as a condition prior to bringing any legal action. *Your* notice must:

1. Identify the coverage, benefit, premium, or other disagreement;
2. Refer to the specific *policy* provision(s) at issue; and
3. Include all relevant facts and information that support *your* position.

Unless prohibited by law, *you* agree that *you* waive any action for statutory or common law extra-contractual or punitive damages that *you* may have if the specified contractual claims are paid, or the issues giving rise to the disagreement are resolved or corrected, within thirty (30) days after *we* receive *your* notice of intention to sue *us*.