UNIVERSITY OF ARKANSAS

Alternate Point of Service Benefit Plan

SUMMARY PLAN DESCRIPTION

Effective January 1, 2011

QualChoice

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Alternate POS Schedule of Benefits

	In-Network Benefits	Out-of-Network Benefits
All Enrollees	Access care through your QualChoice National Network or Participating Provider in the QualChoice network	Access care from Out-of-Network Physicians, Hospitals, and Providers
	In and out-of-network deductibles are separate deductibles and do not cross accumulate	**In and out-of-network deductibles are separate deductibles and do not cross accumulate**
Individual Deductible (l) Family Deductible (l)	$750 (b) $1,500 (b)	$1,000 (b) $2,000 (b)
Coinsurance	20% (c)	40% (c)
Limitation on Out of Pocket Expenses for Coinsurance for Individual Limitation on Out of Pocket Expenses for Coinsurance for Family	$2,000 $4,000	$5,000 (e) $10,000 (e)
Lifetime Maximum	Unlimited	Unlimited
PREVENTIVE CARE SERVICES (a)		
Annual Physical Exams (PCP or OB/GYN)	Paid in Full	Not Covered
Well Baby/Child Visit	Paid in Full	Deductible & Coinsurance
Routine Preventive Gynecological Visits	Paid in Full	Not Covered
Immunizations	Paid in Full	Deductible & Coinsurance
Annual Screening Mammograms	Paid in Full	Not Covered
Bone Density Screening(k)	Paid in Full	Not Covered
Colorectal Screening	Paid in Full	Deductible & Coinsurance
PHYSICIAN SERVICES IN OFFICE (a)		
Primary Care Physician's or Participating OB/GYN Office Visit	$25 Co-payment	Deductible & Coinsurance
Specialist and other Provider Office Visit	$40 Co-payment **(and deductible and coinsurance will apply for the following services in addition to the co-payment):** *Advanced Imaging including but not limited to:* • Nuclear Medicine, • PET Scans, • MRI • MRA • CT Scans • CTA Scans • SPECT Scans All require prior authorization	Deductible & Coinsurance
Surgical Services	Paid in Full	Deductible & Coinsurance
Diagnostic Testing	Paid in Full	Deductible & Coinsurance

PHYSICIAN SERVICES NOT IN OFFICE		
Inpatient Medical Care	Deductible & Coinsurance	Deductible & Coinsurance
Diagnostic Testing	Deductible & Coinsurance	Deductible & Coinsurance
Surgical Services	Deductible & Coinsurance	Deductible & Coinsurance
PHYSICIAN MATERNITY SERVICES		
Maternity / Obstetrical Care	$25 Co-payment for initial visit only (f)	Deductible & Coinsurance
OUTPATIENT FACILITY SERVICES		
Diagnostic Testing (includes ultrasound of the Breast)	Deductible & Coinsurance	Deductible & Coinsurance
Surgical Services	Deductible & Coinsurance	Deductible & Coinsurance
Emergency Room Visit (d)	$150 Co-payment	$150 Co-payment
Urgent Care Center	$50 Co-payment	$100 Co-payment

INPATIENT SERVICES		
Semi-Private Room and Board, Intensive Care Room and Board and Ancillary Charges	$250 Co-payment remainder subject to Deductible and Coinsurance. Maximum of $1,000 per calendar year for inpatient Co-payments	$250 Co-payment remainder subject to Deductible and Coinsurance. Maximum of $1,000 per calendar year for inpatient Co-payments.
OTHER SERVICES		
Ambulance (d)	$100 Co-payment, waived if admitted to hospital	$100 Co-payment, waived if admitted to hospital
Home Health Service 40 visits per year	Deductible & Coinsurance	Deductible & Coinsurance
Speech Therapy 10 visits per year	Deductible & Coinsurance	Deductible & Coinsurance
Physical and/or Occupational Therapy and Chiropractic services 30 visits per year	Deductible & Coinsurance	Deductible & Coinsurance
Durable Medical Equipment Insulin pumps- ($5,500 per year) All other DME combined- ($2,000 a year)	Deductible & Coinsurance	Deductible & Coinsurance
Hospice (6 month maximum)	Deductible & Coinsurance	Deductible & Coinsurance
Mental Health / Substance Abuse **Inpatient Care** **Outpatient services** **Treatment plan may be required after initial visit**	$250 Co-payment remainder subject to Deductible and Coinsurance. Maximum of $1,000 per calendar year for inpatient Co-payments $ 25Co-payment	$250 Co-payment remainder subject to Deductible and Coinsurance. Maximum of $1,000 per calendar year for inpatient Co-payments Deductible & Coinsurance
Routine Vision Exam (every 12 months)(g)	$25 Co-payment	Not Covered
TMJ Rider - $10,000 Lifetime Benefit *	20% Coinsurance after $1,000 Deductible for TMJ	40% Coinsurance after $2,000 Deductible for TMJ

Hearing Aids (h)	Covered up to $1,400 per ear every three years.	Covered up to $1,400 per ear every three years.
Genetic Testing Note: Genetic testing is typically not covered, except in rare situations. When covered, these tests are subject to Deductible and Coinsurance. Talk with your physician. If genetic testing is done and there is no pre-authorization, you will be responsible for the charges. See medical policies at www.qualchoice.com for more information.	No benefits if not pre-authorized 20% after Deductible	No benefits if not pre-authorized 40% after Deductible
Prosthetics and Orthotics (i) Prosthetic Services & Prosthetic Devices Orthotic Services and orthotic Devices(i)	20% after Deductible	40% after Deductible
Prescription Drug Benefit Generic Drugs Preferred Drugs Non-Preferred Drugs Reference Based Pricing (j) See prescription drug program under medical benefits section	 Co-payment - $10 Co-payment - $35 Co-payment - $70 May apply on some drug categories	 Co-payment - $12 Co-payment - $37 Co-payment - $72

- **Note: TMJ deductible is in addition to the medical deductible.**

Footnotes: Some of the services listed above may require Pre-authorization, for details go to www.qualchoice.com for a full list of services that require Pre-authorization. Other services such as Mental Health and Substance Abuse require authorization for medical necessity as outlined under the section for Mental Health.

(a) You pay the PCP Co-payment when you obtain health care directly from your Network Primary Care Physician or designated backup provider for your PCP. For all other services from Network Providers, you pay the Specialist Co-payment. Services rendered in the Network Primary Care Physician or Network Specialist's office may be subject to deductible or coinsurance.

(b) Calendar year Deductible applies to all Covered Services except to those that a Co-payment applies unless otherwise noted above.

(c) Coinsurance applies to all Covered Services except to those that a Co-payment applies unless otherwise noted above.

(d) Both the Emergency Room Co-payment and Ambulance Co-payment are waived if the enrollee is admitted to the hospital. Notification of admission is required.

(e) When you obtain health care through a non-participating provider (Out-of-Network benefit), reimbursement for covered physician services will be limited to the Maximum Allowable Payment as determined by QualChoice. Charges in excess of the Maximum Allowable Payment do not count toward meeting the limitation on your Out-of-Pocket Expense Limitation. Providers under the Out-of-Network benefit may bill the patient for amounts in excess of the Maximum Allowable Payment.

(f) For maternity services, a co-payment for the initial office visit is all that is required. Maternity services include pre-natal and post-natal care from the Network OB/GYN of your choice. One ultrasound is covered during weeks 16-20 of your pregnancy. Any other ultrasounds must be pre-authorized. You will also be responsible for $250 inpatient facility co-payment, Deductible, and Coinsurance at time of confinement and applicable coinsurance. **It is your responsibility to notify the Human Resource office at your campus at the time of your child's birth in order to obtain coverage for your newborn.**

(g) You must see an in-network Ophthalmologist or Opometrist for services to be covered under the plan.

(h) "Hearing aid" means an instrument or device, including repair and replacement parts, that: (1) Is designed and offered for the purpose of aiding persons with or compensating for impaired hearing; (2) Is worn in or on the body; and (3) Is generally not useful to a person in the absence of a hearing impairment.

(i) Prosthetics and Orthotics, UA does not cover replacement or associated services more frequently than one (1) time every three years unless Medically Necessary. Beneftis covered under Prosthetic and Orthotics will be paid at no less than 80% of Medicare eligible charges.

(j) Reference Based Pricing applies a set price per dose in a specific class of drugs. Example: In the Proton Pump Inhibitor (PPI) class, the plan pays a predetermined amount per dose and the member pays the remainder of the cost.

(k) Bone Density screening test preventive for women age 65 and older. Bone Density screening for individual less than 65 years of age may qualify as preventative care if pre-authorization criteria are met.

(l) Each January 1st a new deductible amount is required. However, Covered Charges incurred in and applied toward the deductible in October, November and December will be applied to the deductible in the next Calendar Year as well as the current Calendar Year. Deductibles do not accrue toward the 100% maximum out-of-pocket payment.

This notice is being provided as required by the Patient Protection and Affordable Care Act.

The University of Arkansas health plan believes its plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your coverage under the University of Arkansas health plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. **(Please note that the University of Arkansas health plan is in compliance with all preventive health service requirements and covers all preventive services at zero member copayment).** However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to QualChoice at 1-866-724-3570. You may also contact the U.S. Department of Health and Human Services at www.healthcare.gov.

INTRODUCTION

The University of Arkansas System (UA) has chosen to establish a comprehensive program of medical care benefits ("Plan") for you and your Covered Dependents. We have contracted with QCA Health Plan, Inc. ("QualChoice"), a third party administrator, to provide administrative services for these health care Benefits.

This booklet is for the Alternate Point-of-Service. The amount you pay for the care you and your Covered Dependents receive varies based on how you access service.

QualChoice as the Plan Supervisor, whose name and address are contained in this booklet, handles the day-to-day administration of your Plan.

This booklet is known as a "Summary Plan Description" (SPD) and it provides a description of the major and important provisions of the Plan.

You are entitled to coverage if you are eligible for Benefits according to the provisions of this Plan. This SPD is not applicable if you are not entitled to coverage. No clerical error will invalidate your coverage if it would otherwise be validly in force.

This Plan is self-funded by the University of Arkansas System. This means the cost of you and your dependents medical care is paid out of monies set aside for that purpose by the UA and from employee contributions. The University of Arkansas System has also obtained special insurance protection in the event of large claims. Other Benefits, either insured or self-funded, may also be provided by the University of Arkansas System and such Benefits (if any) are described in separate documents.

General questions regarding Benefits and enrolling for them can be directed to your UA Campus Human Resources Office. Questions regarding your medical care should be directed to Customer Service at QualChoice. QualChoice can also answer most questions regarding the Plan, or can direct you to the appropriate person.

HOW YOUR PROGRAM WORKS

1. FLEXIBLE BENEFIT OPTIONS

When you become an Enrollee eligible for Benefits under the Plan, the Plan provides you with flexible choice in selecting Providers and reimbursement options when obtaining health care services. A number of independent, privately practicing physicians and medical facilities ("Network") are available to you. From this Network, you may select a Network Primary Care Physician to provide and/or arrange for all of your health care needs.

As an alternative, at the time you need medical services, you may seek care from any physician of your choice, whether or not they are a Network provider.

The Plan gives you a single plan with two approaches to obtaining medical services. The amount you pay for the care you and your Covered Dependents receive varies based on your access to the care. (Please refer to Point 4. "Your Payments Under this Plan" below.) You have the freedom to select either In-Network benefits or Out-of-Network benefits at the point you are seeking care.

- **In-Network benefits**, your Network Primary Care Physician (PCP) arranges care and you have minimal costs.

- **Out-of-Network benefits** provide the widest choice of providers: You are free to seek care outside the Network. However, your Out-of-Pocket Expense Limitation is highest under this benefit.

***You and your covered dependents are asked to select a QualChoice Network Primary Care Physician ("PCP") in order to obtain In-Network Benefits*.** The selected PCP(s) will have primary responsibility for your treatment and the treatment of your Covered Dependents.

Services will be determined as In-Network and Out-of-Network based on your access to services.

You have the opportunity to choose either In-Network benefits or Out-of-Network benefits each and every time you seek care as described in greater detail below:

A. In-Network benefits: You seek Covered Medical Services from your Network Primary Care Physician (PCP) who is a Network Provider. This physician provides services and can help arrange for your health care with other Network Providers, if you wish. You pay only a Co-payment to your Network Primary Care Physician for the Network Primary Care Physician's office visit. You do not pay any additional fees for other Covered Medical Services rendered by your Network Primary Care Physician. If you seek Covered Medical Services from any Network Provider, You pay only a Co-payment to the Network Provider for services rendered in their office.

When your Network Primary Care Physician or any other Network Provider orders Covered Medical Services for you from an Out-of-Network Provider, those Covered

Medical Services will be paid as Out-of-Network Benefits. You must pay the Out-of-Network Deductible and Coinsurance up to the maximum Out-of-Pocket Expense Limitation for Coinsurance (See your Schedule of Benefits).

For services which are not available from a Network Provider, any Network Physician may request services from an Out-Of-Network Provider on your behalf. All Out-of-Network services requested to be considered as In-Network Benefits require a **prior authorization** from the medical director at QualChoice. If the medical director does not authorize the Referral to an Out-Of-Network Provider, the services will be paid as Out-of-Network benefits. (See the Schedule of Benefits).

B. Out-of-Network benefits: You may seek Covered Medical Services from a physician or other Designated Provider who is not a Network Provider. When you select this Option, you must satisfy an annual Deductible. You must also pay Coinsurance up to the maximum Out-of-Pocket Expense Limitation for Coinsurance (See your Schedule of Benefits).

You also pay the Out-of-Network Deductible and Coinsurance for all Covered Medical Services, which an Out-of-Network Physician orders for you from any other Out-of-Network Provider, including in-patient care.

If the Out-of-Network Provider orders Covered Medical Services or care for you from a Network Provider, those Network Provider's Covered Medical Services will be paid as In-Network Benefits and any applicable Deductible and Coinsurance will apply (See your Schedule of Benefits). As you can see, Out-of-Network benefits require you to pay a larger share of the cost of your Covered Medical Services.

Special Note: Out-Of-Network Provider. Under Out-of-Network benefits, payment for charges, whether in an in-patient or outpatient setting, is based on the Maximum Allowable Payment for the service. If the charge billed to you is greater than the Maximum Allowable Payment, you must pay the excess portion. Deductibles and Coinsurance are based on the Maximum Allowable Payment. See Definitions for Maximum Allowable Payment.

You must notify QualChoice when you are planning a hospital admission. (See "Special Procedures for Admissions by Out-of-Network Physicians.")

For Medically Necessary (see Paragraph 6, "Medical Necessity" below) Emergency care and/or an unexpected sickness or injury while traveling out-of-area, QualChoice may waive Out-of-Network provisions. Under special circumstances, Covered Medical Services may be considered In-Network Benefits. For more detailed information, see "Review of Emergency Admissions," and "Coverage While Traveling."

In certain circumstances, some Benefits described in this Summary Plan Description have limits or may vary or require you to pay additional cost sharing. You should refer to your Schedule of Benefits and to the specific conditions, limitations, exclusions, and/or payment levels that are set forth in the Section that describes that Benefit in detail (for example, Medical Services, Hospital Care). Please also refer to, "Exclusions," for a description of services and supplies that are not covered under your Plan.

2. THE QUALCHOICE NETWORK

The On-line Provider Directory lists all physicians and providers who have agreed to be a part of the Network and provide Covered Medical Services to Enrollees. QualChoice will update the Network Directory periodically. This list is grouped by specialty and indicates Network medical and OB/GYN Primary Care Physicians, and Network Specialists.

Network Primary Care Physicians include family practice physicians, internists, pediatricians, gynecologists and obstetricians whom you may choose to provide your primary care. Network Specialists include oncologists, cardiologists, orthopedists, and other designated specialists, from whom you may obtain care directly (under In-Network Benefits).

Physicians who are not members of the QualChoice Network are referred to as "Out-of-Network Physicians" throughout this SPD.

Please note that QualChoice contracts with Network Providers are not a guarantee or a warranty by the University of Arkansas System or by QualChoice of the professional services of such provider. The selection of a Network Provider or any other provider and the decision to receive or decline to receive health care service is YOUR responsibility as a member under this plan.

3. SELECTION OF A NETWORK PRIMARY CARE PHYSICIAN

A. Selection of a Network Primary Care Physician. To obtain In-Network Benefits, each Enrollee must select a QualChoice Network Primary Care Physician (PCP) from the QualChoice Network Providers at the time of application for enrollment. You must indicate your selection of a PCP on your Enrollment Application.

If you do not choose a Network Primary Care Physician, then you will only be eligible for the coverage provided under Out-of-Network benefits should you have an emergency out of the Service Area.

For In-Network Benefits you must select a Network Primary Care Physician who will care for your newborn child either before the child's birth or at the time you enroll the child for coverage. You should notify QualChoice of this selection by using the appropriate selection form that is available from your UA Campus Human Resources Department or from QualChoice. You should also select a Network Primary Care Physician for any other dependent eligible for coverage after your initial enrollment.

B. In-Network Obstetrician/Gynecologist. Females age sixteen (16) or older may seek services from any Network Obstetrician/Gynecologist for obstetrical and/or gynecological services for the Co-Payment shown on your Schedule of Benefits. Services obtained from an Out-of-Network provider will be considered under Out-of-Network benefits.

C. Change of Selection of Network Primary Care Physician. You may change your or your Covered Dependent's selection of a Network Primary Care Physician six (6) months following your initial enrollment, and then once every six (6) months. You may change your Network PCP even sooner if you can demonstrate good cause for the change. If your Network Primary Care Physician withdraws from the Network, dies, suspends, or terminates their practice for any reason, you may select another provider at once. You must tell QualChoice each time you change your Network Primary Care Physician. List your choice of a new Network Primary Care Physician on an Enrollment Application and send it to QualChoice or change it on-line at www.qualchoice.com retroactive changes are not permitted.

Please note: If you receive medical services from the new Network Primary Care Physician prior to the effective date of the transfer, you will be liable for the Specialist co-payment associated with that care.

4. YOUR PAYMENTS UNDER THIS PLAN

When you choose In-Network or Out-of-Network benefits, you share in the cost of your Covered Medical Services through payment of Co-Payment, Coinsurance, a Deductible, or combination. Your Deductible, Co-payment, Coinsurance, and Out-of-Pocket Expense are explained below.

A. Co-payment. A Co-payment is a fixed dollar amount that you must pay each time you receive a particular Covered Medical Service. See your Schedule of Benefits for a list of those Services that require Co-payments.

B. Coinsurance. Coinsurance applies to specific services obtained under the In-Network and Out-of-Network benefits. It is a fixed percentage of charges you must pay toward the cost of Covered Medical Services. Your Coinsurance amount is listed in your Schedule of Benefits. Your Plan has negotiated fee schedules and discount arrangements with QualChoice Network providers. These savings can be passed along to you as a lower Coinsurance amount under the In-Network Benefit than under the Out-of-Network benefit. In addition, QualChoice Network Providers agree to accept the QualChoice allowance for Covered Medical Services as the basis for their fees. This means Network Providers may not bill you for additional fees other than your Coinsurance amount.

C. Deductible. Deductible means a fixed dollar amount that you must incur before the Plan begins to pay for the cost of Covered Medical Services you receive during each calendar year. See the Schedule of Benefits for the Deductible amount for each Enrollee.

D. Out-of-Pocket Expense Limitation for Coinsurance. Under this plan, your Out-of-Pocket Expense Limitation is limited each year to the maximum stated in your Schedule of Benefits. After you have paid that amount for Coinsurance, then you do not have additional payments for Coinsurance during the remainder of that year. **Deductibles and Co-payments do not count toward your Out-of-Pocket Expense Limitation. Also, charges in excess of the Maximum Allowable Payment under the Out-of-Network benefit do not count toward meeting your Out-of-Pocket Expense Limitation. Providers under the Out-of-Network benefit may bill the patient for amounts in excess of the Maximum Allowable Payment.**

5. PAYMENTS FOR OUT-OF-NETWORK PROVIDERS

The Plan may make Payment for Covered Medical Services rendered by Out-of-Network Providers either to the provider or directly to you. When you receive the payment you will have to pay the Out-of-Network Provider.

Special Note: Out-Of-Network Providers. Under the Out-of-Network benefit, payment for provider charges, whether in an in-patient or outpatient setting, is based on the Maximum Allowable Payment for the service. If the charge billed to you is greater than the Maximum Allowable Payment, you must pay the excess portion. Deductibles and Coinsurance are based on the Maximum Allowable Payment. Maximum Allowable Payment means the highest amount, as pre-determined by QualChoice, that will be payable for a particular service when it is rendered by a Designated Provider and a claim submitted.

Example (assumes you have already met your annual Deductible):

Out-of-Network Provider charge:	$1,000
Maximum Allowable Payment limit:	$400
Plan pays 60% of $400:	$240
You pay 40% Coinsurance:	$160
Plus balance of charge above $400:	$600
You will be responsible for:	$760

Example for Out-of-Network Hospital Charge:

Out-of-Network Hospital charge:	
Hospital Billed Charges	$50,000
Contractual Discount	N/A
Maximum Allowable Payment limit:	$23,000
Co-Payment Paid by You	-$250
Deductible Paid by You	-$1,000
Coinsurance Paid by You	$9,520
QualChoice Total Payment	$12,280
Difference between Maximum Allowable & Billed Charges	$27,000
Your Total Financial Responsibility	$37,720

If you are considering expensive services under the Out-of-Network benefit that is, using Out-of-Network Providers, it is always a good idea to verify what limits may apply to the charges. Of course, if you use QualChoice Network Providers (under In-Network benefits), you know that these providers have an agreement to limit their charges through their agreement with QualChoice. Also, Network Providers will not bill patients other than for Co-payments, Deductible, and Coinsurance on covered services. Should you have expenses that are excluded from coverage, any provider will have the right to bill you for the services rendered.

Under the Out-of-Network benefit, any charges in excess of the Maximum Allowable Payment do not apply to the Out-of-Pocket Expense Limitation. Providers under the Out-of-Network benefit may bill the patient for any amounts in excess of the Maximum Allowable Payment and any treatment that is excluded from the benefit plan.

6. MEDICAL NECESSITY

Covered Medical Services must be Medically Necessary for payment. This requirement applies to all sections of the SPD. If a Network Provider's service is not Medically Necessary, the Network Provider cannot bill you for the part of the fees that would have been paid if the service had been Medically Necessary.

If QualChoice determines that an Out-of-Network service is not Medically Necessary either before or after it has been given by an Out-of-Network Provider, you will have to pay for the charges for services that were deemed to be not Medically Necessary.

The definition of "Medically Necessary" is included in the Definitions Section.

Examples of medically unnecessary care include but are not limited to: inpatient hospital admission for care that could have been provided safely either in a doctor's office or as an outpatient; a hospital stay longer than is Medically Necessary to treat your condition; when hospitalized, services not medically required to diagnose or treat your condition; care provided in a more costly facility or setting than is necessary; or a surgical procedure instead of a medical treatment that could have achieved equally satisfactory management of your condition.

QualChoice, on the Plan's behalf, will not make any payment for care that is not Medically Necessary. In cases where QualChoice determines that services or care were rendered in an inappropriate setting (e.g., admission to a hospital for care that could have been provided safely

in a doctor's office), the Plan will pay only the amount that would have been paid for care in the more appropriate setting.

In these situations, QualChoice determination of Medical Necessity will be made after considering the advice of trained medical professionals, including physicians, who will use medically recognized standards and criteria. In making the decision, QualChoice will examine the circumstances surrounding your condition and the care provided. This will also include your provider's reasons for providing or prescribing the care, and any unusual circumstances that are brought to QualChoice's attention. *However, the fact that a physician prescribed the care or service does not automatically mean that the care is Medically Necessary or that it qualifies for coverage.*

7. COVERAGE WHILE TRAVELING AND OUT-OF-AREA STUDENT COVERAGE.

If you reside in the Service Area, Out-of-Network Services that you obtain directly are covered as Out-of-Network Benefits and you must pay the Deductible and Coinsurance amounts. However, when you are traveling out of the Service Area for some purpose **other than the receipt of medical care or are a covered dependent <u>through age 25</u> residing out of the service area,** the Plan may provide In-Network Benefits for illness or injury if the following criteria are met:

- The condition is one of rapid onset, or the result of an injury;
- Return to the Service Area to receive treatment from your Network Primary Care Physician or other Network provider is not feasible;
- The treatment is determined to be Medically Necessary;
- We are notified within one business day after any inpatient admission; or as soon as you or a person acting on your behalf are physically able to do so; and
- All claims and proof of service are submitted to us in writing within 60 days after the date on the original bill.

If your care meets the above conditions and you have selected a Network Primary Care Physician, In-Network benefits may be provided. Otherwise, Out-of-Network Benefits will apply.

You must notify QualChoice within forty-eight (48) hours, or as soon as physically possible, any time you require Emergency care.

Your Benefits can then be verified for the physician, urgent care center, or hospital and QualChoice can arrange direct payment to the provider. See Section, "Special Procedures for Admissions by Out-of-Network Physicians" regarding Emergency hospital care.

If you or any Covered Dependents reside outside the Service Area, you will be eligible for Out-of-Network Benefits only.

SPECIAL PROCEDURES FOR ADMISSIONS BY OUT-OF-NETWORK PHYSICIANS or ADMISSIONS IN AN OUT-OF-NETWORK FACILITY

IMPORTANT NOTICE:

This Section applies only when you obtain care through your Out-of-Network benefits and are to be admitted to a hospital or skilled nursing facility. This applies to Out-of-Network hospitals and facilities, when a Physician from whom you sought care directly admits you.

Before the admission, you must call QualChoice at 1-800-235-7111 for Pre-authorization.

When you obtain care from a Physician and they admit you to an Out-of-Network hospital or skilled nursing facility, your Medically Necessary care is paid under Out-of-Network benefits for hospital services. When an Out-of-Network Physician admits you to a Network hospital, the Out-of-Network Physician's services are paid as Out-of-Network benefits and the hospital services are paid as In-Network benefits.

1. PREADMISSION REVIEW OF INPATIENT CARE

All elective medical and surgical inpatient admissions in an Out-of-Network hospital or a skilled nursing facility must be reviewed by QualChoice in advance. Upon completing its review, QualChoice will then approve or disapprove coverage for such admission.

An "elective" admission is for a condition that does not require immediate medical attention and for which reasonable delays will not adversely affect your health or recovery. A foreseeable hospital admission -- such as for the birth of a child -- is also considered an "elective" admission for purposes of this requirement for Preadmission Review. You should notify QualChoice at least two weeks in advance, if possible, that you plan to enter a hospital.

QualChoice will notify you of its decision to approve or disapprove coverage for your admission within five business days after it receives the notice of your proposed admission. QualChoice will approve your admission if inpatient care is Medically Necessary and appropriate. If QualChoice does not approve your admission, and you are admitted anyway, QualChoice will review your claim for payment and, if it is determined that any portion of the care was Medically Necessary, the Plan will cover only that portion of your care.

If QualChoice disapproves coverage for your admission because it is not Medically Necessary for you to have inpatient care, your physician may call QualChoice. If the physician provides QualChoice with additional information that justifies an inpatient admission, QualChoice will approve the reimbursement for that admission. Or, after talking with the Network Physician, the physician may arrange to have your care provided on an outpatient basis.

If you disagree with QualChoice's decision, you may appeal by following the steps described in Paragraph Number 3 of this Section.

If you do not call QualChoice regarding your admission to an Out-of-Network hospital or a skilled nursing facility and obtain your hospital Pre-authorization, you will be held responsible for the bill.

In addition, the Plan will not cover any care that QualChoice's claim review indicates is or was not Medically Necessary.

2. REVIEW OF EMERGENCY ADMISSIONS

QualChoice must review all admissions to a hospital for Emergency care, when you are in an Out-of-Network facility. Upon completing that review, QualChoice then approves or disapproves payment for such admission based on the provisions of this plan.

You, or a family member, or your doctor should call QualChoice at 1-800-235-7111 within forty-eight (48) hours after the Emergency occurred or as soon as physically possible, if later. Remember, if you do not fulfill your hospital authorization requirement, you will be held responsible for the bill.

However, if you notify QualChoice and QualChoice approves payment for the Emergency services, your Benefits will be paid under In-Network benefits, without application of Deductible or Coinsurance.

An Emergency is when both of the following conditions are met: There is a sudden, unexpected onset of a medical or psychological condition; and immediate care is necessary to prevent placing life or health in jeopardy or causing serious impairment to bodily functions.

3. APPEALS

If you disagree with any of QualChoice's decisions, you may appeal by following the grievance and appeal procedures set forth in the Section, "Complaints & Appeals."

ELIGIBILITY AND EFFECTIVE DATE

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

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

A. **"University of Arkansas" or "UA"** means the University of Arkansas System.

B. **"Eligible Employee"** means you are an eligible employee if you are a full time employee of the University, unless you are an employee of a community college not participating in the Plan. A full time employee is any employee who is employed half-time or greater and is on at least a nine month appointment period. However, for purposes of this Plan "Eligible Employees" shall also include Residents, Interns and house staff members at the University of Arkansas for Medical Sciences.

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

D. **"Participant" or "Enrollee"** means an Eligible Employee, Eligible Disabled Employee or Eligible Retiree covered under the Plan in accordance with this Section.

E. **"Eligible Dependent" or "Covered Dependent"** means only the following persons not otherwise eligible for coverage under the Plan as a Participant:

i. The lawful spouse of the Participant;

ii. Each child of the Participant until the date on which they attained the age of twenty-six (26) years.

For retirees, except for HIPAA Family Status Changes as provided herein, only dependents covered under the Plan as of the date of retirement shall be considered Eligible Dependents.

No person may be simultaneously covered as a Participant and as a dependent under the Plan.

F. **"Child"** includes (in addition to a legitimate natural child of the Participant) the following:

i. an adopted child for whom a petition for adoption has been filed or the final court order has been issued;

ii. a step-child as long as a natural parent remains married to the Employee;

iii. a foster child for whom the Participant is legally responsible; or

iv. a person for whom a covered Employee is the Legal Guardian.

No person not described above including a grandchild shall be considered a child.

G. **"Covered Individual"** means only a Participant or a Participant's Eligible Dependent who is covered under this Plan in accordance with this Section.

H. **"Active Work"** means the performance of full or part-time work by an Eligible Employee for UA either at the employee's customary place of employment or at such other place or places as required by UA in the course of work for the full number of hours and full rate of pay in accordance with the established employment practices of UA for full or part-time employees.

I. **"Claims Administrator"** means the agent retained by UA to determine the validity of claims and administer benefit payments. The Claims Administrator is QCA Health Plan, Inc. (QualChoice).

J. "HIPAA Family Status Change" means a change in your coverage level due to marriage, birth or adoption of a child, death or divorce, or court orders mandating medical coverage for minor children. . HIPAA Family Status Changes apply to active employees, retirees and former employees on COBRA. **NOTE: An Individual has 31 days from any of the above-mentioned changes to add UA Medical Benefit Coverage for the employee and any Eligible Dependent.**

K. "HIPAA Special Enrollment" is a 31-day medical plan enrollment period immediately following an employee or Eligible Dependent's loss of COBRA coverage, loss of eligibility for other medical coverage (including medical coverage attributable to the spouse's employment), or loss of the employer contribution for the other coverage. However, the employee must have previously declined the UA Medical Benefit Coverage due to having other medical coverage. **NOTE: Loss of coverage does not include loss due to failure to pay premiums on a timely basis.** HIPAA Special Enrollment periods apply only to active employees or former employees on COBRA. Also, a retiree may, in the event of a HIPAA Special Enrollment event, add a dependent who was a covered dependent under this Plan at the time of retirement but who has been dropped from coverage as a result of the dependent having other coverage.

L. "Eligible Disabled Employee" is a disabled employee with over ten years of consecutive service with the UA, and who has at least 10 consecutive years of medical coverage under the UA Medical Benefit Plan, will be eligible for coverage under the UA Medical Benefit Plan upon full payment of the current premium amount made in the same manner as an eligible retiree.

2. Eligible Classes of Employees

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

A. Eligible Employees of UA;

B. COBRA Qualified Beneficiaries of UA;

C. Surviving Dependents of Deceased Employees of UA, covered under the health Plan at the time of death;

D. Eligible Retirees; or

E. Eligible Disabled Employees previously employed and covered by the UA (as provided in above in number 1, paragraph L.)

3. Employee Eligibility Date

Employees in an Eligible Class of Employees are eligible for coverage on the date they enter Active Work for the Employer. If an Employee is not in an Eligible Class, he will become eligible for coverage on the date he enters an Eligible Class.

4. Effective Date of Participation for Eligible Employees

Subject to the Effective Date, an Eligible Employee shall become a Participant in this Plan at 12:01 a.m. on the earliest of the following dates:

A. January 1, 2011, with respect to an Eligible Employee who, on December 31, 2010,

was covered under the UA Plan which has been amended January 1, 2011; or

B. The first day of the month coincident with or next following the date the Eligible Employee enrolls and authorizes any required contributions for coverage, provided he does so within thirty-one (31) days after the Eligibility Date; or

C. All Eligible Employees please contact your Human Resources Office to complete the forms adding coverage. YOU MUST NOTIFY YOUR HUMAN RESOURCES OFFICE OF ANY ADDITION/CHANGE WITHIN 31 DAYS of your HIPAA Family Status Change or HIPAA Special Enrollment event. Your effective date will be later of the date of the HIPAA Family Status Change or HIPAA Special Enrollment or the first day of the month following date your written election is received by the Human Resources Office. In the case of birth of a child or adoption, the effective date will be the date of birth or placement for adoption. **NOTE: The employee must enroll and authorize any required contributions for employee coverage, provided such employee does so within thirty-one (31) days after his Eligibility Date; or**

D. Benefits-eligible part-time Employees changing to a benefits-eligible full-time position will be effective on the first day of the month coincident with or next following the date the Eligible Employee enrolls and authorizes any required contributions for coverage, provided the Employee enrolls within thirty-one (31) days of this non-HIPAA enrollment event; or

E. During any Open Enrollment period that may be designated by the University of Arkansas, on the effective date of the Open Enrollment following the date the Eligible Employee enrolls and authorizes any required contribution for coverage.

F. An Eligible Employee who does not enroll on his or her eligibility date will not be able to enroll in the plan unless he or she subsequently has a HIPAA Family Status Change, HIPAA Special Enrollment event, a non-HIPAA enrollment event as defined in number 4 D above or the University conducts an open enrollment.

G. Residents, Interns and House Staff members at the University of Arkansas for Medical Sciences will be effective the first officially recognized day of their respective programs.

5. Eligibility Date for Dependent Coverage

Each employee's Eligibility Date for Dependent Coverage shall be the first date on which the employee is eligible for coverage under this Plan and has one or more Eligible Dependents, as defined in this Section .

6. Effective Date of Coverage for Eligible Dependents

Subject to the Effective Date, Coverage for Eligible Dependents shall become effective on the applicable date determined below, but in no event prior to the date the employee becomes a Participant in this Plan:

A. The employee's Eligibility Date for Dependent Coverage, provided the employee enrolls and authorizes any required contributions for Dependent Coverage on or before the date;

B. If the employee has a HIPAA Family Status Change or HIPAA Special Enrollment event, the later of the date of the HIPAA Family Status Change or HIPAA Special Enrollment event or first day of the calendar month following the date your written election to enroll and authorize required contributions is received by the Human Resources Office. In the case of birth or adoption of a child, coverage will be effective as of the date of birth or placement for adoption. In either case, the employee must make the written election to enroll within thirty-one (31) days after the HIPAA Family Status Change or HIPAA Special Enrollment Event.

C. The first day of the calendar month following the date any retiree has a HIPAA Family Status Change event and enrolls and authorizes any required contributions for Dependent Coverage.

D. All Employees please visit your Human Resources Office to complete the forms adding or dropping dependent coverage. YOU MUST NOTIFY YOUR HUMAN RESOURCES OFFICE OF ANY CHANGE WITHIN 31 DAYS OF THE HIPAA Family Status Change or HIPAA Special Enrollment event. Dependent coverage shall be effective from the date of birth for each Dependent child born, provided that the employee notifies the Human Resources Office within 31 days of birth. Your effective date of enrollment for any other HIPAA Family Status Change or HIPAA Special Enrollment event will be the later of the date of the HIPAA Family Status Change or HIPAA Special Enrollment event or the first day of the calendar month following the date your written election is received by the Human Resources Office. **NOTE: An employee with employee only coverage or employee and spouse coverage must enroll and authorize any required contributions for newborn dependent coverage within 31 days after the date of the eligible dependent's birth.**

You may select a Network Primary Care Physician who will care for your newborn child either prior to the child's birth or at the time you enroll the child for coverage.

You should notify QualChoice of this selection by using the appropriate selection form that is available from your UA Campus Human Resources department or from QualChoice. You should also select a Network Primary Care Physician for any other dependent who becomes eligible for coverage after your initial enrollment.

7. Effective Date of Participation for Eligible Retirees

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

TERMINATION OF COVERAGE

When coverage under this Plan stops, Plan Participants will receive a certificate that will show the period of Creditable Coverage under this Plan. Please contact your campus Human Resources Office to determine how to receive a Certificate of Creditable Coverage.

Termination of coverage could occur for failure of the Employee or Dependent to provide information necessary for QualChoice to comply with applicable law, including, but not limited to, the Employee's or Dependent's social security number or other government issued identification number.

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

1. The date the Plan ceases; or

2. The date the Plan ceases for the Class of Employees to which the Participant belongs; or

3. The date active employment ceases, except as provided by the Plan; or

4. The date ending the period for which the last contribution is made, if the employee is required to pay all or part of the cost of the Plan; or

5. In the event that an employee terminates employment before the end of the payroll cycle, your coverage will end on the date in accordance with procedures established by your campus.

Termination of Dependent Coverage

Except as provided in the paragraphs below, coverage for a dependent of a Participant shall terminate at midnight on the earliest of the following dates:

1. The date ending the period for which the Employee's last contribution is made, if they are required to pay all or a part of the cost of the Plan;

2. The date the Employee's coverage ceases, except as provided under For Dependents of Deceased Employees;

3. The date a covered Spouse loses coverage due to divorce or legal separation.. (See the section entitled Continuation Coverage Rights under COBRA.

4. The date a Dependent ceases to be an eligible Dependent, except as provided for a Handicapped Dependent Child as set forth below.

Provided, however:

A. Continuation of Coverage for a Handicapped Dependent Child

A covered unmarried child who, before the date they attain the limiting age, becomes incapable of self-sustaining employment by reason of mental or physical handicap and who is wholly dependent upon the Participant for support and maintenance, shall not cease to qualify as an Eligible Dependent solely because of attained age while they remain so incapacitated and dependent, provided the Declaration of Disability supporting such dependent's incapacity and dependency status is submitted to QualChoice of Arkansas, Inc. no more than ninety (90) days prior to nor thirty-one (31) days after the date such dependent would otherwise cease to be an Eligible Dependent by reason of attained age.

B. For Dependents of Deceased Employees

In the event of the Employee's death at the time that Dependent Coverage is in effect, all medical coverage will be extended for such dependents, but in no event beyond the earliest of the following dates:

i. The date the surviving spouse remarries;

ii. The date the dependent ceases to be an Eligible Dependent, except for a Handicapped Dependent Child; or

iii. The date the Plan ceases; or

iv. The date ending the period for which the last contribution is made, if a contribution is required toward the cost of the Plan.

Coverage may be continued under this provision or under any provision requiring the UA to offer continuation of coverage under any federal law. Coverage may not be continued under both provisions. For continuation of coverage information, please refer to that section.

Periodically the University of Arkansas may require additional information regarding the Continuation of Coverage for a Handicapped Dependent Child.

Continuation During Waiting Period for Long Term Disability. In the event that an employee is disabled, the employee may remain eligible during any accrued sick leave and, if applicable, catastrophic leave. Any such coverage will end at the end of the waiting period for UA long term disability policy or the date the employee is determined to be eligible for social security disability, which ever is earlier.

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

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

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Waiting Periods will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated. Upon returning to work, the Employee is not automatically reinstated. The Employee must complete the requested paperwork as provided by the Human Resource Department. .

Employees on Military Leave.

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

1. The maximum period of coverage of a person under such an election shall be the lesser of:

A. The 24 month period beginning on the date on which the person's absence begins; or

B. The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

This right to continue coverage is not in addition to any COBRA rights.

2. An exclusion or waiting period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

SPECIAL ENROLLMENT RIGHTS

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

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 31 days after the birth, marriage, adoption or placement for adoption. Documentation of the event is required (adoption papers, guardianship papers, divorce decree, marriage certificate, etc.)

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, please contact the Human Resources Department at your campus.

FURTHER DETAILS ABOUT HIPAA FAMILY STATUS AND SPECIAL ENROLLMENT RIGHTS

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

1. Individuals losing other coverage creating a Special Enrollment right**.** An Employee or Dependent, who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage is due to each of the following conditions:

A. The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

B. If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

C. The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated.

D. The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

E. For purposes of these rules, a loss of eligibility occurs if:

i. The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals.

ii. The Employee or Dependent has a loss of eligibility as a result of divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child

under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

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

iv. The Employee or Dependent has a loss of eligibility when coverage is 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, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the Employee or Dependent loses other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), the individual does not have a Special Enrollment right. Also, there is no Special Enrollment Right if the other coverage changes as to benefits or employer contributions towards such coverage (so long as such employer is paying some portion of the cost of such coverage).

2. A Dependent may be enrolled in the plan if:

A. The Employee is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

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

The Dependent Special Enrollment Period is a period of 31 days and begins on the date of the marriage or birth of child. The special enrollment period for adoption or placement for adoption is 60 days. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during these time periods.

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

i. in the case of marriage, the later of the date of marriage or the first day of the calendar month following the date the completed enrollment form is received by the Employer.

ii. in the case of a Dependent's birth, as of the date of birth; or

iii. in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

iv. you or your dependent loses Medicaid coverage or coverage under the state Children's Health Insurance Program (CHIP, for example, ARKids) because you are no longer eligible, or you or your dependent qualifies for state assistance in paying your employer group medical plan premiums. In the event you or your dependent loses Medicaid coverage under the state Children's Health Insurance Program (CHIP, for example, ARKids) because of loss of eligibility or become eligible for a state's premium assistance program, you must notify your Human Resource Department within 60 days following the date of the event.

3. Coverage for children for whom adoption petitions have been filed will begin:

   A. from the moment of birth if the petition for adoption and necessary enrollment forms are filed and any required contributions for Dependent Coverage are authorized within sixty (60) days after the date of birth; or

   B. from the date of the filing of the petition for adoption if the necessary enrollment forms are filed and any required contributions for Dependent Coverage are authorized within sixty (60) days after the date of the filing of the petition for adoption.

4. Under the Qualified Medical Child Support Order, as required by the Federal Omnibus Budget Reconciliation Act of 1993, any child of yours who is an alternate recipient under a qualified Medical Child Support Order shall be considered as having a right to be an Eligible Dependent under this Summary Plan Description.

5. In order to cover an Eligible Dependent who was not previously eligible, the Eligible Employee must notify their Campus Human Resources department promptly to change their dependency class. It may also be necessary for the Eligible Employee to change their contribution to cover an additional Dependent. The Eligible Employee should also notify the UA Campus Human Resources department when a Dependent is no longer eligible for coverage.

6. If you have dependents that reside outside of the USA you may add them to your plan within thirty-one (31) days of their arrival to the USA. If you wish to add dependents after thirty-one (31) days, you must wait for Open Enrollment.

OPEN ENROLLMENT

Though the University of Arkansas System reserves the right to offer an open enrollment period, there is no automatic open enrollment for this plan. In the event of an Open Enrollment Plan participants will receive detailed information regarding the open enrollment period.

OPEN ELECTION

The University of Arkansas System does allow an annual open election at which time plan enrollees may elect to change from one plan to another.

MEDICARE AND YOUR COVERAGE

MEDICARE SECONDARY

Medicare means the Benefits offered under Title XVIII of the Social Security Act. When you, (the Enrollee) are in any of the situations listed below, your coverage with this Plan will be primary, and Medicare will be secondary.

1. An **active** employee who is age sixty-five (65) and over;
2. An **active** employee's spouse age sixty-five (65) and over;
3. An **active** employee under age sixty-five (65) entitled to Medicare because of disability;
4. An **active** employee's spouse under age sixty-five (65) entitled to Medicare because of a disability.

When this Plan is primary, Benefits will be as described as in the SPD. If less than one hundred percent (100%) of the charges are paid by the Plan, Medicare may pay the balance under federal regulations, if you submit a claim to Medicare.

MEDICARE PRIMARY

When you, (the Enrollee) are in any of the situations listed below, your coverage with this Plan will be secondary, and Medicare will be Primary.

1. A **retired** employee who is age sixty-five (65) and over;
2. A **retired** employee's spouse age sixty-five (65) and over;
3. A **retired** employee under age sixty-five (65) entitled to Medicare because of disability;
4. A **retired** employee's spouse under age sixty-five (65) entitled to Medicare because of a disability.

When this Plan is secondary, Medicare will pay in the primary position. If less than one hundred percent (100%) of the charges are paid by Medicare, this Plan will review the payments by Medicare and process your benefits based on the terms and conditions of this Plan.

The Plan will pay benefits as if you (and any eligible dependent) had enrolled in Medicare parts A and B even if you didn't. Therefore, in order to receive maximum benefits you should enroll in Parts A and B when you become eligible for Medicare.

MEDICARE SUPPLEMENTAL BENEFIT

Your Benefit for supplemental coverage to Medicare provides Benefits secondary to Medicare when you have Medicare and are no longer an active employee/member. For information relating to Medicare and Supplemental coverage, go to www.cms.gov or call Medicare Toll-Free:1-800-633-4227

PRE-AUTHORIZATION

Certain Covered Services must be pre-authorized as Medically Necessary by QualChoice before the service is rendered on an elective basis or within two business days after the service is rendered on an emergency basis. Your responsibility for obtaining pre-authorizations varies depending on whether you use Network or Out-of-Network Providers.

When you seek care under In-Network benefits, your Network PCP or other Network Provider will obtain pre-authorization on your behalf with the exception of the authorization requirements that apply to Mental Health and Substance Abuse services. Please see Section: Medical Benefits, Mental Health and Substance Abuse for details of these requirements.

When you seek care under Out-of-Network benefits, the above exception also applies. In addition, you must call or have your provider call the number on your ID card before receiving any of the other services listed in this Section. In order to assure adequate time for the pre-authorization process to be completed, we recommend that this call be made at least five business days, but no less than two business days, prior to when you are scheduled to receive the service. If you make the call, QualChoice will contact your provider on your behalf to obtain the necessary clinical information to authorize your care. You will receive written confirmation of this authorization. If you have not received written confirmation of the authorization before your scheduled service, you must call QualChoice to verify that authorization has been obtained prior to receiving the service. If pre-authorization is not received, no payment will be made for any of the claims related to the service.

In the event of an emergency, QualChoice must be notified within two business days that one of the listed services was performed on an Emergency basis. The services will be reviewed retrospectively. In addition to the review for medical necessity, if the service does not meet the definition of an Emergency payment will be denied due to failure to pre-authorize.

Emergency is defined in the Definition Section: as "those services that are provided in a hospital emergency facility after the sudden onset of a medical or psychological condition, with symptoms of sufficient severity that in absence of immediate medical attention could result in placing the patient's health in jeopardy, serious impairment, or serious dysfunction of any bodily organ or part."

The following services require pre-authorization:

- Any Admissions to an Inpatient Facility or Partial Hospitalization Unit
- Any Referral by your Network PCP or other Network Provider to an Out-of-Network Provider
- Prenatal/Maternity care includes only a Co-payment for the initial office visit. The Plan will cover one ultrasound between the 16th and 20th week of pregnancy. Additional ultrasounds require pre-authorization.
- Home Health Care, Home Infusion Services, or Hospice (Inpatient or Outpatient)
- Transplant Services (including the evaluation to determine if you are a candidate for transplant by any transplant program)
- Any Elective Out-Of-Network services for In-Patient Services or Skilled Nursing Facility
- Screening colonoscopy under the age of 50
- PET Scans, CTA Scans, MRI of the Breast, SPECT Scan, when performed on an outpatient basis whether in an office, a clinic, a hospital outpatient department, or any other outpatient setting
- Screening bone density study under the age of 65
- Psychological testing and neuro-psychological testing go to www.qualchoice.com
- Other services and procedures may require authorization. For a full list see online at www.qualchoice.com

Certain other services have special Pre-authorization requirements. See the appropriate Section for details.

- Surgical treatment of Temporomandibular Joint Dysfunction (TMJ)
- Accidental Injury to Teeth

In addition to the above, services for which coverage may be excluded as indicated in the Exclusions should be submitted in advance for pre-determination of coverage. Examples of such services include, but are not limited to, Cosmetic Surgery, Dental Care for accidental dental injury, and procedures that could be considered Experimental/Investigative.

Appeals: If you or your physician disagrees with any of our determinations, you or your physician may appeal our decision by writing to us within 30 days of the date we notify you of our decision. For services which your physician believes require more immediate attention due to your medical condition, your physician may request an expedited appeal by calling the (501) 228-7111 or (800) 235-7111.

CASE MANAGEMENT

You have a Benefit for a Case Management Program under which QualChoice may identify and offer alternative benefits not otherwise provided to you under this Plan ("Alternative Benefits"). This program is designed primarily for Enrollees who meet the program's criteria and for whom continuing acute or skilled care in an inpatient setting is Medically Necessary.

The Case Management Program design gives you Alternative Benefits for care and services recommended by your physician and tailored to your specific health needs according to the Case Management Program's criteria. Alternative Benefits might include: waiving the limits on existing Benefits or providing coverage for otherwise non-covered services or providers. You have the right to accept or decline any Alternative Benefits QualChoice identifies and offers to you on the Plan's behalf.

The Case Management Program provides Alternative Benefits only to those Enrollees who meet the program's eligibility criteria. If QualChoice decides that Alternative Benefits should cover services recommended by your physician, QualChoice, on the Plan's behalf, may offer to pay for those services by sending you a letter explaining the offer and including detailed information.

Your acceptance of Alternative Benefits is entirely voluntary; you have the right to decide whether or not to accept them. If you do not wish to accept the Alternative Benefits available to you under the Case Management Program, your Benefits under the Plan will continue at the levels described in this Summary Plan Description.

MEDICAL BENEFITS

COVERED MEDICAL SERVICES

QualChoice, on behalf of the University of Arkansas System, will pay or reimburse for the Medically Necessary services described in this Section when a licensed provider performs or orders them. These services are the "Covered Medical Services" under the Plan. Your cost for these services depends on whether you obtain these services through In-Network or Out-of-Network providers.

1. PHYSICIAN OFFICE VISIT FEES

You must pay a Co-payment each time you receive Covered Medical Services for an office or home visit from your Network Physician.

You must pay the Out-of-Network Deductible and Coinsurance for visits to Out-of-Network Physicians.

2. PHYSICIAN OFFICE VISIT/ OUTPATIENT FACILITY COVERAGE

You have Benefits for the following services at a physician's office, surgical center, and/or the outpatient department of the hospital. Physician office visit Co-payments, a Deductible, or Coinsurance may apply depending on how you obtain care. Some of these Benefits may have additional limitations.

A. Preventive Health Services: Routine health care that includes screenings, check-ups, and patient counseling to prevent illness, disease, or other health problems are covered under this plan as outlined by the United States Preventive Services Task Force (USPSTF) outlined in sections A & B. Physical examinations, (including pap tests and annual screening mammograms performed by a Network Provider); well-baby care, including routine pediatric hearing tests; clinical laboratory and radiological tests; and routine immunizations (including, but not limited to, influenza and pneumovax). Screening for colorectal cancer (using fecal occult blood testing or sigmoidoscopy every 5 years with Fecal Occult Blood or Double-contrast barium enema every 5 years or Colonoscopy every 10 years) in adults, beginning at age 50 years and continuing until age 75 years. Hepatitis B vaccine, and any other immunization, will be covered if required for travel as related to work or UA Business, however, immunizations for personal travel is not covered (see Exclusions).

Preventive Health Services are only available under In-Network benefits with the exception of well baby care for children under age 2 that is available under both benefits.

B. Surgery. Surgery includes correction of fractures and dislocations, endoscopies and any incision or puncture of the skin or tissue that requires the use of surgical instruments (including covered oral surgery).

The Benefit amount for the surgery includes payment for Medically Necessary related care by the surgeon before and after the operation. In other words, the one payment covers the operation <u>and</u> the surgeon's care before and after the operation.

Payment for surgery is also subject to the following limitations:

i. When more than one surgical procedure is performed at the same time, whether through one or more incisions, the Plan will pay for the major or first procedure. It will also pay one-half of the payment otherwise payable for the lesser or subsequent procedures; and

ii. When an incidental procedure, including but not limited to, incidental appendectomy, lysis of adhesions, incision of previous scar, puncture of ovarian cyst is performed through the same incision, the Plan will pay for the major procedure only; and

iii. The total payment for an operative procedure that is performed in two or more steps is limited. The Plan will pay only the amount that would have been paid if the procedure was performed in one step.

C. **Diagnosis and Treatment:** Diagnosis and treatment of disease, injury, or other conditions and Emergency and urgent care, including surgical procedures performed in a physician's office, consultations with specialists, and diagnostic work-up to confirm a diagnosis of infertility. Please refer to Section, "Exclusions and Limitations" for details on Infertility Treatment exclusions.

D. **Imaging and Laboratory Services:** Includes prescribed diagnostic imaging, x-ray therapy, electrocardiograms, laboratory tests, and diagnostic clinical isotope services.

E. **Physical, Occupational, and Speech Therapy:** Outpatient visits for physical, occupational, or speech therapy services. The visit limitation includes services whether performed in a physician's office, therapist's office, outpatient therapy center, or in the outpatient department of a hospital. A visit is defined as up to one hour of therapy and up to three modalities. Services beyond one hour or three modalities constitute a separate visit.

F. **Radiation Therapy and Chemotherapy:** Radiation therapy and chemotherapy.

G. **Medications For Use In The Physician's Office**: Medications, injectables, radioactive materials, dressings and casts, administered or applied by your physician or other provider in the physician's office for preventive or therapeutic purposes.

H. **Obstetrical Services:** The full range of obstetrical services (limited to one ultrasound between the 16th and 20th week of pregnancy, pre-authorization required for additional ultrasounds), including prenatal visits and postpartum visits, and all the other services set forth above, with respect to pregnancy.

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

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

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

Charges for the care and treatment of Pregnancy are covered as stated in the schedule of benefits.

I. **Allergy Testing and Treatment:** Tests to determine the nature of allergies and desensitization treatments ("allergy shots") to alleviate allergies, including test or treatment materials.

J. **Second Opinion:** If you request a second opinion, the Plan will provide coverage for a second opinion for proposed surgery or treatment under the following conditions:

The second opinion is given by a physician, who by reason of their specialty, is an appropriate physician to consider the surgical procedure or treatment; the second opinion is given for a covered surgical procedure of a non-emergency nature; and the physician who gives the second opinion does not also perform the surgery or provide the treatment for which the second opinion was obtained.

If the physician who rendered the second opinion does perform the surgery, QualChoice will pay them for the surgery, not the second opinion consultation.

Your benefits will be determined based on the method of obtaining the second opinion. If you seek the second opinion from a Network Provider In-Network benefits are available. However, if you seek the second opinion from an Out-Of-Network Provider, Out-of-Network benefits will be applied.

K. Temporomandibular Joint Treatment (TMJ): Non-surgical care that is connected with the detection or correction of jaw joint problems, including temporomandibular joint and craniomandibular disorders, or other conditions of the joints linking the jawbone and skull. This also includes the complex of muscles, nerves, and other tissues related to that joint. Non-surgical care includes an initial exam, a removable appliance, splints and adult retainers, physical therapy, medications and muscle tests. TMJ and related care does not include dental work, such as, but not limited to, orthodontics, fixed or removable bridgework/dentures, inlays, onlays, crowns or surgery, whether done for dental or medical reasons.

Your Benefit for surgical treatment of Temporomandibular Joint Dysfunction (TMJ) is added to the Summary Plan Description according to the guidelines below.

Benefits are provided for surgical treatment of temporomandibular joint and craniomandibular disorders, or other conditions of the joints linking the jawbone and skull, including the complex of muscles, nerves, and other tissues related to that joint.

Payment will be made according to either the In-Network or Out-of-Network benefits based on the provider of service network affiliation. Please refer to your Schedule of Benefits for the applicable amounts of Deductible and Coinsurance.

L. Chiropractic Services: These services are covered. See summary of benefits.

M. Biofeedback Training: Pre-authorization is required. These services may be covered with the approval of the medical director at QualChoice based on predetermined standards which are available upon request.

N. Cardiac rehabilitation as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.

3. MEDICAL SERVICES WHILE HOSPITALIZED

During any period of covered hospitalization the Plan will cover the following:

A. Surgery. Surgery includes correction of fractures and dislocations, endoscopies and any incision or puncture of the skin or tissue that requires the use of surgical instruments (including covered oral surgery).

The Benefit amount for the surgery includes payment for Medically Necessary related care by the surgeon before and after the operation. In other words, the one payment covers the operation <u>and</u> the surgeon's care before and after the operation.

Payment for surgery is also subject to the following limitations:

i. When more than one surgical procedure is performed at the same time, whether through one or more incisions, the Plan will pay for the major or first procedure. It will also pay one-half of the payment otherwise payable for the lesser or subsequent procedures; and

ii. When an incidental procedure, including but not limited to, incidental appendectomy, lysis of adhesions, incision of previous scar, puncture of ovarian cyst is performed through the same incision, the Plan will pay for the major procedure only; and

iii. The total payment for an operative procedure that is performed in two or more steps is limited. The Plan will pay only the amount that would have been paid if the procedure was performed in one step.

B. Assistance At Surgery In A Hospital: The Medically Necessary assistance by another physician during the course of an operation.

C. Obstetrical Care: Services for the delivery of a baby, for abortion (as provided in exclusions section) or for miscarriage. The amount of the payment for obstetrical care includes payment

for all of the Medically Necessary care provided by the Designated Provider that is related to the pregnancy.

D. Medical Visits In A Hospital: Medical visits by a Designated Provider while you are a registered inpatient in a hospital. The medical visits are for care of illnesses or conditions other than those related to surgery or obstetrical care.

Separate Benefit payments for visits in connection with surgery or maternity care will not be made because the amount of the global payment for surgery or maternity care includes payment for such visits, except under the circumstances described in paragraph E immediately below.

E. Complications In A Hospital: Services of a second physician in a hospital when you have an "exceptional complication" in your surgery, maternity or inpatient hospital care. An "exceptional complication" is a condition that is not related to the condition for which you were admitted to the hospital. It may also be a condition that is so unusual that it requires more than the customary surgical, maternity or medical care.

F. Anesthesia In A Hospital: A Designated Provider's administration of anesthesia in connection with surgery or maternity care. QualChoice will not pay if the provider who administers the anesthesia also performs the care, or assists the provider who performs the care, and receives payment for that care.

G. Consultations In A Hospital: Consultation by a physician who is called in by your physician if both the following conditions are met: The consulting physician is a specialist in your illness or disease; and the consultation takes place while you are a registered inpatient in a hospital.

H Initial Newborn Child Examination: Initial examination of a newborn child in a hospital when a Designated Provider other than the delivering physician, performs the exam. Circumcision is also a Covered Medical Service.

I. Diagnostic Imaging: Diagnostic imaging performed by, or on the order of, a Designated Provider to diagnose a condition or illness for which you showed symptoms.

J. Radiation Services: Radiation services performed by, or on the order of, a Designated Provider. The radiation services may include use of x-rays, radiation or radioactive isotopes.

K. Laboratory Services: Laboratory tests performed by, or ordered by, a Designated Provider.

4. SERVICES IN YOUR HOME

A. Home Visits By A Designated Provider: A home visit (house call) by a provider who provides care to you in your home or other place of residence.

B. Home Health Care By Home Health Agency Personnel: Visits by a licensed home health agency in your home or other place of residence, up to the maximum indicated in your Schedule of Benefits.

If an Out-of-Network Provider recommends home health care, QualChoice must approve Benefits for such care in advance. Failure to meet the pre-authorization requirement for home health care may result in denial of payment for services. If the services denied occurred at an Out-of-Network facility, you will be held responsible for the bill.

Home health care may include the following: Part-time or intermittent home nursing care by or under the supervision of a registered nurse; part-time or intermittent home health aide services that consist primarily of caring for you under the supervision of a registered nurse; physical, occupational, or speech therapy, if provided through a home health agency; and skilled treatments performed by licensed or certified home health agency personnel, including the non-prescription medical supplies and drugs used or furnished during a visit by home health agency personnel. Non-prescription medical supplies and drugs may include surgical dressing and saline solutions, but do not include prescription drugs, certain intravenous solutions, and insulin.

Each visit by a member of a home care team is counted as one home care visit. Up to four (4) hours of home health aide service are counted as one home care visit.

Please call (501) 228-7111 or (800) 235-7111 to obtain pre-authorization for Home Health Care.

5. DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES

The Plan will pay for durable medical equipment, prosthetic devices and medical supplies ordered by your physician and provided by a physician, supplier or pharmacy as defined below.

Durable Medical Equipment ("DME") is equipment that is primarily used to serve a medical purpose, is non-disposable and can withstand repeated use. This equipment is appropriate for use in the home and is generally not useful in the absence of the illness or injury. Durable Medical Equipment includes but is not limited to the following items: crutches, apnea monitor, glucometer, oxygen and oxygen equipment, wheelchairs, special hospital type beds or home dialysis equipment. Covered Medical Services also include orthopedic braces that are used to support a weak portion of the body or to restrict movement in a diseased or injured part of the body. QualChoice will decide whether the item should be purchased or rented. At all times, the maximum payment is the purchase price of the equipment.

Medical supplies are small and often disposable items that are part of medical treatment for an illness or injury. The supply must be compatible with the diagnosis and generally must not be useful in the absence of the illness or injury. Medical supplies include, but are not limited to, the following items: chemstrips for a diagnosis of insulin dependent diabetes, ostomy bags and skin bond for a diagnosis of colostomy, and support stockings for a diagnosis of phlebitis or other circulatory condition.

Other items may be covered with advance written approval by the medical director at QualChoice.

6. PROSTHETIC SERVICES AND PROSTHETIC DEVICES

Prosthetic services and prosthetic devices (as defined in this Section) are covered as described below.

All “prosthetic devices” and “prosthetic services”, including the fitting and/or repair of prosthetic devices, require pre-authorization.

A “prosthetic service” is an evaluation and treatment of a condition that requires the use of a “prosthetic device”.

In order for a device to be a “prosthetic device” under this Certificate, the device must meet all three (3) of the following requirements:

1. The device is (i) intended to replace an absent external body part for the purpose of restoring physiological function or cosmesis to a patient and (ii) custom-designed, fabricated, assembled, fitted, or adjusted for the patient using the device prior to or concurrent with the delivery of the device to the patient; and
2. The device must be prescribed by a (i) licensed doctor of medicine, (ii) licensed doctor of osteopathy, or (iii) licensed doctor of podiatric medicine; and
3. The device must be provided by a (i) licensed doctor of medicine, (ii) licensed doctor of osteopathy, (iii) licensed doctor of podiatric medicine, (iv) licensed orthotist, or (v) licensed prosthetist.

A prosthetic device includes breast prosthesis to the extent required pursuant to the Women’s Health and Cancer Rights Act of 1998.

A prosthetic device does *not* include a/an (i) artificial ear, (ii) dental appliance (which would include corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain

dysfunction syndrome), (iii) cosmetic device such as artificial eyelashes or wigs, (iv) device used exclusively for athletic purposes, (v) artificial facial device, or (vi) any other device that does not have a significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body.

The Plan does not cover replacement of an prosthetic device or associated prosthetic services more frequently than one (1) time every three (3) years unless Medically Necessary or indicated by other coverage criteria under this Certificate. However, the Plan will replace or repair a prosthetic device if necessary due to anatomical changes or normal use.

7. ORTHOTIC SERVICES AND ORTHOTIC DEVICES

Orthotic services and orthotic devices (as defined in this Section) are covered as described below.

All "orthotic devices" and "orthotic services", including the fitting and/or repair of orthotic devices, require pre-authorization.

An "orthotic service" is an evaluation and treatment of a condition that requires the use of an "orthotic device".

In order for a device to be an "orthotic device" under this Certificate, the device must meet all three (3) of the following requirements:

1. The external device is (i) Intended to restore physiological function or cosmesis to a patient; and (ii) Custom-designed, fabricated, assembled, fitted, or adjusted for the patient using the device prior to or concurrent with the delivery of the device to the patient; and
2. The device must be prescribed by a (i) licensed doctor of medicine, (ii) licensed doctor of osteopathy, or (iii) licensed doctor of podiatric medicine; and
3. The device must be provided by a (i) licensed doctor of medicine, (ii) licensed doctor of osteopathy, (iii) licensed doctor of podiatric medicine, (iv) licensed orthotist, or (v) licensed prosthetist.

An orthotic device does *not* include a/an (i) cane, (ii) crutch, (iii) corset, (iv) dental appliance, (v) elastic hose, (vi) elastic support, (vii) fabric support, (viii) generic arch support, (ix) low-temperature plastic splint, (x) soft cervical collar, (xi) truss, or (xii) any similar device meeting both of the following requirements:

1. It is carried in stock and sold without therapeutic modification by a corset shop, department store, drug store, surgical supply facility, or similar retail entity; and
2. It has no significant impact on the neuromuscular, musculoskeletal or neuromusculoskeletal functions of the body.

An orthotic device also does *not* include foot orthotics that have the goal of improving foot function and minimizing stress forces that could ultimately cause foot deformity and pain. This applies to all of the broad categories of orthotics, including those that primarily attempt to change foot function, are mainly protective in nature, and/or combine functional control and protection. This also applies to rigid orthotic devices, soft orthotic devices or semi-rigid orthotic devices.

The Plan does not cover replacement of an orthotic device or associated orthotic services more frequently than one (1) time every three (3) years unless Medically Necessary or indicated by other coverage criteria under this Certificate. However, the Plan will replace or repair an orthotic device if necessary due to anatomical changes or normal use.

8. HEARING AIDS

The Plan covers “hearing aids” which means an instrument or device, including repair and replacement parts, that: (a) is designed and offered for the purpose of aiding persons with, or compensating for, impaired hearing; (b) is worn in or on the body; and (c) is generally not useful to a person in the absence of a hearing impairment.

Hearing aids must be dispensed by a professional licensed by the state following an examination where a hearing aid is prescribed correlated with the hearing loss.

The Plan covers up to (1) one thousand four hundred dollars ($1,400) per ear for each three-year period; (2) Shall provide coverage up to one thousand four hundred dollars ($1,400) per ear beginning on the first day of coverage; and (3) is not subject to policy deductibles or copayment requirements.

9. BLOOD

The following blood related services may be paid, whether or not the blood, blood component or blood derivative is covered: (1) use of transfusion equipment and supplies; (2) administration of blood, including blood typing and cross matching; (3) blood processing charges (also covered when supplied through a community blood program or Red Cross; (4) expenses incurred by hospital in obtaining blood for auto-transfusions, whole blood, blood components or derivatives including telephone charges and transportation expenses.

HOSPITAL CARE

1. ACUTE CARE GENERAL HOSPITAL

The Plan will pay for your Covered Medical Services in an acute care general hospital. An acute care general hospital is a licensed institution primarily engaged in providing: inpatient diagnostic and treatment services for surgical and medical patients; treatment and care of injured and sick persons by or under the supervision of physicians; and twenty-four hour nursing service by or under the supervision of registered nurses.

2. INPATIENT CARE IN A HOSPITAL

You have Benefits for services furnished by an acute care general hospital, when you are a registered inpatient in such a hospital. Your share of the cost will vary depending on whether you obtain care through In-Network or Out-of-Network benefits. Co-payments, Deductibles and Coinsurance are applied as stated in the Schedule of Benefits.

Covered Medical Services are services provided by an acute care general hospital such as room and board, nursing care, medical social work, pharmacy services and supplies, diagnostic laboratory tests, operating room charges, and labor and delivery room charges.

As a general policy, services are not Covered Medical Services unless the following conditions are met: the service is given to you by an employee of the hospital; the hospital bills for the service; and the hospital retains the payment collected for the service.

3. OUTPATIENT CARE IN A HOSPITAL

The Plan will pay for the Covered Medical Services provided to you in the outpatient department of a hospital, including the hospital emergency room, if the Plan would pay for equivalent services that would also be covered on an inpatient basis.

The Plan will also pay the facility's charges for Covered Medical Services provided in a health center, diagnostic center or treatment center that is licensed under the appropriate state law. These facilities are sometimes called birthing centers, ambulatory surgical centers or hemodialysis centers. However, regardless of the name of the facility, the Plan will make payments only if the facility possesses all licenses, permits, certifications, and approvals required by applicable state, local, and federal law.

As in the case of inpatient care, your share of the cost will vary depending on whether you obtain care through In-Network or Out-of-Network benefits.

4. CO-PAYMENTS FOR VISITS TO THE EMERGENCY ROOM

You must pay the Emergency Room Co-payment indicated in your Schedule of Benefits for each visit to a hospital emergency room for Medically Necessary Emergency care. If you are admitted to the hospital following the emergency room visit, the Emergency Room Co-payment will be waived.

Any follow-up services recommended, requested or referred by emergency room physicians after the initial Emergency Room visit, will be paid based on your access of In-Network or Out-of-Network benefits.

5. AMBULANCE SERVICE

Covered Medical Services include a licensed ambulance that charges a fee for its services if:

A. Because of an accident or medical Emergency it is necessary to transport you to the hospital in an ambulance.

B. It is necessary to transport you from a hospital where you are an inpatient to another hospital because: the first hospital lacks the equipment or expertise necessary to care for you properly and you are admitted as an inpatient to the other hospital; or you are taken to another hospital to receive a test or service that is not available at the hospital where you have been admitted, and you return after the test or service is completed.

C. You are transported directly from a hospital where you were an inpatient to a skilled nursing facility where you are then admitted as a patient.

Benefits for Ambulance are subject to the Co-payments indicated in your Schedule of Benefits. The Co-payment will be waived if you are admitted to the hospital as an in-patient.

6. CARE IN A SKILLED NURSING FACILITY, OR REHABILITATION FACILITY

Covered Medical Services include care in a skilled nursing facility or rehabilitation facility if daily skilled care is Medically Necessary for the care of your condition, illness or injury. Payment is subject to the maximum number of days indicated in your Schedule of Benefits notwithstanding that care at such facility may be the result of more than 1 illness or injury. Your share of the cost will vary depending on whether you obtain Skilled Nursing or Rehabilitation Care through In-Network or Out-of-Network benefits.

MENTAL HEALTH AND SUBSTANCE ABUSE CARE

In addition to medical Benefits, you have Benefits for mental health and substance abuse care. Subject to the Exclusions Section, mental health care includes care for mental disorders, mental illnesses, psychiatric illnesses, mental conditions, and psychiatric conditions irrespective of cause, basis or inducement (as defined in the most current Diagnostic Manual of Mental Disorders published by the American Psychiatric Association); provided, however, such disorders, illnesses and conditions caused directly by physical trauma are covered under Medical Services Section. Approved providers include psychiatrists, licensed clinical psychologists, licensed clinical social workers, and licensed professional counselors. To obtain care from mental health and substance abuse providers, you may choose from In-Network or Out-of-Network benefits as described below.

1. **In-Network benefits:** An initial evaluation visit will be allowed when you seek services from a Network Provider under In-Network benefits. If additional visits are required, the mental health provider must submit a verbal or written treatment plan to the QualChoice Managed Care Department for authorization prior to any additional visits. The Managed Care Department is available to discuss the treatment plan request by calling (501) 228-7111 or (800) 235-7111, Monday through Friday, 8:00 a.m. until 5:00 p.m. excluding holidays. After hours, you or your provider can leave a message by calling the same number and following the prerecorded instructions. Submitting a treatment plan or leaving a message does not constitute authorization. Authorization must be specifically made by QualChoice case management. Please refer to your Schedule of Benefits for limitations.

2. **Out-of-Network benefits:** When you seek services from a non-network provider, the Plan will pay for your Covered Services under Out-of-Network benefits. Please refer to your Schedule of Benefits for applicable cost sharing requirements and limitations. As above, only the initial evaluation will be allowed without prior authorization. If additional visits are required, the provider must submit a treatment plan for medical necessity prior to the visits.

Summary of Authorization Requirements

For either option, you or the provider of service must call QualChoice at (800) 235-7111 or (501) 228-7111 for authorization for care in the following circumstances:

1. After the initial outpatient evaluation visit, the provider of care is required to submit a treatment plan for authorization of any additional visits prior to the visits occurring. The treatment plan must be approved in advance by QualChoice and must include at a minimum (i) a detailed diagnosis, (ii) an outline of the intended therapeutic process, (iii) an expected course of treatment, and (iv) the anticipated frequency and duration of treatment.

2. Prior to any psychological testing performed by any provider on an outpatient basis or while you are an inpatient at a non-participating facility.

3. Prior to any admission to a hospital, inpatient facility, or partial hospitalization unit or within 48 hours of any Emergency inpatient admission.

All calls are considered confidential. If you do not obtain authorization of any of the above services, no payment will be made. If during the authorization process, a determination is made that the care is not Medically or Psychologically necessary, you will have no coverage under the Plan. If the inpatient or outpatient care is provided by a Network provider at a Network facility (In-Network benefits), and the care does not meet Medical or Psychological Necessity, you, the member, are not held responsible for the cost, unless you were informed in advance that the care would not be covered. If there is no authorization for services by a Network Provider or at a Network facility (In-Network benefits), you, the member, are not held responsible for the cost. If any portion of the care is not authorized or is found not to meet Medical or Psychological Necessity and the care is provided by a non-Network provider, the non-Network provider may bill you for their portion of the care which is not covered. All care is subject to any limitation and/or exclusion of the Plan.

1. Mental Health and Substance Abuse Benefits.

Inpatient mental health and substance abuse Benefits are provided as indicated on your Schedule of Benefits. Payment for Benefits is determined by the Option under which you receive care, and is subject to your eligibility at the time service is rendered, any exclusions or limitations of the Plan, and certification of Medical or Psychological Necessity.

2. Medical or Psychological Necessity.

The Plan will pay for only those services that are Medically or Psychologically Necessary. This means services which: (a) are appropriate and essential for the diagnosis, evaluation and/or treatment of a mental illness or condition other than those excluded under the Plan (see Exclusions Section); (b) are in keeping with national standards of mental health professional practice; (c) are provided at the level of treatment appropriate to the severity of the patient's illness and capacity to respond to professionally provided treatment; (d) are within the professional competence of the practitioner providing the care; and (e) can be reasonably expected to improve an Enrollee's condition or level of functioning.

3. Determination of Appropriate Levels of Treatment.

In determining the appropriate level of treatment, QualChoice considers: (a) the intensity and scope of care necessary to meet Medical or Psychological Necessity; and (b) the least restrictive environment that will provide adequate care and that offers the maximum reasonable opportunity for independent or community-assisted functioning.

Levels of Treatment Include:

A. Inpatient Hospital -- Acute and Extended Care Programs/Units. Generally, hospital stays will be as brief as possible, consistent with accepted standards of care. Less restrictive levels of treatment will be utilized whenever possible. We cover short-term in-patient hospitalization or partial hospitalization (see below) for treatment of a Mental Health or Substance Abuse. Services for treatment of a Mental Health or Substance Abuse are only covered when provided in a psychiatric hospital or substance abuse unit of a general acute care hospital. Services for treatment of a Mental Health or Substance Abuse are not covered when provided by a facility that is not licensed as a hospital.

B. Partial Hospitalization -- Day and Evening Programs. Partial hospital programs operate four to seven days per week. These programs allow patients to receive all of the therapeutic benefits found in a hospital setting, but to return to home and family (or to work) when not actively engaged in therapy. Partial hospital programs will frequently replace a 24-hour hospital stay or may reduce the time needed in the inpatient hospital setting.

C. Outpatient Care. Psychotherapy may be needed for crisis resolution or symptom relief. Outpatient care may be provided in individual or group settings. Psychotherapy will generally be brief and will be focused on the presenting problem. Treatment for personal growth or enrichment is not a covered service. Outpatient services may also be required following hospitalization or for management of psychiatric medication.

4. EMERGENCY CARE NOT REFERRED

You or a family member must call QualChoice before you are admitted as a patient to a hospital for mental health or substance abuse treatment. If you are admitted on an Emergency basis, a notification call to (501) 228-7111 or (800) 235-7111 must be made within forty-eight (48) hours after the emergency admission, or as soon as physically possible thereafter. Failure to meet the hospital notification requirement may result in denial of payment for services. If notification of an Emergency admission is made within the required forty-eight (48) hour period, retrospective review will be performed to determine Medical or Psychological Necessity. Payment will be denied if the confinement is found not to be Medically or Psychologically Necessary. If an admission that is denied as not Medically or Psychologically Necessary occurred at a non-Network facility, you will be held responsible for the bill.

For an emergency admission where the required authorization is made, the Plan will provide coverage as follows (subject to the limitations and exclusions of the Plan):

A. Admissions to Network Facilities by a Network Provider. If the admission meets criteria for an emergency admission and you provide the required authorization, the Plan will pay under In-Network benefits for as long as the stay continues to meet Medical and Psychological Necessity. If the admission does not meet criteria for an emergency admission, no payment will be made and you are not responsible for the bill.

B. Admission to Non-Network Facilities. If the admission meets criteria for an emergency admission and you provide the required authorization, care up to the point of this determination will be covered at In-Network benefits. You will be given the option of a transfer to a Participating Mental Health facility to maintain In-Network benefits. If you elect to stay at the Non-Participating facility, the remainders of the stay after you were offered the option of a transfer will be at Out-of-Network benefits as long as the stay continues to meet Medical and Psychological Necessity. If the admission does not meet criteria for an emergency admission, no payment will be made and you will be held responsible for the bill.

For emergency admissions to any Facility for which the required authorization is ***not*** made in accordance with the requirements in the Pre-Authorization section, you will be held responsible for the bill.

5. Limitations: Please see the Schedule of Benefits for limitations with regards to annual benefits.

6. Appeals: If you or your physician disagrees with any of our determinations, you or your physician may appeal our decision by writing to QualChoice within 30 days of the date we notify you of our decision. For services which your physician believes require more immediate attention due to your medical condition, your physician may request an expedited appeal by calling (501) 228-7111 or (800) 235-7111.

7. Mental Health/Substance Abuse Exclusions. Covered Medical Services do not include the following conditions and treatments for mental health and substance abuse services:

a. Outpatient psychotherapy or counseling for personal growth or life and social enrichment;
b. Services performed in connection with treatment of a condition not classified as being an Axis I diagnosis in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association by the diagnosing or treating mental health provider;
c. Services rendered by a mental health provider that have not been authorized by QualChoice after its review of the treating mental health provider's treatment plan which must include at a minimum (i) a detailed diagnosis, (ii) an outline of the intended therapeutic process, (iii) an expected course of treatment, and (iv) the anticipated frequency and duration of treatment;
d. Services that are not scientifically supported for the treatment of the Axis I diagnosis recorded;
e. Services not provided by a psychiatrist, licensed clinical psychologist, licensed clinical social worker, licensed professional counselor, or licensed psychological examiner;
f. Psychological testing or neuro-psychological testing for psychological reasons unless prior authorized by medical director at QualChoice;
g. Services provided for treatment of behavior or conduct disorders, oppositional disorders, or neuroeducational testing are not covered, except to the extent they are for the treatment of a

Mental Health or Substance Use Disorder that is part of a mental health treatment plan, authorized by QualChoice;

h. Sexual and Gender Identity Disorders;
i. Martial or Relationship Counseling;
j. Treatment for smoking or nicotine addiction; or
k. Educational services of any type for any reason.

Residential treatment for a Mental Health and Substance Abuse is not a Covered Service.

HOSPICE CARE

Your share of the cost for Hospice Care depends on whether you obtain the care through In-Network or Out-of-Network benefits.

1. HOSPICES

In order to be covered, a hospice must have all licenses, certifications, permits and approvals required by applicable state and local law.

2. HOSPICE CARE COVERED

Covered Medical Services include hospice care authorized by your physician during the period when the hospice admits you to its program. Covered Medical Services include the following services provided by the hospice:

A. Inpatient care in a freestanding hospice, a hospice unit within a hospital or skilled nursing facility, or in a regular hospital bed.

B. Home care services provided by the hospice either directly or under arrangements with other Licensed Providers, including but not limited to: (a) intermittent nursing care by registered nurses, licensed practical nurses, or home health aides; (b) physical therapy; speech therapy; occupational therapy; respiratory therapy; (c) social services; (d) nutritional services; (e) laboratory examinations, x-rays, chemotherapy and radiation therapy when required for control of symptoms; (f) medical supplies; (g) drugs and medications prescribed by a physician and which are included in the US Pharmacopoeia and/or National Formulary (the Plan will not pay for drugs or medications of an experimental or investigative nature); (h) medical care provided by your own attending physician or the hospice physician; (i) counseling and bereavement services provided to children, parents, spouses, and siblings; and (j) other appropriate services covered when approved by QualChoice's Medical Review Department.

Pre-authorization is required for Hospice Care. You or someone doing so on your behalf must call QualChoice at (501) 228-7111 or (800) 235-7111 to obtain Pre-authorization of reimbursement for Hospice Care. Pre-authorization is required to avoid a potential denial of Benefits.

TRANSPLANT BENEFITS

Your coverage for transplants depends on whether you obtain care through In-Network or Out-of-Network benefits. If you need a transplant, you have coverage as follows:

1. TRANSPLANT PROCEDURES COVERED

The Plan will pay for Covered Medical Services for cornea, heart, lung, heart-lung, liver, pancreas, kidney, autologous chondrocyte, stem cell, and bone marrow transplant procedures if they meet Medically Necessary criteria. The Plan will not pay for any organ or tissue transplant procedures not specifically covered under the Plan, or for any expenses in connection with experimental or investigational surgery or treatment not considered reasonable and necessary as so classified by Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services.

2. TRANSPLANT PROCEDURE COVERED SERVICES

Covered Medical Services include any Medically Necessary hospital, medical-surgical and other services related to the transplant, including blood and blood plasma. Specified Covered Medical Services include:

A. Hospital Care. Covered Medical Services include all Medically Necessary inpatient and outpatient care at a transplant center designated by QualChoice.

B. Organ Procurement. Covered Medical Services include the tissue typing, surgical procedure, storage expense and transportation costs directly related to the donation of an

organ or other human tissue used in a covered transplant procedure. For information about Coordination of Benefits with Benefits available to a donor under their health benefit plan, refer to Coordination of Benefits Section, "Coordination of Benefits in Transplant Cases."

C. Pre-Operative Care. The pre-operative Benefit period begins five (5) days prior to surgery. During that period, the Plan will pay for Medically Necessary hospital, medical/surgical and other services related to the transplant.

D. Post-Operative Care. The post-operative Benefit period begins on the day the transplant procedure takes place and extends for a period of one (1) year from that date. Covered Medical Services include any Medically Necessary hospital, medical, laboratory and other services related to the organ transplant, and prescription drugs.

E. Charges for transportation to and from the site of the covered organ transplant procedure for the recipient and one other individual, or in the event that the recipient or the donor is a minor, two (2) other individuals. In addition, all reasonable and necessary lodging and meal expense incurred during the transplant benefit period will be covered. The maximum amount allowable under this paragraph is $10,000 per transplant period.

F. Re-transplantation will be covered for up to two re-transplants, for a total of three transplants per person, per lifetime. Each transplant will be subject to the Pre-authorization requirement for Organ Transplant.

3. PRE-AUTHORIZATION REQUIRED

You, or someone doing so on your behalf, must call QualChoice at 1-800-235-7111 to obtain pre-authorization of Transplant Services, including the evaluation to determine if you are a candidate for transplant by any transplant program. Pre-authorization is required to avoid a potential denial of Benefits.

4. TRANSPLANT CENTERS MUST BE DESIGNATED

As indicated above, the Plan will cover only transplants performed at transplant centers designated by QualChoice.

5. LIMITATIONS

To the extent permitted by applicable law, payment to an Enrollee under this Plan will be secondary to any and all governmental or institutional sources of funding that will offset the cost of Covered Medical Services.

Prescription Drug Program

Benefits for prescription drug coverage are added to the Summary Plan Description according to the guidelines set forth below.

The University of Arkansas System uses MedImpact as the Prescription Benefit Manager (PBM) to administer the prescription drug program for individuals who are covered under the U of A health plan. MedImpact will issue 2 prescription drug identification cards to the subscriber but additional cards can be requested. You must present your prescription drug card to your pharmacist at the time you purchase your medication in order to access your prescription drug benefits.

A temporary ID card can be printed by going to www.medimpact.com, registering and logging in. Click on Temporary ID Card to initiate the process.

For benefits, covered drugs, exclusions, pre-authorizations and other programs, a complete summary of benefits may also be accessed at www.medimpact.com by clicking Prescription Benefit Summary. You may also obtain a prescription benefit summary by going to your campus human resources' webpage, contacting your campus human resource personnel or by logging in at www.medimpact or call Customer Service at (888)-788-2949.

WHEN CLAIMS SHOULD BE FILED

Claims must be filed with the Claims Administrator within 365 days of the date charges for the services were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date will be declined or reduced unless:

1. it's not reasonably possible to submit the claim in that time; and

2. the claim is submitted within one year from the date incurred. This one year period will not apply when the person is not legally capable of submitting the claim.

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

EXCLUSIONS

The following are not covered under this Plan.

1. **Admission to a Hospital Before You Become Covered Under This Summary Plan Description.** If you are admitted to a hospital, Skilled Nursing Facility, or other inpatient facility as a registered inpatient before the date you become covered under this Summary Plan Description, we will not cover any part of your stay in that inpatient facility, or medical services related to that stay, regardless of whether the services were rendered before or after you became covered under this Summary Plan Description.

2. **Abortion.** The Plan will only cover an abortion to save the life of the mother.

3. **Adoption/Surrogate Parenting**. We will not cover services and costs relating to the care of the biological mother of an adopted child, if the biological mother is not covered. We will not cover services and costs related to surrogate parenting.

4. **Against Medical Advice.** We will not cover any costs related to an inpatient admission resulting in the Enrollee's discharge against medical advice.

5. **Air Ambulance.** We will not pay for air ambulance unless the air ambulance service is Medically Necessary due to the patient's critical condition. Coverage will be limited to the regular air ambulance charges for transportation to the nearest Network Hospital having the appropriate facilities to handle the case. If transport to a Network Hospital is not feasible due to the Enrollee's condition, or the distance for our Service Area, we will pay for transport to the nearest appropriate hospital. All air ambulance is subject to review for Medical Necessity.

6. **Alcohol.** Services, supplies, care or treatment to a Covered Person for an Injury or Sickness which occurred as a result of that Covered Person's illegal use of alcohol for which the person has been arrested. The arresting officer's determination of intoxication will be sufficient for this exclusion. Expenses will be covered for Injured Covered Persons other than the person illegally using alcohol and expenses will be covered for Substance Abuse treatment as specified in this Plan.

7. **Alternative or Complementary Medicine.** We will not cover devices or services that derive from alternative systems of medical practice such as acupuncture, homeopathy or naturopathy, bioelectromagnetic care, herbal medicine, manual healing such as aromatherapy or reflexology, mind/body control such as dance or prayer therapies, or pharmacological and biological therapy such as chelation therapy or metabobolic therapy not yet accepted by mainstream medical practitioners.

8. **Blood.** We will not cover blood, blood plasma or derivatives that are donated or replaced, nor will we cover fees for voluntary blood giving or storage of blood products, except to the extent that a refund or credit is given, or as part of the Transplant Benefit.

9. **Blood Donation.** When you choose to designate either yourself or another person to be a blood donor so that you may receive the designated blood at a future time, we will not cover charges for procurement, storage, or administration of such donated blood or any extra charges associated with designated blood donation.

10. **Care Provided By A Family Member.** We will not cover care provided by an individual who normally resides in your household or is a member of your immediate family, which we define as including parents, siblings, spouses, children, grandparents, aunts, uncles, nieces and nephews.

11. **Care Rendered In Certain Non-Hospital Institutions.** We will not cover care or supplies in convalescent homes or similar institutions, facilities providing primarily custodial or rest care; nor will we cover care or supplies in health resorts, spas, sanitariums, tuberculosis hospitals, residential treatment centers, or infirmaries at camps or schools.

12. **Charges In Excess Of Calendar Year Or Lifetime Maximums.** We will not cover any service, supply or treatment in excess of the calendar year or lifetime maximum as shown in the Schedule of Benefits.

13. **Charges For Missed/Canceled Appointments.** We will not pay for charges for appointments that an Enrollee misses or cancels.

14. **Care in Connection with the Detection and Correction of Structural Imbalance, Distortion or Subluxation.** We will not cover any services or supplies rendered in connection with the diagnosis, detection and correction (by manual or mechanical means) of:

    a. structural imbalance;

    b. distortion; or

    c. subluxation

    in the human body for the purpose of removing nerve interference and the effects thereof. This exclusion applies when the nerve interference is the result of or related to distortion, misalignment, or subluxation of or in the vertebral column.

15. **Complications.** We will not cover medical or surgical complications resulting from a non-covered service or that are a direct or closely related result of refusal to accept treatment, medicines, or a course of treatment that a Network Provider has recommended or has been determined to be Medically Necessary.

16. **Convenience Items or Services:** Items that are primarily for your convenience. These are items that are not directly related to Covered Medical Services.

17. **Cosmetic Surgery:** Any procedures, services, equipment or supplies provided in connection with elective cosmetic surgery that is intended primarily to improve your appearance or for your psychological benefit. The Plan will, however, cover the following services:

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

    b. cover services and supplies in connection with reconstructive surgery that is necessary to restore part of the body that is injured or deformed by acute trauma, infection or other pathological disease that occurred while you were an enrollee under the Plan, and

    c. cover reconstructive surgery to correct congenital malformations or anomalies resulting in a functional defect or impairment of a child covered under this Plan.

18. **Custodial Care:** Hospital care, nursing home or skilled nursing facility care, home care or any other service that is custodial in nature. Care is considered custodial when it is primarily for the purpose of meeting personal needs and could be provided by persons without professional skills or training. For example, custodial care includes assisting in activities of daily living such as walking, getting in and out of bed, bathing, dressing, eating and taking medicine**.**

19. **Dental Care.** Under your hospital and medical Benefits, we will not cover: treatment of cavities and extractions; care of the gums or bones supporting the teeth; treatment of periodontal abscess; treatment of dentigerous cysts; removal of soft tissue impacted teeth; orthodontia (including braces); false teeth; orthognathic surgery; or any other dental services you may receive.

20. **Developmental Delay.** Services or supplies provided for developmental delay, including learning disabilities, communication delay, perceptual disorder, sensory deficit, and motor dysfunctions are not covered. This includes the exclusion for developmental delay associated with autism spectrum disorder.

21. **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.

22. **Equipment.** We will not cover air conditioners, humidifiers, dehumidifiers, air purifiers, exercise equipment, arch supports, orthotics, or any other type of personal convenience item even if ordered by your Primary Care Physician or other Provider.

23. **Experimental Procedures and Related Equipment and Supplies.** We will not cover procedures or services, including transplants that, in our sole judgment, are experimental or investigative in nature; nor will we pay for equipment or supplies related to experimental procedures. Experimental procedures include all "experimental" or "investigational" therapies or surgeries that are not generally accepted, as reflected by national scientific and peer medical literature. In addition, any therapy subject to government agency approval must have received final approval before it will be considered for coverage.

24. **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the well adult or well child sections of this Plan.

25. **First Aid Supplies.** We will not cover common first aid supplies.

26. **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the purpose of obtaining medical services.

27. **Free Care.** We will not cover any care if the care is furnished to you without charge or would normally be furnished to you without charge. This exclusion will also apply if the care would have been furnished to you without charge if you were not covered under this Summary Plan Description or under any other health benefit plan or other insurance.

28. **Genetic Counseling and Testing.** Genetic testing is generally not covered. Genetic testing is often done on blood or tissue samples sent by your physician to a laboratory. For genetic counseling or testing to be covered it requires pre-authorization. Pre-authorization will only be given in accordance with QualChoice's medical policies which require the results of the genetic testing to affect choice of treatment or the outcome of treatment. We will not cover genetic counseling or testing to determine the likelihood of:

    a. Developing a disease or condition; or

    b. Disease or the presence of a disease in a relative; or

    c. Passing an inheritable disease, for example, cystic fibrosis, or congenital abnormality to an offspring.

    Any approved genetic testing must be preceded by genetic counseling.

29. **Government Programs.** We will not pay for Covered Services to the extent that Benefits for such services are payable under Medicare or any other federal, state or local government program, except that we will pay even though you are eligible for Medicaid.

30. **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.

31. **Illegal acts.** Charges for services received as a result of Injury or Sickness, occurring directly or indirectly, as a result of a Serious Illegal Act by the Covered Person. For purposes of this exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required.

32. **Illegal drugs or medications.** Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for injured Covered Persons other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan.

33. **Infertility Treatment.** We will cover the diagnostic work-up to confirm diagnosis of infertility. We will not cover services for treatment of infertility such as: artificial insemination, in-vitro fertilization,

fertility drugs, sonograms, SCORIF (Stimulated Cycle Oocyte Retrieval Intravaginal Fertilization), IVC (Intravaginal Culture), fertility drugs, sonograms, or other infertility procedures. We will not cover diagnostic procedures or tests performed after a diagnosis of infertility has been confirmed, or that are related to infertility treatment, such as those used to stage fertilization procedures or determine readiness for fertilization. It does not matter whether the infertility service is diagnostic or therapeutic.

34. **Instructional Programs.** We will not pay for charges for instructional or educational programs such as, but not limited to, childbirth classes, vocational training or testing, diet programs, nutritional programs or smoking cessation classes.

35. **Mammoplasty.** We will not cover mammoplasty for reasons of augmentation, asymmetry (unrelated to breast reconstruction), or removal of breast implants. Please see cosmetic surgery in this section for breast reconstruction coverage.

36. **Mandated or Court Ordered Care.** We will not cover any medical, psychological, or psychiatric care which is the result of a court order or otherwise mandated by a third party (such as, but not limited to, your employer, licensing board, recreation council, or school), unless such care is determined to be Medically or Psychologically Necessary.

37. **Medical Reports.** We will not cover expenses for medical report preparation and presentation, nor will we pay for provider appearances at hearings and court proceedings.

38. **Medical/Surgical Services or Supplies for Control of Obesity or Morbid Obesity.** We will not cover any surgery, medical services or supplies intended for control of either obesity or morbid obesity (such as dietary control, counseling or weight maintenance programs) even if the obesity or morbid obesity aggravates another condition or illness.

39. **Non-Compliance with Treatment Recommendations.** We will not cover services that are provided as the result of an Enrollee's refusal to comply with a physician's or other provider's recommendations or orders, or failure to cooperate with a prescribed plan of treatment or recovery.

40. **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

41. **Non-Referred Services.** Services not provided, ordered or Referred by a Network Physician (except when authorized by QualChoice through its pre-authorization policies and procedures).

42. **Nutritional Counseling.** Benefits are not available for dietary control counseling or weight maintenance programs. However, for Enrollees who are diagnosed with diabetes while covered under the Plan, nutritional counseling may be covered as part of a comprehensive diabetic education program.

43. **Premarital Laboratory Work.** We will not cover premarital laboratory work required by any state or local law.

44. **Private Duty Nurses.** We will not cover private duty nurses.

45. **Private Room.** If you occupy a private room, you will have to pay the difference between the hospital's charges for private room and the hospital's most common charge for semi-private accommodations, unless QualChoice determines that it was Medically Necessary for you to have a private room.

46. **Rehabilitation Services.** We will not cover rehabilitation services primarily intended to improve the level of physical functioning for purposes of enhanced job, athletic or recreational performance, including but not limited to work hardening programs, back schools, and programs of general physical conditioning.

47. **Required Examinations or Services.** We will not cover examinations or services required or recommended by a third party such as those for the purpose of obtaining or maintaining employment, obtaining insurance and/or professional or other licenses, or precedent to engaging in travel, athletic or recreational activities, or attending a school, camp, or other program.

48. **Research or Study.** We will not cover any service provided in connection with research or study.

49. **Residential Care.** Services or treatment in a residential care facility are not covered unless the service or treatment is a result of:

- damage to the spinal cord by trauma, infection, tumor, disease, developmental defect or degenerative disorder or is a result of injury to the brain, and the severity of the damage must result in lack of normal function in three (3) of four (4) areas: paralysis, sensation, bladder control and bowel control.
- traumatic injury to the brain such as diffuse axonal injury, hypoxic-ischemic injury, contusions, hemorrhage, infarction, hematoma, and intracranial pressure. The severity of the damage must result in lack of normal function in three (3) of four (4) areas: mobility, language, ability to swallow, and cognition.

The maximum number of days allowed per calendar year is 60 days and requires pre-authorization

50. **Reversal of Sterilization.** We will not cover any procedures or related care to reverse previous sterilization.

51. **Routine Care of Feet.** We will not cover any services or supplies in connection with (1) care of flat feet; (2) supportive devices of the foot, such as arch supports or pelvic/spinal stabilizers; (3) care of corns or calluses; (4) care of toenails; (5) care of fallen arches, weak feet, chronic foot strain; or (6) orthotics for sports use. However, when related to diabetes or circulatory problems, items (3) and (4) are covered if Medically Necessary and there is a Referral from your Primary Care Physician. In addition, custom molded and fitted shoe and shoe inserts are not covered except for an Enrollee with diabetes. Coverage for an Enrollee with diabetes for custom molded and fitted shoes and shoe inserts is subject to the following limitations:

a. Two (2) pairs of custom molded and fitted shoes per year if the Enrollee is under 18 years of age and one (1) pair of custom molded and fitted shoes for an Enrollee 18 year of age or older; and

b. Two (2) pairs of custom molded shoe inserts per year.

52. **Second Surgical Opinion and Consultation with Specialist.** We will not cover both a second surgical opinion and a consultation with the same specialist or a practice partner with respect to the same or related surgical procedure.

53. **Services Not Specified as Covered.** We will not cover any services not specifically described in this Summary Plan Description.

54. **Sex-Change Treatment.** We will not cover surgical procedures or related care to alter your sex from one gender to the other.

55. **Sperm Preservation.** We will not cover charges related to the donation or preservation of sperm.

56. **Temporomandibular Joint Syndrome.** We will not cover charges related to treatment of TMJ, except as defined under Medical Benefits, 2. (K).

57. **Third Party Liability Exclusion.** We will not pay any Benefits to an Enrollee to the extent that the Enrollee has received payment, in whole or in part, from a third party, or its insurer, for past or future medical or hospital or other health care charges as the result of the negligence or intentional act of a third party. If an Enrollee makes a claim for Benefits under this Summary Plan Description prior to receiving payment from third party, or its insurer, the Enrollee (or legal representative for a minor or incompetent) agrees to repay us from any amount of money received by the Enrollee from the third party, or its insurer. Please refer to "Subrogation," for further information concerning repayment of Benefits.

58. **Travel and Transportation Expenses.** We will not cover travel and transportation expenses, even though prescribed by a physician, except for emergency ambulance service or ambulance service for transfer. We will cover charges for transportation to and from site of a covered organ transplant (see Transplant Benefits section 2; E)

59. **Travel or Work Related Immunizations.** We will not cover immunizations for the purpose of fulfilling requirements for international travel or for work.

60. **Vision and Hearing Services.** We will not cover hearing examinations, services or tests, eyeglasses, contact lenses, hearing aids and other vision care and hearing care services and supplies, except Covered Services required for the diagnosis and treatment of diseases of, or injury to, the eyes or ears. The Plan will, however, cover one routine eye exam every 12 months.

61. **Vision Correction.** We will not cover eye surgery to improve vision or to correct refractory errors.

62. **War or Act of War**. We will not cover any services relating to any injury or sickness resulting from war or any act of war (declared or undeclared), or in the armed forces of any country if any government plan covers that injury or sickness.

63. **Workers' Compensation.** We will not cover any care or supplies for any injury, condition or disease if payment is available to you under a Workers' Compensation Law or similar legislation. We will not make any payments even if you do not claim the Benefits you are entitled to receive under the Workers' Compensation Law.

NOTE: With respect to exclusions as a result of the source of the injury contained in numbers 6, 31 and 32 above, the exclusion will not apply if the injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).

LIMITATIONS

1. **Major Disaster or Epidemic.** If a major disaster or epidemic occurs, Network Physicians and Network Hospitals will render medical services as is practical according to their best judgment within the limitation of available facilities and personnel. Neither QualChoice nor any Network Provider has any liability or obligation for delay or failure to provide or arrange any such services to the extent the disaster or epidemic causes unavailability of facilities or personnel.

2. **Circumstances Beyond QualChoice's Control.** Services and other covered Benefits could be delayed or made impractical by circumstances not reasonably within the control of QualChoice, such as: complete or partial destruction of facilities; war; riot; civil insurrection; labor disputes; disability of a significant part of hospital or medical group personnel; or similar causes. If so, Network Physicians and Providers will make a good faith effort to provide services and other Benefits covered hereunder. But neither QualChoice nor UA shall have any other liability or obligation on account of such delay or such failure to provide services or other Benefits.

3. **Refusal to Accept Treatment.** You may, for personal reasons, refuse to accept procedures or treatment recommended by Network Physicians. In such case, neither QualChoice nor UA shall have further responsibility to provide care for the condition under treatment, unless you later recant the refusal and agree to follow the recommended treatment or procedure.

IF YOU HAVE ANY QUESTIONS ABOUT BENEFITS OR COVERAGE, PLEASE CALL QUALCHOICE DURING OFFICE HOURS AT (501) 228-7111.

COMPLAINTS & APPEALS

COMPLAINT AND APPEAL PROCEDURE

The University of Arkansas recognizes the need to respond in a timely and effective manner to your questions, concerns and complaints. We contract with QualChoice to administer a Complaints and Appeals procedure on our behalf as described in this section.

Any problem or dispute between a Covered Individual and QualChoice of Arkansas, Inc. or between a Covered Individual and a Network Provider must be dealt with through the Complaint and Appeals process. Such procedure shall include the following steps:

Step 1: Informal Communication

QualChoice welcomes discussion of any problems. Enrollees may discuss any situation with their QualChoice customer service representative. QualChoice will make every effort to resolve these issues in an informal manner. If any complaint is not settled at this level, the Enrollee may proceed to the next step in the process.

Step 2: Formal Complaint - Management Review

A formal complaint may be filed by submitting a "Formal Complaint" regarding the issue. Formal Complaint forms are provided to Enrollees upon request. If the Enrollee wishes, a QualChoice customer service representative will help the Enrollee complete the form. Upon receipt of the Formal Complaint, an officer or other agent of QualChoice will conduct a review of the complaint and respond with a decision as soon as possible, but no later than sixty (60) days after receipt of the written complaint.

Step 3: Appeal Process - University of Arkansas Review

(If the dispute is over a determination of Medical Necessity and the Appeal process described in, "Procedures for Pre-authorization", and there is no resolution, further appeal follows this grievance process from Step 3 forward.)

If not satisfied with the outcome of Step 2, the Enrollee may submit a written "Appeal" and request additional review within 30 days of the outcome of Step 2. This request should state the reasons on which the Appeal is based. Within 15 days of receipt of the written Appeal, QualChoice will respond to the Enrollee indicating the Appeal has been forwarded to the University of Arkansas for review. The University of Arkansas will render a written decision on the appeal within 60 days. The response will explain the reasons for its finding and will include contract language and/or policy upon which the judgment is based. Notification of the decision will be communicated immediately by QualChoice upon receipt from the University.

Emergency Appeals: In an Emergency or in urgent circumstances, you may pursue a complaint or appeal with QualChoice directly by calling QualChoice at (501) 228-7111 or (800) 235-7111.

Time Limits for Complaints and Appeals: QualChoice must receive Written Complaints or Appeals within thirty (30) days following the event that is the issue. Failure to submit a written complaint or appeal within the thirty (30) days constitutes a waiver of all rights against the University of Arkansas and QualChoice of Arkansas, Inc.

Any appeal regarding a determination not to authorize payment due to failure to meet Medical or Psychological Necessity should follow the Utilization Review Appeal process as explained in the written denial letter which will be sent to the member at the time the denial is issued. Any member who disagrees with the outcome of the Utilization Review Appeal process after all appeals have been exhausted, may enter this Complaint and Appeal process at Step 3.

External Medical Review for Medical Necessity

This external review is for determinations of medical necessity only. After an Enrollee has exhausted his/her appeal rights described in Step 2 and Step 3 above and the University of Arkansas has made its final determination with regard to the appeal, a voluntary external review process is available to the Enrollee. To find out more about this external review process, including an external expedited review, the Enrollee should contact QualChoice's Appeal Coordinator at 501-228-7111 or 1-800-235-7111.

An expedited external review is available to an Enrollee if: (a) the Enrollee's appeal involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the Enrollee's life or health or would jeopardize the Enrollee's ability to regain maximum function and the Enrollee has filed a request for an expedited internal appeal as described in Step 3 above, or (b) the Enrollee has a medical condition where the timeframe for completion of a standard external appeal would seriously jeopardize the life or health of the Enrollee or would jeopardize the Enrollee's ability to regain maximum function, or (c) if the final internal adverse benefit determination described in Step 3 above concerns an admission, availability or care, continued stay, or health care item or service for which the Enrollee received Emergency services, but has not been discharged from a facility.

An Enrollee's request for an external medical review must be made within four (4) months of the Enrollee's receipt of QualChoice's denial as described in Step 3 above and in writing to:

Appeals and Grievance Coordinator
QualChoice
P.O. Box 25610
Little Rock, AR 72221-5610

The written communication must be marked and identified as a "*Request for External Review*".

The medical review would be conducted by an independent, external medical review organization contracted through QualChoice from a list of approved organizations maintained by the Arkansas Department of Insurance. You would be required to pay a $25.00 fee (not to exceed $75.00 in a plan year) to file the request for the external review which would be refunded to you in the event the University of Arkansas' determination is reversed by the independent medical review organization.

As part of the external review process, you have the opportunity to submit additional information to QualChoice related to your Claim for consideration by the external review organization. You will be required to authorize the release of any medical records necessary for the external review organization to reach a decision.

The determination by the external review organization is binding and final on both you and the University of Arkansas, unless other remedies are available under applicable state or federal law.

MISCELLANEOUS PROVISIONS

1. NO ASSIGNMENT

You cannot assign any Benefits or monies due under this Plan to any person, corporation, organization or other entity. Any assignments by you will be void and have no effect. Assignment means the transfer to another person, corporation, organization or other entity of your right to the Benefits provided under this Plan.

2. NOTICE

Any notice that The University of Arkansas System or QualChoice gives to an Enrollee will be in writing and mailed to them at the address as it appears on our records. If you have to give UA or QualChoice any notice, it should be in writing and mailed to the address set forth in the General Information section of this Summary Plan Description.

3. YOUR MEDICAL RECORDS AND CONFIDENTIALITY

The Plan Sponsor will provide or make available a privacy notice to all enrollees specifically outlining all uses and disclosures of Protected Health Information, including confidentiality of medical records, for benefit determination and health care operations. You may request a copy of the privacy notice from your Human Resource office or QualChoice.

4. NOTICE OF CLAIM

In order for QualChoice to make payments under this program, QualChoice must receive your claim for Benefits within three hundred, sixty-five (365) days after you receive the service.

5. WHO RECEIVES PAYMENT UNDER THIS PLAN

Payments under this Plan for Covered Medical Services provided in a Network Hospital or by a Network Physician or Network Provider will be made on UA's behalf by QualChoice directly to the hospital, physician or provider. If you receive Covered Medical Services in an Out-of-Network Hospital, or from any other Out-of-Network Provider of care covered under the Plan, QualChoice, on UA's behalf, may pay either you or the hospital or other provider.

6. RECOVERY OF OVERPAYMENTS

On occasion, a payment may be made to or for you when you are not covered, for a service that is not covered, or which is more than is appropriate for that service. When this happens, QualChoice will explain the problem to you, and you must return to QualChoice within sixty (60) days the amount of the mistaken payment, or provide QualChoice with written notice stating the reasons why you may be entitled to such payment. To the extent permitted by applicable law, QualChoice, on UA's behalf, may reduce future payments to you in order to recover any mistaken payment. Overpayments and mistaken payments made to providers will be recovered directly from them

7. COMPLAINTS AND APPEALS PROCEDURE

You are entitled to have any complaint or appeal heard and, under the terms of UA's agreement with QualChoice, QualChoice is obligated to hear and resolve such complaints or appeals, including complaints against Network Physicians and other Network Providers, in an equitable fashion according to the rules and procedures set forth above in section, "Complaints & Appeals."

8. RIGHT TO DEVELOP GUIDELINES

The University of Arkansas System reserves the right to cause QualChoice to develop or adopt criteria that set forth in more detail the instances and procedures when QualChoice, acting on UA's behalf, will make payments on Benefits under the Plan. Examples of the use of the criteria are: to determine whether care was Medically Necessary; whether Emergency care in the outpatient department of a hospital was Medically Necessary; or whether certain services are skilled care. These criteria will be interpretive and illustrative only and will not be contrary to any

term or provision of the Plan. If you have a question about the criteria that apply to a particular Benefit, you may contact QualChoice for further information.

9. REVIEW

If a claim for Benefits is denied, you may obtain a review of the denial through the appeal procedure described in section, "Complaints & Appeals."

10. LIMITATION ON BENEFITS OF THIS PLAN

No person or entity other than the Plan Sponsor, QualChoice and Enrollees is or shall be entitled to bring any action to enforce any provision of the Plan against the University of Arkansas, QualChoice or Enrollees, and the covenants, undertakings, and agreements set forth in the Plan shall be solely for the benefit of, and shall be enforceable only by, The University of Arkansas, QualChoice and the Enrollees covered under the Plan. Nothing herein shall be deemed to authorize an action against the University of Arkansas or to waive its sovereign immunity.

11. APPLICABLE LAW

The Plan, the rights and obligations of The University of Arkansas, QualChoice and Enrollees under the Plan, and any claims or disputes relating thereto, shall be governed by all applicable state and federal laws.

12. HEADINGS

Section and subsection headings contained in this Summary Plan Description are inserted for convenience of reference only, shall not be deemed to be part of this Summary Plan Description for any purpose, and shall not in any way define or affect the meaning, construction or scope of any of the provisions hereof.

13. PRONOUNS

All pronouns and any variations thereof shall be deemed to refer to the masculine, feminine, neuter, singular or plural, as the identity of the person or entity may require.

14. FUNDING

Cost of the Plan. The University of Arkansas System shares the cost of Employee and Dependent coverage under this Plan with the covered Employees.

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

15. EMERGENCY TRAVEL ASSISTANCE PROGRAM

Assistance for transportation and medical services may be available by calling Assist America, Inc. at 1-800-872-1414 within the U.S. or outside of U.S. (U.S. access code) 609-986-1234 and identify yourself as a University of Arkansas System employee. In addition, a QualChoice Case Manager may also be able to assist you while traveling by calling 1-800-235-7111.

COORDINATION OF BENEFITS

Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans—including Medicare—are paying. When a Covered Person is covered by this Plan and another Plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered Children are covered under two or more plans, the plans will coordinate benefits when a claim is received. The University of Arkansas Health Plan includes a coordination of benefits (COB) provision to eliminate duplication of payment for services. There is no COB for prescription drugs and The University of Arkansas Health Plan does not coordinate against the following kinds of coverage:

- Individual policies or contracts
- Medicaid
- School accident coverage
- Supplemental sickness and accident policies

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

How COB Works: If you are covered by more than one group plan, COB guidelines determine which carrier pays for covered services first.

- The plan that pays first is your primary plan. This plan must provide you with the maximum benefits available to you under the plan.
- The plan that pays second is your secondary plan. This plan provides payments toward the balance of the cost of covered services, up to the total allowable expense determined by the carriers. This plan's deductible and coinsurance must be satisfied prior to secondary payment beginning for all groups other than Medicare.

COB Allowable Expense*:* Allowable Expense means a health care expense, including deductible, coinsurance or co-payments, that is covered in full or in part by any of the plans covering the person as stated below. This means that an expense or service that is not a Covered Service by any of the plans is not an Allowable Expense.

1. If you are covered by two (2) or more plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fee for a specified benefit is not an Allowable Expense.
2. If you are covered by two (2) or more plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an Allowable Expense.
3. If you are covered by one plan that calculates its benefits or services on the basis of usual and customary fees and another plan that provides it benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all plans.

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

1. Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

2. Plans with a coordination provision will pay their benefits up to the Allowable Charge:

   A. The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

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

C. The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

D. When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:

i. The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

ii. If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

E. When a child's parents are divorced or legally separated, these rules will apply:

i. This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

ii. This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.

iii. This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.

iv. If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

v. For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

3. Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.

4. If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

Reduction of Benefits*:* When this Plan is the secondary plan, we may reduce our benefits so that the total benefits paid or provided by all plans are not more than one hundred percent (100%) of the total COB allowable expenses. We will evaluate each claim for Secondary Benefits as follows:

1. Determine whether services are Covered Services under this Plan.
2. Determine whether there are any unpaid allowable expenses.
3. Pay up to one hundred percent (100%) of the total Allowable Expenses incurred.

Benefits will be reduced, so that benefits payable under the all plans do not total more than the COB Allowable Expenses. When the benefits of this plan are reduced as described, each benefit is reduced in proportion and the charged against any applicable benefit limits or maximums.

Enforcement of Provisions: The University of Arkansas Health Plan will coordinate your benefits, if you properly inform them of your coverage under any other health care plan. We are required to determine if and to what extent you are covered under any other health care plan. You agree to furnish any needed information in order to ensure that claims are processed correctly. Should you fail to provide this information, benefit payments may be delayed.

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

Payments to Other Health Benefits Programs. We may repay to any other Health Care Benefits Plan the amount that it paid for covered services and which we decide we should have paid. These payments are the same as Benefits paid and they satisfy our obligation to a Summary Plan Description Holder, covered dependents, and covered spouses under this Summary Plan Description.

Our Rights to Recover Overpayment. In some cases, we may have made payment mistakenly, such as, where an Enrollee had coverage under another Health Care Benefits Plan. Under these circumstances, it will be necessary for the Summary Plan Description Holder to refund to us the amount of the mistaken payment. We also have the right to recover the mistaken payment from the other Health Care Benefits Plan if we have not already received payment from that other program. You agree to take such further actions, to execute, deliver and file such further documents that we require to help us recover an overpayment or mistaken payment. In accordance with, and to the extent permitted by applicable law, we may reduce our future payments to the Summary Plan Description Holder in order to recover a mistaken payment.

Coordination of this Plan with Automobile Insurance. This Plan will be coordinated with medical benefits available under your or another party's motor vehicle liability insurance coverage including both basic personal injury protection benefits ("PIP") and/or optional motor vehicle insurance to the extent of applicable law. Whenever legally possible, the Plan will be secondary.

Coordination of Benefits in Transplant Cases. Coverage under this Summary Plan Description will be primary where an Enrollee is the donor or the recipient of a transplant that is otherwise covered under this Summary Plan Description. Coverage is not available when an Enrollee is the donor for a transplant that is not covered under this Summary Plan Description or the recipient is not an Enrollee. Please see Section: "Transplant Benefits," for a description of the Benefits that are covered. Coverage of organ and human tissue procurement Benefits (tissue typing, surgical procedure, storage expense and transportation costs) directly related to the donation of an organ or human tissue by another person to the Enrollee (Donation Benefits) will be as follows:

- If the donor is covered under another Health Care Benefit Plan that includes coverage for donations used in the covered transplant procedure, then the donor's plan will be primary and the University of Arkansas coverage will be secondary.

- If the donor is not covered by any Health Care Benefit Plan or is covered under a Health Care Benefit Plan that excludes from coverage donation benefits, then the University of Arkansas coverage will be primary.

IF YOU HAVE QUESTIONS ABOUT COORDINATION OF BENEFITS, PLEASE CALL QUALCHOICE DURING OFFICE HOURS AT (501) 228-7111.

SUBROGATION

If you are injured or become ill through the act of a third party, the University of Arkansas will provide reimbursement for Covered Services for such injury or sickness. Acceptance of such Covered Services will constitute consent by you to the provisions of this Section. The University of Arkansas will not be required to obtain a separate recovery authorization signed by you as a prerequisite to recovery by QualChoice under this Summary Plan Description against any other party for the cost of such Covered Services. The Plan's recovery rights under this section extend to worker's compensation and uninsured and underinsured motorist coverage.

You agree to protect the University of Arkansas's lien rights if you are injured or become ill through the act of a third party. If you are due money from any other party for the cost of such Covered Services, your University of Arkansas Benefits will be subrogated for you for the purpose of collecting for those Covered Services. The University of Arkansas will have the right to bring suit against any other party in your name to the extent permitted by applicable state law. If you receive payment from any other party by suit or settlement for the cost of Covered Services, you are obligated to reimburse the University of Arkansas, less any pro rata share of the reasonable attorney's fees and costs you sustained in obtaining such recovery.

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay medical benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any medical benefits incurred on account of Injury or Sickness caused by a responsible Third Party until after the Covered Person or his authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Defined terms: "Covered Person" means anyone covered under the Plan, including minor dependents except as provided by law the plan shall have no obligation.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and place a lien upon the Covered Person's claims for medical charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

Recovery from another plan under which the Covered Person is covered. This right of Refund also applies when a Covered Person Recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Rights of Plan Administrator. The Plan Administrator has a right to request reports on and approve of all settlements.

You agree to take further actions, to execute, deliver and file further documents and instruments, to furnish such information and assistance, as the University of Arkansas may reasonably require to fully effectuate the terms of this section and to facilitate enforcement of the University of Arkansas's rights under this section. You agree to take no action prejudicing the rights and interests of the University of Arkansas under this section.

CONTINUATION OF BENEFITS

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end.

A notice concerning your COBRA rights will be provided to you at the time you become a participant in the Plan. Also, a notice regarding your rights to elect COBRA coverage will be given when you have a “qualifying event” entitling you to elect COBRA continuation coverage.

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

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

1. Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee.

2. Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order.

Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.

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

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

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

1. The death of a covered Employee.

2. The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

3. The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.

4. A covered Employee's enrollment in any part of the Medicare program.

5. A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

6. A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

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

What factors should be considered when determining to elect COBRA continuation coverage? You should take into account that a failure to continue your group health coverage will affect your rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied by other group health plans if there is more than a 63-day gap in health coverage and election of COBRA continuation coverage may help you avoid such a gap. Second, if you do not elect COBRA continuation coverage and pay the appropriate premiums for the maximum time available to you, you will lose the right to convert to an individual health insurance policy, which does not impose such pre-existing condition exclusions. Finally, you should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the

end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

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

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

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

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

1. the end of employment or reduction of hours of employment; or

2. death of the employee; or

3. commencement of a proceeding in bankruptcy with respect to the employer; or

4. enrollment of the employee in any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Campus Human Resources Department or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Campus Human Resource Department or its designee during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Campus Human Resources Department.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the department listed below.

Campus Human Resources Department

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

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

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

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

Once the Campus Human Resources Department or its designee receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

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

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare? Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected

for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

1. The last day of the applicable maximum coverage period.

2. The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

3. The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.

4. The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.

5. The date, after the date of the election that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).

6. In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

A. (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

B. the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

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

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

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

1. In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

2. In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:

A. 36 months after the date the covered Employee becomes enrolled in the Medicare program; or

B. 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

3. In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the covered retiree ends on the date of the retiree's death. The maximum coverage period for a Qualified Beneficiary who is the covered Spouse, surviving Spouse or Dependent child of the retiree ends on the earlier of the Qualified Beneficiary's death or 36 months after the death of the retiree.

4. In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

5. In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

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

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

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

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

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

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

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

Must a qualified beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage? Since this plan does not have a conversation option for similarly situated non-COBRA beneficiaries, there is no right to enroll in a conversion health plan at the end of COBRA continuation coverage.

Special rules for individuals qualifying for Retiree coverage. For participants qualifying for retiree coverage under the Plan, such individuals will be required to elect between COBRA coverage and retiree coverage under the Plan. Under retiree coverage, HIPAA Family Status Changes, but not HIPAA Special Enrollment rights due to loss of other coverage, applies. Thus, if a dependent is not covered at the time of retiree coverage, a dependent may not be added later as a result of loss of coverage. A dependent may be added to retiree coverage if the retiree adds a dependent through marriage or birth or adoption of a child. If the employee elects COBRA coverage instead of retiree coverage, all HIPAA special enrollment rights to apply during COBRA continuation period.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the COBRA Administrator.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Campus Human Resources Department informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Campus Human Resources Department.

DEFINITIONS

Throughout this Summary Plan Description, QualChoice of Arkansas, Inc. is referred to as "QualChoice." The University of Arkansas is referred to as "we," "us," or "our." The words "you," "your," and "yours" refer to you, the person to whom this SPD is issued, and their covered spouse and Covered Dependents, collectively the Enrollees.

The capitalized words or terms that are used in this SPD that are not otherwise defined have the meanings set forth below:

1. **"Benefits"** means reimbursement or payments for health care available to Enrollees under the Plan.

2. **"Coinsurance"** means a fixed percentage of charges you must pay toward the cost of Covered Medical Services.

3. **"Co-payment"** means a fixed dollar amount that you must pay each time you receive a particular Covered Medical Service.

4. **"Covered Medical Services"** means Medically Necessary services for which Benefits are available (i.e., payments will be made) under this SPD. Covered Medical Services do not include services and care excluded in, "Exclusions" or which do not meet the definition of "Medically Necessary" in this section.

5. **"**Coverage of **Well Newborn Nursery/Physician Care**."

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

6. **"Charges for Routine Physician Care"** The benefit is limited to the Maximum Allowable Payable made by a Physician for the first pediatric visit to the newborn child after birth while Hospital confined.

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

7. **"Creditable Coverage"** includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid, Medicare or public health plans.

Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

Creditable Coverage does not include coverage that was in place before a significant break of coverage of 63 days or more. With respect to the Trade Act of 2002, when determining whether a significant break in coverage has occurred, the period between the trade related coverage loss and the start of the special second COBRA election period under the Trade Act, does not count.

8. **"Deductible"** means a fixed dollar amount that you must incur before QualChoice begins to pay for the cost of Covered Medical Services provided to you during each calendar year.

9. **"Dental Anesthesia"**. The plan will provide coverage for the payment of anesthesia and hospital charges or ambulatory surgical facility charges for services performed in connection with dental procedures performed in those facilities, if the provider treating the patient certifies that because of the patient's age or condition, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures and that patient falls in one of the following categories:

A. A child under seven (7) years of age who is determined by two (2) dentists licensed under the Arkansas Dental Practice Act to require without delay, necessary dental treatment in a hospital or ambulatory surgical center for a significantly complex dental condition;

B. A person with a diagnosed serious mental or physical condition;

C. A person with a significant behavioral problem as determined by a Network Physician

10. **"Designated Provider"** means the following duly Licensed Providers: hospitals, physicians, physical therapists, speech pathologists, doctors of osteopathy, doctors of podiatry, chiropractors, and duly licensed practitioners who provide services under the supervision of a physician, such as: audiologists, dietitians, nutritionists, nurses (including nurse-practitioners, nurse-midwives and nurse-anesthetists), and physician assistants. There are certain practitioners (such as dentists, acupuncturists, electrologists, and optometrists) whose services QualChoice will not cover as a rule; thus, these practitioners are not considered Designated Providers.

11. **"Employee"** means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship. For purposes of this Plan, "Eligible Employees" shall also include Residents, Interns and house staff members at the University of Arkansas for Medical Sciences Campus.

An individual who is not classified for the relevant period as an employee on the Employer's payroll records, whether because the individual is treated as an independent contractor or an employee of another person, shall not be an Employee, even if such classification is determined to be erroneous, or is retroactively revised pursuant to an audit by a governmental agency, civil litigation or otherwise, and even though such individual's pay shall be later determined to be subject to withholding as an employee for previous periods.

12. **"Enrollee" or "Participant"** means an Eligible Employee or Eligible Retiree covered under the Plan in accordance with section: "Eligibility and Effective Date".

13. **"Enrollment Application"** means the form to be accurately completed by prospective Enrollees when they apply for enrollment under the Plan.

14. **"Home Delivery"** is allowed and services of a mid-wife are covered but require care management authorization and coordination. Contact QualChoice care management department at 1-888-795-6810 for authorization requirements and information.

15. **"Home Health Care Plan"** must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

16. **"Hospital"** is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.

- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist

on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

17. **"Licensed Provider"** means a person, licensed by the state in which they practice, performing services within the scope of their license that are covered under the Plan.

18. **"Life-threatening Illness or Injury" or "Emergency"** means those services that are provided in a hospital emergency facility after the sudden onset of a medical or psychological condition, with symptoms of sufficient severity that in the absence of immediate medical attention could result in placing the patient's health in jeopardy; serious impairment; or serious dysfunction of any bodily organ or part.

19. **"Maximum Allowable Payment" (MAP)** means the schedule of fees established by QualChoice for payments to providers for covered services and which may be less than actual charges billed by Network Providers or Out-of-Network Providers.

20. **"Medically Necessary" means** services or supplies that meet all of the following criteria in thasuch services or supplies are:

    - Provided for the diagnosis, or direct care and treatment of a medical condition that is (i) not excluded from coverage under the Plan and (ii) determined by QualChoice, applying its established medical policies and guidelines, to be covered under the Plan;
    - Appropriate and necessary for the symptoms, diagnosis, and/or treatment of a covered medical condition;
    - Within standards of good medical practice recognized within the organized medical community;
    - Not primarily for the convenience of the Enrollee, their family, their physician, or other provider; and
    - The most appropriate supply or level of service that can safely be provided.
    - For definition of Medical or Psychological Necessity see Section, item 2.

21. **"Mental Health or Substance Abuse"** means any psychiatric disorder or disorder of emotion or thought, appropriately classified as an Axis I diagnosis in accordance with the current edition of the Diagnosis & Statistical manual of mental Diseases of the American Psychiatric Association (DSM) classification as further described in the section dealing with Mental Health and Substance Abuse.

22. **"Network Hospital"** means a hospital that has entered into an agreement with QualChoice to make Covered Medical Services available to Enrollees.

23. **"Network Primary Care Physician"** means a physician who has entered into an agreement with QualChoice to provide Covered Medical Services to Enrollees. They are selected by an Enrollee to be their primary care physician.

24. **"Network Physician"** means a physician who has entered into an agreement with QualChoice to provide and/or arrange for Covered Medical Services to Enrollees.

25. **"Network Provider"** means a Network Physician, Network Specialist, hospital or other provider having an agreement with QualChoice to make Covered Medical Services available to Enrollees.

26. **"Network Specialist"** means a medical or surgical specialist who has entered into an agreement with QualChoice to make Covered Medical Services available to Enrollees.

27. **"Out-of-Network Physician, Out-of-Network Hospital or Out-of-Network Provider"** means a physician, hospital or other provider that has not entered into an agreement with QualChoice to make Covered Medical Services available to Enrollees.

28. **"Out-of-Network Service"** means a Covered Medical Service to an Enrollee by an Out-of-Network Provider.

29. "**Referral"** means a written letter of approval, issued by QualChoice, that an Enrollee may seek additional evaluation or treatment from an Out-of-Network Physician, Hospital, or Provider. A

general statement by a Network Provider that a patient should seek a particular type of service or provider does not constitute a "Referral" under this Summary Plan Description. Even with a Referral, many services must be pre-authorized by QualChoice. Referrals are issued for a specific time frame as requested by your Network Physician or as determined based on Medical Necessity.

It is your responsibility to ensure that a Referral for all services provided to you by Out-of-Network Physicians, Hospitals, or Providers are obtained prior to receiving the services and are done during the appropriate time frame. **If services are rendered outside the approved time frame, benefits will allowed at Out-Of-Network reimbursement levels.**

30. **"Service Area"** means the geographical area, i.e., the State of Arkansas and certain contiguous counties where QualChoice maintains agreements with Network Providers.

31. **"Sound Natural Tooth"** means any deciduous tooth or permanent tooth that is free from decay, amalgam or any other restorative work and had at least fifty percent (50%) bony support.

32. **"Sterilization Procedures**" Means health services and associated expenses relating to sterilization procedures.

33. **"Urgent Care Facility"** means a licensed facility that provides medical assistance to treat minor and non life-threatening emergencies.

34. **"Accidental Injury"** means an injury happening unexpectedly and taking place not according to the usual course of events (for example an automobile accident). Accidental injury does not include any damage caused by chewing or biting any object.

35. "**Out-of-Pocket Expense Limitation**" is the maximum amount that you will have to pay in Coinsurance for services. Out-of-Pocket Expense Limitations do not include amounts in excess of the Maximum Allowable Payment, Co-payments, price differential between Generic and Brand name drugs, and Exclusions as stated Exclusions Section.

36. **"Open Enrollment"** means the time period during which Eligible Employees may join, may elect coverage for Eligible Dependents, or may transfer from one plan option to another. The Open Enrollment period will be designated by the University of Arkansas.

PLAN ADMINISTRATION

PLAN ADMINISTRATOR. University of Arkansas Medical Benefit Plan is the benefit plan of The University of Arkansas System, the Plan Administrator, also called the Plan Sponsor. An individual may be appointed by The University of Arkansas System to be Plan Administrator and serve at the convenience of the Employer.

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

No legal action may be taken regarding the Plan until all Complaints and Appeal rights, as described in this SPD, have been exhausted. In the event that legal papers need to be served regarding this Plan, service shall be made on the President of the University of Arkansas. Nothing herein shall waive immunities from suit or civil liability to which the Plan, the University of Arkansas system or any officer, trustee or employee of the University of Arkansas are entitled.

This Plan is self-funded by the University of Arkansas System This means the cost of your and your dependents medical care is paid out of monies set asked for that purpose by the UA and from employee contributions. The University of Arkansas System has also obtained special insurance protection in the event of large claims. Other Benefits, either insured or self-funded, may also be provided by the University of Arkansas System and such Benefits (if any) are described in separate documents.

AMENDMENT OR TERMINATION

The University reserves the right to amend this plan at any time upon notice to the participants. The University of Arkansas System reserves the right to terminate the plan in its entirety, or for specific classes of employees, or to change the employee contribution required. The employee contribution required may be different for different classes of eligible employees.

CHOOSEWELL WELLNESS PROGRAM

The University of Arkansas System offers the ChooseWell Wellness Program to members covered under its health program. The ChooseWell Wellness Program is designed to assist members and their dependents in learning how living a healthy lifestyle results in spending less money for healthcare.

Go to **www.uasys.edu/choosewell** for additional information or call 1-888-795-6810 for information on health coaching, disease management and other programs that are available to you and your covered dependents.

GENERAL INFORMATION

1. **PLAN:** The name of your Plan is the University of Arkansas Medical Benefit Plan.

2. **PLAN EFFECTIVE DATE:** The Original Effective Date of the Plan is November 1, 1994. This Plan Document/Summary Plan Description sets forth the provisions of the Plan, Effective January 1, 2011.

3. **PLAN SPONSOR/EMPLOYER:** The Plan Sponsor is the University of Arkansas System. The address and telephone number of the Plan sponsor is:

   The University of Arkansas System
   c/o President
   2404 N. University Avenue
   Little Rock, Arkansas 72207
   501-686-2500

4. **PLAN SUPERVISOR:** The University of Arkansas Medical Benefit Plan is supervised and administered by:

   QualChoice
   P. O. Box 25610
   Little Rock, AR 72221-5610
   501-219-5133

   QualChoice is licensed by the State of Arkansas.

5. **PLAN FISCAL YEAR:** The Fiscal Year of the Plan begins on July 1 of each year and will end on June 30 of the following year.

6. **TYPE OF ADMINISTRATION:** Contract Administration.

7. **THE FOLLOWING CAMPUSES OF THE UNIVERSITY OF ARKANSAS SYSTEM PARTICIPATE IN THE UNIVERSITY OF ARKANSAS MEDICAL BENEFIT PLAN:**

   University of Arkansas Fayetteville and certain related entities

   University of Arkansas Medical Sciences

   University of Arkansas at Little Rock

   University of Arkansas Cooperative Extension Service

   University of Arkansas at Pine Bluff

   University of Arkansas at Monticello

   University of Arkansas Community College at Batesville

   Arkansas School for Mathematics, Sciences, and Arts

   Phillips Community College of the University of Arkansas

Plan Sponsor HIPAA Certificate Statement

We understand that medical information about Participants and their health is personal, and we are committed to protecting medical information. As the Employer/Plan Sponsor, the University of Arkansas (henceforth "the Plan Sponsor") agrees to comply with the following restrictions and conditions respecting its use and disclosure of Protected Health Information ("PHI") as defined by federal regulations at 45 C.F.R 164.501, and as may be disclosed to the Plan Sponsor by the Plan. As the Employer/Plan Sponsor, we agree that we will:

1. Not use or further disclose PHI disclosed to us by the Plan other than as permitted or required by the plan documents, or as is required by law, within the meaning of federal regulations establishing Standards for the Privacy of Individually Identifiable Health Information.
2. Ensure that any agents, including a subcontractor to whom we provide PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
3. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
4. Report to the Plan any use or disclosure of PHI of which the Plan Sponsor becomes aware that is inconsistent with the uses and disclosures provided for or permitted in the plan documents;
5. Make records containing PHI that is used to make decisions about a Participant available for inspection and copying by the Participant, or otherwise arrange for the Participant to obtain a copy of such records. Participants will be charged a fee for the cost of copying, mailing or other supplies. In some situations, the Plan or we are allowed to deny this request.
6. Make PHI about Participants available for amendment in response to requests by Participants for amendment of records that they feel contain incomplete or incorrect information about them. Such requests may be denied in certain circumstances, and in such cases Participants will be informed of procedures for disagreeing with amendment denials. We or the Plan may ask that these requests be in writing and provide a reason that supports the request;
7. Make records available to permit Participants to obtain an accounting of certain types of disclosures of PHI about them;
8. Make our internal practices, books, and records relating to the use or disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with regulatory Standards for the Privacy of Individually Identifiable Health Information;
9. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor maintains in any form and retain no copies of such information when no longer needed for the purpose of the disclosure, except that, if such return or destruction is not feasible, limit further uses and disclosures to those permitted by law; and
10. Ensure that there is adequate separation between the Plan and the Plan Sponsor by providing:

    - A description of individuals who are under the control of the Plan Sponsor and who will have access to PHI to be disclosed to the Plan Sponsor by the Plan, including any employee or person who receives PHI relating to payment under, or health care operations of, or other matters pertaining to, the Plan in the ordinary course of business, and;
    - Restricted access to and use of the PHI by such employees and others to the plan administration functions that the Plan Sponsor performs for the Plan, and;
    - An effective mechanism for resolving any issues related to noncompliance by the above-referenced persons with the requirements of the plan documents.

Selected individuals in the office of Human Resources may utilize PHI in the course of their duties and responsibilities and have trained in accordance with the federal regulations and the Plan Sponsor Policies and Procedures regarding use and disclosures of PHI.

You may receive a list of these individuals by contacting your Human Resource department.