RETIREE MEDIPAK®'

GROUP BENEFIT CERTIFICATE

GROUP NAME: CENTRAL ARKANSAS WATER

GROUP NO.: 029230

PACKAGE NO.: 0001

IMPORTANT NOTICE

THE GROUP POLICY UNDER WHICH THIS BENEFIT CERTIFICATE IS ISSUED ONLY PROVIDES BENEFITS FOR SERVICES RECEIVED FROM MEDICAL PROVIDERS THAT PARTICIPATE WITH MEDICARE.

THE GROUP POLICY MAY NOT COVER ALL YOUR MEDICAL EXPENSES.

ARKANSAS BLUE CROSS AND BLUE SHIELD
601 S. GAINES STREET
LITTLE ROCK, ARKANSAS 72201

®'Registered Mark of
Arkansas Blue Cross and Blue Shield

® Registered Mark of
Blue Cross and Blue Shield Association

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Table of Contents

NOTICE OF LANGUAGE ASSISTANCE, AUXILIARY AIDS/SERVICES AND NON-DISCRIMINATION NOTICE viii
NOTICE OF PRIVACY PRACTICES x
1.0 INTRODUCTION 14
2.0 BENEFITS AND SPECIFIC LIMITATIONS IN THE PLAN 14
- 2.1 Medicare Extended Hospital Services 14
- 2.2 Medicare Part B Services 15
- 2.3 Medically Necessary Emergency Care in a Foreign Country 16

3.0 EXCLUSIONS AND LIMITATIONS 16
4.0 ELIGIBILITY STANDARDS 16
- 4.1 Eligibility for Coverage 17
- 4.2 Effective Date of Coverage 17
- 4.3 Termination of Coverage 18
- 4.4 Continuation Privileges 19
- 4.5 Conversion Privileges 22

5.0 CLAIM PROCESSING AND APPEALS 23
- 5.1 Claim Processing 23
- 5.2 Claim Appeals to the Plan 25
- 5.3 Authorized Representative 27

6.0 OTHER PROVISIONS 29
- 6.1 Assignment of Benefits 29
- 6.2 Right of Rescission 29
- 6.3 Claim Recoveries 29
- 6.4 Amendment 30
- 6.5 Physician Incentives 30

7.0 GLOSSARY OF TERMS 30
8.0 YOUR RIGHTS UNDER ERISA 32
INNOVATIVE FITNESS PROGRAM RIDER 36
ARKANSAS CONSUMERS INFORMATION NOTICE 37
LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT 38
INDEX 40

NOTICE OF LANGUAGE ASSISTANCE, AUXILIARY AIDS/SERVICES AND NON-DISCRIMINATION NOTICE

We provide free language assistance, appropriate auxiliary aids and services, and reasonable modifications to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, written information in various formats (large print, audio, accessible electronic formats, other formats), and language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, call or contact Customer Service at 1-800-238-8379 (TTY:771) or Civil Rights Coordinator.

ATTENTION: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in assessable formats are available free of charge. Call 1-800-238-8379 (TTY: 711) or speak to your provider.

Spanish: ATENCIÓN: Disponemos de servicios gratuitos de asistencia lingüística. También hay disponibles de forma gratuita ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 1-800-238-8379 (TTY: 711) o hable con su proveedor.

Chinese Simplified: 注意：提供免费语言服务。此外，免费提供适合残障人士使用的辅助和支持服务。请致电 1-800-238-8379 (TTY: 711)或联系您的服务提供商。

Chinese Traditional: 注意：我們提供免費的語言協助服務，以及免費的適當輔助工具和其他服務，讓您能夠獲得無障礙格式的資訊。請撥打 1-800-238-8379 (TTY: 711)或諮詢您的服務提供者。

Tagalog: PAUNAWA: Available para sa iyo ang mga libreng serbisyo sa tulong sa wika. Available rin nang walang bayad ang mga naaangkop na auxiliary na tulong at serbisyo para magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-238-8379 (TTY: 711) o makipag-usap sa iyong provider.

French: ATTENTION : Des services d'assistance linguistique sont gratuitement mis à votre disposition. Des aides et services auxiliaires appropriés visant à vous informer dans des formats accessibles sont également mis à votre disposition gratuitement. Appelez le 1 800 238 8379 (TTY : 711) ou discutez avec votre prestataire.

Vietnamese: CHÚ Ý: Các dịch vụ hỗ trợ ngôn ngữ sẽ được cung cấp miễn phí cho quý vị. Các dịch vụ và hỗ trợ giao tiếp phù hợp nhằm cung cấp thông tin ở các định dạng dễ tiếp cận cũng được cung cấp hoàn toàn miễn phí. Hãy gọi 1-800-238-8379 (TTY: 711) hoặc trao đổi với nhà cung cấp của quý vị.

German: HINWEIS: Ihnen stehen kostenlose Sprachmittlungsdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zum barrierefreien Zugang zu Informationen stehen ebenfalls kostenfrei zur Verfügung. Rufen Sie 1-800-238-8379 (TTY: 711) an oder sprechen Sie mit Ihrem Leistungserbringer.

Korean: 주의: 무료 언어 지원 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 도구와 서비스도 무료로 제공됩니다. 1-800-238-8379 (TTY: 711)번으로 전화하거나 담당 서비스 제공자에게 문의하십시오.

Russian: ВНИМАНИЕ! Вам доступны бесплатные услуги языковой поддержки. Приемлемые вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-238-8379 (TTY: 711) или обратитесь к своему поставщику услуг.

Arabic: ملاحظة: خدمات المساعدة اللغوية متاحة لك مجاناً، كما أن وسائل وخدمات المساعدة الإضافية المناسبة لتوفير المعلومات بصيغ يسهل عليك الوصول إليها متاحة مجاناً أيضاً. يرجى الاتصال على الرقم: 1-800-238-8379 (TTY: 711) أو التحدث إلى مقدم الرعاية

Hindi: ध्यान दें: आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध हैं। आसान फ़ॉर्मैट में सूचना उपलब्ध कराने के लिए उचित सहायक साधन और सेवाएं भी निःशुल्क उपलब्ध हैं। 1-800-238-8379 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

Italian: ATTENZIONE: Ha a disposizione servizi di assistenza linguistica gratuiti. Potrà usufruire gratuitamente anche di sussidi e servizi ausiliari appropriati per ottenere le informazioni in formati accessibili. Chiami il numero 1-800-238-8379 (TTY: 711) o chieda al suo operatore sanitario.

Portuguese: ATENÇÃO: Serviços gratuitos de assistência linguística estão disponíveis para você. Ajudas e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-800-238-8379 (TTY: 711) ou fale com seu provedor.

French Creole: ATANSYON: Genyen sèvis asistans lang gratis disponib pou ou. Epitou, genyen lòt èd ak sèvis apwopriye disponib gratis pou ede moun jwenn enfòmasyon nan yon fòma ki aksesib. Rele 1-800-238-8379 (TTY: 711) oswa pale ak founisè w la.

Polish: UWAGA: może Pan/Pani skorzystać z bezpłatnych usług pomocy językowej. Odpowiednie dodatkowe pomoce i usługi w zakresie zapewniania dostępu do informacji w przystępnym formacie również są dostępne bezpłatnie. Prosimy dzwonić pod numer 1-800-238-8379 (TTY: 711) lub porozmawiać z lekarzem.

Japanese: 注意：無料の言語サポートサービスをご利用いただけます。アクセシブルなフォーマットで情報を提供するための適切な援助やサービスも無料でご利用いただけます。1-800-238-8379（TTY：711）にお電話いただくか、医療提供者にご相談ください

NON-DISCRIMINATION NOTICE

Our Company complies with applicable federal and state civil rights laws and does not discriminate, exclude, or treat people differently on the basis of race, color, national origin, age, disability, or sex.

If you believe that we have failed to provide these language assistance or auxiliary aids and services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex.

Civil Rights Coordinator
601 Gaines Street, Little Rock, AR 72201
Phone: 1-844-662-2276 (TTY: 711)
You can file a grievance in person, by mail, or by email. If you need help filing a grievance our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201
Phone: 1-800-368-1019; TDD: 1-800-537-7697

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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NOTICE OF PRIVACY PRACTICES

ARKANSAS BLUE CROSS AND BLUE SHIELD

THIS NOTICE DESCRIBES HOW CLAIMS OR MEDICAL INFORMATION ABOUT YOU MAY BE USED AND RELEASED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Arkansas Blue Cross and Blue Shield is a business name of USAble Mutual Insurance Company. By law, Arkansas Blue Cross and Blue Shield is required to protect the privacy of your protected health information (PHI). We also must tell you how your PHI held by us may be used and released ("disclosed").

Throughout this notice, we will use the name "Arkansas Blue Cross" as a shorthand reference for Arkansas Blue Cross and Blue Shield.

Disclosure of Protected Health Information (PHI)

"Protected health information" (PHI) is health information that is created, collected, maintained, or transmitted by us that relates to an individual's past, present, or future physical or mental condition, treatment for the condition, or payment for the treatment, and that is protected by law from impermissible disclosures. Legal protections also apply to individually identifiable *non-health* information stored in the same designated record set as PHI that could identify you.

Arkansas Blue Cross must disclose your PHI to provide information:

- To you or someone who has the legal right to act for you (your personal representative)
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected, and
- Where required by law.

Arkansas Blue Cross has the right to disclose your PHI to evaluate and process your health plan or health insurance claims, enroll and disenroll you and your dependents, and perform related business operations.

For example:

- We can use and disclose your PHI to pay or deny your claims, to collect your premiums, or to share your benefit payment or status with another insurer.
- We can use and disclose your PHI for regular healthcare operations, including assessing our business efficiency and outcomes in an effort to continually improve the quality and effectiveness of benefits and services we provide.
- If you employer arranges for your insurance or funds the health plan coverage and serves as plan administrator and meets the requirements outlined by law to ensure adequate separation between the employer and the health plan itself, we can disclose PHI to the health plan to assist in obtaining coverage, processing a claim, modifying benefits, working to control overall plan costs, and improving service levels.
- We may disclose PHI to business associates who provide contracted services on our behalf, Examples include pharmacy management programs, dental benefits, and a copy service we use when making copies of your health record. Our contracts require these business associates to appropriately protect your information in compliance with applicable privacy and security laws.
- We may disclose PHI to a family member, other relative, close personal friend or any other person you identify that includes health information relevant to that person's involvement in your care or payment related to your care; for example, when your spouse calls to verify a claim was paid, or an

adult child inquires about claims for an elderly parent who is unable to address their own health insurance or health plan business.

Arkansas Blue Cross may use or give out your PHI for the following purposes, under limited circumstances:

- To state and federal agencies that have the legal right to receive Arkansas Blue Cross data
- For public health activities (such as reporting disease outbreaks)
- For government healthcare oversight activities (such as fraud and abuse investigations)
- For judicial and administrative proceedings (such as in response to a subpoena, law enforcement agency administrative request or other court order, except that substance use disorder (SUD) records cannot be provided for use in civil, criminal, administrative, and legislative proceedings against you without your specific consent)
- For law enforcement purposes (such as providing limited information to locate a missing person or in response to any federal or state agency administrative request that is authorized by law, except that SUD records cannot be provided for use in civil, criminal, administrative, and legislative proceedings against you without your specific consent)
- For research studies that meet all privacy law requirements (such as research related to the prevention of diseased or disability)
- To avoid a serious and imminent threat to health or safety
- To contact you, either directly or through a business associate, using your postal or email addresses, telephone numbers or other personal information, regarding new or changed health plan benefits of Arkansas Blue Cross.
- To contact you, either directly or through a business associate, using your postal or email addresses, telephone numbers or other personal information, regarding health care providers participating in our networks, disease management, health education and health promotion, preventive care options, wellness programs, treatment or care coordination or case management activities of Arkansas Blue Cross.

By law, Arkansas Blue Cross must have your written permission (an "authorization") to use or release your PHI for any purpose other than treatment, payment or health care operations or other limited exceptions outlined here or in the Privacy regulation or other applicable law. Once you have given your permission for us to release your PHI you may take it back ("revoke") at any time by giving written notice to us, except if we have already acted based on your original permission. To the extent (if any) that we maintain or receive psychotherapy notes or substance use disorder (SUD) counseling notes about you, most disclosures of these notes require your specific authorization or written consent. In addition, most (but not all) uses and disclosures of medical information for marketing purposes and disclosures that constitute a sale of PHI require your authorization. Once we disclose information to a third-party other than a health care provider, health plan, or other person subject to federal privacy laws, the information may no longer be protected by federal privacy laws, and the recipient may use or redisclose that information for other purposes.

Personal Health Record (PHR)

If you have a health benefit plan issued by Arkansas Blue Cross on or after October 1, 2007, you have a Personal Health Record (PHR). Your PHR contains a summary of claims submitted for services you received while covered by your health benefit plan, as well as non-claims data you choose to enter yourself. Your PHR will continue to exist, even if you discontinue coverage under your health benefit plan. You have access to your PHR through the Arkansas Blue Cross website. In addition, unless you limit access, your physician and other healthcare providers have access to your PHR. However, certain information that may exist in the claims records is not available to your physician and other healthcare providers automatically.

To protect your privacy, information about treatment for certain sensitive medical conditions, such as HIV/AIDS, sexually transmitted diseases, mental health, drug or alcohol abuse or family planning, will be viewable by you alone unless you choose to make this information available to the medical personnel who treat you. Similarly, non-claims data, such as your medical, family and social history, will only appear in your PHR if you choose to enter it yourself. It is important to note that you have the option to prohibit access to

your PHR completely, either by electronically selecting to prohibit access or by sending a written request to prohibit access to the Privacy Office at the address below.

Genetic Information

We are prohibited by law from collecting or using genetic information for purposes of underwriting, setting premiums, determining eligibility for benefits or applying any pre-existing condition exclusion under an insurance policy or health plan. Genetic information means not only genetic tests that you have received, but also any genetic tests of your family members, or any manifestations of a disease or disorder among your family members. Except for pre-existing condition exclusions, we may obtain and use genetic information in making a payment or denial decision or otherwise processing a claim for benefits under your health plan or insurance policy, to the extent that genetic information is relevant to the payment or denial decision or proper processing of your claim.

Special Note on Substance Use Disorder Treatment Records

We cannot use or disclose information about your treatment for substance use disorders (or provide testimony based on such information) for any civil, criminal, administrative, or legislative proceedings against you. Any such disclosure is permitted only with your consent or a special type of court order, for which you must have notice and an opportunity to object, as well as a subpoena, court order, or similar legal mandate.

Your Rights Regarding Information About You

You have the right to:

- See and obtain a copy of your PHI that is contained in a designated record set that was used to make decisions about you.
- Have your PHI amended if you believe that it is wrong, or if information is missing, and Arkansas Blue Cross agrees. If Arkansas Blue Cross disagrees, you may have a statement of your disagreement added to your PHI.
- Receive a listing of those receiving your PHI from Arkansas Blue Cross. The listing will not cover your PHI that was released to you or your personal representative, or that was released for payment or healthcare operations, or that was released for law enforcement purposes.
- Ask Arkansas Blue Cross to communicate with you in a different manner or at a different place (for example, by sending your correspondence to a P.O. Box instead of your home address) if you are in danger of personal harm if the information is not kept confidential.
- Ask Arkansas Blue Cross to limit how your PHI is used and released to pay your claims and perform healthcare operations, or to restrict the disclosure of SUD records as otherwise permitted. Please note that Arkansas Blue Cross may not be able to agree to your request.
- Get a separate paper copy of this notice.
- For purposes of obtaining Arkansas Blue Cross' assistance with your application for coverage or associated subsidies through ARHOME (the federal Affordable Care Act Exchange), you have the right in so doing to request that we limit further collection, creation, disclosure, access, maintenance, storage and use of your personally identifiable information.

Breach Notification

In the event of unauthorized access to or disclosure of your PHI, we will provide you with notification of a breach as required by law or where we otherwise deem such notification appropriate.

To Exercise Your Rights

If you would like to contact Arkansas Blue Cross or any of its divisions or affiliates for further information regarding this notice, or to exercise any of the rights described in this notice, you may do so by contacting Customer Service at the following toll-free telephone numbers:

Arkansas Blue Cross 800-238-8379

You also may access complete instructions and request forms from our company's website:

arkansasbluecross.com

Changes to this Notice

We are required by law to abide by the terms of this notice. We reserve the right to change this notice and make the revised or changed notice effective for claims or medical information we already have about you as well as any future information we receive. When we make changes, we will notify you by sending a revised notice to the last known address we have for you or by alternative means allowed by law or regulation. We also will post a copy of the current notice on Arkansas Blue Cross website.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with Arkansas Blue Cross by writing to the following address:

Privacy Office
ATTN: Privacy Officer
P.O. Box 3216
Little Rock, AR 72201
Telephone: 866-254-4001
Email: privacyofficeinquiries@arkbluecross.com

You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must:

1. be in writing;
2. contain the name of the entity against which the complaint is lodged;
3. describe the relevant problems; and
4. be filed within 180 days of the time you became or should have become aware of the problem.

We will not penalize or in any other way retaliate against you for filing a complaint with the Secretary or with us.

Last material revision 07/2025

Last general revision 11/2024

1.0 INTRODUCTION

1.1 Your former employer has established and maintains a retired employee health benefit plan ("Plan") for retired employees and their eligible Dependents. The Employer actively promotes the Plan to its retired employees. The Employer and you, through your premium contributions, have purchased a Plan of insurance benefits provided by the Group Policy and Benefit Certificates issued by Arkansas Blue Cross and Blue Shield that provides a range of coverage for medical services you may need. This is a very valuable benefit for you, but you should understand clearly that the Plan does NOT cover all medical services, drugs, supplies, tests or equipment ("health interventions" or "interventions"). A Plan covering all health interventions would be prohibitively expensive. For that reason, we have offered and you have purchased a more limited Plan. This document is your guide to what you have and have not purchased; in other words, what is and is not eligible for benefits under the Plan. **Accordingly, you should read this entire document carefully both now and BEFORE you obtain medical services to be sure you understand what is covered and the limitations on your coverage.**

1.2 Although this is not a Medicare Supplement Plan, this employer sponsored health benefit plan provides coverage that supplements benefits provided by Medicare.

1.3 Here is an important thing for you to clearly understand. For any health intervention there are five general coverage criteria that must be met in order for that intervention to qualify for coverage under the Plan.

1. The health intervention must be covered by Medicare
2. The health intervention must conform to specific limitations stated in the Plan.
3. The health intervention must not be specifically excluded under the terms of the Plan.
4. At the time of the intervention, you must meet the Plan's eligibility standards
5. You must follow the Plan's procedures for filing claims.

2.0 BENEFITS AND SPECIFIC LIMITATIONS IN THE PLAN

This health benefit plan provides coverage that supplements benefits provided by Medicare. This Section 2.0 describes medical services, drugs, supplies, tests and equipment for which coverage is provided under the Plan, provided all terms, conditions, exclusions and limitations of the Plan, including the five coverage criteria, are satisfied.

2.1 **Medicare Extended Hospital Services**

1. **Benefits.** Subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Benefit Certificate, if you are admitted to a Participating Hospital as a registered bed patient, the Plan will pay these amounts:
   a. One Hundred percent (100%) of the Medicare Part A Inpatient Hospital Deductible (in effect at the time of admission to the hospital) per Benefit Period; and
   b. Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th

day in any Medicare Benefit Period; and

c. Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used; and

d. Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days; and

e. The reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), under Medicare Part A, unless replaced in accordance with federal regulation; and

f. The Coinsurance (in effect under Medicare at the time service is rendered) for Extended Care Services received at a Participating Skilled Nursing Facility during the 21st through the 100th day Benefit Period.

2. **Limitations.** These benefits are limited to services you are eligible for under the definition of Inpatient Hospital Services in those facilities participating with Medicare.

2.2 **Medicare Part B Services.**

1. **Benefits.** Subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Benefit Certificate, if you receive a health intervention covered by Medicare Part B, the Plan will pay:

a. One hundred percent (100%) of the Medicare Part B Deductible (in effect at time service is rendered).

b. The Coinsurance (in effect at the time the service is rendered) of Part B Medicare-eligible expenses;

c. The reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal requirements), under Medicare Part B, unless replaced in accordance with federal regulation.

d. One Hundred Percent (100%) of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare approved Part B charge.

2. **Limitations.**

a. Payment by the Plan will be limited to the reasonable charge as determined by Medicare.

b. No Medicare Part B Benefits will be paid for services provided by a health care provider or Hospital that does not participate in the Medicare program.

2.3 **Medically Necessary Emergency Care in a Foreign Country.**

1. **Benefit.** Subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Benefit Certificate, if you incur emergency medical care in a foreign country, the Plan will cover to the extent not covered by Medicare eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received outside the United States which is within the scope of Medicare coverage when provided in the United States, during the first sixty (60) consecutive days of each trip outside of the United States.

2. **Limitations.**

    a. This benefit is subject to a calendar year Deductible of Two Hundred Fifty Dollars ($250.00), and a lifetime maximum benefit of Fifty Thousand Dollars ($50,000.00).

    b. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an illness or an injury of sudden and unexpected onset.

3.0 EXCLUSIONS AND LIMITATIONS

This Section 3.0 describes the conditions, Provider services or other health interventions for which coverage is excluded.

3.1 **Benefits Available under Laws.** No benefits will be paid by the Plan for any benefits you collect or could collect under or by virtue of any present law. Present Law here means any law enacted by the United States or any of its political subdivisions that provides for medical or hospital care. This includes, among other laws, any Worker's Compensation Law, the Federal Employees Health Benefits Act of 1959, and any law respecting medical care for active or inactive Armed Services Personnel or their dependents.

3.2 **Benefits Available From Medicare.** No Benefits shall be payable hereunder for any benefits that are or could be obtained under Medicare.

3.3 **Conditioned on Medicare Part A and B Enrollment.** No benefit shall be available under this certificate if you do not have Medicare hospital Part A and Medicare medical Part B coverage.

3.4 **At Home Recovery.** No benefits shall be payable for at-home recovery benefits for Medicare covered services.

3.5 **Preventive Care.** No benefits shall be payable for preventive benefits for Medicare covered services.

4.0 ELIGIBILITY STANDARDS

Even if a Health Intervention you receive would be covered under the other coverage standards of this document, you still must be eligible for benefits under the Plan and your coverage must be in effect at the time you receive such Intervention in order to receive benefits. This Section sets out the standards for eligibility under the Plan, Subsection 4.1;

the policies for determining a Covered Person's effective date, Subsection 4.2; policies governing termination of coverage, Subsection 4.3; the options a person who has lost eligibility may have under state and federal law to continue coverage under the Plan, Subsection 4.4; and the rights a person who has lost eligibility may have to receive a Conversion Plan from the Company, Subsection 4.5.

4.1 **Eligibility for Coverage.** The following provisions outline the eligibility requirements for Retirees and Dependents by the Company. In order to be covered, you must meet either the requirements for a Retiree or a Dependent.

1. **Retiree Coverage.** To be eligible, a Retiree must:
   a. have met the requirements established by the Employer to participate in the Employer's Retiree welfare benefit plan;
   b. be eligible for and enrolled in Medicare Part A and Part B.
2. **Dependent Coverage.** Eligible Dependents are the Retiree's:
   a. Spouse or unmarried Child that has met the requirements established by the Employer to participate in the Employer's Retiree welfare benefit plan;
   b. be eligible for and enrolled in Medicare Part A and Medicare Part B.

   Note: Domestic partners are not eligible for coverage as Dependents under this Benefit Certificate.
3. **Additional Eligibility Requirements for Dependent Coverage.** No person may be covered both as a covered Retiree and a Dependent. No person may be covered as a Dependent by more than one covered Retiree.

4.2 **Effective Date of Coverage.** The following provisions outline the Company's policies relative to effective dates of coverage for Retirees and Dependents.

1. **Application and Effective Date.** In order for coverage to take effect, the Retiree must submit a written application for coverage for the Retiree and any Dependents. Subject to payment of the applicable premium and the Company's receipt of applicable enrollment forms, the effective date(s) of coverage shall be determined in accordance with this Subsection 4.2 and indicated by the Company on the ID card, Schedule of Benefits or letter issued to Covered Persons by the Company.
2. **Within 60 Days of Eligibility Date.** If a Retiree or eligible Dependent enrolls within sixty (60) days after first becoming eligible for coverage under the Plan, coverage will become effective on the first day of the Policy Month following the date of enrollment. However, if the date the Retiree or Dependent is first eligible for coverage falls on the first day of the Policy Month, the coverage will become effective at 12:01 a.m. on that day.
3. **Late Enrollment.** In the event a Retiree or eligible Dependent who is eligible for coverage fails to enroll within sixty (60) days of becoming eligible and subsequently requests enrollment, such Retiree or Dependent will not be eligible for coverage under the Plan unless the Retiree or Dependent is eligible for Special Enrollment as described in the next subsection.
4. **Special Enrollment Period** is a 30 day period during which time a Retiree or

Dependent may enroll in the Plan, after his or her initial Eligibility Date and not be a Late Enrollee**.** A Special Enrollment Period occurs (i) after a Retiree's or Dependent's coverage under another group health plan terminated as a result of Loss of Eligibility or (ii) after the employer providing such other health plan coverage terminated its contributions. The effective date will be the 1st day of the Policy Month following loss of prior coverage.

4.3 **Termination of Coverage.** The following provisions outline the Company's policies relative to termination of coverage for you and/or your Dependents.

1. **Termination of Coverage.** Coverage is subject to all terms and conditions of the Plan, and coverage will terminate under certain conditions described in various other places throughout this document. If coverage is not terminated under any other provision of this document, coverage for a Covered Person shall terminate if any of the following events occur:

   a. Coverage shall terminate at 12:00 midnight Central time on the date of event when:

      i. A Retiree or Dependent dies.

      ii. This Plan terminates.

      iii. The Employer to which the Group Policy is issued, terminates or ceases to sponsor the Plan.

   b. Coverage shall terminate at 12:00 midnight Central Time on the last day of the Policy Month in which the event occurs when:

      i. The Covered Person ceases to be eligible as a Retiree or Dependent for any reason.

      ii. The Covered Person is a Dependent Spouse who becomes legally separated or divorced from the Retiree.

   c. Any Covered Person's coverage shall terminate at 12:00 midnight Central Standard Time on the last day of the applicable premium period for which premium was paid if premium is not paid on or before the next premium due date.

2. **Termination of a Covered Person's Coverage for Cause.**

   a. **Bases for Termination.** The Company may terminate coverage under this Benefit Certificate, including termination by rescission of all coverage retroactive to the Covered Person's original effective date, upon fifteen (15) days' written notice for:

      i. concealment of information, misrepresentation (whether intentional or not) or fraud in obtaining coverage; or

      ii. concealment of information, misrepresentation (whether intentional or not) or fraud in the filing of a claim for services, supplies, or in the use of services or facilities.

   b. **Concealment or Misrepresentation.** For purposes of this termination for cause provision, concealment of information or a misrepresentation occurs if (i) information is withheld or if incorrect information is provided that is material to the risk assumed by the Company, or (ii) the

Company would not have issued this Benefit Certificate, would have charged a higher premium, or would not have paid a claim in the manner it was paid had the Company known the facts concealed or misrepresented, or (iii) there is a causal relationship between the concealed information or the incorrect information provided and an illness resulting in a claim under this Benefit Certificate.

c. **Termination Effective Date.** Rescission of coverage shall become effective on the Covered Person's original effective date. If the Company elects to terminate the coverage other than by rescission, the termination shall be effective upon the later of (i) fifteen (15) days after a written notice of termination for cause is posted in the U.S. Mail, addressed to the Covered Person at his or her last known address as provided by the Covered Person to the Company; or (ii) the date stated in the termination notice letter to Covered Person.

d. **Appeal Procedure.** A Covered Person may appeal a termination for cause. Such an appeal must be submitted in writing, addressed to the Appeals Coordinator of Arkansas Blue Cross and Blue Shield, 601 S. Gaines Street, Little Rock, Arkansas 72203. In order for the appeal to be considered the Appeals Coordinator must receive the appeal prior to the later of (i) fifteen (15) days after a written notice of termination for cause is posted in the U.S. Mail, addressed to the Covered Person at his or her last known address as provided by Covered Person to Company; or (ii) the termination effective date stated in the termination notice letter to Covered Person.

3. **Premium Refunds.** If the Company terminates the coverage of a Covered Person, premium payments received on account of the terminated Covered Person applicable to periods after the effective date of termination shall be refunded to the Employer within 30 days, and the Company shall have no further liability under this Group Policy.

   If the Employer terminates coverage of a Covered Person, the Employer must request the Company refund premiums paid for such Covered Person's coverage within 60 days from the effective date of termination of such coverage. Failure of the Employer to make a refund request within 60 days of the effective date of termination of the Covered Person's coverage shall result in the Employer waiving refund of any premiums paid for such coverage. If claims have been paid past the termination date, the payment amount of the claims will be deducted from premium refunds.

4. **Termination of the Group Contract, Impact on Covered Persons.** The coverage of all Covered Persons shall terminate if the Group Contract is terminated.

4.4 Continuation Privileges

1. **Continuation of Hospital Benefits When Group Contract is Replaced.** If a Covered Person is hospitalized on the date the Group terminates coverage with the Company and replaces the coverage with another company, coverage for the Covered Person will continue until the date the Covered

Person is discharged or until benefits under the Plan are exhausted, whichever occurs first.

2. **Continuation Rights under State Law**

   a. If a Dependent's dependency status changes the Dependent shall have the right under state law to elect continuation of coverage under the Plan as outlined below. In order to be eligible for this option, Dependent must:

      i. have been continuously covered under this Benefit Certificate for at least three (3) consecutive months prior to change in dependency status; and

      ii. make the election by notifying the Company in writing no later than ten (10) days after the change in dependency status.

   b. Continuation shall terminate on the earliest of:

      i. one hundred twenty (120) days after the date the election is made;

      ii. the date the Covered Person fails to make any premium payments or the Policyholder fails to pay the premium to the Company;

      iii. the date on which the Covered Person is covered for similar benefits under another group or individual Policy;

      iv. the date on which the Covered Person becomes eligible for similar benefits under another group Plan;

      v. the date on which similar benefits are provided for or available to the Covered Person under any state or federal law; or

      vi. the date on which the Group Policy terminates.

3. **Continuation Rights under Federal Law.** If Section 10001 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) applies to the Group, the coverage of a Retiree or Dependent whose coverage ends due to a Qualifying Event may be continued while the Group Contract remains in force subject to the terms of this Section and all terms and provisions of this Benefit Certificate not inconsistent with this Section.

   This provision shall not be interpreted to grant to any Covered Person any continuation rights under this Benefit Certificate in excess of those required by COBRA. If the Group fails to comply with the provisions of the Group Policy and this Benefit Certificate concerning COBRA or the notice requirements or other standards under COBRA, the Company shall not assume the Group's obligation to provide COBRA continued coverage under the Plan.

   a. **Qualifying Events.** The following is a list of events which could result in termination of a Covered Person's coverage under this Benefit Certificate. If such should occur, for purposes of this Section, the event shall be called a Qualifying Event.

Qualifying Event Causing Loss of Health Coverage	Covered Persons Eligible to Elect Continuation	Maximum Continuation Period
Retiree and Spouse divorce or legally separated	Spouse	36 months
Covered Dependent Child(ren) no longer qualified as Dependent under the Plan	Child(ren)	36 months
Retiree dies	Covered Dependent Spouse and Child(ren)	No Maximum, coverage continues as long as eligible and enrolled in the Plan.
Policyholder declares bankruptcy	Retiree and covered Dependents	18 months

b. **Requirements for COBRA Continuation.** Continuation under this Subsection is subject to a Covered Person requesting it and paying any required premium contributions to the Group within the applicable COBRA election period. In addition, all of the following conditions must be satisfied in order for COBRA continuation coverage to apply:

i. The Group must sponsor and maintain the Plan at the time of the qualifying event, as well as when the Covered Person elects to continue coverage; and

ii. The Group, as Plan Administrator, must have provided the Covered Person an initial notice of COBRA rights at the time coverage commenced under the Plan (this Benefit Certificate); and

iii. The Plan Administrator must notify the person qualified to elect continuation of coverage under COBRA ("Qualified Insured") of the right to elect coverage within 14 days of receiving notice of the happening of any of the qualifying events listed above; and

iv. The Covered Person must notify the Plan Administrator within 60 days of the happening of divorce or legal separation described in Section 4.4.3.a, above; and

v. The Covered Person must elect to continue coverage under the Plan within 60 days of the later of:

(1) the date the notification of election rights is sent, or

(2) the date coverage under the Plan terminates.

If an election is not made by the Covered Person within this 60-day period, the option to elect COBRA shall end.

If a Retiree with Dependent coverage requests continuation of coverage under this Section, such request shall include the Dependent coverage, unless the Retiree asks that it be dropped. In like manner, such a request on the part of the covered Spouse of a Covered Person shall include coverage for all Dependents of the Retiree who were covered.

c. **Coverage Continued.** The coverage continued for a Covered Person in accordance with this Section shall be the same as otherwise provided under this Benefit Certificate for other Covered Persons in the same benefit class in which such Covered Person would have been covered had his or her coverage not terminated.

d. **Effective date.** The effective date for COBRA continuation is the date coverage under the Plan terminates due to a qualifying event.

e. **Termination.** Once in effect, COBRA continuation coverage for a Covered Person under this Section shall terminate on the earliest to occur of the following applicable dates:

i. The date the Group Contract terminates;

ii. At the end of the last period for which premium contributions for such coverage have been made, if the Covered Person or other responsible person does not make, when due, the required premium contribution to the Group;

iii. The date ending the maximum period;

iv. The date the Covered Person becomes covered under any other group health plan that provides coverage for Preexisting Conditions;

v. The date the Covered Person's coverage is terminated for cause. See Section 4.3.2.c. above.

4.5 Conversion Privileges

1. **Eligibility.** If a Covered Person's coverage under the Plan terminates for any reason other than

a. failure to pay any sum required by the Group toward the cost of coverage under this Benefit Certificate, if any, or

b. cause (see Section 4.3.2) or,

c. the Group Contract being replaced by a health benefit plan provided by an organization other than the Company, then the Covered Person may apply for a conversion policy issued by the Company.

2. **Benefits.** The Conversion Policy will be Medi-Pak® Plan F at the premium rate in effect at the time of the conversion. The benefits in the Conversion Policy will not necessarily equal or match those benefits provided in the Group Contract. No evidence of good health or insurability will be required to effect the conversion.

3. **Written Application Deadline.** In order to obtain a Conversion Plan, written application to convert and payment of applicable premium charges must be

submitted to the Company within 30 days following the date on which the Company sends the Covered Person a notice of termination of coverage.

5.0 CLAIM PROCESSING AND APPEALS

The Company acting on behalf of the Plan has authority and full discretion to determine all questions arising in connection with your benefits, including but not limited to eligibility, interpretation of Plan language and findings of fact with regard to such questions. The actions, determinations and interpretations of the Company acting on behalf of the Plan with respect to all such matters, and with respect to any matter within the scope of its authority, shall be conclusive and binding on you and the Plan.

In reviewing a claim for benefits, the Company will apply the terms, conditions, exclusions and limitations of the Plan set out in this Benefit Certificate, including but not limited to the specific exclusions and limitations of the Plan, Section 3.0; and the eligibility standards of the Plan, Section 4.0.

This Section 5 sets out the procedures you must follow in submitting a request for coverage, called a "claim for benefits" or a "claim," with the Plan, Subsection 5.1. The section also describes your rights to appeal if a claim for benefits is denied either in whole or in part, Subsections 5.2. Finally, this section sets out how you may have an Authorized Representative to represent you in submitting claims or appeals, Subsection 5.3.

5.1 Claim Processing.

1. **Claim for Benefits.** "Claim for benefits" means (1) a request for payment for a service, supply, prescription drug, equipment or treatment covered by the Plan. Since the Plan pays benefits that supplement benefits covered by Medicare, the vast majority of claims result from notices the Company receives through the Medicare Crossover Program ("Crossover Claims") of Medicare benefits paid to Covered Persons.

   You must submit written proof of any service, supply, prescription drug, equipment or other treatment within 180 days after such service, supply, prescription drug, equipment or treatment was received. In the case of a claim for inpatient services for multiple consecutive days, the written proof must be submitted no later than 180 days following your date of discharge for that single admission.

2. **Who May Submit a Claim.** In addition to Crossover Claims, a Covered Person, a Provider with an assignment of the claim that is approved by the Company or the Covered Person’s Authorized Representative may submit a claim. See Subsection 5.3 below concerning the Authorized Representative.

3. **Information Reasonably Necessary to Process a Claim.**

   a. In order to be a claim, the submission must comply with the filing and coding policies and procedures established by the Company. You may request a copy of the claim coding policies and procedures from the Company or from your Provider. If the submission fails to comply with the claim filing or code policies or procedures, the Company shall return the submission to the person that submitted it.

b. In addition to the claim completed in accordance with the Company's claim filing procedures, depending upon the service, supply, prescription drug, equipment or treatment that is the subject of the claim, the Company may require one or more of the following items of information to enable the Company to determine whether or to what extent the claimed benefit is covered by the Plan:

   i. Information in order to determine if a limitation or exclusion of the Plan is applicable to the claim, or

   ii. Medical information in order to determine the price for a medical procedure, or

   iii. Information in order to determine if the Covered Person who received the claimed services is eligible under the terms of the Plan, or

   iv. Information in order to determine if the claim is covered by another health benefit plan, workers' compensation, a government supported program, or a liable third party, or

   v. Information in order to determine the obligation of each health benefit plan or government program under coordination of benefits rules, or

   vi. Information in order to determine if there has been fraud or a fraudulent or material misrepresentation with respect to the claim.

4. **Covered Person's Responsibility with Respect to Claim Information.** Before any benefits can be paid, you agree, as a condition of coverage under the Plan, to authorize and direct any Provider of medical services or supplies to furnish to the Company, its agents, or any of its affiliates, upon request, all records, or copies thereof, relating to such services or supplies. Further, as a condition of your coverage, you agree to authorize the release of such records to any third party review person or entity, for purposes of medical review or second opinion surgery. Finally, as a condition of coverage, you agree to fully and truthfully respond to inquiries from the Company about your claim or condition, including, but not limited to, your other insurance coverage, third party liability, or workers' compensation benefits and to request that any Physician or other Provider respond to all such inquiries. You understand and agree that your failure to respond to inquiries from the Company or failure to cooperate fully to obtain information requested by the Company from your Physician or other health care Provider shall be, by itself, grounds for denial of benefits under the Plan.

5. **Explanation of Benefit Determination.** Upon making a determination of a claim, the Company will deliver to you the following information:

   a. The specific reason or reasons for the determination;

   b. Reference to the specific plan provision(s) on which the determination is based;

   c. A description of any additional information necessary for the claim to be perfected and an explanation of why such information is necessary;

d. A description of the Plan's appeal process, see Subsection 5.2 below;

6. **Informal Claim Review.** If you have questions about an Explanation of Benefit Determination, you may contact Customer Service (Telephone (501) 378-2072 or toll free (800) 421-1112, or write Arkansas Blue Cross and Blue Shield, Customer Service, Post Office Box 2181, Little Rock, Arkansas 72203) and ask that the determination be reviewed. Customer Service will respond in like manner with answers to your request. This informal review is not an Appeal (see Subsection 5.2 below) nor a substitute for an appeal. Nor must you ask for an informal review in order to request an appeal.

7. **Benefit Inquiries.** From time to time you or your Provider may want an indication whether a service, supply, prescription drug, equipment or treatment is an eligible benefit of the Plan. You may make a benefit inquiry to Arkansas Blue Cross and Blue Shield Customer Service Division, Post Office Box 2181 Little Rock, Arkansas 72203, or by Telephone to (501) 378-2070 or toll free (800) 421-1112.

   a. **The Company's response to a benefit inquiry is not a guarantee of payment. The Company's ultimate determination of a claim will be based upon the relevant facts as applied to the terms, conditions, limitations and exclusions of the Plan.** A benefit inquiry is not a claim. The Company's response to a benefit inquiry is not a claim determination. The Company's response is based upon the information available to the Company at the time of the inquiry and such information may not be current or accurate. The Company reserves the right to make a final determination of the claim resulting from a health intervention that may have been the subject of a benefit inquiry after the intervention has been completed and all relevant facts are known.

   b. A benefit inquiry is not subject to appeal.

8. **Covered Person's Responsibility with Respect to Erroneous Claim Payments.** Despite our best efforts, we may make a claim payment which is not for a benefit provided under the Plan, or we may make payment to you when payment should have gone directly to the Provider of treatment or services instead. In the event of an erroneous or mistaken payment, you agree to refund the full amount of such payment to us promptly upon our request. If the Company does not receive the full amount of the refund due, the Company will have the right to offset future payments made to you or your Provider under this Policy/ Benefit Certificate or under any other Policy/Benefit Certificate you have with the Company now or in the future.

5.2 Claim Appeals to the Plan.

1. **Legal Actions**. Prior to initiating legal action, you must file an appeal of your claim in accordance with this Subsection 5.2. No legal action shall be brought after the expiration of three (3) years from the time that a claim is required to be submitted.

2. **Who May Request a Review.** A Covered Person or the Covered Person's Authorized Representative may file an appeal to request a review of a claim denial. See Subsection 5.3 concerning the Authorized Representative.

3. **Where and When (Deadline) to Submit an Appeal.** If a claim for benefits is denied either in whole or in part, you will receive a notice explaining the reason or reasons for the denial. See Subsection 5.1.5, above. You may request a review of a denial of benefits for any claim or portion of a claim by sending a request marked "Internal Review Request" to the Appeals Coordinator of Arkansas Blue Cross and Blue Shield, A Mutual Insurance Company, 601 S. Gaines Street, Little Rock, Arkansas 72203. Your request must be made within one hundred eighty (180) days after you have been notified of the denial of benefits.

4. **Documentation.**

   a. **Written Appeals.** You must submit your appeal in writing.

   b. **Appellant's Right to Information.** The Company shall provide you, upon request and free of charge, reasonable access to, and copies of, all documents, records or other information that:

      i. were relied upon in making the benefit determination;

      ii. were submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;

      iii. demonstrate compliance with the terms of the Plan.; or

      iv. constitute a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the your diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

   c. **Appellant's Right to Submit Information.** You may submit with your request for review any additional written comments, issues, documents, records and other information relating to your claim.

   d. **Appeals Coordinator Right to Information.** You and the treating health care professional are required to provide the Appeals Coordinator, upon request, access to information necessary to determine the appeal. Such information should be provided not later than five (5) days after the date on which the Appeals Coordinator's request. Your failure to provide access to such information shall not remove the obligation of the Appeals Coordinator to make a determination on the appeal, but the Appeals Coordinator's determination may be affected if such requested information is not provided.

5. **Conduct of Review.**

   a. **Scope of Review.** The Appeals Coordinator shall conduct a complete review of all information relating to the claim and shall not afford deference to the initial claim determination in conducting the review.

   b. **Qualifications of Appeals Coordinator.** The Appeals Coordinator is an individual with appropriate expertise who is neither the individual who denied the claim that is the subject of the appeal, nor the

subordinate of such individual.

c. **Review of Medical Judgment.** When reviewing a claim in which the determination was based in whole or in part on medical judgment, the Appeals Coordinator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional shall not be an individual that was consulted in the initial claim determination, nor the subordinate of such individual. The Appeals Coordinator shall, upon request, provide the identity of health care professional(s) consulted in conducting the review, without regard to whether the health care professional's advice was relied upon in making the benefit determination.

6. **Timing of Appeal Determination.** The Appeals Coordinator shall render a decision on an appeal related to a claim within a reasonable period of time, but notification of the Appeals Coordinator's determination shall be provided to you not later than sixty (60) days after the Appeals Coordinator received the appeal.

7. **Notification of Determination of Appeal to Plan.** The Appeals Coordinator shall provide notice of the review determination in a printed form and written in a manner calculated to be understood by the claimant. The notice shall include:

   a. The specific reason or reasons for the review determination;

   b. reference to the specific plan provision(s) on which the review determination is based;

   c. 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 the Claim for benefits;

   d. a statement that any internal rule, guideline, protocol or other similar criterion relied upon by the Plan is available upon request and free of charge;

   e. a statement describing the voluntary external review procedures offered by the Plan; and

   f. a statement of the claimant's right to bring an action under the Employee Retirement Income Security Act of 1974.

5.3 Authorized Representative

1. **One Authorized Representative.** A Covered Person may have one representative, and only one representative at a time, to assist in submitting a claim or appealing an unfavorable claim determination.

2. **Authority of Authorized Representative.** An Authorized Representative shall have the authority to represent the Covered Person in all matters concerning the Covered Person's claim or appeal of a claim determination. If the Covered Person has an Authorized Representative, references to "You" or "Covered Person" in this document refer to the Authorized Representative.

3. **Designation of Authorized Representative.** One of the following persons

may act as a Covered Person's Authorized Representative:

a. An individual designated by the Covered Person in writing in a form approved by the Company;

b. The treating Provider, if the claim is a claim involving urgent care, or if the Covered Person has designated the Provider in writing in a form approved by the Company;

c. A person holding the Covered Person's durable power of attorney;

d. If the Covered Person is incapacitated due to illness or injury, a person appointed as guardian to have care and custody of the Covered Person by a court of competent jurisdiction; or

e. If the Covered Person is a minor, the Covered Person's parent or legal guardian, unless the Company is notified that the Covered Person's claim involves health care services where the consent of the Covered Person's parent or legal guardian is or was not required by law and the Covered Person shall represent himself or herself with respect to the claim.

4. **Communication with Authorized Representative.**

a. If the Authorized Representative represents the Covered Person because the Authorized Representative is the Covered Person's parent or legal guardian or attorney in fact under a durable power of attorney, the Company shall send all correspondence, notices and benefit determinations in connection with the Covered Person's claim to the Authorized Representative.

b. If the Authorized Representative represents the Covered Person in connection with the submission of a pre-service claim, including a claim involving urgent care, or in connection with an appeal, the Company shall send all correspondence, notices and benefit determinations in connection with the Covered Person's claim to the Authorized Representative.

c. If the Authorized Representative represents the Covered Person in connection with the submission of a post-service claim, the Company will send all correspondence, notices and benefit determinations in connection with the Covered Person's claim to the Covered Person, but the Company will provide copies of such correspondence to the Authorized Representative upon request.

5. **Term of the Authorized Representative.** The authority of an Authorized Representative shall continue until

a. the claim(s) or appeal(s) for which the Authorized Representative was designated has been fully adjudicated; or

b. the Covered Person is legally competent to represent himself or herself and notifies the Company that the Authorized Representative is no longer required.

6.0 OTHER PROVISIONS

The following information is important in the administration of the Plan.

6.1 **Assignment of Benefits.** No assignment of benefits under this Benefit Certificate shall be valid until approved and accepted by the Company. The Company reserves the right to make payment of benefits, in its sole discretion, directly to the Provider of service or to you.

6.2 **Right of Rescission.** Material misrepresentation, misstatements or omissions of information may be used by the Company as the basis for rescission of coverage of the Policyholder, any Retiree or any Dependent.

6.3 **Claim Recoveries.** There may be circumstances in which the Company recovers amounts paid as claims expense from a Provider of services, from a Covered Person or from a third party. Such circumstances include rebates paid to the Company by pharmaceutical manufacturers based upon amounts of claims paid by the Company for certain specified pharmaceuticals, amounts recovered by the Company from health care Providers or pharmaceutical manufacturers through certain legal actions instituted by the Company relating to the claims expense of more than one Covered Person, recoveries by the Company of overpayments made to health care Providers or to Covered Persons, and recoveries from other parties with whom the Company contracts or otherwise relies upon for payment or pricing of claims. The following rules govern the Company's actions with respect to such recoveries:

1. In the event that such a recovery relates to a claim paid more than two years before the recovery, no adjustment will be made to any Deductible or Coinsurance paid by a Covered Person and the Company shall be entitled to retain such recoveries for its own use.

   If the recovery relates to a claim paid within two years and is not otherwise addressed in this subsection, Deductibles and Coinsurance amounts for a Covered Person will be adjusted if affected by the recovery.
2. Only recoveries made within two years of the date of the error by the Company or overpayments to health care Providers or to Covered Persons by the Company will be applied for the purpose of group rating or divisible surplus calculation, if applicable. The cost actually paid by the Company to procure such recoveries will be treated as an administrative expense in considering group rating or divisible surplus, if applicable.
3. In the event the Company receives from pharmaceutical manufacturers rebates based upon amounts of claims paid for certain specified pharmaceuticals, the Company shall be entitled to retain such rebates for its own use, and no adjustments will be made to claims paid or to Deductibles or Coinsurance amounts paid by a Covered Person.
4. If a Covered Person is no longer covered by the Company at the time of any such recovery, regardless of the amount or of the time of such recovery, the Company shall be entitled to retain such recovery for its own use.
5. If such recovery amounts cannot be attributed on an individual basis, because of having been paid as a lump sum settlement for less than the total amount

of claims expense of the Company or otherwise, no adjustments will be made to any Deductible or Coinsurance amounts paid by the Covered Person and the Company shall be entitled to retain such recovery for its own use.

6.4 **Amendment.** The Company reserves the right to change the benefits, conditions and premiums covered under the Group Policy or Group Insurance Contract, including the terms of this Benefit Certificate. If we do so, we will give thirty (30) days written notice to your Employer or its agent and the change will go into effect on the date fixed in the notice. No agent or employee of the Company may change or modify any benefit, term, condition, limitation or exclusion of this Benefit Certificate. Any change or amendment must be in writing and signed by an officer of the Company.

6.5 **Physician Incentives.** In some parts of Arkansas, but not necessarily in the whole State, the Company may offer incentives to encourage Physicians to practice medicine in a cost-effective manner. Physicians located in part of Arkansas may be entitled to incentive payments in the event that Medical Trends for that part of Arkansas are lower than Medical Trends for the State as a whole for a given year. The incentive payments will be calculated based on a percentage of total medical claims received from the Physicians practicing in that part of Arkansas and will reflect the lower Medical Trends for that part of Arkansas. A Covered Person may want to ask their Physician's administrative staff about compensation methods, including incentives, which apply to the services provided by their Physician.

6.6 **Insurance Department.** Arkansas Blue Cross and Blue Shield is an insurance company regulated by the Arkansas Insurance Department. You have the right to file a complaint with the Arkansas Insurance Department (AID). You may call AID to request a complaint form at (800) 852-5494 or (501) 371-2640 or write the Department at: 1 Commerce Way, Suite 102, Little Rock, Arkansas 72202.

7.0 GLOSSARY OF TERMS

7.1 **Benefit Period** means the period beginning on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for sixty (60) days in a row.

7.2 **Certificate** and **Benefit Certificate** means this certificate of insurance containing the benefits, conditions, limitations and exclusions of the Group Insurance Contract plus the Schedule of Benefits and any amendments signed by an Officer of the Company.

7.3 **Coinsurance** is the part of the charges you must pay:

1. for Medicare approved hospital services;
2. for Medicare approved Physician services; and,
3. for Medicare approved Skilled Nursing Facilities.

7.4 **Company** means Arkansas Blue Cross and Blue Shield.

7.5 **Deductible** means:

1. Part A inpatient hospital deductible applied by Medicare; and

2. Part B calendar year deductible applied by Medicare.

7.6 **Dependent** means any member of a Retiree's family who meets the eligibility requirements of Section 4.0, who is enrolled in the Group, and for whom the Company has received premium.

7.7 **Effective Date** is the date shown on the identification card. Coverage begins on that date, at 12:01 a.m.

7.8 **Employer** means a sole proprietorship, partnership, or corporation which is the Policyholder. Employer, Group and Policyholder shall have a common meaning when used herein.

7.9 **Extended Care Services** means those services and supplies to which you would be entitled under Medicare while a patient in a Skilled Nursing Facility.

7.10 **Inpatient Hospital Services** means those services and supplies to which you are entitled under Medicare as an inpatient in a Participating Hospital.

7.11 **Group Policy or Group Insurance Contract** means the insurance policy issued by the Company to the Employer.

7.12 **Medicare** means the two programs cited as the "Health Insurance for the Aged Act," Title I, Part I, of Public Law 89-97, as amended. Part A refers to Hospital insurance. Part B refers to supplementary medical insurance.

7.13 **Medicare Eligible Expense** means expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

7.14 **Participant, Covered Person** and **Member** mean the person who signed the application or was automatically enrolled and to whom this certificate is issued.

7.15 **Participating Hospital** means a hospital certified by and participating in Medicare.

7.16 **Physician** means a provider of services or supplies to a Medicare eligible recipient and who is entitled to payment therefore under Medicare.

7.17 **Plan** means the employee health benefit plan established by your former Employer. The terms of the Plan are set forth in the Group Policy or Group Insurance Contract between the Company and your former Employer.

7.18 **Plan Administrator** means the former Employer.

7.19 **Plan Year** means the Plan Year stated in the Employee Health Benefit Plan Summary Plan Description, or if not stated in that document, or if that document does not exist, the twelve month period ending on the day before the anniversary date of the effective date of this Policy.

7.20 **Policy** means the Group Policy or Group Insurance Contract.

7.21 **Policy Month** means a month commencing on the first day of a calendar month and expiring on the last day of that calendar month or commencing on the fifteenth day of a month and expiring on the fourteenth day of the following month, depending upon the billing cycle applied by the Company.

7.22 **Policyholder** means the Employer that established and maintains the Plan, as shown in the Application of the Group Insurance Policy.

7.23 **Relevant to the Claim** means a document, record or other information that:

1. was relied upon in making the benefit determination;

2. was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;

3. demonstrates compliance with the administrative processes and safeguards required by 5.2.4.b.; and

4. constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Covered Person's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

7.24 **Regulations** mean the rules and policies of the Secretary of Health and Human Services that apply to Medicare.

7.25 **Retiree** means a person who previously qualified for coverage as an Employee under the terms of the employee health benefit Plan established by the Employer, who is enrolled in the Plan as a Retiree and for whom the Company receives a premium.

7.26 **Secretary** means the Administrator of Medicare under the United States Department of Health and Human Services.

7.27 **Skilled Nursing Facility** means a skilled nursing facility certified by and participating in Medicare.

7.28 **United States** refers to the fifty (50) states plus the District of Columbia, Puerto Rico, Guam, American Samoa, and the Virgin Islands.

7.29 **We, Our and Us** mean the Company.

7.30 **You** and **Your** means the Retiree or other Covered Person.

8.0 YOUR RIGHTS UNDER ERISA

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). This information and the information contained in this Benefit Certificate constitute the Summary Plan Description required by ERISA.

8.1 Information about the Plan

As a participant in the Plan described in this Benefit Certificate, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA provides that all plan participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office all plan documents, including insurance company contracts, 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 applicable plan documents and other plan information upon written request to the Plan Administrator. The administrator may make a reasonable charge for the copies.

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.

8.2 Continuation of Coverage

The Plan provides an opportunity to continue coverage for yourself, spouse, dependents if there is a loss of coverage under the Plan as a result of a qualifying event. See Subsection 4.2.5. You or your dependents may have to pay for such coverage. Review this Benefit Certificate, Subsection 4.4.3 and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

8.3 Creditable Coverage

You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment in your coverage.

8.4 Prudent Actions by Plan Fiduciaries

1. 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 the Plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other participants and beneficiaries.
2. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in a way to prevent you from obtaining a benefit or exercising your rights under ERISA.

8.5 Enforce your Rights

1. If your claim for a benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim.
2. 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 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the 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 is frivolous.

8.6 Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator.

If you have any questions about this statement or your rights under ERISA, you should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

8.7 Claim and Appeal Procedures

The Plan rules and procedures for filing claims and seeking review of adverse claim determinations are set forth in Section 7.0 of this Benefit Certificate.

8.8 Important Information about the Plan

Name of Plan:	CENTRAL ARKANSAS WATER Employee Health Benefit Plan
Employer:	CENTRAL ARKANSAS WATER ATTN: HUMAN RESOURCES DIRECTOR PO BOX 1789 LITTLE ROCK AR 72203
Employer Identification Number:	71-0854036
Type of Plan:	Employee Group Health Plan
Type of Administration	Insurer underwritten and administered

Plan Administrator:	CENTRAL ARKANSAS WATER ATTN: HUMAN RESOURCES DIRECTOR PO BOX 1789 LITTLE ROCK AR 72203
Agent for Service of Legal Process	Tim Gauger Senior Vice President & Chief Legal Officer Arkansas Blue Cross and Blue Shield 601 Gaines Street Little Rock, Arkansas 72201
Health Insurance Issuer	Benefits under the Plan are financed through a Group Health Insurance Policy issued by Arkansas Blue Cross and Blue Shield 601 Gaines Street Little Rock, AR 72201
Plan Year:	01/01/2026 - 12/31/2026

Curtis Barnett, President and Chief Executive Officer

ARKANSAS BLUE CROSS AND BLUE SHIELD
601 S. Gaines Street
Little Rock, Arkansas 72201

Innovative Fitness Program Rider
Silver Sneakers®

Introduction

This Rider makes benefits available for Member's participation in and services received in a specified Silver Sneakers® Fitness Program.

Definitions

Participating Fitness Facility means an Arkansas Blue Cross and Blue Shield approved individual health club, exercise site or wellness studio located in Arkansas, designated and accepted as a Participating Fitness Facility by Arkansas Blue Cross and Blue Shield to provide a Silver Sneakers® Fitness Program to Members under the terms of this Rider.

Silver Sneakers® Fitness Program means a program that includes exercise classes and basic fitness membership services for Arkansas Blue Cross and Blue Shield Members provided through a Participating Fitness Facility. Basic fitness membership services are defined by each Participating Fitness Facility.

Benefits

The Member is entitled to attend, at least once per week, a Silver Sneakers® Fitness Program at any Participating Fitness Facility, at no cost to the Member.

Limitations

Basic fitness membership services exclude all those programs, services and facilities which carry additional charges such as racquetball, tennis and other court sports, massage therapy, lessons related to recreational sports, tournaments, and similar fee-based activities.

Arkansas Consumers Information Notice

For additional information regarding your Arkansas Blue Cross and Blue Shield benefits, please feel free to contact us at:

Arkansas Blue Cross and Blue Shield
Customer Service
Post Office Box 2181
Little Rock, Arkansas 72203
Telephone (501) 378-2010 or toll free (800) 421-1112

If we at Arkansas Blue Cross and Blue Shield fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
1 Commerce Way, Suite 102
Little Rock, AR 72202
Telephone (501) 371-2640 or toll free (800) 852-5494
Email: insurance.consumers@arkansas.gov

LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy and contract owners who live in this state and, in some cases, to keep coverage in force. Please note that the valuable extra protection provided by the member insurers through the Guaranty Association is limited. This protection is not a substitute for a consumers' careful consideration in selecting insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") provides coverage of claims under some types of policies or contracts if the insurer or health maintenance organization becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are significant limits and exclusions. Coverage is always conditioned on residence in the State of Arkansas. Other conditions may also preclude coverage.

The Guaranty Association will respond to any questions you may have which are not answered by this document. Your insurer or health maintenance organization and agent are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy or health maintenance organization coverage.

You should not rely on availability of coverage under the Guaranty Association when selecting an insurer or health maintenance organization.

The Arkansas Life and Health Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol, Suite 2
Little Rock, Arkansas 72201

Arkansas Insurance Department
1 Commerce Way, Suite 102
Little Rock, Arkansas 72202

The state law that provides for this safety net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"), which is codified at Ark. Code Ann. §§ 23-96-101, et seq. Below is a brief summary of the Act's coverage, exclusions and limits. This summary does not cover all provisions of the Act, nor does it in any way change any person's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state; or
- Their policy or contract was issued by a hospital or medical service organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends, voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employer plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contract holders, not individuals);
- Unallocated annuity contracts issued to or in connection with benefit plans protected under the Federal Pension Benefit Corporation ("FPBC"), regardless of whether the FPBC is yet liable;
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution;
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by state or federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, claims for policy misrepresentations, and extra-contractual or penalty claims; or
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliated benefit plan or its trustee(s).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 in life insurance death benefits without regard to the number of policies and contracts there were with the same company, even if they provided different types of coverages. The Guaranty Association will pay a maximum of $500,000 in health benefits, provided that coverage for disability insurance benefits and long-term care insurance benefits shall not exceed $300,000. The Guaranty Association will pay $300,000 in present value of annuity benefits, including net cash surrender and net cash withdrawal values. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity benefits. These are limitations under which the Guaranty Association is obligated to operate prior to considering either its subrogation and assignment rights or the extent to which those benefits could be provided from assets of the impaired or insolvent insurer.

INDEX

A

B

C
CLAIM PROCESSING AND APPEALS 23

D

G
GLOSSARY OF TERMS 30

I
INNOVATIVE FITNESS PROGRAM RIDER 36
INTRODUCTION 14

M
MEDICARE EXTENDED HOSPITAL SERVICES 14
MEDICARE PART B SERVICES . . . 15

O
OTHER PROVISIONS 37

S
SILVER SNEAKERS 36

V