Summary Plan Description For ARHealthNetworks Benefit Plan

Table of Contents

INTRODUCTION 1
ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS 3
OPEN ENROLLMENT 6
SCHEDULE OF BENEFITS 7
MEDICAL BENEFITS 11
COST MANAGEMENT SERVICES 15
DEFINED TERMS 18
PLAN EXCLUSIONS 23
PRESCRIPTION DRUG BENEFITS 27
HOW TO SUBMIT A CLAIM 29
COORDINATION OF BENEFITS 31
THIRD PARTY RECOVERY PROVISION 33
RESPONSIBILITIES FOR PLAN ADMINISTRATION 36
GENERAL PLAN INFORMATION 40

Introduction

The Summary Plan Description explains the benefits you may receive as a member of the ARHealthNetworks Benefit Plan (the Plan). The plan provides coverage for participating employees and eligible dependents.

This document will help you understand and use your benefits. You should review it as it will help you understand the coverage provided, the steps to follow to make sure you get the most out of your coverage and your rights and responsibilities under the plan. Be sure to pay close attention to the definitions, benefit limitations and plan exclusions. This is a limited benefit design; therefore, not every expense you incur for health care is covered by the Plan.

NovaSys Health administers the Plan. If you have any questions about your coverage, rights or responsibilities, be sure to contact NovaSys Health at 1-800-540-7566.

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

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished. In addition, services must be rendered by a NovaSys Health participating provider . No benefits exist for services rendered by a Non-Participating provider, including emergency services.

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

This Plan is not established under nor subject to the Federal Employee Retirement Income Security Act of 1974 (commonly known as ERISA). The plan is paid for by contributions from your employer, employee premiums, tobacco settlement funds and existing Medicaid dollars.

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

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

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

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

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

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

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

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

Claim Provisions. Explains the rules for filing claims.

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

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

Eligibility, Effective Date and Termination Provisions

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

Eligibility

Eligible Employees. All Active Employees of the Employer.

Eligibility Requirements for Employee Coverage. A person employed by an eligible employer participating in the ARHealthNetworks program and who:

(1) is a Full-Time, Active Employee of the Employer currently working at least 30 hours per week and is on the regular payroll of the Employer for that work.

(2) completes the employment Waiting Period an Active Employee. A "Waiting Period" is the time between the first day of employment as an eligible Employee and the first day of coverage under the Plan. Coverage will become effective on the 1st of the month following 90 days of employment.

(3) physically resides or works in the state of Arkansas.

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(4) has not been offered health coverage by the Arkansas State Employees or Arkansas Public School Employees Group Plan. For purposes of this plan, if an employee or spouse is an employee of the State of Arkansas or is an Arkansas Public School employee, both the employee and the spouse are excluded from participating in ARHealthNetworks.

(5) does not have employer sponsored group health insurance or Medicaid coverage.

In addition, leased employees of an employer group may be eligible if they meet all other eligibility criteria as specified by their employer, and agreed to in writing by NovaSys Health. Contracted employees of an employer are not eligible. Certain exemptions may apply.

Timely Enrollment

Timely Enrollment - the enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 15 days before the person becomes eligible for the coverage.

Timely Disenrollment

Timely Disenrollment - the disenrollment will be "timely" if the notification is received by the Plan Administrator no later than 5 business days after the Employer group receives notification of termination date.

Special Enrollment Rights

Special Enrollment provisions are available under some circumstances. If an Employee is declining enrollment for himself or their spouse because of other group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other group health plan coverage.

In addition, in the case of a birth, marriage, divorce, legal separation, adoption or placement for adoption, there may be a right to reevaluate or activate enrollment in this Plan.

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

Special Enrollment Periods

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

(1) **Individuals losing other coverage creating a Special Enrollment right.** An Employee 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 was covered under a group health plan 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 group health coverage was the reason for declining enrollment.

(c) For purposes of these rules, a loss of other group coverage will require the eligible employee to enroll in ARHealthNetworks. For purposes of this plan, if an employee or spouse is an employee of the State of Arkansas or is an Arkansas Public School employee, both the employee and the spouse are excluded from participating in ARHealthNetworks even if the eligible employee voluntary declines spouse coverage.

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

Effective Date

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the first day of the calendar month following the date that the Employee satisfies all of the following:

(1) The Eligibility Requirement.

(2) The Active Employee Requirement.

(3) The Enrollment Requirements of the Plan.

Active Employee Requirement.

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

Termination of Coverage

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates:

(1) The date the Plan is terminated.

(2) The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. It also includes an Employee on disability, leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods.

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

For disability leave only: the date the Employer ends the continuance.

For leave of absence or layoff only: the date the Employer ends the continuance.

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

Rehiring a Terminated Employee. Rehires are eligible for coverage at the first of the month following rehire, given the employee was previously participating in ARHealthNetworks through its current employer within the last 12 months. Following the rehire, benefits will resume from the previous coverage period. If the rehire was not previously participating in ARHealthNetworks, the rehire must satisfy the waiting period.

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

(1) The maximum period of coverage of a person and the person's Dependents under such an election shall be the lesser of:

  (a) The 24 month period beginning on the date on which the person's absence begins; or

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

(2) A person who elects to continue health plan coverage is not required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

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

(4) The earliest date the Dependent has a claim that is denied in whole or in part because it meets or exceeds a lifetime limit on all benefits.

Open Enrollment

Open Enrollment

Open enrollment for an ARHealthNetworks Group is allowed once a year, usually 60 days prior to the group's annual renewal (anniversary) date and runs for 30 days. Renewal documentation is to be received by NovaSys Health on the 15th of the month prior to the renewal date. Open enrollment is available to all ARHealthNetworks eligible employees. Thereafter, eligible employees that waived coverage may only enroll at the group's next open enrollment period, unless a valid qualifying event occurs.

During the annual open enrollment period, covered Employees will be able to change their spousal coverage decisions based on what coverage is right for them.

Benefit choices made during the open enrollment period will become effective on the anniversary date of the group and remain in effect until the next open enrollment period (which is typically a 12 month period) unless there is a Special Enrollment event or a loss of coverage due to loss of a Spouse's employment. To the extent previously satisfied, coverage Waiting Periods will be considered satisfied when changing from one coverage option under the Plan to another coverage option under the Plan.

A Plan Participant who fails to make an election during open enrollment will automatically retain his or her present coverage.

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

Schedule of Benefits

Verification of Eligibility 1 (800) -540-7566

Call this number to verify eligibility for Plan benefits **before** the charge is incurred.

Medical Benefits

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Usual and Reasonable; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

Only a general description of health benefits covered by this Plan is included in this document. A more detailed schedule of coverage is available to any Plan Participant, at no cost, who requests one from the Plan Administrator.

Note: The following services must be precertified or reimbursement from the Plan may be reduced.

Inpatient Hospitalizations
Outpatient Services
Office Surgeries
Major Diagnostic Testing

In addition, all Emergency Room visits require notification be made to the plan administrator within 48 hours after the visit.

Please see the Cost Management section in this booklet for details.

The Plan contains a Participating Provider Organization plan.

PPO name:	NovaSys Health
Address:	P.O. Box 25230 Little Rock, AR 72221
Telephone:	1-800-540-7566
Website:	www.ARHealthNetworks.com

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Participating Providers. Because these Participating Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

It is the Covered Person's choice as to which Provider to use, however, there will be no reimbursement made to providers that are not participating in the NovaSys Health provider network.

Additional information about this option, as well as a list of Participating Providers, will be given to Plan Participants, at no cost, and updated as needed.

Deductibles and Coinsurance payable by Plan Participants

The Plan is a limited benefit plan design that includes coverage for physician, outpatient, emergency and inpatient visits. Each of these areas is subject to benefit visit maximum. Each member must satisfy a $100 deductible, excluding office visits as defined below. After the deductible has been satisfied, all covered allowable charges will be subject to a 15% coinsurance until a maximum out of pocket of $1,000 is reached. The deductible will count

towards the maximum out of pocket amount. After the maximum out of pocket is reached, the plan will then pay 100% of covered allowable charges up to a maximum amount of $100,000 per plan year.

	Benefits for Services Performed by Participating Providers
MAXIMUM PLAN YEAR BENEFIT AMOUNT	$100,000
The Covered Person is responsible for verifying with the provider of service, prior to receiving medical attention, that they are a Participating Provider. No Coverage exists for services rendered by a Non-Participating provider. No exceptions.	
DEDUCTIBLE, PER PLAN YEAR	
Per Covered Person	$100
MAXIMUM OUT-OF-POCKET DEDUCTIBLE AND COINSURANCE AMOUNT, PER PLAN YEAR	
Per Covered Person	$1,000
A deductible must be paid before any money is paid by the Plan for any Covered Charges. Each plan year, a new deductible amount is required. Deductibles do accrue toward the 100% maximum out-of-pocket coinsurance amounts. After the dedutible is met, the Plan will pay the designated percentage of Covered Charges until out-of-pocket coinsurance amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Plan Year unless stated otherwise.	

Physician Services	Benefits for Services Performed by Participating Providers
Professional Office Visits includes the evaluation, managment, consultation or treatment services rendered by a licensed physician, nurse practitioner, chiropractor, optometrist, social worker, licensed professional counselor, or psychologist. - Includes all charges billed by the physician for services covered under this benefit plan that are for services incurred in the provider's office not considered to be outpatient services. See section on Outpatient Services. - Charges for lab, radiology and pathologogy services will be covered if billed separately from the professional visit, if the services are provided on the same day/day before/day after a covered professional office visit.	85%. No deductible applies. Eye Exams are limited to 1 per plan year. 6 Visits per plan year (distinct dates of service)
Outpatient Services, Major Diagnostic Services, Emergency Room Visits, Surgeries	
- Includes services performed in emergency rooms, outpatient facilities, ambulatory surgery centers, imaging centers, breast centers, eye centers and other free standing outpatient centers. Also includes certain services performed in the providers office that are considered to be major diagnostic services or surgical procedures. - Includes all charges billed by physicians, facility and ancillary providers for services covered under this benefit plan.	85% after deductible. 2 Services per plan year (distinct dates of service) Pre-notification is required for all services included in this category. The plan administrator must be notified within 48 hours for all Emergency Room Visits.
Hospital Services	
Inpatient Visits in Acute Care Hospital - Includes all charges billed by the facility for professional, surgical, anesthesia, blood, drug, equipment, implant and supply charges associated with covered inpatient days. - Includes all charges billed by physicians, facility and ancillary providers for services covered under this benefit plan.	85% after deductible. Limited to 7 inpatient days per plan year. Pre-certification is required for all inpatient stays

Physician Services	Benefits for Services Performed by Participating Providers	
Prescription Drugs		
Prescription Drugs – covered under the formulary management plan.	2 prescriptions per month (30 day supply each) $5 Generic $15 Brand Formulary $30 Brand Non-Formulary **Mail order prescription drugs are not covered.**	

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

DEDUCTIBLE

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

BENEFIT PAYMENT

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

OUT-OF-POCKET LIMIT

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

MAXIMUM BENEFIT AMOUNT

The Maximum Benefit Amount is shown in the Schedule of Benefits. It is the total amount of benefits that will be paid under the Plan for all Covered Charges incurred by a Covered Person per Plan Year.

Covered charges are the Usual and Reasonable Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

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

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

(a) SOBRA.
An eligible ARHealthNetworks employee or spouse may compliment the ARHealthNetworks employer group plan with a Medicaid plan for the purposes of pregnancy. SOBRA allows the state of Arkansas to provide certain medical services to low-income pregnant women, with annual earnings at or below 200% of the Federal Poverty Level. Claims should be filed with the state of Arkansas under SOBRA regulations before filing with NovaSys Health. Additional information can be found at www.medicaid.state.ar.us or by calling 1-800-682-8970.

(3) **Physician Care.** The professional services of a Physician for surgical or medical services.

Charges for **multiple surgical procedures** will be a Covered Charge subject to the following provisions:

(a) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Usual and Reasonable Charge that is allowed for the primary procedures; 50% of the Usual and Reasonable Charge will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures:

(b) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Usual and Reasonable Charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Usual and Reasonable percentage allowed for that procedure; and

(c) If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the surgeon's Usual and Reasonable allowance.

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

(a) **Anesthetic**; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

(b) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered:

1. under the supervision of a Physician;
2. in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery;
3. initiated within 12 weeks after other treatment for the medical condition ends; and
4. in a Medical Care Facility as defined by this Plan.

(c) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.

(d) Initial **contact lenses** or glasses required following cataract surgery.

(e) Care, supplies and services for the diagnosis of infertility**.**

(f) **Laboratory studies.**

(g) Treatment **of Mental Disorders and Substance Abuse**. Covered charges for care, supplies and treatment of Mental Disorders and Substance Abuse will be limited as follows:
All treatment is subject to the benefit payment maximums shown in the Schedule of Benefits.

Physician's visits are limited to one treatment per day up to the plan benefit maximum.

Psychiatrists (M.D.), psychologists (Ph.D.), counselors (Ph.D.) or Masters of Social Work (M.S.W.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

(h) Injury to or care of **mouth, teeth and gums**. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

Emergency repair due to Injury to sound natural teeth.

Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

Excision of benign bony growths of the jaw and hard palate.

External incision and drainage of cellulitis.

Incision of sensory sinuses, salivary glands or ducts.

Removal of impacted teeth.

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

(i) **Occupational therapy** by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

(j) **Physical therapy** by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions, which are subject to significant improvement through short-term therapy.

(k) **Prescription** Drugs (as defined).

(l) Routine **Preventive Care.** Covered charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits.

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

(m) **Reconstructive Surgery.** Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges.

This mammoplasty coverage will include reimbursement for:

(i) reconstruction of the breast on which a mastectomy has been performed,

(ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and

(iii) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

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

(n) **Speech therapy** by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (ii) an Injury; or (iii) a Sickness that is other than a learning or Mental Disorder.

(o) **Spinal Manipulation/Chiropractic services** by a licensed M.D., D.O. or D.C.

(p) **Sterilization** procedures.

(q) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.

(r) Diagnostic **x-rays**, including CAT Scans, MRIs, PET Scan and other imaging services

Cost Management Services

Cost Management Services Phone Number

NovaSys Health should be contacted at 1-877-362-9002 for all services requiring pre-notification or pre-certication.

In addition, the Employee ID card also includes the Cost Management Services phone number.

The patient or family member must call this number to receive certification of certain Cost Management Services. This call must be made at least 48 hours in advance of services being rendered or within 48 hours after an emergency.

Utilization Review

Utilization review is a program designed to help insure that all Covered Persons receive necessary and appropriate health care in a cost effective manner.

The program consists of:

(a) Precertification or Prenotification of Medical Necessity for the following non-emergency services before Medical and/or Surgical services are provided:

Inpatient Hospitalizations
Outpatient Services
Office Surgeries
Major Diagnostic Testing

(b) Retrospective review of Medical Necessity of the listed services provided on an emergency basis;

(c) Concurrent review, of the listed services, based on the admitting diagnosis as requested by the attending Physician; and

(d) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

If a particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, please read the following provisions carefully.

Here's How the Program Works

Before a Covered Person enters a Medical Care Facility **or** receives listed outpatient services, the utilization review administrator will, in conjunction with the attending Physician, review and determine the care as appropriate for Plan

reimbursement. When the care is determined to be appropriate within the Plan's benefits structure, precertification or prenotification for medical necessity is rendered.

Precertification Process. Precertification must be obtained before a Covered Person enters a Medical Care Facility on a non-emergency basis. (A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance).

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the utilization review administrator **within 48 hours** of the first business day after the admission.

The utilization review administrator will determine the number of days of Medical Care Facility confinement authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been precertified, the attending Physician must request the additional services or days. Please note that there is a Plan limitation of 7 inpatient days per plan year.

Pre-notification Process. Pre-notification is required before a Covered Person receives any services performed in outpatient facilities, ambulatory surgery centers, imaging centers, breast care centers, eye centers or other free standing outpatient centers. Pre-notification is also required for any surgical or major diagnostic procedure rendered in the office setting.. In addition, NovaSys requires notification of all emergency room visits **within 48 hours** of the visit.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services on an outpatient basis than what was originally received in Prenotification process, the attending Physician must request the additional services.

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

The utilization review program is set in motion by a telephone call from the Covered Person. Contact the utilization review administrator at the telephone number on your ID card **at least 48 hours before** services are scheduled to be rendered with the following information:

- -- The name of the patient
- -- The name, Social Security number, Member ID and address of the covered Employee
- -- The name of the Employer
- -- The name and telephone number of the attending physician
- -- The name of the Medical Facility, outpatient facility, ambulatory surgery center, imaging center or other
- -- freestanding outpatient and the requested date of service (for Outpatient services)
- -- The name of the Medical Care Facility, requested date of admission and requested length of stay (for Inpatient Admissions)
- -- The Diagnosis, the type and number of procedures and/or requested medical services

Case Management

Case Management. The Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide Case Management services.. Case Management intervention shall be determined on a case-by-case basis, and the Plan's determination to provide the service in one instance shall not obligate the Plan to provide the same or similar service for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

A case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

- -- personal support to the patient;
- -- contacting the family to offer assistance and support;
- -- monitoring Hospital or Skilled Nursing Facility;
- -- determining alternative care options; and
- -- assisting in obtaining any necessary services.

Case Management occurs when the service will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan within the provisions of the Plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Administrator will direct the Plan to reimburse for Medically Necessary expenses as stated in the treatment plan.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

Defined Terms

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

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

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

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

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

Brand Name means a trade name medication.

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

Covered Person is an Employee who is covered under this Plan.

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

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

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

Employer is the group by whom the Employee is employed .

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

Experimental and/or Investigational means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

(1) If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

(2) If the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

(3) If Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

(4) If Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

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

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

Genetic Information means information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense 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.

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

Infertility means incapable of producing offspring.

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

Intensive Care Unit is defined as a separate, clearly designated service area, which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Medical Care Facility means a Hospital, a facility that treats one or more specific.

Medical Emergency means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

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

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

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

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

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person.

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

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

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

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Optometrist (O.D.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means ARHealthNetworks Benefit Plan, which is a benefits plan for certain Employees of and is described in this document.

Plan Participant is any Employee who is covered under this Plan.

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

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

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

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

(1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

(2) Its services are provided for compensation and under the full-time supervision of a Physician.

(3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

(4) It maintains a complete medical record on each patient.

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, Custodial or educational care or care of Mental Disorders.

(7) It is approved and licensed by Medicare.

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

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

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

Usual and Reasonable Charge is a charge, which is not higher than the usual charge made by the provider of the care, or supply and does not exceed the usual charge made by most providers of like service in the same area. This

test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience.

The Plan will reimburse the actual charge billed if it is less than the Usual and Reasonable Charge.

The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable.

Plan Exclusions

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

This section contains general exclusions and limitations of your plan. Other parts of this SPD and Schedule of Benefits dealing with coverage of specific services, treatments, medications and supplies contain additional exclusions and limitations.

1. **Abortion.** Purely elective or voluntary abortions are not covered.
2. **Acupuncture.** Services related to acupuncture are not covered.
3. **Ambulance.** All ambulance services are excluded, including both ground and air.
4. **Appointments/medical records.** If you fail to keep and appointment with a provider and he charges for the appointment the charges will not be paid by your plan. Charges for completion of insurance forms, or for acquisition of medical records, are not covered.
5. **Audiological Services.**
6. **Bereavement services.** Medical Social services and outpatient family counseling and/or therapy for bereavement, except as provided as Hospice Care, are not covered.
7. **Biofeedback.** Hypnotherapy, biofeedback and other forms of self-care or self-help training, and any related diagnostic testing are not covered.
8. **Chelation therapy.** Services or supplies provided as, or in conjunction with, chelation therapy, except for treatment of acute metal poisoning are not covered.
9. **Chiropractic or Portable X-Rays**.
10. **Cochlear implants.**
11. **Comfort items.** If you are hospitalized and semi-private rooms are available, a private room will not be paid unless your physician provides documentation the private room is medically necessary. Personal convenience items such as assistive talking devices, automobile/van conversion or addition of patient lifts, hand controls, or wheel chair ramps, and home modifications such as overhead patient lifts and wheelchair ramps are not covered.
12. **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under this SPD are not covered.
13. **Cosmetic services.** All services or procedures related to or complications resulting from Cosmetic Services are not covered.
14. **Court ordered or third party recommended treatment.** Services required or recommended by third parties, including physicals and/or vaccines/immunizations for employment, overseas travel, camp, marriage licensing, insurance, and services ordered by the court or arranged by law enforcement officials.
15. **Custodial care.** Services or supplies for custodial, convalescent, domiciliary, supportive or maintenance care, and non-medical services to assist you with activities of daily living are not covered.
16. **Dental care.** Dental Implants, abutments, dental restorations, and services or supplies are not covered except when required following accidental injury or as a result of Sjögren's syndrome. Orthognathic surgery and Orthodontics and braces regardless of your age are not covered.
17. **Domestic Partners.** Domestic partners of the same sex or opposite sex are not covered.
18. **Donor services.** Services or supplies incident to organ and tissue transplant, or other procedures when you act as the donor are not covered.
19. **Durable Medical and Ventilator Equipment.** Durable Medical Equipment and Ventilator Equipment that are not supplied as a part of a covered physician visit, outpatient visit or inpatient visit are not covered.
20. **Eating Disorders.** Anorexia, bulimia, and services related to eating disorders are not covered except for

medical stabilization or related conditions such as bradycardia or fluid and electrolyte imbalance.

21. **Electrotherapy stimulators.** All treatment using electrotherapy stimulators, services and supplies used in connection with treatment, and complications resulting from the treatment are not covered.
22. **End Stage Renal Disease Services/Hemodialysis.**
23. **Enteral Feedings.** Enteral tube feedings are not covered.
24. **Excess charges.** The part of an expense for care and treatment of an Injury or sickness that is in excess of the allowable charge is not covered.
25. **Exercise programs.** Exercise programs for treatment of any condition are not covered.
26. **Experimental/Investigational.** Any treatment, procedure, facility, equipment, drug, device or supply deemed by your benefit coordinator to be experimental or investigational as defined in this SPD is not covered. Diagnostic procedures, services and supplies provided in connection with experimental or investigational studies or treatment are not covered.
27. **Eye care.** Refractive keratoplasty, epikeratophakia procedures, Low Vision Enhancement System (LVES), and eyeglasses and contact lenses except the initial acquisition following cataract surgery are not covered.
28. **Family planning and infertility services.** Any services or supplies provided for, in preparation for, or in conjunction with the following are not covered:
    a. Elective or voluntary abortions; and complications for these procedures.
    b. Sterilization reversal (male or female).
    c. Sexual dysfunction including sex therapy.
    d. Surrogate mother services or in vitro fertilization.
    e. Diagnostic testing or treatment of infertility.
29. **Foot care.** Services or supplies for treatment of flat feet or fallen arches, routine foot care such as hygiene care, removal of corns, warts or calluses, and toenail trimming, except when required for prevention of complications associated with diabetes are not covered.
30. **Genetic testing.** Services related to genetic testing are limited to those approved by your benefit coordinator. Examples of genetic testing that are covered include but are not limited to testing for Down's syndrome, phenylketonuria/galactosemia, (PKU), medullary thyroid carcinoma, hypothyroidism and sickle cell anemia.
31. **Government coverage.** Coverage for which you are eligible through entitlement programs of the federal, state, or local government, including but not limited to any insurance carrier, Veterans Administration, Medicare, or Medicaid are not covered.
32. **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 are not covered under medical benefits.
33. **Hearing or talking aids.** Hearing aids or assistive talking devices including special computers are not covered.
34. **High dose chemotherapy.** High dose chemotherapy and all related procedures are not covered.
35. **Investigational/Unproven Services.**
36. **Lab, Radiology, Pathology or Anesthesia services not provided as part of a covered inpatient, outpatient or physician visit.**
37. **Home Health, Hospice, Skilled Nursing Facility, Long Term Care, Intermediate Care Facility, Residential Treatment, Personal Care, Private Duty Nursing or other Domiciliary or Assisted Living Facility Service.**
38. **Long-term care.** Services or supplies furnished by an institution, which is primarily a place of rest or a place for the aged, residential long-term care for mental health disorders, youth homes, or any similar institution are not covered.
39. **Mail Order Drugs.** All mail order drugs are not covered.
40. **Midwives.** Services provided by midwives are not covered unless working under the direction of a plan physician.

41. **Naturopath/Homeopath services.** Naturopathic or Homeopathic remedies for treatment of any condition are not covered.
42. **Non-covered services.** Services not specifically included as a benefit herein, complications related to non-covered services, services provided after exceeding the benefit maximum for specified services, and services for which the Member is not responsible for payment are not covered.
43. **Not Medically Necessary.** Services and supplies that are not medically necessary are not covered except for preventive health services for which coverage is otherwise specifically listed. Hospitalization that is extended for reasons other than medical necessity, e.g. lack of transportation, lack of caregiver at home, inclement weather, and other social reasons not justifying coverage for extended hospital stay is not covered.
44. **Nutritional counseling services.** Dietary and nutritional counseling services are not covered except in conjunction with diabetic self-management training, and for a nutritional assessment program provided in and by a hospital and approved by your benefit coordinator.
45. **Nutritional supplements.** Regular formulas, special formulas, and food additives are not covered except for formulas necessary for the treatment of phenylketonuria (an inherited condition that may cause severe mental retardation), and other heritable diseases.
46. **Obesity therapy or treatment, including bariatric services and surgical treatment for Morbid Obesity.**
47. **Organ Transplant Services.**
48. **Orthotic and Prosthetic Services. Orthotic and Prosthetic services** that are not supplied as a part of a covered physician visit, outpatient visit or inpatient visit are not covered.
49. **Other Professional Evaluation and Management Exclusions.**
50. **Physician Standby, Case Management, Telephonic, Care Plan Oversight.**
51. **Prescribed drugs and medications.** Medications obtained by prescription through your pharmacy plan will have associated co payments as determined by the plan. IV medications administered in your physicians office, or in an outpatient setting will be paid by the health plan as long as they are provider as part of a covered service.
52. **Private duty nursing**. Private duty nursing services are not covered.
53. **Reconstructive Surgery.** Reconstructive surgery or orthognathic procedures are not covered. All services or procedures related to or complications resulting from reconstructive surgery are not covered except corrective surgical procedures performed to reshape structures of the body in order to alter the individual's appearance. Breast augmentation, mastopexy, breast reduction for cosmetic reasons, otoplasty, rhinoplasty, collagen injection and scar reversals are examples of cosmetic services. A cosmetic service also includes any procedure required to correct complications caused by or arising from prior cosmetic services. Cosmetic services do not include the following services in connection with a mastectomy resulting from cancer: (a) reconstruction of the breast on which the cancer-related surgery has been performed, and (b) surgery to reconstruct the other breast to produce a symmetrical appearance.
54. **Relative giving services.** Professional services performed by a person who ordinarily resides in your home, or is related to you such as a spouse, parent, child, brother or sister, grandparent and grandchild, whether the relationship is by blood or exists in law are not covered.
55. **Services outside of Service Area.** Services rendered outside of your benefit coordinator's service area are not covered.
56. **Sex changes/sex therapy.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change are not covered. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment or other treatment of sexual dysfunction including sex therapy.
57. **Short stature syndrome.** Any services related to the treatment of short stature syndrome are not covered.
58. **Sleep study centers.** Services provided by contracted sleep study centers are covered when ordered by your plan provider. Services and supplies provided by or in connection with freestanding sleep study centers or sleep laboratories are not covered unless pre-approved by your benefit coordinator.

59. **Supplies.** Medical Supplies regardless of where prescribed or purchased that are covered by the Prescription Medication Program are not covered. This includes supplies that are ordered by mail and ancillary diabetic supplies. Your Prescription Drug Benefit specifically covers diabetic supplies.
60. **Telephone Consultation.** Telephone calls by a plan provider to you for consultation or medical management, or for coordinating care with other health care professionals including reporting or obtaining tests and/or laboratory results except telephone calls made by a plan physician responsible for the direct care of a member in case management.
61. **Temporomandibular Joint (TMJ) Dysfunction.** Services or supplies for the treatment of TMJ.
62. **Transplant procedures.** Transplant procedures and services are not covered.
63. **Therapeutic Injections, Infusion and Hyper Alimentation Services.**
64. **Travel or accommodations.** Travel or transportation as a treatment modality or to receive consultation treatment except emergency transportation and ambulance services covered under Part 1, Section K, and transportation in connection with organ transplant services Part 1, Section S are not covered.
65. **Vision Corrective Services.**
66. **Vocational rehabilitation.** Vocational rehabilitation services, vocational counseling, employment counseling or services to assist you in gaining employment are not covered.
67. **War.** Services or supplies provided for injuries sustained as a result of war, declared or undeclared, or any act of war; or while on active or reserve duty in the armed forces of any country or international authority are not covered.
68. **Weight Management Services.** Weight Loss Services/Programs are excluded.
69. **Workers Compensation.** Treatment of any compensable injury, as defined by the Workers' Compensation Law is not covered, regardless of whether or not you timely filed a claim for workers' compensation benefits.

Prescription Drug Benefits

Pharmacy Drug Charge

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. Express Scripts is the administrator of the pharmacy drug plan.

Co payments

The co payment is applied to each covered pharmacy drug charge and is shown in the schedule of benefits. The co payment amount is not a covered charge under the medical Plan. Each pharmacy prescription is limited to a 30-day supply.

If a drug is purchased from a non-participating pharmacy, or a participating pharmacy when the Covered Person's ID card is not used, the amount payable in excess of the amounts shown in the schedule of benefits will be the ingredient cost and dispensing fee.

Covered Prescription Drugs

(1) All drugs prescribed by a Physician that require a prescription either by federal or state law. This includes oral contraceptives, but excludes any drugs stated as not covered under this Plan.

(2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.

(3) Insulin and other diabetic supplies when prescribed by a Physician. Other injectables are not covered.

Limits To This Benefit

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

(1) Refills only up to the number of times specified by a Physician.

(2) Refills up to one year from the date of order by a Physician.

Expenses Not Covered

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

(1) **Administration.** Any charge for the administration of a covered Prescription Drug.

(2) **Allergans.** Any charges for allergens**.**

(3) **Appetite suppressants.** A charge for appetite suppressants (ex, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.

(4) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.

(5) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.

(6) **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as photo aged skin products (ex. Renova, Avage); hair growth products (ex. Propecia, Vaniqa); treatment of wrinkles (ex. Botox, Retin-A); anabolic steroids.- or medications for hair removal.

(7) **Contraceptives.** Charges for contraceptive treatments such as non-injectables (ex. Oral, Orho Evra, Nuva Ring, Seasonale); injectables (ex. Depo-provera, Lunelle); implants (ex. Norplant) or diaphragms.

(8) **Experimental.** Experimental drugs, even though a charge is made to the Covered Person.

(9) **FDA.** Any drug not approved by the Food and Drug Administration.

(10) **Growth hormones.** Charges for drugs to enhance physical growth or athletic performance or appearance.

(11) **Immunization.** Immunization agents or biological sera such as serums, toxoids and vaccines (ex. Synagis, Lymerix, Rhogam).

(12) **Impotence.** A charge for impotence medication such as non-injectibles (ex. Viagra, Levitra, Cialis, Muse, Yohimbine) or injectables (ex. Caverject, Edex).

(13) **Infertility Treatment/Fertility Agents.** A charge for infertility medication such as oral/vaginal (ex. Clomid, Crinone); injectable (ex. Profasl, HCG).

(14) **Injectable supplies.** A charge for hypodermic syringes and/or needles (other than for insulin).

(15) **Inpatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

(16) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".

(17) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.

(18) **No charge.** A charge for Prescription Drugs that may be properly received without charge under local, state or federal programs.

(19) **Non-legend drugs.** Charges for FDA approved drugs that are prescribed for non-FDA approved uses.

(20) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.

(21) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

How to Submit a Claim

Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them.

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

(1) Obtain a Claim form from the Personnel Office or the Plan Administrator.

(2) Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.

(3) Have the Physician complete the provider's portion of the form.

(4) For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:

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

(5) Send the above to the Claims Administrator at this address:

NovaSys Health
P.O. Box 25330
Little Rock, Arkansas 72221
800-540-7566

When Claims Should be Filed

Claims should be filed with the Claims Administrator within 90 days of the date charges for the service that was incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

(a) it's not reasonably possible to submit the claim in that time; and

(b) 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.

A request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. If a claim is wholly or partially denied, the Claims Administrator will furnish the Plan Participant with a written notice of this denial. This written notice will be provided within 90 days after receipt of the claim. The written notice will contain the following information:

(a) the specific reason or reasons for the denial;

(b) specific reference to those Plan provisions on which the denial is based;

(c) a description of any additional information or material necessary to correct the claim and an explanation of why such material or information is necessary; and

(d) appropriate information as to the steps to be taken if a Plan Participant wishes to submit the claim for review.

A Plan Participant will be notified within 90 days of receipt of the claim as to the acceptance or denial of a claim and if not notified within 90 days, the claim shall be deemed denied.

If special circumstances require an extension of time for processing the claim, the Claims Administrator shall send written notice of the extension to the Plan Participant. The extension notice will indicate the special circumstances requiring the extension of time and the date by which the Plan expects to render the final decision on the claim. In no event will the extension exceed a period of 90 days from the end of the initial 90-day period.

Claims Review Procedure

In cases where a claim for benefits payment is denied in whole or in part, the Plan Participant may appeal the denial. This appeal provision will allow the Plan Participant to:

(a) Request from the Plan Administrator a review of any claim for benefits. Such request must include: the name of the Employee, his or her Social Security number, the name of the patient and the Group Identification Number, if any.

(b) File the request for review in writing, stating in clear and concise terms the reason or reasons for this disagreement with the handling of the claim.

The request for review must be directed to the Plan Administrator or Claims Administrator within 60 days after the claim payment date or the date of the notification of denial of benefits.

A review of the denial will be made by the Plan Administrator and the Plan Administrator will provide the Plan Participant with a written response within 60 days of the date the Plan Administrator receives the Plan Participant's written request for review and if not notified, the Plan Participant may deem the claim denied. If, because of extenuating circumstances, the Plan Administrator is unable to complete the review process within 60 days, the Plan Administrator shall notify the Plan Participant of the delay within the 60 day period and shall provide a final written response to the request for review within 120 days of the date the Plan Administrator received the Plan Participant's written request for review.

The Plan Administrator's written response to the Plan Participant shall cite the specific Plan provision(s) upon which the denial is based.

A Plan Participant must exhaust the claims appeal procedure before filing a suit for benefits. A full disclosure of the Appeals process can be found on the back of the Covered Person’s Explanation of Benefits received upon payment or denial of a submitted claim.

COORDINATION OF BENEFITS

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

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance up to each one's plan formula minus whatever the primary plan paid. This is called non-duplication of benefits. The total reimbursement will never be more than the amount that would have been paid if the secondary plan had been the primary plan -- 50% or 80% or 100% -- whatever it may be. The balance due, if any, is the responsibility of the Covered Person.

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

(1) Group or group-type plans, including franchise or blanket benefit plans.

(2) Blue Cross and Blue Shield group plans.

(3) Group practice and other group prepayment plans.

(4) Federal government plans or programs. This includes Medicare.

(5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.

(6) No Fault Auto Insurance, by whatever names it is called, when not prohibited by law.

Allowable Charge. For a charge to be allowable it must be a Usual and Reasonable Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

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

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

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

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

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

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

(b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those benefits of a benefit plan which covers that person as 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 beneficiary.

(d) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.

(3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, 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.

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

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

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

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

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

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

When this provision applies. The Covered Person may incur medical or dental charges due to Injuries, which may be caused by the act or omission of A Third Party or A Third Party, may be responsible for payment. In such circumstances, the Covered Person may have a claim against that Third Party, or insurer, for payment of the medical or dental charges. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any rights the Covered Person may have to recover payments from any Third Party or insurer. This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The payment for benefits received by a Covered Person under the Plan shall be made in accordance with the assignment of rights by or on behalf of the Covered Person as required by Medicaid.

In any case in which the Plan has a legal liability to make payments for benefits received by a Covered Person, to the extent that payment has been made through Medicaid, the payment for benefits under the Plan shall be made in accordance with any state law that has provided that the state has acquired the rights of the Covered Person to the payments of those benefits.

The Covered Person:

(1) automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and

(2) must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

Amount subject to Subrogation or Refund. The Covered Person agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a 100%, first dollar priority over <u>any</u> and all Recoveries and funds paid by a Third Party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any responsible third party. Further, accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan the Covered Person's Third Party Claims.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for medical or dental expenses from the Covered Person. Also, the Plan's right to Subrogation still applies if the Recovery received by the Covered Person is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to Subrogate.

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay medical or dental 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 or dental 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.

"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 or dental charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental 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 or dental 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 or dental 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.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator 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 Plan Administrator.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

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

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

DUTIES OF THE PLAN ADMINISTRATOR.

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To delegate to any person or entity such powers, duties and responsibilities, as it deems appropriate.

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

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

COMPLIANCE WITH HIPAA PRIVACY STANDARDS. Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access subject to the following:

(1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

(2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean

activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities.

(3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce, who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.

(a) **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

(b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

(i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment:

(iii) Mitigating any harm caused by the breach, to the extent practicable; and

(iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(4) **Certification of Employer.** The Employer must provide certification to the Plan that it agrees to:

(a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

(b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

(e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

(h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

(j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

(1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers described above.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee Coverage: Funding is derived solely from the funds of the Employer.

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

PLAN IS NOT AN EMPLOYMENT CONTRACT

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

CLERICAL ERROR

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

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect

amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

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

PLAN NAME

ARHealthNetworks Benefit Plan

CLAIMS ADMINISTRATOR

NovaSys Health
P.O. Box 25330
Little Rock, Arkansas 72221
800-540-7566