

**ARKANSAS HIGHER EDUCATION CONSORTIUM BENEFITS TRUST
EMPLOYEE MEDICAL BENEFIT PLAN
GROUP NUMBER M572200**

A SUMMARY PLAN DESCRIPTION

**J. P. Farley Corporation
P.O. BOX 41779
MEMPHIS, TN 38174-1779**

Revised 01/31/2007

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PLAN SPECIFICATIONS

COMPANY	Arkansas Higher Education Consortium Benefits Trust
PLAN NAME	Arkansas Higher Education Consortium Benefits Trust
PLAN EFFECTIVE DATE	July 1, 1992
PLAN RENEWAL DATE	Annually on July 1
PLAN SUPERVISOR	J. P. Farley Corporation P.O. Box 41779, Memphis, TN 38174-1779
PLAN ADMINISTRATOR	Arkansas Higher Education Consortium Benefits Trust P.O. Box 140, Hope, Arkansas 71802

The benefits and provisions of this Plan Document constitute the entire Plan.

It is the intention of the Plan Administrator to hereby establish a program of benefits constituting an "Employee Benefit Plan" under the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments thereto.

IN WITNESS WHEREOF, the Plan Administrator has executed, and the Plan Supervisor has acknowledged this Plan Document as of the Plan Effective Date shown herein.

Arkansas Higher Education
Consortium Benefits Trust

Jerald Barber
Authorized Representative
Plan Administrator

J. P. Farley Corporation

Wanda King
Authorized Representative
Plan Supervisor

ELIGIBILITY

Limitations: This Schedule of Benefits applies only to:

1. Covered Employees in the Eligible Class or Classes of employees as shown below;
and
2. The dependents of such employees.

Eligible Class or Classes of Employees:

Shall include all actively employed employees of participating agencies, boards, commissions, institutions and Constitutional Officers;

Eligible employees are those whose employment is not seasonal or temporary as determined by the board policy of each institution.

Retired Employees are Employees who:

1. have a minimum of ten (10) years of state service; and
2. qualify under each Institutions Retirement guidelines.

An Employee is considered to be in the Retired Class from the date of application for retirement.

Part-time Employees that elect coverage prior to full-time status will be given credit from part-time effective date. Part-time eligibility qualifies under each institution's guidelines.

Service Requirement:

Begins the first day of the month following employment for all college locations. Colleges do have the right to implement a 60 or 90 day waiting period for new employees if they choose to do so.

Open Enrollment:

Open enrollment is held annually from November 1 through November 30 with an effective date of January 1. Special Open Enrollment periods may be adopted by the Board of Trustees.

Special Enrollment Rights:

If an employee refuses enrollment for himself/herself or his/her dependents, the employee may later enroll within thirty (30) days of a change in family status or loss of other health coverage. Loss of health coverage includes legal separation, divorce, death, termination of employment, reduction in work hours, exhaustion of COBRA continuation or state continuation, or if employer contributions toward your coverage have terminated.

Change in family status includes marriage, legal separation, divorce, death, birth, adoption, or placement for adoption of a child. If employee or dependent spouse are not enrolled for this coverage, you can also enroll during the special enrollment period when a change in family status occurs provided you request enrollment within thirty (30) days after the marriage, birth, adoption, placement for adoption.

OPTION TO CONTINUE HEALTH CARE COVERAGE

These provisions apply to the Medical Health Care Coverage of the Plan. They describe who has the right to continue benefits under those coverages and how those benefits may be continued. The provisions are concerned with continuation of coverage beyond the date it would have otherwise ended as detailed above and on prior pages, and are in conjunction with the Consolidated Omnibus Budget Reconciliation Act, or COBRA. A right to continue coverage under this part is subject to the following provisions:

1. The Employee has the right to continue his/her Employee or Employee and Dependents coverage under the health care coverages of the Plan if the benefits under those coverages would have ended:
 - a. because the employment ended for a reason other than gross misconduct, or
 - b. because the work hours were reduced, or
 - c. effective January 1, 1990, because of total disability as defined by the Social Security Administration.
2. Each of the eligible dependents has a right to continue benefits under the health care coverages of the Plan if the benefits for the eligible dependent under those coverages would have ended:
 - a. because the Employee's employment ended for a reason other than gross misconduct, or
 - b. because the Employee's work hours were reduced, or
 - c. at the Employee's death, or
 - d. because the Employee retired before age 65 (until Medicare becomes primary), or

- e. in the case of your eligible dependent (spouse or child,) when that spouse or child ceased to be an eligible dependent under the rules of the Plan.

Note: If the benefits for an eligible dependent would end due to an event shown in (e) above, and if a person wants to continue the coverage written notice of the event must be given to the Institution within sixty (60) days after the event shown in (e) above or the right to continue is forfeited.

Continuation of Benefits: The Plan Supervisor will mail a written election notice of the right to continue the coverage to the person's last known address. Such notice will state the amount of the payments required for the continued coverage. If a person wants to continue the coverage, the election notice must be fully completed and returned to the Company, along with any required payment, within sixty (60) days after:

1. the date the coverage would have otherwise ended, or
2. the date of the notice informing the person of the right to continue.

If this is done, the coverage will be continued from the date it would have ended with the following specifications:

1. If the coverage is being continued due to the employee's end of employment or a reduction of the employee's work hours, the day eighteen (18) months from the date the coverage would have ended.
2. If the coverage is being continued due to:
 - a. the Employee's death, or
 - b. the Employee's retirement before age 66, or
 - c. the Employee's eligibility for primary Medicare coverage upon retirement, or
 - d. the Employee's eligible dependent spouse or child ceased to be eligible under the rules of the Plan. The day thirty-six (36) months from the date the coverage would have ended.
3. If the person fails to make any payment required by the Company for the continued coverage, the end of the period for which the person has made required payments.
4. The day the person becomes eligible for coverage under any other health plan for persons in a group, on an insured or uninsured basis, unless such plan has a pre-existing limitation or exclusion in effect.
5. The day the person becomes eligible for Medicare on a primary basis.
6. The day the part of the Plan providing the coverage ends.

7. If the coverage is being continued due to the employee's total disability:
 - a. the day up to twenty-nine (29) months from the date the coverage would have ended, or
 - b. the month that begins thirty (30) days after the date the employee is no longer considered disabled.

Increased premium payment will apply to the 19th through 29th months.

When Dependent coverage is continued under COBRA, all other terms of the Plan will apply, except that benefits under the Health Care Coverages will be paid to or for the person who elected the continuation right. If the person electing the continuation right (or, in the case of an active Employee, the Employee) is not living, the following will apply:

1. If the Employee elected the continuation right, benefits will be paid to:
 - a. your spouse, if living, or
 - b. your spouse's estate, if your spouse is not living but survived by your Eligible Dependent children, or
 - c. the person or institution appearing to the Company to have assumed the main support of your Eligible Dependent children, if neither (a) or (b) applies.
2. If your spouse elected the continuation right, benefits will be paid to:
 - a. your spouse's estate, if your spouse survived your Eligible Dependent children, or
 - b. the person or institution appearing to the Company to have assumed the main support of your eligible Dependent children, if (a) does not apply.
3. If your Eligible Dependent child elected the continuation right, benefits will be paid to your Eligible Dependent child's estate. If an amount is so paid, the Company will not have to pay that part of the benefit again.

Health Insurance Portability And Accountability Act Of 1996 (HIPAA)

On August 21, 1996, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) was signed into law. Effective January 1, 1997, HIPAA section 421 made changes, described below to three areas in the continuation coverage rules applicable to group health plans.

1. **Disability Extension**. Under the old law, if an individual entitled to the COBRA continuation coverage is disabled (as determined under the Social Security Act) and satisfies the applicable notice requirements, the plan must provide COBRA continuation coverage for 29 months, rather than 18 months. Under the old law, the individual must be disabled at the time of the termination of employment or reduction in hours of employment. HIPAA makes changes to the law to provide that beginning

January 1, 1997, the disability extension will also apply if the individual becomes disabled at any time during the first 60 days of COBRA continuation coverage. HIPAA also makes it clear that, if the individual entitled to the disability extension has no disabled family members who are entitled to COBRA continuation coverage, those nondisabled family members are also entitled to the 29-month disability extension.

2. **Definition of Qualified Beneficiary.** Individuals entitled to COBRA continuation coverage are called qualified beneficiaries. Individuals who may be qualified beneficiaries are the spouse and dependent children of a covered employee and, in certain cases, the covered employee. Under the old law, in order to be a qualified beneficiary, an individual must generally be covered under a group health plan on the day before the event that causes a loss of coverage (such as a termination of employment, or a divorce from or death of the covered employee). HIPAA changes this requirement so that a child who is born to the covered employee, or who is placed for adoption with the covered employee, during a period of COBRA continuation coverage is also a qualified beneficiary.
3. **Duration of COBRA Continuation Coverage.** Under the COBRA rules, there are situations in which a group health plan may stop making COBRA continuation coverage available earlier than usually permitted. One of those situations is where the qualified beneficiary obtains coverage under another group health plan. Under current law, if the other group health plan limits or excludes coverage for any pre-existing condition of the qualified beneficiary, the plan providing the COBRA continuation coverage cannot stop making the COBRA continuation coverage available merely because of the coverage under the other group health plan. HIPAA limits the circumstances in which plans can apply exclusions for pre-existing conditions. HIPAA makes a coordinating change to the COBRA rules so that if a group health plan limits or excludes benefits for pre-existing conditions but because of the new HIPAA rules those limits or exclusions would not apply to (or would be satisfied by) an individual receiving COBRA continuation coverage, then the plan providing the COBRA continuation coverage can stop making the COBRA continuation coverage available. The HIPAA rules limiting the applicability of exclusions for pre-existing conditions become effective in plan years beginning on after July 1, 1997 (or later for certain plans maintained pursuant to one or more collective bargaining agreements).

HIPPA PRIVACY RULE

This notice of Privacy Practices describes how AHEC may collect, use and disclose your protected health information.

“Protected Health Information” (PHI) is information about you, including demographic information collected from you, that can reasonably be used to identify you and that relates to your past, present or future physical or mental health or condition, the provision of health care to you or the payment for that care.

AHEC complies with the requirements of section 164.504(f) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160 through 164. This Act establishes the extent to which AHEC will receive, use and/or disclose PHI. This notice takes effect April 14, 2003, and will remain in effect until

replaced, modified, or amended. AHEC will not use or disclose members' PHI other than as described in this amendment to the Plan Document and permitted by the "504" provisions.

AHEC will not disclose any of the members' PHI for employment related actions and decisions or in connection with any other benefit or employee benefit plan. AHEC will also ensure that any business associates to whom it provides members' PHI under the Plan agrees to the same restrictions and conditions that apply to AHEC with respect to such PHI.

I. USES AND DISCLOSURES OF PHI WITHOUT YOUR AUTHORIZATION

A. Uses and Disclosures for Payment, Health Care Operations and Treatment:

Payment: AHEC will use your PHI to administer your health benefits policy or Contract, which may involve the determination of eligibility; claims payment; utilization review; care management; medical necessity review; coordination of Care, benefits and other services; and responding to complaints, appeals and external review requests. PHI will also be used for the purposes of premium billing, and the determination of premium rates, co-payments, deductibles, co-insurance and other cost sharing amounts.

Health Care Operations: Your PHI will be used to support other business activities with "Business Associates" only if the Business Associate signs an agreement to comply with this privacy policy. A "Business Associate" is any person or entity who Performs or assists in the performance of a function or activity on behalf of another entity that involves the use and disclosure of PHI. Other business activities may Include the following:

- Health claims analysis
- Premium determination and administration of reinsurance
- Risk management
- Transfer of eligibility and plan information to business associates
- (Insurex, Insurance Brokers, Express Scripts, etc.)
- Other general administrative activities involving health care

Health Care Treatment: Unless you request Restriction or Confidential Communication, AHEC may disclose to a member of your family, a relative, or any other person you identify, the protected health information directly relevant to that person's involvement in your health care or payment for health care if we determine That disclosure is in your best interest.

B. Required by Law:

- **Public Health:** AHEC may disclose your PHI to an authorized public health authority for purposes of public health activities. The information may be disclosed for such reasons as controlling disease, injury or disability. In addition, we may make disclosures as required by the Food and Drug Administration to report adverse events, product defects or problems, track

products; to enable product recalls; etc.

- **Abuse or Neglect:** We may make disclosures to government authorities concerning abuse, neglect or domestic violence.
- **Health Oversight:** We may disclose your PHI to a government agency authorized to oversee the healthcare system or government programs, or its contractors (e.g., state insurance departments, U.S. Department of Labor) for activities authorized by law, such as audits, examinations, investigations, inspections and licensure activity.
- **Legal Proceedings:** AHEC may disclose your PHI in the course of any legal proceeding, in response to an order of a court or administrative tribunal and in certain cases, in response to a subpoena, discovery request or other lawful process.
- **Law Enforcement:** We may disclose your PHI under limited circumstances to law enforcement officials. For example, disclosures may be made in response to a warrant or subpoena or for the purpose of identifying or locating a suspect, witness or missing persons or to provide information concerning victims of crime.
- **Coroners, Funeral Directors and Organ Donation:** We may disclose your PHI in certain instances to coroners, funeral directors and in connection with organ donation.
- **Threat to Health or Safety:** We may disclose your PHI to the extent necessary to avert a serious and imminent threat to your health or safety or to the health or safety of others.
- **Military Activity and National Security:** We may disclose your PHI to Armed Forces personnel under certain circumstances and to authorized federal officials for the conduct of national security and intelligence activities.

II. USES AND DISCLOSURES OF PHI WITH AN AUTHORIZATION

Other uses and disclosures of PHI will be made only with your written authorization. You may revoke this authorization, at any time, in writing, except to the extent that we have taken an action in reliance on the use of disclosure indicated in the authorization being revoked. To authorize us to disclose any of your PHI to a person or organization for reasons other than those described in this notice, please contact the appropriate party listed in the “Contact Information for Exercising Member Rights” below. You may limit the information to be disclosed and to revoke the authorization at any time by sending a letter to the contact address. Please include your name, address, member identification number and a telephone number where we can reach you.

III. MEMBER RIGHTS

- **Right to Request Restrictions:** You have the right to ask AHEC to place restrictions on the way we use or disclose your PHI for treatment, payment or healthcare operations. However, we are not required to agree to these restrictions. If we do agree to a restriction, we may not use or disclose your PHI in violation of that restriction, unless it is needed for an emergency. All requests for restrictions should be sent to the AHEC Privacy Official.
- **Confidential Communications:** AHEC will accommodate reasonable requests to

communicate with you about your PHI by alternative means or to alternative locations. Requests for Confidential Communications should be made in writing to the AHEC Privacy Official.

- **Access to Protected Health Information:** You have the right to receive a copy of PHI about you that is contained in a “designated record set”. A “designated record set” means a group of records that are used by or for us to make decisions about you, including enrollment, payment, claims adjudication and case or medical management records. Any request to access PHI should be directed to our group health plan administrator. All requests should be in writing whenever possible.
- **Amendment of Protected Health Information:** You have the right to ask us to amend any protected health information about you that is contained in the designated record set. All requests must be in writing to our group health plan administrator. In certain cases, we may deny your request if we did not create the information (e.g., doctor’s diagnosis). If, for example, the diagnosis in your records is wrong, the doctor making the diagnosis must change your PHI.
- **Accounting of Certain Disclosures:** You have the right to have us provide you an accounting of times when we have disclosed your protected health information for any purpose other than the following: (i) treatment, payment or health care operations; (ii) disclosures that you or your personal representative has authorized; and (iii) certain other disclosures such as national security purposes. All requests for an accounting must be made to the group health plan administrator. You will be asked to supply us with the specific information we need to fulfill your request. The accounting requirement applies for seven (7) years from the date of the disclosure, beginning with disclosures occurring after April 14, 2003.
- **Contact Information for Exercising Member Rights:** You may exercise any of the rights described above by contacting the AHEC Privacy Official, group insurance plan administrator or the U.S. Department of Health and Human Services.

AHEC Privacy Official
Mr. Jerald Barber
P.O. Box 140
Hope, AR 71802-0140
Phone 870-777-5722
jbarber@uacch.edu

J.P. Farley Corporation
Ms. Wanda King – Privacy Official
P.O. Box 41779
Memphis, TN 38174-1779
Phone 901-725-6435
wking@jpfarley.com

U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
Toll Free 1-877-696-6775

- **Change to Privacy Practices:** AHEC may change the terms of our notice at any time. Any material changes to the Privacy Policy will be made available to all members.
- **Questions and Complaints:** If you have questions about this notice or if you are concerned that your privacy rights may have been violated, please contact the AHEC Privacy Official. You also have the right to complain to the Secretary of Health and Human Services without fear of retaliation.

IV. SEPARATION OF PLAN AND PLAN ADMINISTRATOR

Each college in AHEC will have employees who receive members' PHI relating to payment under, health care operations of, or other matter pertaining to plan administration functions that the Plan Administrator provides to the Plan. These individuals will have access to members' PHI solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with AHEC) for any use or disclosure of members' PHI in violation of, or noncompliance with, the provisions of this amendment.

AHEC will promptly report any such breach, violation, or noncompliance to the appropriate officials and will cooperate with those officials to correct the violation, or noncompliance; to impose appropriate disciplinary action and/or sanctions, and to mitigate any deleterious effect of the violation or noncompliance.

Participant Review Program

Following submission of a claim, the Participant will receive an Explanation of Benefits. The Explanation of Benefits will detail dates of service, type of medical care and the provider of the care. The Participant should also receive an invoice or statement from the provider itemizing the items submitted to the Plan Supervisor for payment. The invoice should be reviewed by the Participant to detect any errors or mistakes in the billing. Examples of errors or mistakes are billing for services not rendered, incorrect diagnosis and duplication of charges. **If the Participant detects an error or mistake, on any bill of \$1,000.00 or more, and the result is a reduction in the charge for services, the Plan will recalculate the benefit payment and reimburse the Participant 25% of the difference between the original benefit payment and the new payment resulting from detection of the error or mistake.**

The Participant Review Program is applicable following claim submission and processing by the Plan Supervisor. No reimbursement shall be made for detection of errors or mistakes made by the Plan Supervisor in the payment of claims.

SCHEDULE OF BENEFITS

COMPREHENSIVE MEDICAL EXPENSE COVERAGE BENEFIT

All Plans	Maximum Life Time Benefit Per Covered Person subject to Automatic Reinstatement (Up to \$10,000 Annually)	\$1,500,000
	Deductible Covered Person, Per Calendar Year; Maximum of 2 Deductibles Per Family The Deductibles for PPO and Non-PPO will not cross apply; If you meet your deductible under the PPO Plan and then go out of Network, you will have to meet the deductible again.	\$400.00
	Prescription Drug Program Covered Person, Per Calendar Year; Maximum of 2 Deductibles Per Family	\$50.00
	In-Patient Deductible (for PPO participants) for Non-PPO Hospital Confinements	\$100.00
	Emergency Room (illness only) Per Visit If admitted to the Hospital, co-pay is waived	\$100.00

Coinsurance:	Indemnity Plan	PPO Plan	
		In-Network	Out-of-Network
<i>(All benefits subject to deductible except as stated in the Schedule of Benefits)</i>			
Comprehensive Medical Per Covered Person of the first \$10,000 of Covered Expenses	70%	80%	60%
Thereafter to end of the Plan Year	100%	100%	100%
Injury/Accident (Eligible Expenses) No Deductible up to \$500.00 Per Accident.	100%	100%	100%
Thereafter Subject to Deductible	70%	80%	60%
Second Surgical Opinions of covered expenses for additional	100%	100%	100%

medical opinion on the need for surgery. The cash deductible does not apply to these expenses and they must be approved by the Pre-Certification Review.

For Eligible Expense Incurred for Pre-natal Care Usual, Customary and Reasonable Charges	70%	80%	60%
For Eligible Expense Incurred for Maternity Care Maximums	70%	80%	60%
For Eligible Expense Incurred for Well Baby and Well Child Care From Birth to 17 years according to schedule listed in the Medical Expense Section	70%	80%	60%
Flu Shots - One per Covered Person, Per Calendar Year	70%	80%	60%
For Eligible Expense Incurred for Temporomandibular Joint Syndrome Maximum Benefit \$ 2,000 Per Covered Person's Lifetime	70%	80%	60%
For Eligible Expense Incurred for Tests for Hypothyroidism, Phenylketonuria, Sickle-Cell Anemia, Mammography, Pap smear And Prostate Specific Antigen (PSA)	70%	80%	60%
For Eligible Expense Incurred for Office Visits	70%	80%	60%
For Eligible Expense Incurred for Annual Physical Examinations Maximum \$150.00 Per Calendar Year Deductible Waived	100%	100%	100%
For Eligible Expense Incurred for Chiropractic Treatment Maximum \$500.00 Per Calendar Year	70%	70%	70%
For Eligible Expense Incurred for Alcohol/Substance Abuse Inpatient/Outpatient Usual, Reasonable and Customary Charges	70%	80%	60%

Maximum Benefits Lifetime Maximum			\$15,000
Combined In-Patient/Out-Patient \$7,500 Per Covered Person, Per Calendar Year			
Out-Patient Care limited to \$ 2,000 Per Covered Person, Per Calendar Year Regardless of Lifetime Benefit			
For Eligible Expense Incurred for Mental/Nervous Illness	70%	80%	60%
In-patient Maximum 30 days Per Covered Person, Per Calendar Year			
Outpatient Maximum 30 visits Per Covered Person, Per Calendar Year			
Human Organ Transplants If surgery performed in a network Transplant Facility, Maximum. \$1,000,000 If surgery is performed in a facility other than the network, Maximum \$250,000 Per Covered Person's Lifetime	70%	80%	60%
For Eligible Expense Incurred for Hospital Room and Board Up to the hospital's most common semi-private room & board charge. If the Hospital only has private rooms, the private room rate will be considered. Non-PPO Hospital confinements for PPO plan participants are subject to an additional \$100 deductible	70%	80%	60%
Emergency Room Visits (illness only) After co-pay of \$100.00	70%	80%	60%
Intensive Care Unit Usual, Customary and Reasonable Charges for the Hospital in which confined	70%	80%	60%
All Other Hospital Expenses	70%	80%	60%
For Eligible Expense Incurred for Extended Care Facility. Care must begin 7 days after a period of 5 consecutive days of Hospital Confinement - 60 days Maximum	70%	80%	60%

Per Covered Person, Per Calendar Year.
Balance will not apply to Out-of-Pocket.

For Eligible Expense Incurred for Hospice Services. Lesser of 6 months of Treatment or \$10,000 - Balance will not apply to Out-of-Pocket.	70%	80%	60%
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For Eligible Expense Incurred for Home Health Care. Maximum of 100 visits Per Calendar Year - Lifetime Maximum of \$10,000. Balance will not apply to Out-of-Pocket	70%	80%	60%
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For All Other Eligible Expense Usual, Customary, and Reasonable	70%	80%	60%
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Out-Patients Benefits	70%	80%	60%
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Retail Prescription Drug Card

Generic Drug - 100% after deductible and \$10.00 co-pay

Preferred Brand - 100% after deductible and \$25.00 co-pay

Non-Preferred Brand - 100% after deductible and \$50.00 co-pay

Mail Order Prescription Drug Program

Maximum 90 day Supply - Mail Order Co-pays may be made over 90 days.

Generic Drug - 100% after deductible and \$20.00 co-pay

Preferred Brand - 100% after deductible and \$50.00 co-pay

Non-Preferred Brand - 100% after deductible and \$100.00 co-pay

Specialty Pharmacy Benefits:

Specialty Pharmacy applies to prescription injectible drugs with a cost of \$500.00 or more regardless of the route of administration. Insulin is excluded from this requirement. Specialty pharmacy drugs are covered by the Plan only if dispensed by the Plan's authorized specialty pharmacy vendor. **These drugs are subject to prior authorization through Connected Care. Call Connected Care at 1-800-634-0173.**

If medically necessary services are Not Available through any PPO Provider or Facility, then benefits will be paid at Indemnity Plan percentages.

If treatment is rendered by a Non PPO Emergency Room Physician at a PPO Facility, benefits will be considered at the PPO rate.

Plan participants enrolled at Arkansas Northeastern College and East Arkansas Community College have the Baptist HSG network for Mississippi County and St. Francis County in Arkansas and Shelby County in Tennessee. In all counties in the state of Arkansas, except Mississippi County and St. Francis County and Shelby County in Tennessee, plan participants at Arkansas Northeastern College and East Arkansas Community College will access the AMCO network. Outside of the Baptist and AMCO service areas, participants will be able to access the Beach Street Wrap Network.

The Coinsurance Limit applies to all Eligible Expense other than:

Eligible Expense covered for Alcohol and/or Chemical Dependency Treatment; Extended Care Facility; Home Health Care; Hospice, and Prescription Drug co-pays.

Out-of-Pocket Maximum, per Covered Person / Indemnity Plan - \$3,000.00 of covered expenses incurred during a calendar year plus deductible, subject to applicable limitations. Maximum of \$3,400.00 per calendar year.

Out-of-Pocket Maximum, per Covered Person / PPO Plan - \$2,000.00 of covered expenses incurred during a calendar year plus deductible, subject to applicable limitations. Maximum of \$2,400.00 per calendar year.

Out-of-Pocket Maximum, per Covered Person / PPO Plan-Out-of-Network - \$4,000.00 of covered expenses incurred during a calendar year plus deductibles, subject to applicable limitations. Maximum of \$4,400.00 per calendar year.

In Patient Hospital-Pre-Certification

Call Connected Care: 1-800-634-0173

TO PRE-CERTIFY EACH IN-PATIENT HOSPITAL ADMISSION. ALL IN-PATIENT ADMISSIONS REQUIRE PRE-ADMISSION REVIEW BY CONNECTED CARE.

48 HOURS BEFORE ANY NON-EMERGENCY ADMISSION

TO REPORT EMERGENCY HOSPITALIZATION NOTIFY WITHIN TWO (2) BUSINESS DAYS AFTER ADMISSION.

NOTE: The Beech Street PPO Wrap Network provides PPO services outside of your PPO service area **only**. Refer to the back of your identification (ID) card for the toll-free telephone number for Beech Street providers.

FAILURE TO COMPLY WILL RESULT WITH A PENALTY OF AN ADDITIONAL \$200.00

DEDUCTIBLE.

COVERAGE PROVISIONS

Eligibility For Coverage

Employees

Employees are eligible for Employees' Coverage if they:

are in an eligible class as shown in the Schedule of Benefits and have completed the Service Requirement, if any, as shown in the Schedule of Benefits.

Dependents

"Dependent" means spouse and unmarried dependent children of the Covered Employee (including adopted children, stepchildren residing in the Covered Person's household, children under legal guardianship and children not residing in the Covered Person's household when the Covered Employee or Spouse is legally required to support such children) who are:

under 19 years of age; or

under 25 years of age and regularly attending, on a full-time basis, an accredited school, college or university and principally supported by the Covered Employee; or

incapable of sustaining employment by reason of mental retardation or physical handicap and who became so incapacitated prior to the attainment of age 25 and who are chiefly dependent upon the Covered Employee for support and maintenance.

No person is eligible for coverage both as an Employee and as a Dependent. If both parents of a child are Covered Employees under the Employer's Plan, the child may be covered as the dependent of only one parent.

Note: Any unmarried dependent child will be covered six (6) months past the date they lose eligibility as long as the Employee continues family coverage.

Effective Date Of Coverage

Eligibility Date - First of the Month Following Employment, unless Otherwise Stated under Service Requirement in the Schedule of Benefits.

Coverage begins for employees and dependents on the effective date shown below:

The date upon which coverage becomes effective for an eligible employee depends on the date of written application requesting such coverage.

If the application card is signed before the eligible employee's eligibility date, the coverage will become effective for the eligible employee on his/her eligibility date.

If the application card is signed on or after the eligible employee's eligibility date but within thirty-one (31) days after such eligibility date, the coverage (or change in coverage) will be effective on the first day of the month following the eligibility date.

If an Employee does not enroll within 31 days of the date of eligibility, that participant will only be allowed to apply for enrollment during the annual open enrollment period from November 1 through November 30 with an effective date of the following January 1 unless there is a "change in family status or loss of other coverage". See "**Special Enrollment Rights**" below.

However, there are these exceptions:

An Employee cannot become covered if he/she is absent from work due to Injury or Sickness. In this case, the Employee will become covered on the date of return to active work.

An eligible newborn child is covered for the first thirty-one (31) days after birth. However, if a Contribution Agreement has not been signed, one must be signed to validate and document for the first thirty-one (31) days and to continue coverage past these thirty-one (31) days, unless the covered Employee has family coverage. Please note any added contribution must be paid from the date of birth.

Note: It is the responsibility of the Insured Employee to notify his/her employer of any changes in their dependent's status. In no event may coverage for a dependent become effective before the coverage of the Insured Employee becomes effective.

Special Enrollment Rights:

If an employee refuses enrollment for himself/herself or his/her dependents, the employee may later enroll within thirty (30) days of a change in family status or loss of other health coverage. Loss of health coverage includes legal separation, divorce, death, termination of employment, reduction in work hours, exhaustion of COBRA continuation or state continuation, or if employer contributions toward your coverage have terminated.

Change in family status includes marriage, legal separation, divorce, death, birth, adoption, or placement for adoption of a child. If employee or dependent spouse is not enrolled for this coverage, you can also enroll during the special enrollment period when a change in family status occurs provided you request enrollment within thirty (30) days after, the marriage, birth, adoption, placement for adoption.

Termination Of Coverage

Subject to the Continuance of Medical Coverage provision, Employees' Coverage ends when the first of these events takes place:

the date this Plan of Benefits ends;

the date this Plan of Benefits is changed to end coverage from the class to which the Employee belongs;

the month the Employee is no longer in an eligible class, in which case coverage stops at the end of that month;

for Contributory Coverage, the end of the period from which the Employee has paid for the coverage.

retiree's coverage ends at the death of the retiree. Coverage for Dependents of the deceased retiree shall be eligible to continue coverage at their own expense until death.

The end of coverage will not affect any claim made for a loss that took place while the coverage was in force.

Dependent's Coverage

Subject to the Continuance of Medical Coverage provision, Dependent's Coverage ends when the first of these events takes place:

the date the Employee's coverage ends;

the date this Plan of Benefits is changed to end Dependent's Coverage;

the month the dependent is no longer eligible for this coverage, in which case coverage stops at the end of that month;

for Contributory Coverage, the end of the period for which the Employee has paid for the coverage.

Age limits may be waived for a mentally retarded or physically handicapped child. The child may remain covered beyond the age coverage would end, if the child:

is not capable of working at a self-sustaining job; and

depends mainly on the Employee for support and care.

The Employee must furnish the Planholder with proof that the child is eligible for continued coverage. This proof must be given with thirty-one (31) days after the child reaches the limiting age, and as often after that as reasonably requested. However, after the child is two (2) years older than the limiting age, proof will not be required more than once a year. All proof must be at the Employee's expense. If proof is not given within thirty-one (31) days of a request for it, the child's coverage ends.

The end of coverage will not affect any claim made for a loss that took place while the coverage was in force.

Leave Of Absence

If an employee is on an approved leave of absence due to injury, sickness, educational or sabbatical, the covered individual's medical expense coverage may continue until the first of these events takes place:

the date the leave ends, or

the date the leave has lasted twelve (12) months with formal approval.

Family Medical Leave Act of 1993 (Title 29, Part 825)

Employees on leave under the Family Medical Leave Act may continue their group health insurance coverage at the same level and under the conditions coverage would have been provided if the employee had continued in employment. The institution's obligation to maintain health insurance coverage ceases under the FMLA if an employee's premium payment for their portion of the premium is more than thirty (30) days late.

Omnibus Budget Reconciliation Act (OBRA)

In order to comply with the ERISA provisions of the Omnibus Budget Reconciliation Act (OBRA) of 1993, this Plan includes the following provisions.

Qualified Medical Child Support Orders

A "medical child support order" is a child support order of a court, which requires that an employee benefit Plan, provide coverage for a Dependent child of a Participant if the Plan normally provides coverage for Dependent children. Typically these types of orders are generated as a part of a divorce proceeding or a paternity action.

When the Plan receives a medical child support order it will notify the Participant and each child specified in the order that the order is or is not a Qualified Order. If the order is determined to be a Qualified Order, each named child will be covered by the Plan in same manner as any other Dependent child is covered by the Plan. In order for the child's coverage to become effective as of the date the court order has been issued, the Participant must apply for coverage within the time periods specified under the section entitled "Dependent Effective Date".

Each named child will be considered a Participant under the Plan but may designate another person, such as a custodial parent or legal guardian, to receive copies of explanations of benefits, checks and other material, which would otherwise be sent directly to the named child.

If it is determined that the order is not a Qualified Order, each named child may appeal that decision by submitting a written letter of appeal to the Plan Administrator. The Plan Administrator shall review the appeal and reply in writing within thirty (30) days of receipt of that appeal.

To be considered a Qualified Order the medical child support order must contain the

following information:

1. The name and last known mailing address of the Participant and the name and address of each child to be covered by the Plan.
2. A reasonable description of the type of coverage to be provided by the Plan to each named child, or the manner in which the type of coverage is to be determined.
3. The periods to which such order applies.
4. Each Plan to which such order applies.

This Plan will not provide any type or form of benefit, or any option, not otherwise provided under the Plan and all other dependent eligibility, effective date and termination provisions will apply.

Adopted Child

The term "Dependent" found in the Plan shall include an unmarried child under the age of 18 who has been placed for adoption or who has been adopted by the Participant. Such a child shall be eligible for coverage as of the date of placement for adoption, or as of the date of actual adoption, whichever occurs first. Coverage under the Plan for the child shall be the same coverage which is available to all other Dependent children under the Plan except that all pre-existing condition exclusions or waiting periods will be waived for such a child provided the child is enrolled within the time periods specified under the section entitled "Dependent Effective Date".

COMPREHENSIVE MEDICAL EXPENSE PROVISIONS

Benefit Period

A Benefit Period begins each JANUARY 1. It ends on the start of the next Benefit Period.

Medical Deductible

The Medical Deductible applies to each Covered Person for each Benefit Period as described in the Schedule of Benefits.

Carry Over Deductible

Any covered charges incurred in the last three (3) months of the Benefit Period and which are applied to the Calendar Year Deductible within that three (3) month period shall carry forward and apply to the next Calendar year Deductible.

Medical Benefit

The Medical Benefit is paid for Eligible Expense incurred for any Injury or Sickness while covered. The Medical Benefit will be computed for each Benefit Period in this way:

for Eligible Expense subject to the Coinsurance Limit: First, the Medical Deductible must be met. Next, for all Eligible Expense up to the Coinsurance Limit, an amount equal to the Eligible Expense times the proper Coinsurance Factor will be paid. Then, for all Eligible Expense in excess of the Coinsurance Limit, an amount equal to the Eligible Expense will be paid.

for Eligible Expense not subject to the Coinsurance Limit: First, the Medical Deductible must be met. Then, an amount equal to the Eligible Expense times the proper Coinsurance Factor will be paid.

in no event may the Medical Benefit exceed the proper maximum shown in the Schedule of Benefits.

Routine Well Baby Care

Routine Well Baby Care and pediatric charges are payable on the same basis as for sickness for charges made during the first year of birth. "Routine Well Baby Care" means expense incurred for nursery, circumcision, pediatric visits, and required general care and treatment. Expenses must be incurred during the first year of birth subject to deductible and coinsurance for dependent coverage.

MAXIMUM BENEFITS

Inpatient/Outpatient Alcohol/Substance Abuse Treatment

A maximum benefit applies to the treatment of alcohol, and substance abuse disorders on an inpatient and outpatient basis. Benefits are paid based on the reasonable and customary charges for treatment of alcohol/substance abuse. Benefits paid for each covered individual will not be more than the Inpatient or Outpatient treatment maximum shown in the Schedule of Benefits.

Medical Maximum

The Medical Benefit for each Covered Person may not exceed the medical Maximum shown in the Schedule of Benefits.

Hospitalization Review through Connected Care at 1-800-634-0173

Pre-admission Certification - Pre-admission Certification is a pre-admission determination of the medical necessity of an Inpatient Hospital setting and the appropriate length of stay. Pre-admission Certification must be obtained for all In-Patient Hospital Admissions.

It is the Covered Person's responsibility to obtain pre-certification and inform Provider that they are participants in a program, which has Pre-admission Certification requirements.

In order to obtain Pre-admission Certification:

1. Information necessary to make a decision as to the Medical necessity of the admission must be provided, and
2. Notice must be given no later than 48 hours prior to the admission to the Hospital unless the admission is an Urgent Care Admission. Refer to "Emergency and Urgent Care Review" for Urgent Care Admission requirements. Notice can be provided by:
 - a. the Hospital;
 - b. admitting Physician;
 - c. Covered Person; or
 - d. a family member of the Covered Person.

Notice may be given by telephone using the number shown on your identification card. If this procedure is not followed for each covered admission, the penalty will be an additional \$200.00 deductible not to exceed the actual charges.

When Pre-admission Certification is provided to the Covered Person, a certain number of In-Patient Hospital days for the stay will be assigned.

Continued Stay Review - During a Covered Person's Hospital Stay, a Continued Stay Review will be conducted. This review applies to all hospital admissions.

The purpose of Continued Stay Review is to:

1. Provide an update as to the Covered Person's condition/progress; and if necessary,
2. Re-evaluate the Medical Necessity of a continued Hospital stay.

If a Continued Stay Review (hospital days which exceed the original certified length of stay) is not approved, charges for room and board will not be considered an eligible expense.

Weekend Admission Review - All weekend (Friday and Saturday) admissions will be reviewed. Coverage is limited to Medically Necessary admission.

Surgery - Notify the Utilization Review office at least ten (10) business days, or as soon as possible, before any scheduled Inpatient Surgery performed in a hospital setting.

Second Surgical Opinion - The Utilization Review office may require you to obtain a Second Surgical Opinion from a Physician who is not associated with the one who recommended the surgery. If the two opinions conflict, a third opinion may be required.

Emergency and Urgent Care Review - If a Covered Person is admitted to a Hospital for an Emergency or Urgent Care Admission, notice of the admission must be provided within two (2) business days of the admission. Notice may be given by:

- a. Hospital;
- b. Admitting Physician;
- c. Covered Person; or
- d. A family member of the Covered Person.

If this procedure is not followed for each Covered Person's Emergency or Urgent Care Admission, the penalty will be an additional \$200.00 deductible not to exceed the actual charges.

The case will be reviewed within one (1) working day of the date informed. The review will be performed with the Covered Person's Physician to determine if a continued Hospital Stay is Medically Necessary.

An Emergency Admission is an admission to a Hospital through the emergency room of that facility for treatment of a life-threatening illness or injury. An Urgent Care Admission is an unplanned admission or an admission scheduled less than 48 hours prior to the admission, for a condition requiring prompt medical attention. An Urgent Care Admission is not an admission through the emergency room.

Discharge Planning - Review for Discharge Planning occurs during Hospitalization Review. The purpose is to:

1. Identify patients requiring extended care following discharge; and
2. Determine the most appropriate setting for continued care.

Large Medical Case Management - Large Medical Case Management is designed to inform patients of more cost-effective settings for treatment. On an exception basis, subject to approval by the Plan Administrator, coverage may be provided for settings and/or procedures not expressly provided for, but not prohibited by law, rule, or Federal policy. Large Medical Case Management is a voluntary program, which requires acceptance by the patient's Physician, the patient and/or his or her family.

Eligible Expense - "Eligible Expense" means the following types of Expenses incurred for an Injury or Sickness, which are Medically Necessary while Covered.

Hospital Expense - Eligible Hospital Expense is that incurred for:

1. Room and board for each day of Hospital stay--but only up to the Hospital's most common semi-private room rate;
2. A stay in an intensive care unit;
3. Miscellaneous Services received while confined; and
4. These Miscellaneous Services on an Out-Patient basis:
 - a. Emergency Medical Treatment within 72 hours of an Injury;
 - b. Pre-Admission Tests or Exams; and
 - c. Medical Care and Treatment received on the day of and in connection with surgery performed in an Out-Patient facility or in an Ambulatory Surgical Center.

Benefits for health care treatment or services given by an Ambulatory Surgical Center are payable on the same basis as benefits for the same health care treatment or services given by a Hospital. The Ambulatory Surgical Center must be licensed by the appropriate authority.

Other Hospital Expenses - USUAL AND CUSTOMARY CHARGES MADE BY A HOSPITAL FOR NECESSARY HOSPITAL SERVICES FURNISHED BY THE HOSPITAL.

Second Surgical Opinion - "Second Surgical Opinion" means an evaluation of the need for surgery by a second Physician (or a third if the opinion of the Physician recommending surgery and the second Physician are in conflict), including the Physician's exam of the patient and diagnostic testing.

Second Surgical Opinion benefits are shown in the Schedule of Benefits.

Surgical Expense

Eligible Surgical Expense is that incurred for:

1. Services of a Physician for performing surgery; and
2. Services of an Anesthesiologist.

Note: If a Covered Person undergoes a surgical operation because of injury or illness, the Plan, subject to all provisions of this Plan Document will consider the amount charged by the Physician for performing the operation, but not to exceed the maximum amount payable during one confinement subject to Usual, Reasonable and Customary charges.

If more than one operation is performed during the same operating session through the same incision, consideration will be made for the operation with the highest benefits of those performed plus 50% of the amount specified for the other procedures.

Medical Expense

Eligible Medical Expense is that incurred for:

1. Charges made by a Hospital for Miscellaneous Services--but only if they have not been considered as Hospital Expense;
2. Physician Services other than for surgery;
3. The services of a Radiologist or Pathologist;
4. Ambulance service is transportation by a vehicle designed, equipped and used only to transport the sick and injured:
 - a. from your home, scene of an accident or medical emergency to a Hospital, limited to two (2) ambulance moves per period of confinement;
 - b. between Hospitals;
 - c. between Hospital and Skilled Nursing Facility; or
 - d. from a Hospital or Skilled Nursing Facility to your home.
5. Surface trips must be to the closest local facility that can give Covered Services appropriate for your condition. If none, you are covered for trips to the closest such facility outside your local area. Air transportation is covered when such transportation is Medically Necessary because of a life threatening Injury or Sickness. Air ambulance is air transportation by vehicle designed, equipped and used only to transport the sick and injured to and from a Hospital for Inpatient care;
6. Anesthesia, oxygen or other gases;
7. Private Duty Nursing Services - Coverage is provided for services of a practicing registered nurse (R.N.) or licensed practical nurse (L.P.N.) when ordered by a Physician. Nursing Services do not include care which is primarily non-medical or custodial in nature such as bathing, exercising, and feeding;

8. Home Services are services that are determined to require an R.N. or L.P.N.'s continual skills. Coverage is not provided for a nurse who usually lives in your home or is a member of your immediate family;
9. Extended Care Facility - Charges for room, board and other services and supplies up to the lower of:
 - a. The Facility's regular daily charge for semi-private room; or
 - b. 50% of the regular daily charge for a semi-private room in the Hospital from which the patient was transferred.

The following limitations will apply:

- c. payment will be limited to the first sixty (60) days confinement each Plan Year;
 - d. care in the Facility must begin within seven (7) days after leaving the Hospital;
 - e. the Hospital confinement must have been for at least five (5) days and the care needed for the same cause; and
 - f. all care must be supervised by a Physician;
10. Charges for diagnostic x-ray and laboratory tests, electrocardiograms, basal metabolism readings, electroencephalograms, allergy testing, also tests for hypothyroidism, Phenylketonuria, sickle-cell anemia, mammography and Pap smear. Benefits are payable for these tests on the same basis as for sickness;
 11. Radiation therapy treatment, intravenous chemotherapy, kidney dialysis, inhalation therapy;
 12. Drugs or medicines which require a prescription under federal law and are approved for general use by the Food and Drug Administration are covered under the Express Scripts retail and mail order drug programs only. No coverage is provided for administration of any drug or syringes, unless prescribed by a Physician;
 13. Casts, splints, crutches, surgical dressings or trusses and other medical supplies that are medically necessary for the treatment of medical conditions;
 14. Electronic heart pacemaker;
 15. The rental cost--up to the purchase price--of Durable Medical Equipment such iron lung, wheelchair and hospital bed. Durable Medical Equipment must be prescribed by a Physician, serve a medical purpose and be able to withstand repeated use. Maintenance of the Durable Medical Equipment is not a Covered Expense;
 16. Initial prosthetic or orthopedic devices such as artificial limbs, eyes, or braces for a loss or injury that occurs while the person is covered; and the replacements of these devices only when required by the Covered Person's growth to maturity;

17. Orthopedic adjustments to shoes for adjustments other than those caused by weak, strained, flat, unstable or unbalanced feet bunions, corns, calluses or metatarsalgia, but not the cost of the shoes unless attached permanently to a brace;
18. Blood transfusions--including the cost of whole blood or plasma not donated or replaced;
19. The first pair of glasses or contact lenses, or initial permanent lens needed after cataract surgery and subsequent lens prescription change;
20. Aphakic lens;
21. Charges for ultra-sound and acupuncture;
22. Charges made by a Ambulatory Surgical Center for performing surgery;
23. Human Organ Transplants:

A Human Organ Transplant is a human heart, heart/lung, liver, pancreas, kidney, bone marrow and cornea transplant. Coverage is limited to two (2) transplants per Covered Organ per Covered Person. The lifetime maximum benefit for Human Organ Transplants is \$1,000,000 in network and \$250,000 outside the network per Covered Person.

The Plan will pay the Provider's Reasonable Charges for:

All Covered Services of this Plan, and expenses related to the acquisition of a Human Organ. Acquisition means the acquisition, preparation, transportation and the storage of a Human Organ. The maximum benefit for the acquisition of a Human Organ is \$10,000. Human Organ means heart, lung, liver, kidney, bone marrow or cornea.

In order to receive benefits for Human Organ Transplants, you must obtain pre-certification. Notification must be received as soon as you learn you are a candidate for transplant surgery, and in no event later than five (5) days prior to surgery. Pre-certification will only be granted if the Human Organ Transplant is Medically Necessary and the surgery is performed in an approved Hospital. Any other pre-certification requirements of this certificate do not apply to Human Organ Transplants.

No coverage will be provided for services or supplies:

considered to be Experimental/Investigative; or related to a transplant surgery for which pre-certification was not obtained.

There is a one (1) year waiting period from the Employee's Effective Date of Coverage for all Covered Persons with respect to expenses incurred for Human Organ Transplants. Any other Pre-existing Condition Limitation of this certificate does not apply to Human

Organ Transplants.

24. Charges for Dental Services rendered by a Physician or Dentist for the treatment of:
- a. accidental injury to sound natural teeth as a result of an accident and which was caused by a force and external blow to the mouth;
 - b. fractured jaw;
 - c. oral surgery charges for cutting procedures for the treatment of disease or injuries of the jaw or the extraction of impacted teeth including diagnostic visits and x-rays prior to such covered oral surgery;
 - d. Temporomandibular Joint Syndrome (TMJ) disorders subject to a Maximum Lifetime Benefit as specified in the Schedule of Benefits; and
 - e. hospitalization is covered if Medically Necessary to safeguard the Covered Person's life or health for a specific non-dental organic impairment.
25. Injury/Accident Expense Benefits are paid at 100% for Eligible Expenses incurred as a result of an injury. The Eligible Expense must be incurred within 60 days of the Injury. Refer to the Schedule of Benefits for the maximum benefit per Injury. Eligible Expenses that exceed the Injury/Accident Maximum will be subject to the deductible and the coinsurance factor.
26. Charges for Speech Therapy only when it is rendered by a Physician or Licensed Speech Therapist and required for rehabilitation following an injury, disease, surgery or congenital anomalies;
27. Occupational Therapy - means treatment rendered on an In-Patient or Outpatient basis as part of a physical medicine and rehabilitation program to improve functional impairments where the expectation exists that the therapy will result in practical improvement in the level of functioning within a reasonable period of time. No benefits are provided for diversionary, recreational and vocational therapies (such as hobbies, arts and crafts).
28. Physical Therapy - means treatment by physical means including modalities such as whirlpool and diathermy; procedures such as massage, ultrasound and manipulation; and tests of measurements required to determine the need and progress of treatment. Such treatment must be given to relieve pain, restore maximum function and to prevent disability following disease, injury or loss of body part. Treatment must be for acute conditions where rehabilitation potential exists and the skills of a Physician or other professional is required.
29. Charges for elective sterilization;
30. Charges incurred for surgery, care or treatment solely for cosmetic purposes made necessary by an accident that occurred or for correction of a congenital defect of an eligible newborn child;

31. Charges incurred for chiropractic treatment as shown in the Schedule of Benefits;
32. Charges for annual physical examinations as shown in the Schedule of Benefits;
33. Hospice Services - Hospice Services are the following services that are provided to a terminally ill patient with a life expectancy of six (6) months or less. Hospice Services must be provided by a Hospice Provider according to a Physician prescribed plan of care that has been previously approved and agreed to by the patient:
- a. Nursing Care;
 - b. Medical Social Services;
 - c. Physical, Speech and Occupational Therapy;
 - d. Inhalation Therapy;
 - e. Home Health Care Services;
 - f. Dietary Counseling;
 - g. Prescription Drugs;
 - h. Medical/Surgical Supplies;
 - i. Medical Equipment;
 - j. Lab Services;
 - k. Bereavement Counseling (limited to two visits);
 - l. Twenty-four (24) hours continuous Nursing Care (up to three (3) intervals of continuous care, five (5) days per interval).

Eligible Expenses are limited to the maximum as shown in the Schedule of Benefits per a Covered Person's lifetime.

34. Home Health Care must be for the care or treatment of sick or injured persons that is ordered in writing by the Covered Person's Physician, and provided in the Covered Person's home by a state approved Home Health Care Agency. Home Health Care consists of the following services and supplies:
- a. part-time or intermittent home nursing care from or supervised by a registered nurse (RN);
 - b. part-time of intermittent home health aid services;

- c. physical, occupational and speech therapy; and
- d. medical supplies, drugs and medications prescribed by a Physician and laboratory services to the extent that they would have been covered in a Hospital or Extended Care Facility.

Each visit from a Home Health Care Agency team of four hours or less is considered a single visit;

- 35. Charges for oral contraceptives covered under Express Scripts.
- 36. Charges for the medical food or low protein modified food products that are prescribed as medically necessary for the therapeutic treatment of Phenylketonuria. Charges will be subject to coordination of state benefits.
- 37. Charges for Well Child Care physical examinations for Covered Dependent Children. To qualify as a covered physical examination, the Physician's examination must include at least:
 - a. a review and written record of the patient's complete medical history;
 - b. a check of all body functions; and
 - c. a review and discussion of the examination results with patient or with the parent or guardian.

Well Child Care visits are limited to:

for a newborn child:

- neonatal Hospital confinement with Physician services;
- circumcision to the age of one (1).

for a Covered Dependent Child:

- six(6) visits from birth to 18 months; and at
- 2,3,4,5,6,8,10,12,14,and 16 years.
- immunizations to age seventeen (17).

- 38. Mastectomy - if while covered, a Covered Person has a mastectomy performed, the Plan provided benefits in the same manner and subject to the same conditions and limitations as any other Covered Service for:

- a. all stages of reconstructive breast surgery on the diseased breast, and any surgical procedure on the non-diseased breast deemed necessary to establish symmetry between the two breast in a manner chosen by the Covered Person and his/her physician, provided such procedure is performed within five (5) years of the date the reconstructive surgery was performed on the diseased breast.

LIMITATIONS

No benefit will be paid for Expense incurred for or in connection with:

1. War or act of war, or taking part in a rebellion or riot;
2. Military services for any country or organization including service with military forces as a civilian whose duties do not include combat;
3. Taking part in a felony or attempted felony;
4. Injury or Sickness for which the Covered Person is not under the Regular Care of a Physician;
5. Services or supplies from a government-owned or operated Hospital--unless a charge must be paid by the Covered Person;
6. Services of a Physician employed by any government unless a charge must be paid by the Covered Person;
7. Charges to the extent that they are in excess of the Reasonable and Customary Charges for service and supplies;
8. Charges, which are Experimental/Investigative;
9. Charges for unnecessary care or treatment of care not uniformly or professionally endorsed as standard medical care;
10. Eye refractions, glasses, contact lenses, hearing aids or exams for their prescription or fitting--except the first pair of either glasses or contact lenses or permanent lens needed after cataract surgery;
11. Charges for Kerato-Refractive Eye Surgery (surgery to improve nearsightedness, farsightedness, and/or astigmatism by changing the shape of the cornea, including but not limited to radial keratotomy and keratomileusis surgery);
12. Custodial Care, or rest cures;
13. Cosmetic surgery, unless it is performed as soon as medically feasible and is needed for:
 - a. the repair of an injury received while the person is covered;
 - b. the reconstruction that follows surgery resulting from an Injury or Sickness; or
 - c. the correction of a congenital defect that results in a functional defect of a Covered Child;
14. Medical Care or Treatment given by the spouse, child, brother, sister, or parent of the

Covered Employee or spouse;

15. Charges for vitamins; except for pre-natal for pregnant women;
16. A Pre-Existing Condition up to the limits outlined in the Definitions;
17. Treatment of obesity including any care that is primarily dieting, exercise for weight loss or the surgical treatment of morbid obesity; (Morbid Obesity, See Definitions)
18. Charges for reversal of sterilization;
19. Charges for elective abortions performed when the mother's life would not be in danger if the fetus were carried to term, but this does not exclude medical complications arising from or after such abortion;
20. Charges for pregnancy of a dependent child;
21. Charges for room, board, and general nursing care for Hospital admissions mainly for physical therapy or diagnostic studies;
22. Charges for transsexual surgery or any treatment leading to or in condition with transsexual surgery;
23. Charges for marital counseling or hospitalization for environmental changes;
24. Charges for services or supplies primarily for educational, vocational or training purposes except for diabetes, cardiovascular disease or kidney disease;
25. Charges for non-oral contraceptives, birth control devices or Norplant;
26. Charges for treatment of the teeth or gums including dental implants except as specifically provided in the Plan;
27. Charges that are not specified as Eligible Expenses.
29. Charges for In Vitro Fertilization, infertility services and artificial insemination.

TRANSFER OF PLANS

This provision applies only to those persons covered by the Planholder's previous plan of benefits on the day before this Plan of Benefits went into effect.

Credit will be given for deductibles and service requirements and Co-Insurance limits met in part or in full under the provisions of the plan being replaced.

Benefits may be paid for a Pre-Existing Condition that a Covered Person has when this policy goes into effect. The amount paid for this condition is the lesser of:

1. the benefits of this Plan without regard to the Pre-Existing Condition limitation; or
2. the benefits of the plan being replaced.

When benefits are payable under both plans, the amount of the benefit will be reduced by the amount paid by the previous plan.

"Pre-Existing Condition" means an Injury or Sickness for which a Covered Person received medical advice or treatment during the six (6) month period before the person's coverage began under this Plan of Benefits. An Injury or Sickness will no longer be considered a "Pre-Existing Condition" when the first of these events takes place:

1. if the person is an Employee, the Employee has been covered by this Plan of Benefits for twelve (12) consecutive months, or
2. if the person is a Dependent, the Dependent has been covered by this Plan of Benefits for twelve (12) consecutive months.

A participant has the right to demonstrate "creditable coverage" and he/she must be given credit for any prior "creditable coverage" against the pre-existing condition period. If there is a break in coverage of more than 63 days, prior coverage does not count. "Creditable coverage" includes coverage under employer health plans, other health insurance, public health plans, and Social Security. "Creditable coverage" does not include coverage where the health benefits are incidental, such as accident or disability income, liability, workers' compensation, automobile medical insurance, dental plans, vision benefits or long-term care plans. Prior coverage does not need to be as good as, or even similar to the new plan to be counted. Pre-existing limits must be reduced month-for-month by any previous health insurance coverage that a participant had, unless the break in coverage was more than sixty-three (63) days.

Certification - New health plan enrollees will be required to provide proof of their coverage to receive credit under their new health plan's pre-existing condition limitation.

A "Pre-Existing Condition" exclusion period cannot be applied to pregnancy, to a newborn, an adopted child under age 18 or a child placed for adoption under age eighteen (18) if the child becomes covered within thirty (30) days of birth, adoption or placement for adoption.

Effect of Medicare

If the Covered Employee or Spouse is affected by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), the Deficit Reduction Act of 1984 (DEFRA) or the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), he or she must be offered a choice of electing the Policyholder's Health Care Program as primary or Medicare as primary for hospitalization, medical/surgical and other health care programs. If the Covered Employee or Spouse elects the Policyholder's Health Care Program, he or she will be enrolled for the full coverage, up to the Benefit Plan's maximum and other benefit limitations. If the Covered Employee or Spouse elects Medicare as primary, he or she will be canceled from the Employer's program.

Generally, a Covered Employee or Spouse is affected by TEFRA, DEFRA, and COBRA if he or she is:

1. age 65 or older; and
2. if the Covered Employee is an active, full-time employee of an employer with 20 or more employees.

However, you should contact the Planholder to determine if you are affected by TEFRA, DEFRA or COBRA.

If a Covered Person is eligible for Medicare and is not affected by TEFRA, DEFRA or COBRA, benefits will be based on Coordination of Benefits. Any benefits you receive under Medicare will be coordinated with this Benefit Plan.

COORDINATION OF BENEFITS

Definitions

"Allowable Expense" means any Expense which is:

1. for Reasonable and Customary Charges; and
2. which is covered under The Plan covering the Person for whom the Claim is made.

When a Plan provides services directly, the reasonable cash value of each service is deemed to be both an Allowable Expense and benefit paid.

"Claim Determination Period" means a full or partial Calendar Year during which the Person for whom claim is made is covered under This Plan.

"Plan" means any policy, contract, or other arrangement to pay the cost of medical or dental care. This includes:

1. group coverage, except school accident coverage;
2. any hospital or medical service plan for prepaid group coverage;
3. labor-management trustee plans, union welfare plans, employer organization plans, employee benefit organization plans and professional plans;
4. government programs including compulsory no-fault automobile coverage, but excluding Medicare and Medicaid, unless an applicable law forbids coordinating benefits with type of program.

"This Plan" means the Planholder's Plan.

Coordination Of Benefits

Coordination of benefits considers the amount payable by all the group health plans involved. The amount of benefits paid by an individual plan depends on whether that plan is determined to be Primary or Secondary, according to the coordination of benefits rules. If the plan is Primary, it pays benefits first, without regard to the amount payable by other plans. In other words, the Primary Plan pays the same amount of benefits it would have paid if there was no coordination of benefits.

Benefit payments under a Secondary Plan, on the other hand, are reduced to take into account the amount paid by a Primary Plan or Plans. The Secondary Plan pays the amount it would have paid if it was Primary less the amount actually paid by a Primary Plan or Plans. There is an exact method of determining the amount the Secondary Plan will pay. First, the amount of benefits the Secondary Plan would have paid if it was Primary is determined. Next, subtract the amount of benefits actually paid by any Primary Plan of

Plans. The Secondary Plan pays the difference.

There are two (2) important facts you ("the Employee") should note about this formula. First, the formula is designed to prevent benefit payments from being greater than the largest amount payable by any one of the plans involved. Also, if the amount of benefits paid by a Primary Plan or Plans is greater than that of the Secondary Plan; the Secondary Plan will not pay any benefits. Therefore, duplicate coverage may not be valuable. You may wish to discontinue some of the coverage on yourself and your dependents.

Each case is different. Make sure you understand what each plan pays for, and how the coordination of each benefit provision works. Consider the amount you are paying for each plan. Based on this information, make a decision as to what coverage is best for you and your dependents. But remember, while you may wish to drop some of your duplicate coverage, you should always make adequate provisions for unexpected health care needs.

Order of Benefit Determination

If a person is covered under This Plan and another Plan at the same time, the Plan will pay benefits in this order:

1. any Plan that has no coordination of benefits provision will pay first;
2. when all Plans have a coordination of benefits provision, the Plan that covers the person as an employee will pay first;
3. when two (2) Plans cover the same child as a dependent of different persons, called parents, the Plan will pay in this order:

First: any Plan covering the parent whose birthday falls earlier in the year;

Second: any Plan covering the parent whose birthday falls later in the year. If both parents have the same birthday, the Plan which covered the parent the longest pays first. The Plan which covered the other parent for a shorter time pays second.

However, other rules apply if a claim is made for a covered dependent child whose parents are separated or divorced:

1. if the parent with the custody of the child has not remarried, the Plans will pay in this order:

First: any Plan in which the child is covered as a dependent of the parent who has custody;

Second: any Plan in which the child is covered as a dependent of the parent who does not have custody.

2. if the parent with custody of the child has remarried, the Plans will pay in this order:

First: any Plan in which the child is covered as dependent of the parent who has custody;

Second: any Plan in which the child is covered as the dependent of the stepparent;

Third: any Plan in which the child is covered as the dependent of the parent who does not have custody.

These rules do not apply when a court decree fixes the responsibility for the health care costs of a child whose parents have separated or divorced. Any Plan in which the child is covered as the dependent of a parent with this legal responsibility will always pay first.

In some cases, the order of payment may be unclear. Priority then goes to the Plan that has covered the Covered Person for the longest continuous time.

Right to Receive and Release Needed Information

The Planholder will have the right to obtain or give information needed to coordinate benefit payments with other Plans. This can be from or to any other insurance company, organization or person. The Planholder need not give notice or obtain anyone's consent to do this.

Any person who claims benefits must provide to the Planholder the information needed to coordinate benefit payments.

Right to Make Payment

The Planholder has the right to pay any other organization as needed to properly carry out this provision. These payments that are made in good faith are considered benefits paid under This Plan. Also, they discharge the Planholder from further liability, to the extent the payments are made.

Right of Recovery

If the Planholder paid more than it should have, the Planholder has the right to recover the excess amount. This can be from the person for whom the payments were made. It can also be from any other insurance company or organization.

Subrogation

Subrogation applies to situations where you or your dependent spouse and/or child are injured and another party is responsible for payment of health care expense incurred because of the injury. The other party may be an individual, insurance company, or some other public or private entity. Automobile accident injuries or personal insurance on another's property are examples of cases frequently subject to subrogation.

This Plan may recover any payments made for such injuries from the other party. Recovery

may be from any payments made to you or the legal representative of a minor or person declared to be legally incompetent for such injury for any judgment or settlement of claim.

You or the legal representative of a minor or person declared to be legally incompetent must cooperate fully and must provide all information needed to recover such payments and execute any papers necessary for such recovery.

You or the legal representative of a minor or person declared to be legally incompetent must not do anything that will limit or prohibit rights from the responsible party. For example, if claims are submitted and no action is taken to recover payments from the responsible party, no action or signing of any statements that relieve the party of responsibility for health care expenses shall be taken.

If you choose to recover payments from the responsible party, you must include the amount paid by the Plan in the requested settlement. If you receive a settlement from the responsible party, you must reimburse the Plan an amount equal to the amount paid less an equitable adjustment for the costs and legal fees needed to recover the money.

When the Plan pays for expenses that were either the result of the alleged negligence of another person, or which arise out of any claim or cause of action which may accrue against any third party responsible for injury, sickness or death to the Covered Employee, Dependent of the Covered Employee, (hereinafter named the Covered Employee) by reason of their eligibility for benefits under the Plan, the Covered Person, or the legal representative of a Covered Employee, or Covered Dependent agree to the following:

The Covered Person will reimburse the Plan out of the Covered Person's recovery for all benefits paid by the plan. The Plan will be reimbursed in full prior to the Covered Person receiving any monies recovered from any party or their insurer as a result of judgment settlement of otherwise. The duty and obligation to reimburse the Plan also applies to any money the Covered Person receives from any under insured or uninsured motorist policy of insurance. The Covered Person is obligated to repay the Plan even if the Covered Person is not fully compensated or made-whole from any money they receive.

The Plan has the right to the Covered Person's full cooperation in any case involving the alleged negligence of a third party. In such cases, the Covered Person is obligated to provide the Plan with whatever information, assistance and records the Plan may require to enforce the rights in this provision. The Covered Person further agrees that in the event that the Plan has reason to believe that the Plan may have a subrogation lien, the Plan may require the Covered Person to complete a subrogation questionnaire, sign an acknowledgment of the Plan's Subrogation rights and an agreement to provide ongoing information; before the Plan pays, or continues to pay any claims. Upon receipt of the requested materials the Plan will commence, or continue, payments of claims according to its terms and conditions, provided that said payment of claims in no way prejudices the Plan's rights.

The Plan may, but is not obligated to, take legal action it sees fit against the third party or the Covered Person, to recover the benefits the Plan has paid. The Plan's exercise of this right will not affect the Covered Person's right to pursue other forms of recovery, unless the Covered Person and his legal representative consent otherwise.

In the event that the Claims Payer believes that a subrogation recovery exists, the Claims Payer retains the right to employ the services of an attorney to recover the money due to the Plan. The Covered Person agrees to cooperate with the attorney who is pursuing the subrogation recovery. The compensation that the Plan's attorney receives will be paid directly from the dollars recovered for the Plan.

The Plan specifically states that it has no duty or obligation to pay a fee to the Covered Person's attorney for the attorney's services in making any recovery on behalf of the Covered Person.

The Covered Person is obligated to inform their attorney of the subrogation lien and to make no distributions from any settlement or judgment which will in any way result in the Plan receiving less than full amount of its lien without the written approval of the Plan.

The Covered person further agrees that he will not release any party or their insured without prior approval from the Plan, and will take no action which prejudices the Plan's subrogation right.

Recovery of Payments

The Plan Administrator reserves the right to deduct from any benefits properly payable under the Plan the amount of any payment which has been made in error, pursuant to a misstatement contained in a proof of loss, or pursuant to a misstatement made to obtain coverage under the Plan, or with respect to an ineligible person, or pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational injury or disease to the extent that such benefits are recovered. This provision shall not be deemed to require the Plan Administrator to pay benefits under the Plan in any such instance. Such deduction may be made against any claim for benefits under the Plan by a covered employee or by any of his covered dependents if such payment is made with respect to such covered employee or any person covered or asserting coverage as a dependent of such covered employee.

Legal Actions

Proper written proof of loss must be filed in accordance with the requirements of the Plan. If timely decisions or other ERISA claims procedures regulations fail to be made or followed, a claimant shall be deemed to have exhausted the administrative remedies available under the Plan and shall be entitled to pursue any available remedies under section 502(a) of the Act to enforce their rights.

GENERAL PROVISIONS

Definitions

"1998 Budget Appropriations Act" requires group health plans (for the plan years beginning on or after October 21, 1998) to provide benefits for reconstructive breast surgery if medical and surgical benefits are provided for a mastectomy.

"Actively at Work" or **"Active Work"** means that active Employees are doing all of the main duties of their job with the Planholder where these duties are normally carried out.

"Ambulatory Surgical Center" means a licensed surgical or medical center operating within the scope of its license.

"Contribution Agreement" means an agreement an Employee signs that permits payroll deductions for Contributory Coverage.

"Contributory Coverage" means Employees' Coverage or Dependents' Coverage toward which an Employee must contribute.

"Covered Persons" means the Employee and under Family Coverage, the Employee's spouse and unmarried Dependent children as defined under this Plan of Benefits.

"Custodial Care" means care designed mainly to help a person with daily living activities. It is not care primarily intended to help a person recover from an Injury or Sickness.

"Dental Care or Treatment" means services or supplies for teeth and their supporting tissues and structures.

"Dependents' Coverage" means coverage this Plan of Benefits provides for a Covered Employee's eligible dependents.

"Employee" means a person in an eligible class, as shown in the Schedule of Benefits.

"Employee's Coverage" means coverage this Plan of Benefits provides for a Covered Employee.

"Expense" means a charge a person is legally obligated to pay. The expense is applied in the order incurred. An Expense is considered to be incurred on the date the service or supply is furnished.

"Experimental/Investigative" means a drug, or device or medical treatment or procedure is Experimental or Investigative if:

1. 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 reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, toxicity, safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis; or
3. if reliable evidence shows that the consensus among experts regarding the drug, device, or 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 the standard means of treatment or diagnosis. Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure.

"Extended Care Facility" also includes:

1. inpatient medical care and treatment to convalescing patients;
2. full-time supervision by a least one Physician or registered nurse;
3. 24-hour nursing service by licensed professional nurses; complete medical records for each patient; and utilization review plans for all patients.

An "Extended Care Facility" also includes:

any Extended Care Facility which meets the Medicare definition, if the patient is eligible for Medicare.

"Home Health Care Agency" means a public or private agency that specializes in giving nursing or therapeutic services in the home and is licensed by the State of Arkansas as a Home Health Care Agency and operates within the scope of its license.

"Hospital" means a licensed institution, other, than an Extended Care Facility, that provides inpatient medical care and treatment for sick and injured persons. Services provided by a "Hospital" must also include:

1. diagnosis of Injury or Sickness;
2. full-time supervision by at least one Physician;
3. surgery or formal arrangement for available surgical facilities, and
4. therapeutic care of patients who are convalescing from Injury or Sickness.

The surgery rule will be waived if treatment or services are provided for:

1. mental illness; or
2. rehabilitation from an illness; and
3. the institution would otherwise qualify as a "Hospital."

"Hospital" also includes:

1. any hospital, psychiatric hospital, or tuberculosis hospital which meets the Medicare definition, if the patient is eligible for Medicare;
2. any Alcohol or Other Drug Dependency Treatment Center.

"Injury" means a bodily injury sustained accidentally and independently of all other causes by an outside traumatic event or due to exposure to the elements. The term "Injury" does not include injury which arises out of or in the course of any employment or occupation for compensation or profit.

"Medical Expense Coverage" means any coverage provided under the Comprehensive Medical Expense Coverage Provisions.

"Medically Necessary" or **"Medical Necessity"** means the criteria used to determine the Medical Necessity of Comprehensive Medical Expenses under this Plan.

To be Medically Necessary, Covered Services must:

1. be rendered in connection with an Injury or Sickness;
2. be consistent with the diagnosis and treatment of your condition;
3. be in accordance with the standards of good medical practice;
4. not to be considered Experimental or Investigative;
5. and not be for your convenience or your Physician's convenience.

To be Medically Necessary, Covered Services must also be provided at the most appropriate level of care or in the most appropriate type of health care facility. Only your medical condition (not the financial status or family situation, the distance from a Facility or any other non-medical factor) is considered in determining which level of care or type of health care facility is appropriate.

In order to pay Covered Services, the services must be Medically Necessary. Any service failing to meet the Medical Necessity criteria may be the Covered Person's liability.

"Medicare" means the medical care program described in Title XVIII of the Social Security Act of 1965, as amended.

"Miscellaneous Services" means medically necessary services and supplies, other than Room and Board and professional services. These services or supplies must be provided by

a Hospital or Extended Care Facility.

“Morbid Obesity” means the condition of weighing two or three or more times the ideal body weight based upon height and body frame. The condition of morbid obesity will be determined by reference and use of medically approved industry standard height, weight, and body frame charts.

Morbid Obesity is so called because it is associated with many serious and life-threatening disorders, including but not limited to diabetes mellifluent, arteriosclerosis, hypertension, etc. It is obesity of such degree as to interfere with normal activities.

“Newborns’ and Mothers’ Health Protection Act (NMHPA)” means group health plans must allow 48 hours’ stay for normal delivery and 96 hours for Caesarean section.

“Routine Well Baby Care” means expense that is incurred for nursery, circumcision, pediatric visits and required general care and treatment. Also, the expenses must be incurred during the first year of birth subject to deductible and coinsurance for dependent coverage.

“Non-Contributory Coverage” means coverage toward which an Employee does not contribute.

“Physician” means a person who is:

1. licensed or legally authorized to give medical care or treatment; and
2. acting within the scope of the license or authorization.

“Physician” also means a clinical psychologist; a dentist (D.D.S./D.M.D.), podiatrist (D.P.M.), or chiropractor (D.C.) rendering a service within the scope of his license that is not specifically excluded by the Plan.

“Plan Administrator” means the party responsible for the day-to-day functions and management of the Plan. The Plan Administrator may employ persons/firms to process claims and perform other Plan-connected services. The Plan Administrator is the Planholder.

“Plan Year” means a period commencing on the Plan Effective Date or any anniversary of this Plan and continuing until the next succeeding anniversary.

“Planholder” means the Employer.

“Pre-Existing Condition” means an Injury or Sickness for which a covered Person received medical advice or treatment during the six (6) months period before the person’s coverage began under this Plan of Benefits. An Injury or Sickness will no longer be considered a “Pre-Existing Condition” when the first of these events takes place:

1. if the person is an Employee, the Employee has been covered by this Plan of benefits for twelve (12) months in a row; or
2. if the person is a Dependent, the Dependent has been covered by this Plan of benefits for

twelve (12) months in a row.

A participant has the right to demonstrate “creditable coverage” and he/she must be given credit for any prior “creditable coverage” against the pre-existing condition period. If there is a break in coverage of more than 63 days, prior coverage does not count. “Creditable coverage” includes coverage under employer health plans, other health insurance, public health plans, and Social Security. “Creditable coverage” does not include coverage where the health benefits are incidental, such as accident or disability income, liability, workers’ compensation, automobile medical insurance, dental plans, vision benefits or long-term care plans. Prior coverage does not need to be as good as, or even similar to the new plan to be counted. Pre-existing limits must be reduced month-for-month by any previous health insurance coverage that a participant had, unless the break in coverage was more than sixty-three (63) days.

Certification - New health plan enrollees will be required to provide proof of their coverage to receive credit under their new health plan’s pre-existing condition limitation.

A “Pre-Existing Condition” exclusion period cannot be applied to pregnancy, to a newborn, an adopted child under age 18 or a child placed for adoption under age eighteen (18) if the child becomes covered within thirty (30) days of birth, adoption or placement for adoption.

“Reasonable and Customary Charges” means charges that do not exceed the usual amount charged in the locality for similar services or supplies. They must be needed for the care of a Covered Person and be in keeping with the extent of the Injury or Sickness.

“Regular Care” means on going medical supervision or treatment which is in keeping with the nature of the Injury of Sickness involved.

“Retrospective Review” means a review that is performed subsequent to denial of benefits.

“Riot” means all forms of public violence, disorder or disturbance of the peace by a group of three or more persons. It does not matter whether:

1. there was common intent; or
2. there was intent to damage any person or property, or to break the law.

“Room and Board” means the following charges to inpatients by a Hospital Hospice or Extended Care Facility:

1. a bed;
2. meals; and
3. the general services essential to daily medical care.

“Service Requirement” means an unbroken period of Active Work.

“Sickness” means these conditions:

1. when the body's organs do not function normally;
2. when a temporary ailment reduces the body's ability to function normally, or pregnancy.

“Surgical Procedure” means only the following: a cutting operation, suturing of a wound, treatment of a fracture, reduction of a dislocation, radiotherapy (excluding radioactive isotope therapy) if used in lieu of a cutting operation for removal of a tumor, electro cauterization, diagnostic and therapeutic endosperm procedures, injection treatment of hemorrhoids and varicose veins, cryosurgery, laser surgery.

“Third Party Administrator (TPA) Plan Supervisor” is the person or firm providing consulting services to the Employer in connection with the operation of the Plan and performing such other functions, including processing and payment of claims, as may be delegated to it.

“Total Disabled” or “Total Disability” means an Injury or Sickness approved by the Social Security Administration that results in:

1. active Employees being unable to perform the main duties of their normal occupation of business, or
2. any other Covered Persons being unable to engage in the normal activities, duties or responsibilities of healthy people of the same age and sex.

THE PLAN

Plan is Not a Contract

This Plan shall not be construed as a contract, consideration, or inducement of employment, or as affecting in any manner or to any extent whatsoever the rights or obligations of the Planholder or any Employee to continue or terminate employment at any time.

Plan Description

The Planholder shall provide to Employees who are Covered Persons a Summary Plan Description containing the benefits of this Plan and the rights and obligation of Covered Persons under this Plan.

Changes to Plan - This Plan may be changed by the execution of an amendment to this Plan by the Planholder at any time without prior notice to or the consent of any Covered Person or of any person entitled to receive payment of benefits under the Plan. The Planholder shall provide to the Covered Employees a summary of any material change to this Plan within two hundred and ten (210) days after the end of the Plan Year in which the change is adopted.

Effect of Changes - All changes to this Plan shall become effective as of the date established by the Planholder, EXCEPT that:

No increase or reduction in benefits shall be effective with respect to Covered expenses incurred prior to the date a change was adopted by the Planholder,

regardless of the effective date of the change.

Termination of Plan

The Planholder may terminate this Plan at any time of providing written notice to the Covered Employees. Such termination will become effective on the date set forth in such notice.

Written Notice - Any written notice required under this Plan, which, as of the effective date, is in conflict with the law of any governmental body, or agency, which has jurisdiction over this Plan, shall be interpreted to conform to the minimum requirement of such law.

Waivers - The failure of the Planholder to strictly enforce any provision of this Plan shall not be construed as a waiver of the provision. Rather, the Planholder reserves the right to strictly enforce each and every provision of this Plan at any time regardless of the prior conduct of the Planholder and regardless of the similarity of the circumstances or the number of prior occurrences.

Worker's Compensation - This Plan is not provided in lieu of nor does it affect any requirement for coverage by worker's compensation insurance.

Miscellaneous - Section titles are for conveniences of reference only and are not to be considered in interpreting this Plan.

No failure to enforce any provision of this Plan shall affect the right thereafter to enforce such provision, nor shall such failure affect its right to enforce any other provision of this Plan.

Free Choice of Physician - Any Employee or Dependent covered hereunder will have free choice of Physician.

STATEMENT

Not Warranties

Statements made by or on behalf of any person to obtain coverage under this Plan shall be deemed representations and not warranties.

Mis-Statements on Application

If any relevant fact has been mis-stated by or on behalf of any person to obtain coverage under this Plan, the true facts shall be used to determine whether coverage is in force and the extent, if any, of such coverage. Upon the discovery of any such mis-statement, an equitable adjustment of any contributions will be made.

Time Limit for Mis-statement - No mis-statement made to obtain coverage under this Plan shall be used to void the coverage of any person, which has been in force for a period of two (2) years, or to deny a claim for a loss incurred or disability commencing after the expiration of such two (2) year period. The provisions of this paragraph shall not apply if any such mis-statement has been made fraudulently.

Use of Statements

No statements made by or on behalf of any person shall be used in any contest unless a copy of the written instrument containing such statement has been or is furnished to such person claiming a right to receive benefits with respect to such person.

Legal Proceedings

Legal action to recover any lost benefits under this Plan may not be brought until the Plan's appeal procedure, including utilization of a professional/peer review committee, has been exhausted per the terms of ERISA, and is not later than three (3) years after the expenses/disability were incurred.

Conformity with Law - If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform thereto.

Basis on Which Payments are to be Made from the Plan

The Planholder shall from time to time evaluate the costs of the Plan and determine the amount to be contributed by the Planholder and the amount to be contributed (if any) by each covered participant.

Funding Policy - Notwithstanding any other provision of the Plan, the Planholder's obligation to pay claims otherwise allowable under the terms of the Plan shall be limited to its obligation to make contributions to the Plan as set forth in the preceding paragraph entitled "Basis on Which Payments are to be Made to and from the Plan". In the event that the Planholder terminates the Plan, then as of the effective date of termination, the Planholder (and Covered Employee and Dependent participants) shall have no further obligation to make additional contributions to the Plan. In addition, coverage for allowable claims filed after such Plan termination date shall be limited to those remaining assets of the Plan. If there are not sufficient assets in the Plan fund to provide the benefits otherwise payable under the Plan and such benefits are not covered under an insurance contract purchased under the Plan, then such benefits shall not be payable under the Plan and neither the Planholder, Plan Administrator, Trustee or Plan Supervisor shall be liable for such benefits.

CLAIMS

Claim Determinations Made In Accordance With Plan Documents

The Plan's claims procedures shall include administrative safeguards and processes designed to ensure and verify that benefit claims determinations are made in accordance with governing Plan documents and, where appropriate, that the Plan's provisions have been applied consistently with respect to similarly situated claimants.

Claim Defined

A "claim" is any request made by a claimant or a claimant's representative for benefits under the Plan that complies with the Plan's reasonable procedure for filing claims. A request for

benefits includes a request for coverage determination, pre-authorization or approval of a plan benefit, or a utilization review determination in accordance with the terms of the Plan. Requests for eligibility determinations are not claims for benefits. However, when a claim is denied because the claimant is not eligible for benefits under the terms of the Plan, the claimant has the right to appeal that determination in accordance with the Plan's claims procedures.

Claims Filing

The Plan Administrator (or Employer) will furnish to the Covered Participant, upon request, forms for filing proof of loss. If such forms are not furnished within 15 days after receipt of notice of a claim, any written form that includes information indicating the occurrence, character, and extent of the loss for which a claim is made may be used to submit a proof of loss. A claim form may be required to be submitted at least once per year for each individual who incurs covered expense.

The completed claim form and the original bills for expenses incurred must be submitted to the Claims Administrator within 365 days after the date the loss occurred or commenced.

Limitation of Liability

The Plan Sponsor shall not be obligated to pay any benefits under the Plan for any claim if the proof of loss for such claim was not submitted within the period provided in "Claim Filing" above, except in the case of legal incapacity of the Covered Participant.

Urgent Care Claim Rules

For urgent care claims, the Claims Administrator will notify the claimant of its determination, whether adverse or not, as soon as possible but not later than 72 hours from receipt of the claim at the initial benefit determination level (and within not later than 36 hours at the appeal level upon review of an adverse benefit determination).

Notice of a benefit grant or denial may be provided orally, provided that a written or electronic notice of benefit grants or denials is sent to the claimant not later than three (3) days after the oral notification.

The term "urgent care claim" means any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Except as provided in the next Sentence, whether a claim is an urgent care claim is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Any claim that a physician with knowledge of the claimant's medical condition determines is an urgent care claim involving urgent care shall be treated as an urgent care claim for purposes of these provisions.

Concurrent Care Decision Rules

For concurrent care decisions, the Claims Administrator will notify the claimant of its decision

to terminate or reduce benefits that have already been approved that may disrupt an ongoing course of treatment to be provided over a period of time or a number of treatments at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that decision before the benefit is reduced or terminated.

Any urgent care claim involving ongoing care (requesting to extend a course of treatment beyond the initially prescribed time period or number of treatments) must be decided within 24 hours provided that the claim is made at least 24 hours prior to the expiration of the initially prescribed period.

Pre-Service Claim Rules

For pre-service claims, generally, the Claims Administrator must notify the claimant of its determination, whether adverse or not, within a reasonable period of time appropriate to the medical circumstances but not later than 15 days from receipt of the claim at the initial level. One 15-day extension of time is available if the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit necessary information, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Written or electronic notice of benefit grants or denials must be provided in the case of pre-service claims.

A “pre-service” claim is a claim for a benefit under the Plan where plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care (for example, pre-certification).

Post-Service Claim Rules

For post-service claims, generally, the Claims Administrator will notify the claimant of its adverse determination within a reasonable period of time, but not later than 30 days from receipt of the claim at the initial level. One 15-day extension of time is available if the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit necessary information, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from the receipt of the notice within which to provide the specified information. A “post-service” claim is considered to be filed when the following information is received by the Claims Administrator together with a Form HCFA or Form UB92:

1. the date of service;
2. the name, address, telephone number and tax identification number of the provider of the service or supplies;
3. the place where the services were rendered;
4. the diagnosis and procedure codes;

5. the amount of charges;
6. the name of the Plan;
7. the name of the Covered Employee; and
8. the name of the patient.

Written or electronic notice of benefit denials must be provided in the case of post-service claims.

Incomplete Claims Notice Disclosure Requirement

The Claims Administrator will determine whether a filed claim is incomplete. A claim is filed in accordance with reasonable filing procedures of the Plan, without regard to whether all information necessary to decide the claim accompanies the filing

The Claims Administrator must notify the claimant or claimant's representative of failure to follow proper claims filing procedures. With respect to urgent care claims, the Claims Administrator will provide incomplete claims notice within 24 hours of receipt of the claim. With respect to pre-service claims, notice of incomplete claims will be provided within five (5) days after receipt of the claim. Notification by the Claims Administrator may be oral, unless written notification is requested by the claimant or claimant's authorized representative.

Manner and Content of Benefit Determination

The Claims Administrator shall provide a claimant with written or electronic notification of any adverse benefit determination. The notification shall set forth, in a manner calculated to be understood by the claimant the following:

1. the specific reason(s) for the adverse determination;
2. references to the specific plan provisions upon which the determination is based;
3. a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
4. a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review;
5. if the Plan utilizes a specific internal rule, guideline, protocol, or other similar criterion in making the determination, either the specific rule, guideline, protocol or other similar criterion; or a statement that such a rule, guideline, protocol or similar criterion will be provided free of charge to the claimant upon request;
6. if the determination is based on a medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the Plan's terms to the claimant's medical circumstances, or a statement that such an explanation will be provided free of charge upon request;
7. in the case of a determination concerning an urgent care claim, a description of the expedited review process applicable to such claims.

PHYSICAL EXAMINATIONS

The Planholder reserves the right to have a Physician of its own choosing examine any Covered Person whose condition, sickness or injury is the basis of a claim. All such examinations shall be at the expense of the Planholder. This right may be exercised when and as often as the Planholder may reasonably require during the pending of a claim. The opportunity to exercise this right shall be condition precedent to obtaining payment of benefits for the claim.

Autopsy

The Planholder reserves the right to have an autopsy performed upon any deceased Covered Person whose condition, sickness or injury is the basis of a claim. This right may be exercised only where not prohibited by law.

PAYMENT OF CLAIMS

Payment of Benefits

All benefits under the Plan are payable to the Covered Employee or Assignee whose Illness or Injury or whose Covered Dependent's Illness or Injury is the basis of a claim.

In the event of death or incapacity of a covered employee and in the absence of written evidence to the Plan of the qualification of a guardian for the covered employee's estate, the Plan may, at its sole discretion, make any and all such payments to the individual or institution which, in the opinion of the Plan Administrator, is or was providing the care and support of such employee.

Benefits for expenses covered under the Plan may be assigned by a covered employee to the person or institution rendering the services for which the expenses were incurred. No such assignment will bind the Plan Administrator unless it is in writing and unless it has been received by the Claims Administrator prior to the payment of the benefit assigned. The Claims Administrator will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered employee and the assignee, has been received by the Claims Administrator before the proof of loss is submitted. Payment of benefits will be made by the Plan in accordance with any assignment of rights made by or on behalf of a Covered Person if required by a Qualified Medical Child Support Order (QMCSO). The Plan will not take Medicaid eligibility into account and will pay benefits in accordance with any assignment of rights under a state Medicaid law.

Discharge of Liability

Any payment made in accordance with the provisions of this section shall fully discharge the liability of the Planholder to the extent of such payment.

ERISA INFORMATION

The following information is being provided in accordance with certain requirements of the Employee Retirement Income Security Act of 1974 (ERISA).

Important Information About Your Employee Benefit Plan

This Plan information is a summary of the Arkansas Higher Education Consortium Benefits Trust Employee Health and Welfare Group Medical Plan.

Name Of Plan: Arkansas Higher Education Consortium Benefits Trust, P.O. Box 140, Hope, AR 71802-0140

Maintained By Plan Administrator: Arkansas Higher Education Consortium Benefits Trust, P.O. Box 140, Hope, AR 71802-0140

Type Of Plan: A Self-Funded Group Medical Plan

Type Of Administration: This Plan is administered by the Employer who maintains the Plan's records, supervises the operation of the Plan and interprets the Plan's provisions.

Employer Identification Number: 71-6157730

Group Number: AHEC200, AHEC2003 and AHEC2007

Agent For Service Of Legal Process: Arkansas Higher Education Consortium Benefits Trust, P.O. Box 140, Hope, AR 71802-0140

Agent For Claim Service: J P Fraley Corporation., P.O. Box 41779, Memphis, TN 38174-1779 901-725-6435

Plan Number For Claim Service: 501

Sources Of Plan Contributions: The Employer and Covered Employees contribute to the cost of the Plan.

End Of Plan Year: June 30

End Of Fiscal Year: June 30

Disclaimer: At any time without notice, the Employer may terminate the Plan or may modify, amend or change the provisions, terms and conditions of the Plan. No consent of any participant or any other person shall be required to terminate, modify, amend or change the Plan.

Appeal of Denied Claim and Review Procedure

A claimant will be notified in writing by the Claims Administrator if a claim or any part of a claim is denied. If a claimant does not agree with the reason for the denial (including a denial of benefits based on a determination of a claimant's eligibility to participate in the Plan), he

may file a written appeal within 180 days after the receipt of the original claim determination for the first appeal and sixty days for the second appeal. The request should state the basis for the disagreement along with any data, questions, or comments he thinks are appropriate, and should be sent to the office of the Claims Administrator. An appropriated named fiduciary who is neither the individual who made the initial determination, nor the subordinate of such individual, shall conduct a full and fair review of the determination. The review shall not defer to the initial determination, and it shall take into account all comments, documents, records and other information submitted by the claimant without regard to whether such information previously submitted or considered in the initial determination. In addition, in deciding an appeal of any determination based in whole or in part on a medical judgment, including determinations with regards to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional, who was neither the individual who was consulted in connection with the initial benefit determination, nor the subordinate of such individual, and who has appropriate training and experience in the field of medicine involved in the medical judgment. The Claims Administrator will provide upon request the names of the medical or vocational experts consulted as part of the claims process.

In the case of the review of urgent care determination, a request for an expedited appeal of a claim denial may be submitted orally or in writing by the claimant; and all necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

The Claimant will be notified of the results of the review by the Claims Administrator. On Pre-service and post-service claim denials, the Plan provides two levels of appeal. The levels of appeal will be resolved within 15 days of the date the appeal was received for pre-service claims, and 30 days of the date the claim was received for post-service claims.

Manner and Content of Notification of Benefit Determination on Review

The Claims Administrator shall provide a claimant with written or electronic notification of any adverse benefit determination on review. The notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. the specific reason(s) for the adverse determination on review;
2. references to the specific plan provisions upon which the review is based;
3. a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to his claim for benefits;
4. a statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain the information about such procedures, and a statement of the claimant's right to bring an action under section 502(a) of ERISA;
5. if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination on review, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination on review and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the claimant upon request;
6. if the adverse benefit determination on review is based on a medical necessity or

experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

7. the following statement: "Other voluntary alternative dispute resolution methods, such as mediation, may be available. You may seek additional information by contacting your local U.S. Department of Labor office and your State insurance regulatory agency."

Authorized Representatives

A claimant's authorized representative, including a health care provider, is not precluded from acting on behalf of the claimant in pursuing a benefit claim or appeal. The Claims Administrator shall recognize a health care professional with knowledge of a claimant's medical condition as the claimant's representative in connection with an urgent care claim. The Claims Administrator may establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a claimant.

Claims Appeal Procedure

If you are not satisfied with the review by the Claims Administrator, you may file an appeal with Appeals Committee for their review. The Appeals Committee meets quarterly to review and make final determinations on all appeal requests. All appeals must be in writing with a copy of the Explanation of Benefits form and any other correspondence with the Agent for Claim Service included. All appeals must be mailed to: **AHEC Appeals Committee, Ms. Linda Brown, North Arkansas Community/Technical College Pioneer Ridge, Harrison, AR 72601**

Statement Of ERISA Rights

As a participant in the Arkansas Higher Education Consortium Benefits Trust System's Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

1. examine, without charge, at the Plan Administrator's office and/or at any other specified locations, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions;
2. obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The administrator may make a reasonable charge for the copies; and
3. receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants, and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to

prevent you from obtaining a welfare benefits or exercising your rights under ERISA. If your claim for a welfare benefits is denied in whole or in part, you must receive a written explanation of the reason for denial. You have the right to have the plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide the materials and pay you up to \$100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim frivolous. If you have any questions about your Plan, you may contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest area office of the Pension and Welfare Benefits Administration, U.S. Department of Labor listed below or the division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, D.C. 20210.

Pension and Welfare Benefits Administration (PWBA) Offices:

Atlanta Regional Office
61 Forsyth Street, SW, Ste. 7B54
Atlanta, GA 30303
Telephone: 404-562-2156

Miami District Office
111 NW 183rd Street, Ste. 504
Miami, FL 33169
Telephone: 305-651-6464

Boston Regional Office
One Bowdoin Square, 7th Floor
Boston, MA 02114
Telephone: 617-424-4950

New York Regional Office
1633 Broadway, Room 226
New York, NY 10019
Telephone: 212-399-5191

Chicago Regional Office
200 West Adams Street, Ste. 1600
Chicago, IL 60606
Telephone: 312-353-0900

Philadelphia Regional Office
Gateway Building
3535 Market Street, Room M300
Philadelphia, PA 19104
Telephone: 215-596-1134

Cincinnati Regional Office
1885 Dixie Highway, Ste. 210
Fort Wright, KY 41011-2664
Telephone: 606-578-4680

St. Louis District Office
815 Olive Street, Room 338
St. Louis, MO 63101-1559
Telephone: 314-539-2691

Dallas Regional Office
525 Griffin Street, Room 707
Dallas, TX 75202-5025
Telephone: 214-767-6831

San Francisco Regional Office
71 Stevenson Street, Ste. 915
P.O. Box 190250
San Francisco, CA 94119-0250
Telephone: 415-975-4600

Detroit District Office
211 West Fort Street, Ste. 1310
Detroit, MI 48226-3211
Telephone: 313-226-7450

Seattle District Office
1111 Third Avenue, Ste. 860
MIDCOM Tower
Seattle, WA 98101-3212
Telephone: 206-553-4244

Kansas City Regional Office
City Center Square
1100 Main, Ste. 1200
Kansas City, MO 64105-2112
Telephone: 816-426-5131

Washington D.C. District Office
1730 K Street NW, Ste. 556
Washington, D.C. 20006
Telephone: 202-254-7013

Los Angeles Regional Office
790 East Colorado Boulevard,
Ste. 514
Pasadena, CA 91101
Telephone: 818-583-7862