

Bylaws of the Municipal Health Benefit Program

Effective December 1, 1981 (As Amended January 1, 2024)



The Municipal Health Benefit Program (“Program”) is a self-funded trust of municipalities. The Program is not governed by the Rules and Regulations of the Insurance Department of the State of Arkansas but is regulated by its Board of Trustees and follows the rules of the Affordable Care Act.

Mandatory Administrative Appeals Procedure

As a condition precedent to all the benefits, terms and conditions of this Program, an Employer member and its Employee Members must agree to exhaust all their administrative remedies including, but not limited to, the claims procedures, the internal review procedures, including review by the Board of Trustees, and, to the extent available, federal external review processes, before any legal action is brought in any court.

Program Administrative Office
P.O. BOX 188, North Little Rock, AR 72115
501-978-6137

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Declaration of Trust

The provisions of this Health Benefit Plan Booklet (“Program Booklet”) are authorized by the Declaration of Trust, the document that created the Program. The terms of this Program Booklet are subject to the terms and conditions of the Declaration of Trust as amended.

This Program Booklet describes benefits that may be available to you under the Program. Consult your Employer to determine the specific benefits available to you under the Program.

Group health plans sponsored by state and local governmental employers must generally comply with federal law requirements. However, these employers are permitted to elect to exempt a plan from the requirements listed below for any part of the plan that is “self-funded” by the employer rather than provided through a health insurance policy.

The Program has elected to exempt the Program from all of the following requirements:

1. Standards relating to benefits for mothers and newborns.
2. Standards relating to the Mental Health Parity and Addiction Equity Act.
3. Certain requirements to provide benefits for breast reconstruction after a mastectomy.
4. Standards relating to the Women’s Health and Cancer Rights Act.
5. The exemption from these Federal requirements will be in effect for the 2024 plan year that begins on January 1, 2024, and ends on December 31, 2024.
6. This election may be renewed for subsequent plan years.

Patient Privacy

The Program does not sell, market or otherwise distribute your medical and personal health care information. However, the Program may release medical information to persons who are engaged in the determination of claim eligibility and for the processing or appeal of a claim.

The specifics of coverages provided by the Program are contained in the following pages.



Mark R. Hayes
Plan Administrator

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Section 1: General Eligibility Information

General Eligibility Information

Eligibility Dates—If you are an employee or member of an Eligible Class, you will become eligible for benefits on (a) the date your Employer becomes a Participating Employer, or (b) the first day of the calendar month following the date you have continuously been a member of such class for 60 consecutive days (with the exception of February), whichever is later. For members of Class 1, you will become eligible on the first day of your term of office.

Eligible Class—The Eligible Classes include employees, elected officials, members of boards and commissions, and other individuals who are eligible for Coverage under the Program.

Eligible Classes include the following:

- **Class 1**—Active elected officials (including those appointed to an elected office)
- **Class 2**—Members of boards and commissions
- **Class 3**—Volunteer firefighters
- **Class 4**—Auxiliary police
- **Class 5**—Full-time employees of a Participating Employer
- **Class 6**—Retired members age 55 or over (See Retiree Coverage for further details.)

Coverage under the Program must be offered to all full-time active employees of a Participating Employer who work an average of 30 hours or more per week (Class 5). Coverage under the Program may be offered to individuals belonging in any of the other classes subject to the election of a Participating Employer, and other requirements of the Program (Classes 1-4, 6). If you are a member of a class other than Class 5, consult your Participating Employer to determine if you may be a member of an Eligible Class.

Special Provisions related to individual Eligible Classes:

Classes 1-4—Members of these Eligible Classes are not eligible for medical Coverage under the Program if they are eligible for Medicare.

Class 1—Active elected officials and their Eligible Dependents (i.e. spouse) who are on Medicare are eligible for dental, vision, drug card and hearing aid Coverage. Enrollment in all parts of Medicare, Parts A, B and D, is required for active elected officials choosing to continue Coverage under the dental, vision, drug card and hearing aid Coverage benefits.

Eligibility Requirements

To be covered under the Program, you must enroll in the Program as of your Eligibility Date and agree to make any required premium contributions. If you do not enroll yourself and your Eligible Dependents before your Eligibility Date, you may not enroll or change your Coverage election until the next Open Enrollment Period unless you have a Qualifying Event described in this Booklet.

An Eligible Dependent is a dependent of an employee who is eligible for Benefits under the Program and includes the following:

- **An Employee's Spouse**—Not legally separated or divorced from the Employee;
- **An Employee's Adult Dependent**—A Dependent (other than the Employee's spouse) who is between age 19 to age 26;
- **An Employee's Child**—Under the age of 19 years; the term Child(ren) shall include:
 - a. An Employee's natural child(ren) from birth until less than 19 years of age.
 - b. An Employee's stepchild(ren), foster child(ren), adopted child(ren), or child(ren) under legal guardianship or legal custody, if such child depends primarily on the Employee for support and maintenance and lives with the Employee in a regular parent-child relationship.
 - c. Adopted children and stepchildren ages 19 to 26 must have met the above requirements at the time the Child turned 19 to be considered an Eligible Dependent. Copies of supporting documentation will be required for these Dependents.

Open Enrollment

Open Enrollment is the period immediately preceding the beginning of each calendar year as established by the Board of Trustees, during which an Employee may enroll or change his or her Coverage selections under the Program. At times, the Board of Trustees may recommend a mid-year Open Enrollment Period, and if approved, the mid-year enrollment period will be the period immediately preceding July of each calendar year.

Special Enrollment Periods/Qualifying Event

There are certain life events that will require you to change your Coverage outside of the Program's Open Enrollment period. These are called "Qualifying Events." Except as otherwise provided below, you must apply for or request a change of Coverage within 30 days from the date of the Qualifying Event and provide any requested supporting documentation. **Except for the birth or the adoption of a child, the effective date of Coverage related to the Qualifying Event will be the first day of the month coincident with or immediately following the occurrence of the Qualifying Event.**

Qualifying Events:

1. You gain or lose an Eligible Dependent through marriage or divorce.
2. You gain or lose an Eligible Dependent through birth or adoption, or through legal guardianship or custody. New Coverage for you and your Eligible Dependent will be effective on the date of the birth or adoption. However, the effective date for an Eligible Dependent acquired through legal guardianship or custody will be the first day of the month coincident with or immediately following the date of the legal guardianship or custody.
3. Your Eligible Dependent loses his or her health Coverage. You must provide a letter from your Eligible Dependent's previous health Coverage carrier showing the date health Coverage terminated (sometimes referred to as "Letter of Creditable Coverage").

In order to change your Coverage due to a Qualifying Event, you must complete a *Change of Status Form* (available from your Employer or the Program) and provide a copy of supporting documentation of the Qualifying Event within 30 days of the date of the Qualifying Event (unless adding an Eligible Dependent as described below to existing family Coverage). If you do not add a newly acquired Eligible Dependent(s) within these guidelines, you may not enroll the Eligible Dependent(s) until the next Open Enrollment Period.**

****60 Days to Add an Eligible Dependent through Birth or Adoption**

You may apply for or request a change of Coverage within **60 days** from the date of birth or adoption of a child. The Eligible Dependent must be added within 60 days of their date of birth or adoption regardless if a Social Security Number has been received. If the Eligible Dependent is not added to your Coverage within 60 days of their date of birth, adoption, or placement, the newborn may not be eligible for Coverage until the next Open Enrollment Period.

Supporting documentation required for certain Qualifying Events:

Adding an Eligible Dependent through Marriage or Divorce—Copy of the marriage license, and/or divorce decree with settlement agreement instructing which party is to cover dependents (if available, otherwise Coordination of Benefits Rules will apply).

Adding an Eligible Dependent through Birth or Adoption—Copy of the birth certificate, certificate or record of live birth, Adoption decree.

Adding an Eligible Dependent through Court-Order—Copy of the court order obligating Employee to cover an Eligible Dependent or bestowing legal guardianship or legal custody of the Eligible Dependent upon the Employee.

Retiree Coverage

The Program will provide Retiree Coverage consistent with the Participating Employer's established criteria, provided a written copy of the ordinance or policy is furnished to the Program by January 1 of the Program year. If no ordinance or policy is provided, then the Program will provide Retiree Coverage as authorized by state law.

For municipalities, state law allows a retired employee or official (excluding police officers) to participate in the health care plan of the Participating Employer if the retiring municipal official or employee:

- Is receiving a retirement benefit from the Arkansas Local Police and Fire Retirement System, Arkansas Public Employees Retirement System, or a local pension fund;

- Pays both the Employer and Employee contribution to the Program;
- Is not covered at any time during retirement by another health care plan; and
- Notifies the Employer within 30 days of the official date of retirement of their intent to participate in the Program. The retired employee or official may include his or her Eligible Dependents in the Program provided the dependent premium is paid. (Ark. Code Ann. § 24-12-132)

For eligible police officer retirees employed by a Participating Employer, state law allows those officers to participate in the health care plan offered by the municipality or county if:

1. The officer is an eligible police officer, which means:
 - a. Law enforcement officer engaged in official duty who is a member of any regular or auxiliary police force of a municipality or county on a full-time or part-time basis, including sheriffs, sheriff deputies, constables and night marshals;
 - b. Eligible to retire with full retirement benefits under Arkansas Local Police and Fire Retirement System, Arkansas Public Employees Retirement System, a municipal or county retirement system, or a local pension fund;
 - c. Is at any age with twenty-eight (28) years of credited service; at least fifty-five (55) years of age and has at least twenty (20) years of credited service; at least sixty years of age and has at least five (5) years of credited service; or at least sixty (60) years of age and has at least ten (10) years of actual Arkansas Local Police and Fire Retirement System service credit.
2. The officer is not eligible for Medicare enrollment;
3. Pays the portion of the premium as determined by the municipality or county or the cost of the policy issued to the eligible police officer.
4. Notifies the Employer within sixty (60) days from the date of retirement of their intent to participate in the Program. The eligible police officer may include his or her Eligible Dependents in the Program as well. (Ark. Code Ann. § 14-1-110)

Please refer to the ordinance or policy of your Participating Employer, or to the applicable state law, for more information.

Important Information

It is the Member's responsibility to notify the Program of any change to the Member's, or his or her Eligible Dependent's name or address, or other changes to eligibility.

Adult Dependents must be added to the Program during an Open Enrollment Period prior to their 26th birthday to be Covered under their parent's health Coverage. Adult Dependents are not entitled to Coverage upon attaining the age of 26 years. Coverage for an Adult Dependent will end on the first day of the Month coincident with or immediately following his or her attainment of 26 years of age.

Members moving from one covered group to another without a lapse in Coverage do not have to meet the 60-day employment requirement. If this provision applies to you, please contact the Program Director for additional information.

Special Notice—Coverage will not be changed for the Member to add or drop Family Coverage without the Member's and/or the Participating Employer's notification at the time of the event. The Program will not credit premiums for failure to notify the Program as required.

Family Medical Leave Act—The Program recognizes and complies with the Family Medical Leave Act of 1993 for Participating Employers who employ 50 or more employees for at least 20 work weeks in the current or preceding calendar year. Your Employer must notify the Program in writing at its administrative offices if you have left your employment under provisions of the Family Medical Leave Act.

Certificate of Group Health Plan Coverage—Under the 1996 HIPAA regulations, the Program will provide a terminating Member a "Certificate of Group Health Plan Coverage." You may need this certificate for enrolling in a new plan or in purchasing insurance. Ask your Employer for details.

When Your Benefits Stop

When your employment ceases, your Coverage under the Program also ends, albeit on the last day of the Month in which your employment ceases, or in which you receive your final paycheck, whichever is the earlier date. Coverage ends whether you leave your employment, retire, die or go on unpaid leave of absence. If you cease being a member of an Eligible Class, your Coverage will end on the last day of the Month in which you cease being a member of an Eligible Class.

In addition to the above, your Coverage under the Program is also terminable for failure to make premium payment. Your Coverage will end on the earliest of:

- The last day for which your premium has been paid.
- When the Participating Employer fails to make the required premium payments. Coverage will be suspended if monthly premium payments are thirty (30) days past due and Coverage will be terminated if monthly premium payments are sixty (60) days past due.
- When the Participating Employer cancels Coverage under the Program.

Your Eligible Dependents' Coverage under the Program will automatically terminate on the earliest of:

- The date your personal Coverage terminates.
- The last day for which your Eligible Dependents' premium has been paid.
- The last day of the Month following your termination from the payroll of your Employer.
- The date Coverage for Eligible Dependents is terminated under the Program.
- For any Eligible Dependent, the last day of the Month in which he or she ceases to be an Eligible Dependent.
- The last day of the Month you cease to meet the eligibility requirements as defined herein.

Eligibility as a Dependent will cease:

- a. For any Dependent, on the date he or she becomes covered individually under the Program, enters active service with the armed forces of any country, or otherwise ceases to be in a covered classification according to the definition of an Eligible Dependent;
- b. For your Spouse, the end of the month following the date of divorce or legal separation; and
- c. For your Adult Dependent, the end of the month following the attainment of age 26.

However, if your Adult Dependent is incapable of sustaining employment by documented reason of mental disability or physical handicap following attainment of age 26 and if Covered hereunder up to that time, your Adult Dependent will continue to be an Eligible Dependent so long as he or she remains continuously in that condition, provided you notify the Program and such condition actually exists. If there is a conflict between dates when Coverage could end, the earliest date governs. Additionally, the Program will not pay for services or supplies furnished after the date Coverage ends, even if the Program pre-certifies or provides Benefit information for a treatment plan submitted before the end of Coverage.

Right to Continuation Coverage under COBRA

The right to COBRA continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation Coverage can become available to you when you would otherwise lose your group health Coverage. It can also become available to other members of your family who are Covered under the Program when they would otherwise lose their group health Coverage.

The COBRA notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of Coverage under the Program. This notice, which will be mailed to you at your last address on file, generally explains COBRA continuation Coverage, when it may become available to you and your family and what you need to do to protect the right to receive it.

What is COBRA Continuation Coverage?

COBRA continuation Coverage is a continuation of Program Coverage when Coverage would otherwise end because of a life event known as a "Qualifying Event." Specific Qualifying Events are listed later in this notice. After a Qualifying Event, COBRA continuation Coverage must be offered to each person who is a "Qualified Beneficiary." You, your spouse, and your dependent children could become Qualified Beneficiaries if Coverage under the Program is lost because of a Qualifying Event. Under the Program, Qualified Beneficiaries who elect COBRA continuation Coverage must pay for COBRA continuation Coverage.

If you are an Employee, you will become a Qualified Beneficiary if you lose your Coverage under the Program because either one of the following Qualifying Events happens:

- Your hours of employment are reduced.
- Your employment ends for any reason other than your gross misconduct.

If you are the Spouse of an Employee, you will become a Qualified Beneficiary if you lose your Coverage under the Program because any of the following Qualifying Events happens:

- Your spouse dies.
- Your spouse's hours of employment are reduced.
- Your spouse's employment ends for any reason other than his or her gross misconduct.
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both).
- You become divorced or legally separated from your spouse.

Your dependent children will become Qualified Beneficiaries if they lose coverage under the Program because any of the following Qualifying Events happens:

- The parent-employee dies.
- The parent-employee's hours of employment are reduced.
- The parent-employee's employment ends for any reason other than his or her gross misconduct.
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both).
- The parents become divorced or legally separated.
- The child stops being eligible for Coverage under the Program as a "Dependent Child."

When is COBRA Coverage Available?

The Program will offer COBRA continuation Coverage to Qualified Beneficiaries only after the Program has been notified that a Qualifying Event has occurred. A "Qualified Beneficiary" is the Employee, covered Spouse, and/or covered Eligible Dependent at the time of the Qualifying Event. When the Qualifying Event is the end of employment or reduction of hours of employment, death of the Employee or the Employee becoming entitled to Medicare benefits (under Part A, Part B or both), the Employer must notify the Program of the Qualifying Event.

Notice Must Be Given of Some Qualifying Events

For the other Qualifying Events (divorce or legal separation of the Employee and Spouse or a Dependent child losing eligibility for Coverage as a Dependent child), you must notify the Program within 60 days after the Qualifying Event occurs. You must provide this notice to:

MHBP Eligibility & Enrollment

Municipal Health Benefit Program

P.O. Box 188

North Little Rock, AR 72115

How can you elect COBRA continuation Coverage?

To elect continuation Coverage, you must complete the Election Form provided by the Program or your Employer and furnish it according to the directions on the Form. Each Qualified Beneficiary has a separate right to elect continuation Coverage. For example, the Employee's Spouse may elect continuation Coverage even if the Employee does not. Continuation Coverage may be elected for only one, several, or for all Eligible Dependents who are Qualified Beneficiaries. A parent may elect to continue Coverage on behalf of any Dependent children. The Employee or the Employee's Spouse can elect continuation Coverage on behalf of all of the Qualified Beneficiaries.

How much does COBRA continuation Coverage cost?

You shall be required to pay the entire cost of the continuation Coverage. The amount a Qualified Beneficiary is required to pay may not exceed 102 percent (or, in the case of an extension of Coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for Coverage of a similarly situated plan participant or beneficiary who is not receiving continuation Coverage.

When and how must payment for COBRA continuation Coverage be made?

If you elect continuation Coverage you must make your first payment for continuation Coverage not later than 45 days after the date of your election. (This is the date the Election Notice is postmarked, if mailed.) If you do not make your first payment for continuation Coverage in full not later than 45 days after the date of your election, you will lose all continuation Coverage rights under the Program. You are responsible for making sure that the amount of your first payment is correct. You may contact the employer or the Program premium office to confirm the correct amount of your first payment.

Periodic payments for continuation Coverage

After you make your first payment for continuation Coverage, you will be required to make periodic payments for each subsequent Coverage period. The periodic payments must be made on a monthly basis. Under the Program, each of these periodic payments for continuation Coverage is due on the first (1st) day of each calendar month for that Coverage period. If you make a periodic payment on or before the first day of the Coverage period to which it applies, your Coverage under the Program will continue for that Coverage period without any break. The Program will send a monthly notice of payments due for these Coverage periods to the participating employer along with their regular monthly premium notice.

Grace periods for periodic payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the Coverage period to make each periodic payment. Your continuation Coverage will be provided for each Coverage period as long as payment for that Coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the Coverage period to which it applies, but before the end of the grace period for the Coverage period, your Coverage under the Program may be suspended as of the first day of the Coverage period and then retroactively reinstated (going back to the first day of the Coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your Coverage is suspended may be denied and may have to be resubmitted once your Coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that Coverage period, you will lose all rights to continuation Coverage under the Program.

Your first payment and all periodic payments for continuation Coverage should be sent to the participating Employer for your group, or you may send them directly to the Program address.

Keep the Program informed of address changes

In order to protect you and your family's rights, you should keep the Program informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Program. Additionally, if you have changed marital status or you or your spouse have changed addresses, please notify the Program in writing at the above address. Please note: If you have questions concerning your Program or your COBRA continuation Coverage rights, contact your Employer, or the Program, Municipal Health Benefit Program, P.O. Box 188, North Little Rock, AR 72115. For additional information about your rights under COBRA, the Health Insurance Portability and Accountability

Act (HIPAA), and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

Section 2: Major Medical Benefits

The Program utilizes a network of providers (Preferred Providers) to offer a health benefit designed to provide Covered Members with economic incentives for using the Program's network. A directory of Preferred Providers can be accessed at www.arml.org/mhbp, and is subject to periodic changes. Covered Members should check with his or her chosen provider before undergoing any treatment to make certain of its network status. The Program does not deny a Covered Member access to healthcare, or to a provider of his or her choice, however benefits will be greater if accessed in the Preferred Provider network. Any provider not included in the Preferred Provider network will be considered Out-of-Network, and benefits will be paid accordingly.

Unless otherwise provided*, Covered Members should be aware that if they elect to utilize the services of an Out-of-Network provider for Covered Services, benefit payments are not based upon the amount billed. The basis of a Covered Member's benefit when seeking treatment with an Out-of-Network provider will be determined according to charges equivalent to 150% of Medicare, and as established by the Board of Trustees on an annual basis, or charges as established by the Program's utilization of health care cost management services (i.e. Fair Market Pricing). Generally, Covered Members who seek care Out-of-Network should expect to pay more than the applicable Calendar Year Deductible, copayment and Coinsurance amounts (Covered Member's cost share) after the Program has paid its portion of the Allowed Amount. Out-of-Network Providers are not under any obligation to accept the Program's Allowed Amount as payment in full and Covered Members will be responsible for all amounts billed by Out-of-Network Providers in excess of the Allowed Amount (in addition to the Covered Member's applicable cost share of the Allowed Amount, this is referred to as "balance billing"). (For more, see Section 5: Preferred Provider Network)

*Covered Members who have an emergency medical condition and get emergency services from an out-of-network provider or facility may not be balance billed. Furthermore, Covered Members who receive services from an out-of-network provider providing services at an in-network hospital or ambulatory surgical center also may not be balance billed. The most these provider or facilities may bill you is the MHBP in-network cost-sharing amount (such as copayments and coinsurance). Please see Section 5: How MHBP Pays Benefits, "No Surprise Billing: Out-of-Network Emergency Services & Out-of-Network Providers at In-Network Facilities" for additional information related to certain out-of-network services

Allowed Amount

The Allowed Amount is the maximum amount deemed by the Program, in its sole discretion, to be reasonable payment for a Covered Service. The Allowed Amount for Preferred Providers means the amount Preferred Providers have agreed to accept as payment in full for Covered Services. Unless otherwise provided*, for Out-of-Network Providers, the Allowed Amount means charges equivalent to 150% of Medicare, and as established by the Board of Trustees on an annual basis, or charges as established by the Program's utilization of health care cost management services (i.e. Fair Market Pricing), less any adjustments applied according to the Program's Utilization Review Program, or the Program's AWP provision (see below). Generally, Out-of-Network Providers are not under any obligation to accept the Program's Allowed Amount as payment in full and may bill Covered Members up to the billed charge after the Program has paid its portion. Covered Members will generally be responsible for all amounts billed by Out-of-Network Providers in excess of the Allowed Amount (in addition to the Covered Member's applicable cost share of the Allowed Amount).*

The Allowed Amount does not include charges used to satisfy the Member's Calendar Year Deductibles or copayment assessed under the Program's Major Medical Benefit or the Prescription Drug Card Program. Charges used to satisfy the Member's applicable Calendar-Year Deductible or copayment will be deducted from the Allowed Amount.

Calendar Year Deductibles for Major Medical Benefits

The Program offers two types of deductible plans, a Standard Deductible Plan, wherein a standard deductible applies, and a Qualified High Deductible Plan, where in a higher deductible applies.

Standard Individual Calendar Year Deductible—Major Medical \$500, \$1,200 or \$2,000

Qualified High Deductible Plan Individual Calendar Year Deductible—Major Medical and Prescription Drug \$2,500

Standard Family Maximum Deductible—Major Medical \$6,000

Qualified High Deductible Plan Family Calendar Year Deductible*—Major Medical and Prescription Drug \$7,500

Standard Deductible Plan

For Covered Members not participating in a Qualified High Deductible Plan, the Calendar Year Out-of-Pocket Maximum for the Major Medical benefit is \$4,000 for a Covered Member, and \$8,000 for a Covered Member and his or her family.

For Covered Members not participating in a Qualified High Deductible Plan*, please consult your Employer for your specific Calendar Year Deductible. The Calendar Year Deductible shall be applied to the amount of covered *medical expenses* that are incurred each calendar year. For these Covered Members, it is important to know that only costs incurred under the Major Medical benefit count towards your Calendar Year Deductible, and that the Office Visit copay does NOT count towards your Calendar Year Deductible.

Each Covered Member shall satisfy the \$500, \$1,200 or \$2,000 Individual Calendar Year Deductible, or up to a Family Maximum Deductible of \$6,000, before a Covered Members benefits will begin. Under Family Coverage, each member must meet their own Individual Calendar Year Deductible until the total amount of the costs paid towards the Individual Calendar Year Deductible collectively meet the overall Family Maximum Deductible for the same Calendar Year.

Qualified High Deductible Plan

For Covered Members participating in a Qualified High Deductible Plan, the Calendar Year Deductible, covered charges incurred under the Major Medical *and* the Prescription Drug benefit count towards your Calendar Year Deductible.

Under Family Coverage, each member must meet their own Individual Calendar Year Deductible until the total amount of the costs paid towards the Individual Calendar Year Deductible collectively meet the overall Family Maximum Deductible for the same Calendar Year.

Individual Coinsurance

Coinsurance is the percentage of costs a Covered Member must pay after he or she has met their Calendar Year Deductible.

For services provided by a Preferred Provider, the Covered Member's Coinsurance responsibility is 20% of the Allowed Amount; for emergency services provided by an Out-of-Network provider, the Covered Member's coinsurance responsibility is 20% of the Allowed Amount**; and for non-emergency services provided by an Out-of-Network provider, the Covered Member's coinsurance responsibility is 50% of the Allowed Amount**

**Generally, Covered Members can expect to pay more than the applicable copayment and/or Coinsurance amounts after the Program has paid its portion of the Allowed Amount when seeking care Out-of-Network. Out-of-Network providers may bill Covered Members up to the billed charge after the Program has paid its portion of the Allowed Amount.

After the Calendar Year Deductible(s) are met, the Program will pay the following percentages for Covered Services:		
	<u>In-Network</u>	<u>Out-of-Network</u>
Emergency Room Services (In-State or Out-of-State)	80% of the Program's Preferred Provider Allowed Amount	80% of the Program's Out-of-Network Allowed Amount
All other Services (In-State or Out-of-State)	80% of the Program's Preferred Provider Allowed Amount	50% of the Program's Out-of-Network Allowed Amount

The basis of a Covered Member's benefit when seeking treatment with an Out-of-Network provider will be determined according to charges equivalent to 150% of Medicare, and as established by the Board of Trustees on an annual basis, or charges as established by the Program's utilization of health care cost management services (i.e. Fair Market Pricing). When seeking treatment with an Out-of-Network provider, the Covered Member's benefit will never be based on the amount billed by the provider.

**However, when a Covered Member receives emergency care out-of-network, or when a Covered Member receives care at an in-network facility, but the care is provided by an out-of-network provider, the benefits paid by the Program may be different than the Out-of-Network benefits and percentages included above. Please see Section 5: How MHBP Pays Benefits, "No Surprise Billing: Out-of-Network Emergency Services & Out-of-Network Providers at In-Network Facilities" for additional information related to certain out-of-network services.

Stop Loss/Out-of-Pocket Maximum for Major Medical

An out-of-pocket maximum is a cap, or limit, on the amount of money a Covered Member must pay for Covered Services.

For Covered Members not participating in a Qualified High Deductible Plan*, the Calendar Year Out-of-Pocket Maximum for the Major Medical benefit is \$4,000 for a Covered Member, and \$8,000 for a Covered Member and his or her family. For these Covered Members, it is important to know that this Major Medical Out-of-Pocket Maximum is separate from the Program's Prescription Drug benefit Out-of-Pocket Maximum and only applies to medical expenses that are covered by the Program.

For Covered Members participating in a Qualified High Deductible Plan, the Calendar Year Out-of-Pocket Maximum for the Major Medical *and* the Program's Prescription Drug benefit is \$5,000 for a Covered Member, and \$10,000 for a Covered Member and his or her family. This means that the Calendar Year Out-of-Pocket Maximum applies to medical and prescription drug expenses that are covered by the Program.

Once the Out-of-Pocket Maximum has been met under either plan, the Program will pay 100 percent (100%) of the Allowed Amount of all in-network Covered Services for the remainder of the plan year, unless excluded or modified by other portions of this Program Booklet.

Generally, any costs incurred towards Calendar Year Deductibles, penalty deductible(s), applicable copayments, out-of-network services, and prescription drug copayments do not count toward the Calendar Year Out-of-Pocket Maximum(s).

For Covered Members participating in a Qualified High Deductible Plan* however, costs incurred towards Calendar Year Deductible (either under the Major Medical or Prescription Drug benefit) *do* count toward the Out-of-Pocket Maximum.

Further, under both the Standard and Qualified High Deductible Plan, the Out-of-Pocket Maximum does not apply to Out-of-Network provider services. This means that any amount of money paid towards services provided by Out-of-Network providers do not count toward the Calendar Year Out-of-Pocket Maximum, and that the Program will not pay one-hundred percent (100%) of the Allowed Amount for services provided by Out-of-Network providers. The Covered Member or Eligible Dependent will always be responsible for his or her portion of coinsurance for all Covered Services received from Out-of-Network providers (as well as any amounts beyond the Allowed Amount charged by the Out-of-Network provider, also referred to as "balance billing")

Copayment

A copayment is a fixed amount of money a Covered Member pays to the provider, facility, pharmacy, etc. when you receive certain services. Copayments are not applicable under a Qualified High Deductible Plan.

The Program offers two copayment options—1) Traditional Copayment Option and 2) Enhanced Copayment Option.

Under both options, a Covered Member is responsible for a copayment of \$20.00 for outpatient professional services rendered by a physician or other healthcare professionals at an office location (primary or specialist), at an urgent care location, or via telehealth that is not affiliated with eDoc America (“Office Visit Copayment”). The Office Visit Copayment of \$20.00 also applies to each visit for services provided by a mental health medical provider. The Office Visit Copayment will not count toward the Calendar Year Deductible.

Under the Traditional Copayment Option, the Office Visit Copayment will only be applied to services that are billed by a medical provider under CPT Codes 99201 through 99215, and CPT Codes 90791-90792, 90833-90834, 90836-90839 and 99492-99494. Any services or procedures rendered other than those billed under the CPT codes listed above will be reimbursed subject to the Calendar Year Deductible and applicable Co-insurance.

Under the Enhance Copayment Option, the Office Visit Copayment will be applied to the CPT codes as listed above, as well as any other services or procedures rendered during the office visit.

The Office Visit Copayment is not applicable under a Qualified High Deductible plan.

Preventive Care Benefits

Under both the Standard and Qualified High Deductible Plan, the Program will pay 100 percent (100%) of the Allowed Amount for Preventive Care provided by a Preferred Provider (as described further below under “Preventive Care Program”), and any Benefits provided under Preventive Care will not be subject to Coinsurance, the Calendar Year Deductible, or a copayment.

Major Medical Benefits

The Program provides certain health Benefits, subject to the terms and conditions of this Program Booklet. Please refer to Definitions, Eligibility, and Benefit Exclusions sections of this Program Booklet for additional information regarding any limitations and/or special conditions pertaining to your Benefits.

In addition, the Benefits described in this section will be provided only when you receive services on or after your Eligibility Date and they are rendered upon the direction and under the direct care of a medical professional. Such services must be Medically Necessary and are subject to the Program’s Utilization Review Program.

Pre-certification

It is the member’s responsibility to pre-certify the following services by calling 888-295-3591.

A \$1,500 penalty deductible will be assessed for failure to pre-certify any service or procedure requiring precertification, per occurrence. Pre-certification requirements apply even if the Program is a secondary payer. A covered member must pre-certify the following services including but not limited to:

- Ambulatory Surgical Procedures (whether they are performed in a hospital, ambulatory surgery center or doctor’s office)
- Bariatric Weight Loss Program
- Chemical Dependency Treatment
- Certain Durable Medical Equipment
- Home Health Care Services (care in a home setting)
- Hospice Care
- Inpatient Hospital Confinements (including Inpatient Mental Health and Rehabilitation)
- Organ Transplant Services
- Outpatient Observation lasting more than 23 hours (all outpatient stays lasting more than 24 hours will be reimbursed as Inpatient Confinements, and/or charges will be reduced to 23 hours of observation)
- PET Scans
- Prosthetic Devices (if purchase price exceeds \$2,000)
- Wound Care & Hyperbaric Oxygen Treatments Surgical Procedures

Precertification is required for surgical procedures regardless of where they are performed.

If you have any doubt whether or not a procedure or service requires precertification, please call 888-295-3591.

Once a service or procedure has been pre-certified, the services must be rendered within 30 days of the pre-certified date of service. If the services are not rendered within the 30-day time period, the pre-certification process must be started again.

You or your doctor must pre-certify by calling the Utilization Review Program at 888-295-3591. **The ultimate responsibility to pre-certify rests with the Covered Member.**

Penalty Deductibles & Inpatient Admission

Emergency Room Penalty Deductible

A penalty deductible of \$250 will be assessed against Outpatient emergency room visits. This \$250 penalty deductible is in addition to any other Program deductible, copayment or co-insurance requirement. Emergency room penalty deductibles do not apply to the Calendar Year Deductible or towards the Out-of-Pocket Maximum. When an emergency room visit results in hospital admission, the \$250 emergency room penalty deductible will be waived. However, this does not apply when you are admitted to a different hospital than where you received emergency services.

Failure to Pre-certify Penalty Deductible

You must notify the Program of a scheduled in-patient admission prior to the date of service. As soon as you know you will be hospitalized, you or your physician must pre-certify your care by calling the Utilization Review Program at 888-295-3591. Inform the Utilization Review Program that you are covered under the Program and provide the Utilization Review Program with your doctor's name and telephone number. **Failure to notify the Utilization Review Program prior to admission will result in the assessment of a \$1,500 penalty deductible.**

If your admission is due to an emergency, you or your family or physician will have until 5:00 p.m. the next business day to notify the Utilization Review Program of that admission. Direct admissions from your physician's office are not considered emergencies and must be pre-certified by you or your physician within twenty-four (24) hours. **Failure to do so will result in the assessment of a \$1,500 penalty deductible.**

Outpatient observations lasting more than 23 hours may be considered as an inpatient admission and/or reduced to the 23 hour observation limit. No benefits will be paid for any charges related to non-certified days or services. Any observations lasting more than 23 hours must be pre-certified. **Failure to do so will result in the assessment of a \$1,500 penalty deductible.**

Exception for Childbirth

The Program does not restrict the duration of hospital stay for the mother or newborn child up to a stay of 48 hours following a normal vaginal delivery or less than 96 hours following a cesarean section. The Utilization Review Program must be notified for stays more than 48 hours or 96 hours at 888-295-3591.

Prior Authorization

The Program has established Coverage policies for certain medications and drug classes that are typically administered by the provider, and which will require Prior Authorization. When these medications are prescribed by your provider, your provider will be required to obtain authorization from the Program in order for the medication to be eligible for benefits (Prior Authorization). Consideration for Coverage will be given for those medications listed on the Program's Provider Administered Drug List Requiring Prior Authorization, **located at www.arml.org/mhbp**. Your provider must contact The UAMS Evidenced-Based Prescription Drug Program (EBRx) at (833) 339-8401 to request and start the Prior Authorization process. Although you may currently be on a certain medication or medications therapy, your claim may need to be reviewed to see if the criteria for Coverage of further treatment has been met.

NOTE: Medications requiring Prior Authorizations are subject to change and other medications may be added with or without notice.

Utilization Review Program

The Program has adopted a Utilization Review Program. The Utilization Review Program is the critical examination of healthcare services to patients to evaluate the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the health benefit plan. The Utilization Review Program is provided directly by the Program, which is a licensed review agent.

The Utilization Review Program may include but is not limited to: quality of care provided, preauthorization or precertification of claims, referrals, etc., claims review, participating in case management and discharge planning, coordinating care with other providers, determining whether the services are Medically Necessary, and determining whether the services comply with the most current Health Benefit Plan. The Program may also include review of claims and billing to ensure proper claims preparation and submission, and any claims that include inaccurate coding, upcoding, unbundling of services, billing for medically unnecessary services, or services not provided, duplicate claims, or insufficient documentation may not be considered for reimbursement. The Program may further include office review of medical records, periodic inspections and surveys, case specific reviews, and other concurrent and retrospective reviews by the Program. The Program and its Health Benefit Plan may also adopt physician approved clinical practice guidelines and will require compliance with such guidelines, except when the best interest of the Covered Individual dictate otherwise. The Program will give Provider information about such guidelines and other requirements upon request.

In certain cases (as described above), the Utilization Review Program requires certification prior to treatment, as well as concurrent review, discharge planning, cost effectiveness, and medical case management. Please see Precertification for more information.

Additional Utilization Review Program Information

If the Utilization Review Program disagrees with the number of days recommended by the doctor, or the use of durable medical equipment, you and your doctor will be advised. The Program will not pay for treatment which is not approved by the Utilization Review Program. If you disagree with any payment decision, you may appeal. See Section 7: Appeals, page 51. The decision to accept treatment is between you and your provider.

Medically Necessary means that services or charges submitted to the Program must meet the conditions of being medically necessary to be considered for payment. The Program will generally consider care or treatment to be Medically Necessary if:

- It is consistent with the patient's medical condition or accepted standards of good medical practice;
- It is medically proven to be effective treatment of the condition; and
- It is the most appropriate level of service(s) which can be safely provided to the patient.

Only your medical condition is considered in determining whether the level of care or type of health care facility is appropriate. Neither your financial status nor family situation, the distance from a facility, patient or physician convenience, nor any other non-medical factor is considered in the determination of medical necessity.

Services and supplies which are not Medically Necessary are not covered, except for preventive health services for which Coverage is listed herein. Hospitalization that is extended for reasons other than medical necessity, i.e., lack of transportation, lack of caregiver at home, inclement weather, and other social reasons not justifying Coverage for extended hospital care is not covered.

Additionally, Medically Necessary standards apply to all covered benefits outlined in the Program. If Utilization Review Program determines that a service is not Medically Necessary before or after a participating PPO Provider renders it, we prohibit the Provider who rendered the service from billing you for those services, UNLESS you agreed in writing to be responsible for payment before the services were rendered. Charges for services or supplies rendered by non-PPO Providers

that are not considered medically necessary by the Utilization Review Program will be the responsibility of the member receiving the services.

Appeals made by a provider as to medical necessity will be referred to a Medical Reviewer designated by the Plan Administrator. **The decision of the Plan Administrator's Medical Reviewer shall be final and binding to all parties.** Appeals made by covered members or their legal representative shall be done in accordance with the internal/external review process set out in Section 7, page 51.

The Program will not pay for services or supplies furnished after the date your Coverage ends, even if the Program pre-certifies or provides benefit information for a treatment plan submitted before the end of your Coverage.

Case Management

Case Management should be utilized by the Member of the Program where services with high expenses are expected or where such services are expected but are not available within the Preferred Provider Network. See Section 5, page 42, for more information. The Case Manager will work with the Covered Member and provider to seek out a cost-effective approach to the illness or injury as described in the Utilization Review Program portion of this booklet.

In an effort to reduce recurring visits to a hospital setting, Alternative Case Management may be recommended. Benefits may be extended, based on the recommendation of the Case Manager if such recommendation would tend to provide for physician-approved treatment outside the hospital setting. Alternative Case Management may be considered if medical expenses are expected to exceed the Program's defined maximum for a specific benefit. Alternative Case Management will normally include, but will not be limited to, durable medical equipment, home health and hospice, inpatient and outpatient therapy.

At the sole option of the Program, alternative benefits may be provided by the Program in lieu of Major Medical Benefits. Alternative benefits shall be provided if, in the sole discretion of the Program, such services are feasible, cost-effective, medically necessary and available in your locale. The Case Manager will have the ability to recommend a treatment plan above the annual benefit maximum. This benefit will not exceed \$5,000 in a calendar year. Eligible Case Management charges will be paid using the Program's percentage reimbursements.

Major Medical Schedule of Benefits

The following Schedule of Benefits includes a list of medical care and services provided under the Program's Coverage, as well as any applicable Benefit maximum allowance.

Benefit	Benefit Maximum Allowance	
Individual Medical Coverage	Lifetime	No Maximum Dollar Limit
Acute Inpatient Habilitation/Rehabilitation	Annual	30 Days
Sub-Acute Inpatient Habilitation/Rehabilitation Habilitative Services		15 Days
Bariatric Weight Loss Program*		
Chemical Dependency Treatment	Annual	1 Treatment Plan **
Diabetic Training	Annual	1 Day Session
Emergency Ambulance Services-Ground	Annual	2 Occurrences
Emergency Ambulance Services-Air	Annual	2 Occurrences, \$10,000/Occurrence
Non-Emergency Surgical Procedures Requiring Precertification (Hospital or Ambulatory Surgery Center)	Annual	2 Procedures
Hearing Aids	One per ear	one (1) time every three (3) years
Home Health Services	Annual	20 Visits
Hospice Care	Lifetime	90 Days
Inpatient Hospital Services	Annual	30 Days
Mental/Nervous Disorders Inpatient	Annual	10 Days
Individual Therapy Sessions	Annual	24 Visits
PET Scans	Annual	2 Each
Nutritional and Weight Counseling	Annual	2 Visits
Outpatient Occupational, Physical, Speech, Habilitative Therapy and Chiropractic Services (Combined Benefit)	Annual	40 Visits Combined
Organ Transplant Benefits	Lifetime	2 Transplants***
Custom Molded Foot Orthotics	Annual	2 Pairs
Diabetic Related Footwear/Shoes	Annual	2 Pairs
Prosthetic Bra for Oncology Covered Members	Annual	2 Each
Wound Care and Hyperbaric Oxygen Treatment	Annual	20 Visits
Sleep Study	Annual	1 Visit****

*These services will be covered exclusively through the Metabolic & Bariatric Surgery Accreditation & Quality Improvement Program (MBS-AQIP). All services must be precertified and must be performed at a designated facility. For more information call 888-295-3591.

**Services must be rendered at a Program Chemical Dependency Treatment Center to be covered. For details regarding this benefit, call 888-295-3591.

***Transplants must be performed at a Program Designated Transplant Center to be covered. For more information call 888-295-3591.

****Sleep study, including titration, must be completed in one night. The Program will not cover a second night.

Covered Major Medical Charges

Covered major medical charges include only the charges and fees described below that (a) are not excluded by other provisions applicable to these Benefits, (b) are medically necessary for the care and treatment of illness or injury of a Covered Member, (c) are recommended by an attending physician, (d) do not exceed the Usual, Customary and Reasonable charges (see “UCR” section for more information) as determined by the Program in accordance with health care industry standards for the area in which the services and supplies are furnished, and are deemed necessary by the Utilization Review Program (See the “*Utilization Review Program*” section below). A charge is considered to be incurred on the date a Covered Member receives the services or supplies which the charge is made. (For more information see “Medically Necessary” under Important Information).

Accident-Related Dental Charges—Dental charges are not covered under Major Medical Benefits except for the prompt repair of sound natural teeth or other body tissues required as a result of accidental injury sustained while covered. A Treatment Plan must be submitted prior to any treatment or services being rendered. Treatment/services must start within 30 days and be completed within six months of the initial injury or accident, unless otherwise agreed to in writing by the Program. Any injury to teeth while eating is not covered in this provision.

NOTE: Charges incurred in a hospital setting for the pulling of teeth which are not the result of an accident or injury, are not covered under the Major Medical Benefits, unless otherwise provided under this booklet.

Ambulance Services (Ground and Air)—Charges for emergent, medically necessary, local transportation of a covered member by a professional ambulance company to and from a hospital will be covered under the per occurrence maximums of the Program, being two each per year.

Anesthesia Charges—For the administration of anesthesia when not included in hospital or ambulatory surgery center charges.

Cataract Surgery—Charges for cataract surgery, including the first pair of standard eyeglasses or standard contact lenses when needed as a result of and purchased within ninety (90) days of such surgery. Glasses and lenses will be reimbursed at the Program’s Allowed Amount. Any additional glasses and/or lenses may be covered under the optional Vision Care Benefits Coverage.

Emergency Room Charges—Charges for medically necessary emergency room services.

Family Planning—Benefits are provided for an elective vasectomy performed only in a physician’s office. The Program will also provide benefits for an elective tubal ligation.

Inpatient Hospital Charges—The Program will pay up to a maximum of 30 days per year for covered room and board and other necessary services and supplies, unless defined elsewhere in this booklet. In-hospital room accommodations covered are: semi-private room (two or more beds), approved intensive and cardiac care units and private room. If you choose to have a private room, you will be responsible for the difference between the hospital’s charge for an average semi-private room and its private room charge. If the hospital is an all-private room facility, the Program will consider 90 percent of the private room charge as the covered charge.

Medical Supplies and Pharmaceutical Charges—The Program will pay for up to a thirty (30) day supply for medical supplies and pharmaceutical charges prescribed by a medical doctor for the treatment of a medical condition, including but not limited to diabetic and insulin supplies, unless defined otherwise under the Drug Card Benefit.

Physicians’ Fees—For medical care and treatment other than the performance of surgical procedures.

Prosthetic/Orthotic Devices—When ordered by a physician, Coverage is provided for prosthetic devices such as orthopedic braces, custom built shoes or supports, internal fixation (such as hip pinnings), internal prostheses, and re-placement of artificial legs, arms, and eyes. Also included is the replacement of these devices when required by a change in your physical condition, as well as repairs to prosthetic devices. Precertification is required for purchase of all prosthetic/orthotic devices that exceed \$2,000. Coverage for replacement of a prosthetic or orthotic device may, at a minimum, be one (1) time every three (3) years, unless it is medically necessary as indicated by medical criteria. However, these devices will not be covered if they are misused or lost. (See Exclusions.)

Radiological and Laboratory Charges—For radiological examinations and diagnostic laboratory services.

Rental or Purchase of Durable Medical Equipment—The Program will pay for standard durable medical equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is only useful to a person with an illness or injury, and (d) is appropriate for use in the home. Additionally, the Program will replace standard durable medical equipment that is no longer serviceable provided it meets the criteria above. The Program will not pay for air conditioners, dehumidifiers, humidifiers, air purifiers, waterbeds, car seats, whirlpools, spas, exercise equipment, motorized or other specialty or customized equipment, nor for service and/or maintenance contracts and agreements for durable medical equipment. Durable medical equipment, such as a standard hospital bed, standard wheelchair, etc., must be prescribed by a physician and must be required for temporary therapeutic use. If a member must rent durable medical equipment for an extended period of time, the Program reserves the right to pay for the rental monthly, not to exceed the purchase price. If an item of durable medical equipment is not available for purchase, the Program reserves the right to establish a rental or purchase price based on the reasonable and customary charge for such equipment. The Program will never pay more than the purchase price for any durable medical equipment.

Precertification is required for the following specific durable medical equipment:

- Bilevel Positive Airway Device (Bi-Pap)
- Oxygen Concentrator
- Portable Ventilator
- Wearable Defibrillator
- Insulin Pump
- Continuous Glucose Monitor
- Bone Growth Stimulator
- Spinal Cord Stimulator
- Intrathecal Pump

Surgeons' Fees—For the performance of surgical procedures by a physician. Pre-op and post-op care is paid for when the surgeon bills under the global surgical CPT coding rules.

Preventive Care Program

The Program will reimburse for Preventive Care Benefits at 100 percent (100%) of the Allowed Amount. Preventive Care Benefits are not subject to the Calendar Year Deductible, copayments, or coinsurance. To be considered as a Preventive Care Benefit, the provider's bill for the service must designate a routine preventive diagnosis code, with the proper CPT Code and diagnosis pointer to be considered as a preventive service. Claims received with diagnoses other than or in addition to routine preventive will be considered under the Major Medical Benefits and reimbursed accordingly. Preventive benefits are generally not payable when done at flu clinics, health fairs or other public or private venues.

The following list is an example of the types of services often considered as Preventive Care Benefits:

- Mammogram—one (1) per calendar year
- PAP Screening—one (1) per calendar year
- PSA (Prostate Specific Antigen test)—one (1) per calendar year
- Colon-Rectal examination—Coverage for medically-recognized screening examination for the detection of colorectal cancer for covered individuals who are forty-five (45) years of age or older, or for covered individuals who are less than forty-five (<45) years of age and that have a family or personal history of colorectal cancer, or certain types of polyps, or a personal history of inflammatory bowel disease (“increased risk for colorectal cancer”). This includes annual fecal occult blood tests and a colonoscopy and/or flexible sigmoidoscopy (examination of the large intestine) performed every three (3) years for covered individuals with an increased risk for colorectal cancer, or performed every ten (10) years for all other covered individuals. This Benefit includes routine and diagnostic colon-rectal examinations, including COLOGARD, and excludes Coverage for virtual colonoscopies.
- General Health Panel
- Tuberculosis (TB)
- Chest X-Ray (front and lateral)
- Well Baby Care/Well Child Care

Immunizations/Inoculations

- DT (Diphtheria and Tetanus Toxoids)
- DtaP (Diphtheria, Tetanus Toxoids, and Pertussis)
- Td (Tetanus) booster
- MMR (Measles, Mumps, Rubella)
- MMR booster
- Poliomyelitis Vaccine
- Oral Polio
- Varicella Vaccine (Chicken Pox)
- Influenza
- Hepatitis A
- Hepatitis B
- Pneumococcal (Pneumonia)
- Pediarix (Diphtheria and Tetanus Toxoids and Acellular Pertussis Absorbed, Hepatitis B [Recombinant], and Inactivated Poliovirus Vaccine Combined)
- HIB (Hemophilus Influenza B)
- HPV (Genital Human Papillomavirus)
- Rotovirus
- Shingles Vaccine

PLEASE NOTE: *Allergy injections and expenses related to birth of a child are not considered part of this benefit. Other injectable medicines may be covered under the Prescription Drug Card Program. Please see the Prescription Drug Card section of this Program Booklet (Section 3, page 31). Pharmacy copays will be assessed if the above are administered at your local pharmacy, except for Influenza.*

Tobacco Cessation Program—The Program recognizes the benefits of a tobacco-free environment and will, therefore, support its members' efforts in the discontinuation of tobacco use. The Program's Tobacco Cessation Program is designed to assist members in their efforts to discontinue tobacco use by providing access to specific medications designed to diminish the dependence upon nicotine.

How the Tobacco Cessation Program Works—Members who wish to discontinue their tobacco use and participate in this program must obtain the appropriate prescriptions from their physician. These medications will be covered at a \$0 copay; for members > 18 years of age. Annual Limit: 2 cycles of treatment (12 weeks/cycle) in keeping with the Affordable Care Act (Healthcare Reform).

Special Limitations on Specific Types of Medical Treatments

Acute Inpatient Habilitation/Rehabilitation—Payment for this benefit is limited to a maximum of 30 days per illness or incident, but not to exceed the annual inpatient hospital maximum benefit. Payment is limited to acute rehabilitation as prescribed by a physician and is subject to review by Case Management to identify medical criteria and cost effective alternatives.

Sub-acute Inpatient Habilitation/Rehabilitation—Payment for this benefit is limited to a maximum of 15 days per illness or incident, but not to exceed the annual inpatient hospital maximum benefit. Payment is limited to sub-acute rehabilitation services as prescribed by a physician and is subject to review by Case Management to identify medical criteria and cost effective alternatives.

Average Wholesale Pricing (AWP)—The charge determined by the Program for drug products provided to Covered Members, employing the most current Average Wholesale Price (AWP) of the drug product or other industry-accepted benchmarks as set forth by Medispan, First Databank, or other industry-accepted databases. The Program has the right to review all claims for such drug products provided to its Covered Members and will reimburse providers at eighty-five (85%) percent of the most current AWP for the drug products included on the claim. The National Drug Code (NDC) is a unique product identifier used in the United States for drugs intended for human use.

Bariatric Weight Loss Program*—The Program will provide Coverage for bariatric surgery to include:

- a. Gastric bypass surgery
- b. Sleeve gastrectomy surgery or
- c. Duodenal switch biliopancreatic diversion.

Precertification is required to review the eligibility for this Bariatric Weight Loss Program. Expenses incurred related to the Bariatric Weight Loss Program will be covered subject to medical case management approval and Program limitations. Under the Bariatric Weight Loss Program, eligible expenses include the pre-obesity evaluation, medical and surgical treatment for post obesity follow-up care including but not limited to treatment of any complications. Any related treatment must be performed at a Program-designated facility and must be an eligible benefit for Covered Members nineteen (19) years of age or older.

Non-Covered Nutrition—The Program will not cover food, shakes, vitamins, or any supplements regardless of who prescribed or recommended them.

Non-Designated facility—If the treatment is performed at a non-designated facility or if case management is refused, services under this program will not be covered.

Disqualification from Program—If a covered Member does not follow the guidelines as instructed by case management and/or the bariatric surgeon and is disqualified for any reason from this program, they must wait until the next Program Year to requalify.

Any obesity related charges for services not rendered under this program will not be covered by the Program. Furthermore, morbid obesity treatment procedures will not be paid if the procedure is an experimental and investigative medical procedure.

How to Obtain a Precertification

4. Call your Program case manager at 888-295-3591 and notify them that you are interested in the Bariatric Weight Loss Program.
5. You will then need to obtain a referral letter from your Primary Care Physician (PCP) and send to the Program case manager.
6. Once the referral has been received and approved by the Program case manager and a Bariatric Weight Loss Program provider, the provider will contact you for an initial consultation.
7. Pre-surgery requirements must be completed upon approval of the referral unless otherwise requested by the Bariatric Weight Loss Program provider. Those requirements include, but are not limited to:
 - A. Bariatric psychological evaluation;
 - B. Dietician consult;
 - C. EKG;
 - D. Sleep study with documentation of C-Pap compliance if necessary;
 - E. EGD if Gastric Sleeve is being performed.

**These services will be covered exclusively through the Metabolic & Bariatric Surgery Accreditation & Quality Improvement Program (MBS-AQIP). All services require a Precertification. Retroactive determinations will not be considered. Participation in this program must be performed at a designated facility.*

Chemical Dependency Treatment—These services are limited to one treatment plan per year. Services must be rendered at the Program Chemical Dependency Treatment Center to be covered. You must contact Program case management at 888-295-3591 who will direct your care and Precertify services. No benefits will be available for Chemical Dependency services performed at any facility which is not designated by the Program. An order by a court or state agency for psychiatric treatment is not an indication of eligibility under this benefit.

Diabetic Education or Training—The Program will allow for a one-day diabetic education or training session per calendar year. However, if there is significant change in the covered member's condition or symptoms making it medically necessary to change the covered member's diabetic management process, the Program will allow for an additional one-day diabetic education or training session. The additional diabetic or training session must be prescribed by a physician.

Enteral Feeds (tube feeding)—The Program will cover enteral feeds when it is the member's only means of nutrition.

Hearing Aids—The Program will pay up to a maximum of \$1,400 per ear one (1) time every three (3) years for hearing aids, including the repair and replacement parts that are designed and offered for the purpose of: • Aiding a person with or compensating for impaired hearing;

- Is worn on or in the body;
- Is generally not useful to a person in the absence of a hearing impairment; and
- Is sold by a professional licensed by the state to dispense a hearing aid or hearing instrument.

Individual coinsurance and the individual annual deductible will not be applied to the hearing aid benefit; however, any out-of-pocket costs associated with these devices will not be credited toward the individual annual deductible. Additionally, these devices will not be covered if they are misused or lost. (See Exclusions, page 26.) All charges and/or costs above the \$1,400 maximum per ear one (1) time every three (3) years will be the member's responsibility.

PLEASE NOTE: *Payment for hearing aids will not be considered before they have been received by the individual member and MHBP has received a signed delivery receipt.*

Home Health Care Services (care performed in a home setting)—Payment of these benefits is limited to an annual maximum of 20 visits per year and is subject to review by Case Management to identify medical criteria and cost effective alternatives. Coverage for this benefit will be limited to charges for Home Health Care visits made by a Registered Nurse, a Licensed Practical Nurse, a Physical Therapist, an Occupational Therapist, or a Speech Therapist and in accordance with a home health care plan established by a doctor and/or recommended by Case Management. You must be homebound to qualify for Home Health Care Services. (See Section 8: Definitions, page 61.)

Hospice Care—The Program will pay for covered Hospice charges, whether in the home or in an inpatient setting, including equipment and supplies, which are medically necessary for treatment if the member is totally disabled as a result of terminal illness and has a life expectancy of six months or less. A treatment plan is required and must be submitted to Case Management for precertification before benefits can be considered. Hospice Care charges will be limited to a lifetime maximum of 90 days. (Please see Alternative Case Management, page 19, for additional information.)

Maternity Benefits and Newborn Child Care—If you have family Coverage, an eligible newborn can be added to your Coverage on the newborn's date of birth. The newborn must be added within 60 days of their date of birth regardless if Social Security Number is received or not. The Program's annual inpatient hospital maximum applies to this benefit.

If you have elected single Coverage, family Coverage may be added on the first day of the month following the newborn's date of birth. You may also elect family Coverage at any Open Enrollment Period prior to the birth of the newborn.

Mental and Nervous Disorders—Payment for services incurred in connection with treatment of mental illness or functional nervous disorders, is limited to a maximum of 10 inpatient days per calendar year, with 24 physician visits per calendar year for inpatient and outpatient charges. These payments are not eligible for the Stop Loss Provision. (See

Exclusions for further information.)

Nutritional and Weight Counseling—Payment for services provided by a Registered Dietician for the purpose of nutritional counseling. Restrictions may apply.

Organ Transplant Benefit Charges—Transplant benefits are all inclusive and limited to two per lifetime. All-inclusive means all charges for all services for an organ transplant, including but not limited to, testing prior to transplant and all post-operative treatment. Additionally, donor procurement, tissue typing, surgical procedure, along with storage and transportation costs are included in the annual benefit but must be billed inclusively under the covered member of the Program to be considered. Eligible procedures are: heart, lung, liver, kidney, pancreas, cornea, and bone marrow.

All transplants must be performed at one of the MHBP Designated Transplant Centers to be covered. You must contact MHBP Case Management at 888-295-3591 who will direct your care and pre-certify services. No benefits will be available for transplants performed at any facility which is not designated by the Program. Travel and lodging expenses are not a covered benefit.

Outpatient Clinical Setting Physical Therapy, Speech Therapy, Habilitative, Chiropractic, and Occupational Therapy Services—These therapeutic services, when provided in an outpatient clinical setting, will be combined to allow for an annual maximum of 40 visits unless excluded elsewhere in the policy.

Please note that Chiropractic Services are covered only for an eligible member five (5) years and older and that Temporomandibular Joint Dysfunction (TMJ) is not a covered benefit under Chiropractic Services. TMJ is addressed under the optional Dental Benefits Coverage.

Non-Emergency Surgical Procedures—Non-Emergency Surgical Procedure means a medical procedure to improve health or quality of life when the medical condition is not considered immediately life-threatening. Non-emergency surgical procedures are pre-scheduled for a specific date and are not considered emergent in nature. Covered Members are limited to two (2) Non-Emergency Surgical Procedures per calendar year.

For a comprehensive list of non-emergency surgical procedures, please call 888-295-3591. Members are allowed a yearly maximum of two procedures.

Please call 888-295-3591 anytime to verify if precertification will be needed.

Wound Care and Hyperbaric Oxygen Treatment—The total number of one-hour sessions for hyperbaric oxygen therapy and/or the total number of treatments received in an outpatient Wound Care facility will be limited to a maximum of 20 per year provided the treatment is for a condition that is covered under the Program and is prescribed by and administered under the direct supervision of a licensed physician.

Special Benefits

Telemedicine

eDocAmerica—The Program offers a telemedicine and telehealth benefit through eDoc America. eDoc offers Covered Members unlimited email access to board certified physicians, psychologists, pharmacists, dentists, dieticians, and fitness experts who provide personal answers to all health-related questions.

eDoc also provides 24-hour nurse line access for any health need, and a telehealth benefit that enables Covered Members to seek medical care from a licensed provider via a secure-remote connection.

All eDoc services are at no extra cost, confidential, and unlimited for Program Covered Members. No co-payment or coinsurance is required.

Contact eDoc at 866-842-5365 or visit www.edocamerica.com to set up or access your free account.

Benefit Exclusions — WHAT IS NOT COVERED

General Information—The Program does not pay benefits for exclusions and health care services and items not specifically described within this booklet, even if the following is true:

- It is recommended or prescribed by a physician;
- It is the only available treatment for your condition; • Was a covered benefit in previous Program years; or
- Items that are misused or lost.

No benefits are payable for charges a covered member is not required to pay or which would not be made if Coverage did not exist.

Expenses for the following are not covered by the Program:

Not Medically Necessary—hospitalization, or health care services and supplies which are not Medically Necessary.

Abortion—The Program will not cover an elective abortion, nor will charges for medical services, supplies or treatments utilized to cause an elective abortion be considered. Charges for supplies or treatment provided arising from medical complications of an elective abortion will not be covered.

Acupuncture—Any service or charge associated with acupuncture treatment, regardless of the provider performing the services.

Against Medical Advice—The Program will not cover any services required for complications arising out of the member's discharge from care contrary to medical advice.

Alcohol Consumption—Health care or services for the treatment of injuries and/or injury-related diseases, brought about in whole or in part, by the member's use or misuse of alcohol, including, but not limited to, driving or operating a motor vehicle as defined by the laws of the jurisdiction in which the vehicle or other device was being driven or operated.

Alcoholism and Related Diseases—Health care or services for the treatment of alcoholism and other alcohol related diseases, unless defined elsewhere in this booklet.

Benefits Outside the United States—The Program will reimburse costs, after deductible and co-insurance, for treatment required while traveling outside the U.S. for emergency services, but will require the member(s) to acquire travelers' insurance when available. The Program will then coordinate payment of benefits with the travelers' insurance carrier.

Breast Reduction or Augmentation Procedures—Services and procedures to reduce or augment breast size, with the exception of breast cancer, will not be covered by the Program.

Convalescent Care—Any service or charges associated with convalescent, residential treatment, custodial, or sanitarium care unless defined elsewhere in this booklet.

Cosmetic—Cosmetic procedures, surgery, services, equipment or supplies, provided in connection to elective cosmetic or reconstructive surgery, including, but not limited to reconstruction of the jaw to improve dental alignment or bite, or any complications related to a previous cosmetic surgery or procedure unless incurred as a result of (1) an accidental injury sustained while covered under this Program or (2) for the reconstruction of both breasts due to cancer.

Counseling Services—Outpatient counseling services billed as marriage or group counseling (other than family) will not be covered by the Program, unless defined elsewhere in this booklet.

Diagnostic Cardiac Catheterizations—Coverage for cardiac catheterizations in environments where cardiac interventions cannot be performed.

Deductible(s), Copayment(s), or Coinsurance—Services that are reimbursable under any other Program provisions or charges that are applied to the Program's deductible, coinsurance, or copayment provisions.

Dental Care—Dental Care is not a covered benefit under the Major Medical Benefits of the Program.

Domestic Partners—The Program does not provide Coverage for domestic partners of the same sex or opposite sex.

Durable Medical Equipment—Charges for misuse or loss of durable medical equipment will not be covered by the Program.

Exercise—Any routine exercise or wellness programs unless specifically provided for by the Program.

Genetic Testing or Services—Testing or measurements of biochemical markers as a diagnostic or screening technique and the services of geneticists or genetic counselors are generally not covered under the Program. A limited number of specific genetic tests may be covered to determine the presence of a disease, condition, or congenital anomaly of a fetus (prenatal genetic testing) or for the testing of a symptomatic Member's blood or tissue to determine if the Member has cancer.

Prenatal genetic testing is covered only when a Covered Member (a) will be 35 or older on their due date; (b) has had abnormal results from a screening test designed to estimate the risk of certain birth defects; (c) carries or whose partner carries an inherited disease such as Tay-Sachs, sickle cell anemia or cystic fibrosis; (d) has undergone an ultrasound test that has found abnormalities in the fetus.

Genetic testing related to the diagnosis of cancer is covered only when the Program has determined that the particular genetic test (a) is the only way to diagnose the disease or condition; (b) has been scientifically proven to improve outcomes when used to direct treatment; or (c) will affect the individual's treatment plan

Hearing—Charges for misuse or loss of hearing aid devices will not be covered by the Program.

Hyperhidrosis—Surgical treatment of Hyperhidrosis is not a covered benefit under the Program.

IDET Procedures—Intra-Discal Electro-Thermal Therapy (IDET) or similar procedures or any complications arising out of these types of procedures.

Illegal Act—Health care or services for the treatment of injuries occurring in the course of or in the furtherance of the member's commission of acts contrary to federal, state, or local law.

Immediate Relative—Services or charges provided by someone who is an immediate relative as defined in the Definitions section or who ordinarily resides in your home. (See Section 8: Definitions, page 61.)

Infertility—Any service associated with testing or treatment for infertility, in vitro fertilization, or artificial insemination.

Late Charges—Charges for late payments and/or penalties submitted by a provider. The Program will not pay 100 percent of a provider's billed charges in these instances.

Long-Term Care—Long-term care is not a covered benefit under the Program.

Maintenance Care—All services, equipment, and supplies which are provided solely to maintain a covered individual's condition and from which no functional improvement can be expected or is not life sustaining treatment for a medical condition.

Mandated or Court Ordered Care—Coverage for medical, psychological, or psychiatric care required by court order, or otherwise mandated by a third party, is not covered by the Program.

Midwifery—Services and providers of midwifery are not covered under the Program. Additionally, any complications associated with services provided under this exclusion will not be covered.

Missed or Cancelled Appointments—Charges for missed or cancelled medical, dental or vision appointments.

Muscle Therapy—Any service performed by masseurs, masseuses or for massages.

Never Events—A list of events compiled by the National Quality Forum and Medicare and defined as adverse nonreimbursable reportable events/conditions which are considered unacceptable and eminently preventable.

Orthotripsy—Extracorporeal Shock Wave Therapy is not a covered benefit under the Program.

Penile Implants and Erectile Pumps—Charges incurred for any services or procedures related to penile implants and pumps will not be covered by the Program.

Prescription Drugs—Refer to the Prescription Drug Coverage section of the booklet for exclusions and limitations pertaining to prescription drugs.

Records—Charges for medical records, photocopying, or related charges for materials necessary to determine the Program liability or claim.

Routine Foot Care—The Program does not cover any services or supplies in connection with:

- a. Care of corns or calluses;
- b. Care of toenails;
- c. Care of flat feet;
- d. Supportive devices of the foot such as arch supports and/or pelvic or spinal stabilizers;
- e. Orthotics for sports use.

Prosthetic/Orthotic Devices—Charges for misuse or loss of prosthetic or orthotic devices will not be covered by the Program.

Service and Maintenance Contracts—Any contract for service and/or maintenance for durable medical equipment.

Sex Change—Charges for or related to sex change or any treatment of gender identity.

Sexual—Reversals of elective vasectomies or elective tubal ligations are not covered.

Substance Abuse and Related Diseases—Health care or services for treatment of substance abuse or related diseases brought about in whole or in part by the member's use or misuse of either legal or illegal substances. Nor will payment be made for health care or services for the treatment of traumatic injuries brought about in whole or in part by the member's use or misuse of either legal or illegal drugs.

Surrogate Pregnancy—Any services or charges associated with surrogate pregnancy.

Tattooing—Any service or charges associated with tattooing for any reason will not be covered by the Program.

Third Party Injuries—Treatment, services, and supplies for injury or illness for which, as determined by the Program, another party or payer for a party is liable, including, but not limited to employment related injuries or illnesses; automobile medical payment Coverage; liability insurance, whether provided on the basis of fault or non-fault; and any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program. Nor will the Program pay for treatment, services, and supplies required by school-based programs, federally mandated programs, Medicare, employment physicals, tests, and exams requested or directed by a court of law.

If benefits are paid or provided by the Program whenever this exclusion applies, the Program reserves all rights to recover the reasonable value of such benefits, as provided in the Program Booklet under the Right of Reimbursement terms on page 49.

TMJ—Temporomandibular joint dysfunction and related procedures by whatever name called, diagnosis and/or treatment even when deemed medically necessary is covered solely under the optional Dental Care Benefit.

Travel Related Medical Services—Medical services and immunizations to fulfill requirements for international travel.

Travel and Lodging—Travel and lodging expenses incurred as a result of obtaining treatment for a medical condition are not covered benefits.

Unproven Medical Procedures/Treatment—Any medical procedure or drug that falls under any of the following:

- a. Not consistent with standards of good medical practice in the United States as evidenced by endorsement by national guidelines (such as those prepared by the NIH and/or NCCN);

- b. Under study in clinical trials other than those clinical trials meeting criteria established by federal law;
- c. Exceeds (in scope, duration or intensity) that level of care which is needed; or
- d. Are given primarily for the personal comfort or convenience of the patient, the family, or the provider.

Vision—Eye refractions, eyeglasses, contact lenses, or the fitting of such items or exercises for the eyes, and charges for eye surgery to correct refractive errors including, but not limited to, Radial Keratotomy (RK), Photo Refractive Keratotomy (PRK), Automated Lamellar Keratoplasty (ALK), LASIK or any related kerato-refractive surgery to correct refractive errors are excluded under the Program. See Vision Care Coverage section of this Program for covered services.

Vitamins—Over-the-counter vitamins and/or nutritional supplements.

Voluntary Exposure to Danger—An oral or written waiver purporting to release or otherwise protect a third party from liability to the releasing party, *including a release executed on behalf of a minor by parent or guardian*, for injury or illness suffered by the releasing party, shall fully relieve the Program from any and all liability or obligation it may otherwise have to the covered member(s) providing the waiver. More particularly, the waiver shall relieve obligations of the Program with respect to Coverage for charges for illness, injury, or treatment having some causal connection to: either the acts or omissions of the third party, or the participation by the releasing party in the activity excepting waivers entered into so to allow participation in activities sponsored by public entities or religious entities.

Waivers affected by this exclusion are often used before allowing participation in an activity or sport for leisure, recreation, competition, entertainment or monetary purposes that involves inherent danger. Inherent danger is usually found, but is not limited to, activities involving speed, height, physical exertion, specialized gear, and stunts involving intrinsic uncontrollable variables along with pronounced risk-taking that allows for and encourages individual creativity in the innovation of new maneuvers and the stylish execution of existing techniques requiring control of risk. These activities are often called or regarded as extreme as in the case of “extreme sports.” The following are some but not all examples of inherently dangerous activities:

BASE jumping; bull fighting, bull riding and bull running; bungee jumping; whitewater racing; motocross; hang-gliding; mudding; extreme obstacle course racing; paragliding; race car driving; rappelling; rock climbing; competitive skateboarding; sky diving; competitive street BMX riding; wall climbing without safety equipment; zip lining; tight rope walking.

Regardless of whether a waiver is used or not, injuries arising out of participation in these inherently dangerous activities are not covered by the Program.

War—Any health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion extends to services for treatment of military service-related disabilities when you are legally entitled to other Coverage.

Work Rehabilitation—Work-hardening programs or performance-oriented therapy using graded and sequential advancement of activities simulating work situations, task ergonomics and proper body mechanics to rehabilitate patients for a return to work.

Work Related—Injuries and illness arising out of or in the course of any employment for compensation or profit even if Coverage under worker’s compensation or similar legislation is optional and the member chooses not to elect such Coverage. Medical physicals or other medical services required by an employer for an employee to maintain their employment status are excluded from Coverage and are excluded from payment under the Preventive Benefits portion of the Program.

PLEASE NOTE: *that medical complications occurring as a result of receiving services excluded under the Program, including but not limited to, surgeries, procedures, or medications, are not covered by the Program. For other policy provisions, explanation of services and limitations, please see Section 8: Definitions, page 61.*

Circumstances That May Result in the Reduction or Loss of Benefits:

- Coordination of benefits when a covered person is enrolled in more than one plan and this Program is not the primary plan.
- Subrogation, reimbursement, and third-party recovery rights of the Program.
- Reductions for certain multiple surgical procedures.
- Reductions for charges that exceed the usual and customary or negotiated fee Allowed Amounts.
- Reductions and/or denials for services which are not medically necessary or generally accepted as inappropriate and/or are considered as over utilization.
- Denial for services for anyone currently residing outside the United States or Canada, except for emergency services.

- Denial for anyone already covered under the Program as an employee or dependent of another member (no dual Coverage).
- Reduction and/or denial for anyone who is actively serving in the armed forces of any country.
- Denial for services, treatments, medications, and supplies that are excluded under the Program.
- A Covered Member failing to provide requested documentation such as an accident claim form, multiple Coverage inquiry, certificate of acceptance of plan provisions, 2-page accident and injury questionnaire, etc.
- Services must be performed at an accredited, licensed, certified facility for the treatment received.

For Covered Members who decline to purchase the minimum medical and hospital benefits under their automobile insurance Coverage, pursuant to Ark. Code Ann. § 23-89-202(1), the Program will coordinate as if the covered member had purchased this Coverage.

Notice and Proof of Claim

Filing a Claim—All claims are to be filed with the Program and mailed to Municipal Health Benefit Program, P.O. Box 188, North Little Rock, AR 72115. For any questions, you may call 501-978-6137. All claims, along with supporting information/documentation must be received in the Program office or by the Program within 180 days of the date the claim was incurred, unless defined otherwise in this section. Please note that the timely filing guidelines also apply to secondary payer rules (COB, as outlined within this booklet.) If an entire group or individual member is terminating Coverage, any incurred claim for benefits, along with supporting information/documentation, must be filed within 60 days of the last day of membership in the Program, or within the 180 days of the date of service, whichever is less. Additionally, providers seeking to appeal any denial or reduction of benefit payments must make their appeal within 60 days from the date of the denial or reduction in payment.

The Program may provide forms to facilitate a claims determination. If a form or supplemental information is requested by the Program, all forms must be completed and returned in a timely fashion (as defined by the requesting letter or form and are subject to the limitations in the above paragraph) before a claims determination will be made. The Member may request forms to facilitate a claims determination.

Failure to file a claim as required above, will cause the claim to be denied unless the Member can present written proof that it was not reasonably possible to give notice or proof within the required time period.

No legal action will be brought against the Program prior to 90 days after proof of claim has been filed with the Program Administrator. If the time for beginning legal action is less than that permitted by law of the jurisdiction in which the Program is domiciled, such limit is extended to the minimum period permitted by such law.

Payment of Benefits—Benefit payments for a Covered Service up to the Program's Allowed Amount will be paid to you or your provider promptly upon receipt of due written proof of claim. The Member is responsible for reimbursement to the Program to the extent of any overpayment that is in excess of the amount payable under the Program. If any benefit remains unpaid at your death, or if you are a minor or, in the opinion of the Program, are legally incapable of giving a valid receipt and discharge for any benefit, the Plan Administrator, may at his option, pay all or any part of such benefit (a) to your guardian or your estate, (b) to any institution or individual toward satisfaction of whose charges payment of such benefit is based, or (c) to any one or more persons among the following relatives: your spouse, parents, children, brothers, or sisters. The Plan Administrator's obligations will be completely discharged to the extent of such payment, and the Plan Administrator will not be required to see the application of the payment.

Assignment—Benefits that are not based on expenses incurred may not be assigned. However, benefits payable to you for expenses incurred in connection with a specific period of disability, hospital, surgical or medical treatment, resulting from one injury or period of illness of a covered member, may be assigned by you to the institution or individual furnishing the respective services or supplies for which such benefits are payable, otherwise such benefits may not be assigned. The Plan Administrator assumes no responsibility for the validity of any assignment, nor will he be liable under assignment, until and unless satisfactory proof of assignment is submitted to the Administrator prior to payment of the assigned benefits. Any payment made by the Administrator prior to receipt of satisfactory proof of assignment will completely discharge the Administrator's obligations to the extent of such payment and the Administrator will not be required to see the application of the payment.

Section 3: Prescription Drug Program

General Coverage

The Program will provide coverage for medications and specified supplies obtainable only on a physician's written prescription. It is important to know, however, that certain drugs and supplies are restricted or excluded from coverage by the Program. Every effort is made to identify restricted and excluded medications in the Program's documentation. Important information regarding specific prescription drug coverage is available on the Program's website, www.arml.org/mhbp.

MedImpact serves as the Program's prescription drug claims processor and pharmacy network provider. To locate a participating MedImpact pharmacy go to www.medimpact.com and enter your address or zip code.

You also have access to MedImpact's online prescription tool at www.medimpact.com. On this site, you can compare medication costs at local pharmacies, and see savings between brand-name and generic medications. If you have any questions regarding your prescription drug plan, please feel free to contact the Evidence-Based Prescription Drug Program (EBRx) at (833) 339-8401.

Prescription/Medical ID cards should be delivered within 30 days from the date the Program has received and processed your enrollment paper work. Be sure to provide this card to your pharmacist to ensure accurate submission of prescription claims on behalf of you and your family.

Coordination of Benefits Rules do not apply to the Prescription Drug Card Program except as provided under this Section.

Copayments

Covered Member copayments are outlined below (per 30-day supply). However, Copayments are not applicable under a Qualified High Deductible plan until the Major Medical and Prescription Drug Benefit Individual Calendar Year Deductible or Family Deductible has been met.

			Specialty Drugs	
Generic Drugs	Preferred Brand Name Drugs	Non-Preferred Brand Name Drugs	Drug Cost < \$1,000/30 days	Drug Cost > \$1,000/30 days
\$10.00	\$30.00	\$50.00	\$100.00	\$200.00

Deductible

Covered Members covered under a Qualified High Deductible Plan are subject to a *combined* Major Medical and Prescription Drug Benefit Individual Calendar Year Deductible of \$2,500, and a Family Calendar Year Deductible of \$7,500. This means that the Calendar Year Deductible applies to the Major Medical benefit, as well as to prescription drugs covered by the Program and that the Individual or Family Deductible shall be met before the Program will begin paying benefits. All other Covered Members are not subject to a Prescription Drug Benefit Deductible.

Out-of-Pocket Maximum

For Covered Members not participating in a Qualified High Deductible Plan*, the Calendar Year Out-of-Pocket Maximum for the Prescription Drug Benefit is:

- \$2,600 per Individual
- \$5,200 per Family

For these Covered Members, it is important to know that this Out-of-Pocket Maximum is separate from the Major Medical Out-of-Pocket Maximum and only applies to prescription drugs that are covered by the Program.

For Covered Members covered under a Qualified High Deductible Plan however, the *combined* Calendar Year Major Medical and Prescription Drug Benefit Out-of-Pocket Maximum is \$5,000 for an individual Covered Member, and \$10,000 for a Covered Member and his or her family. This means that the Calendar Year Out-of-Pocket Maximum applies to the Major Medical benefit, as well as to prescription drugs covered by the Program.

Once the Out-of-Pocket Maximum has been met under either the Standard or Qualified High Deductible Plan, the Program will pay 100 percent (100%) of the Allowed Amount of prescriptions drugs covered by the Program, unless excluded or modified by other portions of this Program Booklet.

Also note that expenses related to prescription drugs involved in the Program's Reference Pricing program (described below) are deemed **excluded** from Coverage and do not apply to the out-of-pocket maximum.

*Qualified High Deductible Plan is only available to certain groups, and the Individual Calendar Year Deductible shall apply to all Major Medical and Pharmacy benefits.

Brand-Name Drugs with a Generic Available—The Program enforces a Generic Incentive Policy for brand-name drugs that are available generically. In the event a brand-name drug is chosen for which an equivalent generic drug exists, the member will pay their generic co-payment PLUS the difference in cost between the generic and brand-name drug. Members are encouraged to choose generic drugs, when possible, to reduce out-of-pocket cost.

Covered Prescriptions—The Program only covers those medications and drug classes included on the Preferred Drug List located at www.arml.org/mhbp. The Preferred Drug List is updated quarterly, and the most recent version of the Preferred Drug List shall be used to determine coverage. While most commonly prescribed drugs are included on the Preferred Drug List, any new drugs entering the market will automatically be excluded from coverage. These drugs will remain excluded until evaluated by the EBRx Pharmacy and Therapeutics Committee. If this committee, made up of practicing physicians and pharmacists, determines that a product should be covered, it will then be moved to the appropriate preferred or non-preferred copay tier on the Preferred Drug List. Otherwise, it will remain excluded from Coverage. Non-FDA approved medications are also excluded from coverage.

Diabetes Testing Supplies—To assist members with diabetes in managing their disease, the Program provides the following supplies for a \$0 copayment (available at no charge to Covered Members covered under a Qualified High Deductible plan as well).

Blood Glucose Meter (1 free meter per year)

- Accu-Chek Guide-Me blood glucose meter

Blood Glucose Test Strips

- Accu-Chek Guide Test Strips

Lancets

NOTE: *This list is subject to change.*

You can receive your blood glucose strips and lancets at your local pharmacy. These supplies are available at no charge when purchased within 100 days of your insulin or diabetic medication. The pharmacy must process the prescription for your insulin or diabetic medication before processing the supplies. **Please Note:** The brands of diabetes testing supplies, syringes and pen needles provided by the Program are subject to change. Such changes will be communicated to affected Program participants.

Note: Medicare Retirees and/or those Medicare-eligible Covered Members whose primary insurance is Medicare must purchase their diabetic supplies under Medicare Part B. The pharmacy must electronically bill Medicare as primary and then bill MHBP/MedImpact as secondary. If a Covered Member purchases diabetic supplies within 100 days of filling an insulin or diabetic medication, the Covered Member will have a \$0 copayment on those related supplies.

Continuous Blood Glucose Monitoring Devices—To assist members with diabetes who require intense monitoring of blood glucose levels and who may be at increased risk of blood glucose fluctuations, the Program provides access to the following continuous glucose monitoring (CGM) devices. It is important to know that access to these devices are subject to prior authorization and will require a copayment. The brands currently provided by the Program are listed below and are subject to change.

- Dexcom Sensors \$50 (or Tier 3 copay per 30-day supply)
- Dexcom Transmitter \$0 copay
- Dexcom Receiver \$0 copay

Tobacco Cessation Program— The Program recognizes the benefits of a tobacco-free environment and will, therefore, support its members’ efforts in the discontinuation of tobacco use. The Tobacco Cessation Program is designed to assist members in their efforts to discontinue tobacco use by providing access to specific medications designed to diminish the dependence upon nicotine.

How the Tobacco Cessation Program Works—Members who wish to discontinue their tobacco use and participate in this program must obtain the appropriate prescriptions from their physician. These medications will be covered at a \$0 copayment; for members > 18 years of age. **Annual limit:** 2 cycles of treatment (12 weeks/cycle) in keeping with the Affordable Care Act (Healthcare Reform).

Preventive Services—The Program provides Coverage for the following “preventive” medications/drug categories as required by the ACA. These products will be available at \$0 copayment (and at \$0 charge for Covered Members covered under a Qualified High Deductible plan as well) unless otherwise specified when accompanied by a prescription from your physician. Reasonable medical management processes will be in place to ensure appropriate frequency, method, treatment, or setting for an item or service.

Drugs / Drug Categories	Coverage Parameters
Aspirin to Prevent Cardiovascular Disease	For members > 45 years of age. Quantity Limit of 100
Iron Supplementation for Children	For children up to 1 year of age
Oral Fluorides for Children	For children > 6 months and < 6 years of age
Folic Acid Supplements	For female members < 55 years of age. Quantity Limit of 100
Tobacco Cessation	For members > 18 years of age. Annual Limit: 2 cycles of treatment (12 weeks/cycle)
Routine Vaccinations for Children & Adults	Please refer to the Preventive Care section of the Program Booklet for detailed coverage policy
All FDA approved contraceptive methods	Coverage limited to The Program’s custom list and is subject to change
Breast Cancer Prevention	Tamoxifen, raloxifene
Vitamin D Supplementation	For members > 65 years of age
Cholesterol Reducers (Statins)	The following low-to-moderate potency agents are covered for members between 40–75 y/o for primary prevention: Atorvastatin 10mg, 20mg; Lovastatin 10mg, 20mg, 40mg; Pravastatin 10mg, 20mg, 40mg, 80mg; Rosuvastatin 5mg, 10mg; Simvastatin 5mg, 10mg, 20mg, 40mg

Mail-Order Pharmacy— The Program’s standard co-payment structure will apply to each 30-day supply of medication obtained through the mail service pharmacy. A maximum of a 90-day supply of medication may be obtained through the mail service pharmacy, however a copayment for each one-month supply will be charged.

If you’d like to get a 90-day supply of your maintenance medication(s), MedImpact Direct® provides free home delivery. Please register at www.medimpact.com.

Specialty Pharmacy—Specialty medications are those that treat potentially catastrophic illnesses (e.g. cancer, multiple sclerosis, rheumatoid arthritis, etc.), require specialty handling, and/or are very expensive. Specialty medications are generally covered under the prescription drug card benefit. However, due to the extreme cost of these products, they will be covered through a specialty pharmacy provider, Allcare Specialty Pharmacy. The Evidence-Based Prescription Drug program (EBRx) at UAMS will need to be contacted by the prescriber for Prior Authorization by calling (833) 339-8401. If approved, the authorization will be referred to Allcare Specialty Pharmacy. The member or physician will then be contacted to arrange for shipment of the medication.

The member will also be provided instructions on how to obtain subsequent refills, when refills are prescribed by the physician. Specialty medications are limited to a maximum of 30 days per prescription.

The list of Specialty medications is available on the Program's website at www.arml.org/mhbp.

Allcare Specialty Pharmacy (refills): 855-780-5500

Specialty Pharmacy Copayment: If the total cost of the medication is between \$0.01 and \$1,000 the member will be responsible for a \$100 copayment; if the total cost of the medication is over \$1,000, the member will be responsible for \$200 copayment.

Drug Therapy Management Features

In an effort to ensure that prescription coverage remains affordable for the Program's members, it is necessary to employ a variety of Drug Therapy Management Programs for covered drugs. These programs help reduce unsafe usage and costly medication wastage as well as encourage cost-effective drug therapy. Brief descriptions of these programs are provided below.

Dosing Guidelines/Quantity Limitations

Dosage guidelines or quantity limits are employed by the Program to ensure safe and effective drug usage. These guidelines are consistent with FDA-approved labeling and limit the amount of a particular medication that can be dispensed (1) per prescription, (2) per day, or (3) per time frame. The list of drugs managed by quantity limits is available at www.arml.org/mhbp.

NOTE: *Drugs may be added to the Program's quantity limit list throughout the year without notice.*

Step/Contingent Therapy

Step Therapy is designed to manage drug therapy in a "stepped" fashion that is consistent with established treatment guidelines. Step therapy also promotes cost-effective drug therapy, where appropriate, where the most cost-effective or clinically superior drugs are tried before other therapies can be used. It is important to understand that Step Therapy does not promote or require the use of inferior drug products and is not based solely on cost. In many situations, the newest and most heavily promoted drugs lack documented evidence that they are better than older and less expensive drugs. Therefore, Step Therapy may allow "step 2" drugs to be covered contingent upon (1) the prior use of a "step 1" drug or (2) presence or absence of a particular diagnosis or circumstance.

NOTE: *Drugs may be added to the Program's Step Therapy list throughout the year without notice.*

Reference Pricing

Reference Pricing is applied to drug classes where little to no clinical difference exists among drugs in the class, but where significant differences exist in cost. Based on published clinical evidence, the Program will select the Best-In-Class or Reference Drug for each drug class involved in Reference Pricing. The amount paid by the Program per tablet or capsule for the Reference Drug will be the amount the Program will pay for all other drugs in the same class. The member will be able to obtain a prescription for the Reference Drug for the Program's standard co-payment amount. For all other drugs in the same category, the member will pay the difference between the Total Cost of the drug being dispensed and the cost of the Reference Drug. This copayment can be substantial. Prescription drug expenses related to the Program's Reference Pricing program do not apply to the out-of-pocket maximum.

Members are encouraged to ask their doctor for a Reference Drug when appropriate in order to save money. Drug categories affected by Reference Pricing are identified on the Program's Preferred Drug List located on the Program's website at www.arml.org/mhbp.

NOTE: *Drugs and drug categories may be added to the Program's Reference Pricing list throughout the year without notice.*

Prior Authorization

The Program has established Coverage policies for certain medications and drug classes which will require Prior Authorization. When these medications are prescribed by your provider, your provider will be required to obtain authorization from the Program in order for the medication to be eligible for coverage (Prior Authorization). Your provider must contact The UAMS Evidenced-Based Prescription Drug Program (EBRx) at (833) 339-8401 to request prior authorization for medications requiring prior approval by the Program.

NOTE: *Medications requiring Prior Authorizations are subject to change and other medications may be added with or without notice.*

Provider Assistance

EBRx will administer the Prior Authorization management for selected medications and will address questions from providers (physicians and pharmacists) about these drugs. EBRx's call center hours of operation are Monday through Friday, 8:00 a.m.–5:00 p.m. CST.

Member Assistance

Members having general questions about the Program's prescription drug Coverage should call the UAMS Evidence-Based Prescription Drug Program (EBRx) at (833) 339-8401. The EBRx call center's hours of operation are Monday through Friday, 8:00 a.m.–5:00 p.m. CST.

Prescription Coverage for Members and Their Dependents who have Medicare as Their Primary Coverage

A benefit is provided by the Program to supplement Medicare Part D prescription drug Coverage. Enrollment for Medicare Part D Coverage is required in order to be eligible for this benefit supplement.

The supplement pays benefits toward out-of-pocket costs for expenses eligible under Medicare Part D that are also eligible under the provisions of Prescription Drug Coverage of the Program for Employees and Dependents.

Steps to Receive Medicare Part D Benefits

- Enroll in a Medicare Part D Plan and pay the monthly premium;
- Instruct the pharmacist to submit the prescription drug expense to the selected Medicare D Plan as the primary carrier and then submit to MedImpact as the secondary carrier;

Important Note:

If the pharmacy cannot coordinate benefits, submit a Prescription Drug Claim Form (available at www.arml.org/mhbp) to:

EBRx
Patient Reimbursement c/o UAMS College of Pharmacy
4301 W. Markham St.,
Slot #522
Little Rock, AR 72205

Attach copies of prescription receipts showing the following information:

Patient Name

- Pharmacy Name & Address
- Prescription Number
- Fill Date
- Drug Name & Strength
- Quantity & Days Supply
- Drug Cost
- Amount Paid

Please allow 4-6 weeks for processing.

Status of these claims can be obtained by calling the EBRx Call Center at 833-339-8401.

Section 4: Optional Benefits

Optional Benefits

The Program offers the following list of optional benefits that an Employer may elect to offer its eligible employees, elected officials, members of its boards and commissions, retirees, etc. However, for its members to be eligible for any optional benefits, such member must be enrolled in the Program's Major Medical Benefits.

Dental Benefits

Benefits Payable—Dental Benefits are payable if a Covered Member incurs Covered Dental Charges and has satisfied the Dental Calendar Year Deductible of \$50 for the year in which the charges are incurred, unless otherwise provided for in this Section. Benefits are payable based on the Allowed Amount and as provided below. However, the total amount payable for all Covered Dental Charges incurred by a Covered Member during a calendar year will not exceed the Annual Maximum of \$1,200 unless defined otherwise in the Schedule of Benefits.

Allowed Amount

The Allowed Amount for Covered Dental Charges is the maximum amount deemed by the Program, in its sole discretion, to be reasonable payment for Covered Dental Charges. The Allowed Amount for Preferred Providers means the amount Preferred Providers have agreed to accept as payment in full for Covered Dental Charges. For Out-of-Network Providers, the Allowed Amount means 50% of billed charges. Out-of-Network Providers are not under any obligation to accept the Program's Allowed Amount as payment in full and may bill Covered Members up to the billed charge after the Program has paid its portion of the Allowed Amount.

The Allowed Amount does not include charges used to satisfy the Member's Dental Calendar Year Deductible. Charges used to satisfy the Covered Member's applicable Dental Calendar Year Deductible will be deducted from the Allowed Amount.

Dental Care Coverage Maximums and Deductible

Dental Calendar Year Deductible (covers all services below)	Annual	\$50
Covered Dental Charges	Annual Maximum	\$1,200
Orthodontic	Lifetime Maximum	\$1,000
Temporomandibular Joint Dysfunction (TMJ)	Annual Maximum	\$1,000

Individual Coinsurance

After the Dental Calendar Year Deductible has been met by a Covered Member, the Program will pay the following percentages up to the Annual Maximum:

- Preferred Providers, In-State or Out-of-State—80% of the Program's Allowed Amount for Covered Dental Charges; 100% of the Program's Allowed Amount for Preventive Dental Services
- Out-of-Network Providers, In-State or Out-of-State—50% of the Program's Out-of-Network Allowed Amount for Covered Dental Charges; 50% of the Program's Out-of-Network Allowed Amount for Preventive Dental Services

Covered Dental Charges

Covered Dental Charges include only those charges for reasonable and necessary dental services and supplies as described below that are received by a covered member directly on account of dental treatment necessitated by dental disease or defect to teeth and which do not exceed the Program's Allowed Amount for the services and supplies furnished:

- Oral examinations, including prophylaxis, but not more than two examinations in any calendar year.
- Topical application of sodium or stannous fluoride and the application of sealants.
- Dental X-rays.
- Fillings, extractions, space maintainers, and oral surgery.
- Anesthetics administered in connection with covered dental services.
- Injection of antibiotic drugs by the attending dentist.
- Treatment of periodontal and other diseases of the gums and tissues of the mouth.
- Endodontic treatment, including root canal therapy.
- Repair or re-cementing of crowns, inlays, bridgework or relining or repair of dentures.
- Initial installation (including adjustments for the six-month period following installation) of partial or full removable dentures to replace one or more natural teeth extracted while covered under these provisions.
- New Dentures or Bridgework:

Two years after the effective date of the covered member's benefits, the Program will cover a new denture, or new bridgework, including crowns and inlays forming the abutments for the replacement of teeth that replaces an existing partial, fully removable denture(s) or fixed bridgework; or the Program will cover the addition of teeth to an existing partial removable denture or bridgework to replace extracted natural teeth, but only if evidence satisfactory to the Program is presented that:

- A. The existing denture or bridgework cannot be made serviceable and was installed at least five years prior to its replacement; or
- B. The existing denture is an immediate temporary denture and replacement by a permanent denture is required and takes place within 12 months from the date of installation of the immediate denture; or
- C. The replacement or addition of teeth is required to replace one or more additional natural teeth, extracted while covered under these provisions and after the existing denture or bridge work was installed.
 - Inlays, gold fillings, crowns (including precision attachments for dentures), and initial installation of fixed bridgework (including inlays and crowns to form abutment) to replace one or more natural teeth extracted while covered under these provisions.
 - Orthodontic treatment, including correction of malocclusion—However, the total amount of benefits payable for all such expenses incurred will not exceed the maximum benefit of \$1,000 even if required as a part of a medical procedure. Orthodontic benefits are not payable under the TMJ provisions of the Program.
 - Temporomandibular Joint Dysfunctions (TMJ)—Payment for services for the treatment of TMJ is limited to \$1,000 per calendar year. The calendar year limit will include services for facial or joint pain related to temporomandibular joint dysfunction. This limit applies to TMJ services, even if treatment is related to a medical condition, and is covered only under the Dental Benefit. TMJ benefits are not payable under the Orthodontic provisions of the Program.

Preventive Dental Services

The Program will pay 100 percent (100%) of the Allowed Amount for Preventive Dental Services provided by a Preferred Provider and only as provided below. Preventive Services are not subject to Coinsurance or the Dental Calendar Year Deductible. Preventative Services include:

Oral examination, including prophylaxis (cleaning)	Two examinations & cleaning/year
X-rays (Bitewing, Panoramic)	Bitewings, one/year as required
X-rays (Full Mouth)**	One/60 consecutive months
Flouride Application	One/year for dependent children up to age 19
Sealants	Payable once/tooth for dependent children up to age 19

**A combination of periapical and bitewing x-rays (10 or more films) or a panoramic film and additional x-rays make up a Full Mouth series.

Dental Exclusions

No benefits are payable for charges a covered member is not required to pay or which would not be made if benefits did not exist, or for expenses incurred:

On account of or in connection with:

- a. The replacement of a lost or stolen prosthetic device.
 - b. Charges made by a provider other than a dentist, or charges for treatment by a provider other than a dentist, except for a prophylaxis, which may also be performed by a licensed dental hygienist working under the supervision of a dentist.
 - c. Incurred due to a medical condition.
 - d. Services performed in a hospital or out-patient surgery setting, unless the member's treating provider deems it medically necessary to perform such services in a hospital or out-patient surgery setting
 - e. Prosthetic devices (including bridges, crowns and appliances) and the fitting thereof which were ordered for an individual prior to his becoming covered under these provisions.
- For care, treatment, services, and supplies that are:
 - a. Furnished primarily for cosmetic purposes.
 - b. Provided by someone who is an immediate relative as defined in Section 8: Definitions, page 61, or who ordinarily resides in your home.

PLEASE NOTE: *The Program does not pay for preparatory work done for the eventual placement of crowns, fixed bridge-work, and dentures until services for the placement have been received and completed.*

Vision Care Benefits

Vision Care Services

	Member Cost In-Network	Out-of-Network Member Reimbursement up to:
Exam (With dilation as necessary)	\$25 Copay	\$40

Frames

Any available frame at provider location.	\$0 Copay; \$100 allowance 20% off balance over \$100	\$50
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Contact Lenses

Contact Lens allowance includes materials only.

Conventional	\$0 Copay; \$120 allowance 15% off balance over \$120	\$96
Disposable	\$0 Copay; \$120 allowance plus balance over \$100	\$96
Medically Necessary	\$0 Copay, Paid-In-Full	\$210

Standard Plastic Lenses

Single Vision	\$25 Copay	\$40
Bifocal	\$25 Copay	\$60
Trifocal	\$25 Copay	\$80
Lenticular	\$25 Copay	\$100
Standard Progressive	\$80 Copay	\$60
Premium Progressive Tier 1	\$110 Copay	\$60
Premium Progressive Tier 2	\$120 Copay	\$60
Premium Progressive Tier 3	\$135 Copay	\$60
Premium Progressive Tier 4	\$200 Copay	\$60

Covered Lens Options

Standard Anti-Reflective	\$45 Copay	\$5
Premium Anti-Reflective Tier 1	\$57 Copay	\$5
Premium Anti-Reflective Tier 2	\$68 Copay	\$5
Premium Anti-Reflective Tier 3	\$85 Copay	\$5
Standard Polycarbonate under age 19	\$0 Copay	\$5

Additional Vision Care Services

Discounted Exam Services

Member Cost In-Network

Retinal Imaging Benefit	Up to \$39
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Contact Lens Fit and Follow Up

(Contact lens fit and two follow-up visits are available once a comprehensive eye exam has been completed.)

Standard Contact Lens Fit & Follow-Up	\$40
Premium Contact Lens Fit & Follow-Up	10% off retail price

Discounted Lens Options

Photochromic (Plastic)	\$75
Tint (Solid & Gradient)	\$15
UV Treatment	\$15
Standard Plastic Scratch Coating	\$15
Standard Polycarbonate—age 19 and over	\$40

Monthly Rate:

Individual Coverage:	\$4.58
Family Coverage:	\$11.70

If you are interested in adding vision benefits your group Coverage please contact the Program at 501-978-6137.

Once your group is enrolled, the vision benefit will be administered by EyeMed. You can reach EyeMed's customer service support at 844-409-3401.

Life Coverage

Life Benefits—If a death occurs while covered under the Program, the amount of Life benefits will be payable as described below:

Employee (up to age 81)		Consult your Employer for amount
Spouse	\$10,000	
Child by Age at Death 2 weeks	\$0	
2 weeks but less than 6 months	\$200	
6 months but less than 19 years	\$2,000	
19 years or over	\$0	

Life benefits cease when Coverage terminates, members go on retired status or go on COBRA.

Please consult your Employer to determine the amount of your Life and AD&D Benefits.

Payment of Claim—Upon receipt by the Program at its office of due written proof of claims for either employee or dependent, such amount will be promptly paid to you or your beneficiary, if living at the time payment is made. Otherwise, such amount will be paid in a single sum to the estate of the deceased.

Accidental Death and Dismemberment Benefits—A separate certificate outlines your benefits for Accidental Death and Dismemberment that are underwritten by an insurance company. Consult your Employer for amount of benefit. Benefit reduces by 50% at age 70.

Important:

For benefits to be paid to an unemancipated minor child named as a beneficiary, the minor child must be under the care of a parent or legal guardian. Proof of guardianship will be required.

In this instance the term Child shall include:

- a. An employee's natural child from birth less than 19 years of age.
- b. An employee's adopted child or stepchild under legal guardianship, if such child depends primarily on the employee for support and maintenance and lives with the employee in a regular parent-child relationship.
- c. An employee's grandchild who is under legal guardianship or legal custody of the employee.

Disability Income Benefits

Optional Coverage for Full-Time Employees Only

Some employers have an accident and illness income benefit that the Municipal Health Benefit Program administers. Please consult your Employer to determine if your group Coverage includes Disability Income Benefits.

Benefits Payable—Benefits are payable in the amount and for the period of time stated below based on the appropriate Weekly Benefit, Maximum Number of Weeks, and First Benefit Day. These benefits are payable if, while covered and as a result of illness or injury, you become totally disabled to the extent that you are completely and continuously prevented from performing any and every duty which your Employer may offer you, are under the direct care of a physician, are not engaged in any other work for compensation or profit, including self-employment and a physician determines that you are totally disabled. The Program reserves the right to request a determination of disability by a physician selected by the Program. This benefit is not assignable.

Option A (26 Week Benefit)		Option B (52 Week Benefit)	
Weekly Benefit	\$105	Weekly Benefit	\$105
First Benefit Day for Disability due to Accident	1 st Day	First Benefit Day for Disability due to Accident	183 rd Day
Illness	8 th Day	Illness	183 rd Day
Maximum Number of Weeks Payable	26 Weeks	Maximum Number of Weeks Payable	52 Weeks

Weekly Benefits are payable from the First Benefit Day of any one continuous period of disability up to the appropriate Maximum Number of Weeks. One-seventh of the Weekly Benefit is payable for each full day of covered disability but no benefit is payable for part of a day. Successive periods of disability, separated by less than two consecutive weeks of continuous full-time work with the Employer, will be considered one continuous period of disability unless the later disability is due to an unrelated cause, and begins after return to full-time work with the Employer for at least one full day.

Filing a Claim—For a covered member to file a disability claim, he or she should contact their Employer to obtain a Request for Disability Income Form. The requested forms must be submitted and received by the Program within 180 days of the first date of disability. The Disability Income Form is also available online at www.arml.org/mhbp. Timely filing guidelines for active members and when benefits stop apply to this benefit.

Disability Income Benefits Exclusions—Disability payments will not be made unless you are under the continuous care of a physician, or for any disability due to intentionally self-inflicted injury, or for any disability due to injury or illness arising out of or in the course of any employment for compensation or profit. The Exclusions provision of the Hospital or Major Medical Expense Benefits will, to the extent not inconsistent, also apply to these benefits.

Section 5: How MHBP Pays Benefits (PPO)

Preferred Provider Network for Major Medical, Optional Dental, and Optional Vision Care

The Program utilizes a network of providers (Preferred Providers) to offer a health benefit designed to provide Covered Members with economic incentives for using the Program's network. Preferred Providers for medical, optional dental, and optional vision have agreed to certain terms and conditions, including to accept the Program's Allowed Amount as payment in full for Covered Services. A directory of Preferred Providers can be accessed at www.arml.org or at www.firsthealth.org, and is subject to periodic changes. Covered Members should check with his or her chosen provider before undergoing any treatment to make certain of its network status. The Program does not deny a Covered Member access to healthcare, or to a provider of his or her choice, however benefits will be greater if accessed in the Preferred Provider network. Any provider not included in the Preferred Provider network will be considered Out-of-Network, and benefits will be paid accordingly.

Unless otherwise provided, Covered Members should be aware that if they elect to utilize the services of an Out-of-Network provider for Covered Services, benefit payments are not based upon the amount billed. Generally, Covered Members can expect to pay more than the applicable Calendar Year Deductible, copayment (if applicable) and Coinsurance amounts (the Member's cost share) after the Program has paid its portion of the Allowed Amount. Most Out-of-Network Providers are not under any obligation to accept the Program's Allowed Amount as payment in full and Covered Members will be responsible for all amounts billed by Out-of-Network Providers in excess of the Allowed Amount (in addition to the to the Covered Member's applicable cost share of the Allowed Amount, this is referred to as "balance billing"). Please see below, "No Surprise Billing: Out-of-Network Emergency Services & Out-of-Network Providers at In-Network Facilities" for additional information related to certain out-of-network services.

Allowed Amount

The Allowed Amount is the maximum amount deemed by the Program, in its sole discretion, to be reasonable payment for a Covered Service. Benefits under the Program will always be limited by the Allowed Amount. This means that regardless of how much a health care provider may bill for any service, drug, medical device, equipment, or supplies, the benefits under this Program will be limited to the Allowed Amount.

The Program calculates and pays Program benefits on the basis of the Allowed Amount, an amount that may vary substantially from the amount a provider chooses to bill. Once the Allowed Amount is determined with respect to any provider's submitted charges, the Covered Member may be responsible for a percentage or portion of the Allowed Amount, depending on the terms of the Program with respect to copayments, Coinsurance, and the Calendar Year Deductible.

The Allowed Amount for Preferred Providers means the amount Preferred Providers have agreed to accept as payment in full for Covered Services.

Unless otherwise provided below (See "No Surprise Billing: Out-of-Network Emergency Services & Out-of-Network Providers at In-Network Facilities"), for Out-of-Network Providers, the Allowed Amount means charges equivalent to 150% of Medicare, and as established by the Board of Trustees on an annual basis, or charges as established by the Program's utilization of health care cost management services (i.e. Fair Market Pricing), less any adjustments applied according to the Program's Utilization Review Program, or the Program's AWP provision (see below). Generally, Out-of-Network Providers are not under any obligation to accept the Program's Allowed Amount as payment in full and may bill Covered Members up to the billed charge after the Program has paid its portion. Covered Members will be responsible for

all amounts billed by Out-of-Network Providers in excess of the Allowed Amount (in addition to the Covered Member's applicable cost share of the Allowed Amount).*

To illustrate, if Covered Services are provided by a Preferred Provider, once the Covered Member has satisfied his or her Calendar Year Deductible requirement, the Program may pay 80% of the Allowed Amount. Therefore, in this case, the Covered Member would be responsible for the remaining 20% of the Allowed Amount, but not for the difference between the Allowed Amount and the Preferred Provider's billed charges. In this situation, the Preferred Provider contract protects the Covered Member from additional "balance billing" beyond the Allowed Amount.

For an Out-of-Network Provider, unless otherwise provided, the circumstances are substantially different. For example, if services are provided by an Out-of-Network Provider, once the Covered Member has satisfied his or her Calendar Year Deductible, the Program may pay only 50% of the Allowed Amount, in which case the Covered Member would be responsible for the remaining 50% of the Allowed Amount. However, the Covered Member might also be held responsible by the Out-of-Network Provider for paying the difference between the Allowed Amount and the Provider's full, billed charges ("balance billing").

Preferred Provider Network

The Program manages a network of directly contracted providers as well as leases access to a complementary network of providers through an agreement with First Health (collectively referred to as Preferred Providers). A directory of Preferred Providers, as well as a list of participating pharmacies can be accessed at www.arml.org/services/mhbp, or you may contact Customer Service at **501-978-6137, Option 6**. The list is subject to periodic changes. Covered Members should check with his or her chosen provider before undergoing any treatment to make certain of its network status. The Program does not deny a Covered Member access to healthcare, or to a provider of his or her choice, however benefits will be greater if accessed in the Preferred Provider network. Any provider not included in the Preferred Provider network will be considered Out-of-Network, and benefits will be paid accordingly.

After the Calendar Year Deductible(s) are met, the Program will pay the following percentages for Covered Services under the Major Medical Benefit:		
	<u>In-Network</u>	<u>Out-of-Network</u>
Emergency Covered Services (In-State or Out-of-State)	80% of the Program's Preferred Provider Allowed Amount	80% of the Program's Out-of-Network Allowed Amount*
All other Services (In-State or Out-of-State)	80% of the Program's Preferred Provider Allowed Amount	50% of the Program's Out-of-Network Allowed Amount*

* When a Covered Member receives emergency care out-of-network, or when a Covered Member receives care at an in-network facility, but the care is provided by an out-of-network provider, the benefits paid by the Program may be different than the Out-of-Network benefits and percentages included above. Please see the section below entitled, "No Surprise

Billing: Out-of-Network Emergency Services & Out-of-Network Providers at In-Network Facilities“ for additional information related to certain out-of-network services.

Out-of-Network Covered Services

Unless otherwise provided below (See “No Surprise Billing: Out-of-Network Emergency Services & Out-of-Network Providers at In-Network Facilities”), for Covered Services provided by Out-of-Network Providers, the Allowed Amount means charges equivalent to 150% of Medicare, and as established by the Board of Trustees on an annual basis, or charges as established by the Program’s utilization of health care cost management services (i.e. Fair Market Pricing), less any adjustments applied according to the Program’s Utilization Review Program, or the Program’s AWP provision (see below).

The Program may also utilize Fair Market Pricing. Fair Market Pricing incorporates geographic and provider-specific benchmarks to maximize claim discounts. Some of the benchmarks that may be used include, but are not limited to the following:

- Proprietary database with over 280,000 claims reviewed, processed, and accepted as full and final payment by the provider
- Locality-specific Medicare rates
- National Correct Coding Initiatives Edits (NCCI)
- Cost-to-charge ratios

Specific hospital payments, charges and costs reported by code

- Tricare reimbursement rates
- Appropriate adjustments of modifiers
- Financial data reported by hospitals

All Covered Services provided by an Out-of-Network provider are subject to the terms and conditions of the Program Booklet, including any benefit exclusions and/or limitations, AWP, and its Utilization Review Program. Out-of-Network Providers are not under any obligation to accept the Program’s Allowed Amount as payment in full and Covered Members will be responsible for all amounts billed by Out-of-Network Providers in excess of the Allowed Amount (in addition to the Covered Member’s cost share of the Allowed Amount).

No Surprise Billing: Out-of-Network Emergency Services & Out-of-Network Providers at In-Network Facilities

In certain out-of-network scenarios, a Covered Member may be protected from “balance billing” under the No Surprise Act. The scenarios are limited to when a Covered Member receives emergency care treatment by an out-of-network hospital or ambulatory surgical center, or receives care by an out-of-network provider at an in-network facility.

Balance Billing (“Surprise Billing”)

When a Covered Member receives services from a doctor or other health care provider, there are certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible, that the Covered Member must pay. Generally, there are additional costs that the Covered Member must pay in additions to these out-of-pocket costs if the Covered Member seeks care that isn’t within the Municipal Health Benefit Plan (MHBP) Preferred Provider network (“out-of-network”). “Out-of-network” describes providers and facilities that haven’t signed a contract with the Program. Out-of-network providers may be permitted to bill a Covered Member for the difference between what the Program has agreed to pay and the full amount charged for a service. This is called “**balance billing**.” This amount is likely more than in-network costs for the same service and might not count toward a Covered Member’s annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when a Covered Member can’t control who is involved in their care—like when there is an emergency or when a Covered Member schedules a visit at an in-network facility but is unexpectedly treated by an out-of-network provider.

Covered Members are protected from balance billing when seeking emergency care out-of-network, or when seeking care at an in-network facility, but the care is provided by an out-of-network provider.

Emergency services

If a Covered Member has an emergency medical condition and receives emergency services from an out-of-network provider or facility, the most the provider or facility may bill the Covered Member is the Program’s in-network cost-sharing amount (such as copayments and coinsurance). The Covered Member **can’t** be balance billed for these emergency services. This includes services the Covered Member may get after they’re in stable condition, unless the Covered Member gives written consent and gives up their protections not to be balance billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When a Covered Member receives services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill the Covered Member is the Program’s in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can’t** balance bill a Covered Member and may **not** ask a Covered Member to give up their protections not to be balance billed.

All Covered Services provided by an Out-of-Network provider are subject to the terms and conditions of the Program Booklet, including any benefit exclusions and/or limitations, AWP, and its Utilization Review Program, regardless of the type of Covered Services provided.

Qualified Payment Amount

When a Covered Member receives Out-of-Network Emergency Services or Out-of-Network Services at an In-Network Provider, the Allowed Amount is based on the “Qualified Payment Amount”.

Qualified Payment Amounts are based on the median of the following:

- Contracted Rates for Covered Services with the same or similar HCPCS, CPT or DRG, as applicable, and the same or similar modifier(s) where such modifier(s) impact rates.
- Contracted Rates for Covered Services as provided by the same or similar provider-types (e.g., hospital, laboratory, ambulatory surgery center);
- Contracted Rates for Covered Services provided in the same or similar geographic area. If insufficient data is available in the Metropolitan Statistical Area, broader geographic areas may be used (e.g., region, state); and
- Contracted Rates in the same or similar benefits market (e.g., self-insured employer-sponsored health plans).

Section 6: Coordination of Benefits

Coordination of Benefits (COB)

You or your family members may have Coverage under more than one health plan. This Program contains a coordination of benefits provision which eliminates duplication of payment for services you receive while you have Coverage under this Program. The benefits payable under this Program for medical, dental, or vision expenses will be coordinated with other group insurance and health benefit plans providing benefits for such expenses to cover up to 100 percent of Allowed Amounts incurred, after the deductible has been satisfied. Benefits payable under the Program will also be coordinated with any other applicable medical payment or hospital benefit Coverage, including, but not limited to, Coverage provided under travelers, auto*, and homeowners insurance. The Program will follow the usual rules of coordination of benefits. It is your responsibility as a member of the Program to notify MHBP of any and all health coverages that are active for you and/or your eligible dependents. If the other coverage ends, you must provide a Certificate of Coverage from the insurance carrier that shows the termination date of that policy.

***PLEASE NOTE:** For covered Members who decline to purchase the minimum medical and hospital benefits under their automobile insurance Coverage, pursuant to Ark. Code Ann. § 23-89-202(1), the Program will coordinate as if the covered member had purchased this Coverage.

Integration of Benefits

Integration of benefits applies when a covered person is receiving benefits for medical expenses from more than one source. The benefits payable under this Program will not exceed 100 percent of the annual eligible benefits when combined with all other plans.

When Medicare pays as the Primary Plan (defined below), you must first file all charges with Medicare. You will receive an Explanation of Medicare Benefits (EOMB) outlining their payment or denial information. This EOMB must accompany any claim submitted to the Program for consideration of reimbursement from the Program as Secondary Plan (defined below).

For covered Members who are totally disabled or reach age 65 and are eligible for Medicare and fail to apply for Medicare in a timely fashion, the Program will coordinate with Part A, Part B and Part D of Medicare in the same manner as if the covered Member had Part A, Part B and Part D of Medicare and Medicare is the Primary Plan. This means that the Program will reimburse only 20 percent of the eligible charge and you will be responsible for the deductible and then 80 percent of the remaining eligible charge.

Prescription drug card or managed care prescription plan copayments will not be reimbursed under the Coordination of Benefits provision, except for Medicare Part D.

The Program's Administrators have the right to exchange information required to administer this provision with any other party (insurance company, organization, or person) to recover any overpayment made to any party.

How Coordination of Benefits (COB) Works

1. This is how COB usually works, if there is no med-pay issue involved: If more than one group covers you, COB guidelines determine which plan pays for the covered services first.
 - A. Your Primary Plan is the plan paying first.
 - B. Your Secondary Plan is the plan paying second or after the Primary Plan has paid.
2. This is how to determine which is the Primary Plan and Secondary Plan:

- A. The plan covering the Employee is primary unless the employee's automobile med-pay comes into play such as in the event of a single-vehicle accident. The plan covering the Employee as an Eligible Dependent is secondary.
- B. If both the mother's and father's plans cover the child, the plan of the parent whose birthday month is earlier in the year is the primary plan.
- C. Benefits for children of divorced or separated parents are determined in the following order:
 - a. Plan of the parent the court has established as financially responsible for the child's health care pays first (we must be informed of this requirement and documentation will be required).
 - b. Plan of the custodial parent.
 - c. Plan of the custodial parent's new spouse (if remarried).
 - d. Plan of the non-custodial parent.
 - e. Plan of the non-custodial parent's new spouse (if remarried).

If the Primary Plan cannot be determined by using the guidelines above, then the plan covering the child for the longest period is primary. If a group medical plan does not have a Coordination of Benefits provision, that plan is primary.

If you or your Eligible Dependent has Coverage under a Primary Plan other than the Program, but you do not follow the plan benefit requirements of the Primary Plan, the Program's reimbursement for your claims will be reduced by 80 percent. In other words, the maximum the Program will pay is 20 percent of the Allowed Amount for a claim.

If you or your Eligible Dependent(s) have Coverage with another health care issuer that constitutes a Primary Plan and you do not follow that issuer's benefit requirements for that Coverage, then the Program will not be responsible for the payment of benefits. Nor will the Program coordinate benefits in these cases.

1. Guidelines to Determine Primary and Secondary Plans for Medicare Recipients:

- A. If your Employer has less than 20 employees, Medicare is primary for covered members eligible for Medicare due to age.
- B. If your Employer has less than 100 employees, Medicare is primary for covered members eligible for Medicare due to disability.
- C. If your Employer has more than 100 employees, the Program is primary over Medicare for covered members eligible for Medicare due to age or disability.

A Member eligible for Medicare based solely on end stage renal disease is entitled to receive benefits of this Program as primary for a 30-month waiting period.

COB Allowed Expense—COB Allowed Expense is a health care expense (including deductible, coinsurance or copayments) covered in full or in part by the Primary Plan. This means an expense or service not covered by your Primary Plan is not an Allowed expense under the Program.

Notice and Proof of Claim

Filing a Claim—All claims are to be filed with the Program and mailed to Municipal Health Benefit Program, P.O. Box 188, North Little Rock, AR 72115. For any questions, you may call 501-978-6137. All claims, along with supporting information/documentation must be received in the Program office or by the Program within 180 days of the date the claim was incurred, unless defined otherwise in this section. Please note that the timely filing guidelines also apply to secondary payer rules (COB, as outlined within this booklet.) If an entire group or individual member is terminating Coverage, any incurred claim for benefits, along with supporting information/documentation, must be filed within 60 days of the last day of membership in the Program, or within the 180 days of the date of service, whichever is less. Additionally, providers seeking to appeal any denial or reduction of benefit payments must make their appeal within 60 days from the date of the denial or reduction in payment.

The Program may provide forms to facilitate a claims determination. If a form or supplemental information is requested by the Program, all forms must be completed and returned in a timely fashion (as defined by the requesting letter or form and are subject to the limitations in the above paragraph) before a claims determination will be made. The Member may request forms to facilitate a claims determination.

Failure to file a claim as required above, will cause the claim to be denied unless the Member can present written proof that it was not reasonably possible to give notice or proof within the required time period.

No legal action will be brought against the Program prior to 90 days after proof of claim has been filed with the Program Administrator. If the time for beginning legal action is less than that permitted by law of the jurisdiction in which the Program is domiciled, such limit is extended to the minimum period permitted by such law.

Payment of Benefits—Benefit payments for an allowable expense up to the Program’s Allowed Amount will be paid to you promptly upon receipt of due written proof of claim. The Member is responsible for reimbursement to the Program to the extent of any overpayment that is in excess of the amount payable under the Program. If any benefit remains unpaid at your death, or if you are a minor or, in the opinion of the Program, are legally incapable of giving a valid receipt and discharge for any benefit, the Plan Administrator, may at his option, pay all or any part of such benefit (a) to your guardian or your estate, (b) to any institution or individual toward satisfaction of whose charges payment of such benefit is based, or (c) to any one or more persons among the following relatives: your spouse, parents, children, brothers, or sisters. The Plan Administrator’s obligations will be completely discharged to the extent of such payment, and the Plan Administrator will not be required to see the application of the payment.

Assignment—Benefits that are not based on expenses incurred may not be assigned. However, benefits payable to you for expenses incurred in connection with a specific period of disability, hospital, surgical or medical treatment, resulting from one injury or period of illness of a covered member, may be assigned by you to the institution or individual furnishing the respective services or supplies for which such benefits are payable, otherwise such benefits may not be assigned. The Plan Administrator assumes no responsibility for the validity of any assignment, nor will he be liable under assignment, until and unless satisfactory proof of assignment is submitted to the Administrator prior to payment of the assigned benefits. Any payment made by the Administrator prior to receipt of satisfactory proof of assignment will completely discharge the Administrator’s obligations to the extent of such payment and the Administrator will not be required to see the application of the payment.

Overpayments: Right of Recovery

As discussed more fully herein, the Program specifically excludes from Coverage any illness or injury for which a “third party” may be liable or legally responsible. For this purpose, “third party” means a person or organization other than the participant or insured who suffers the loss. If you or your dependents receive payment, expect to receive or seek payment from a third-party insurer, surety, or other type plan for medical expenses resulting from such illness or injury, you should not submit a claim under this Program for such medical expenses. However, the Program, at its sole discretion, may provide benefits according to Program terms provided that the participant agrees, in writing:

- To give the Program written notice whenever a claim against a third party is made for damages as a result of an injury, sickness or condition.
- The participant or insured agrees to promptly notify the Program as to whether the participant or insured or anyone acting on his/her behalf is pursuing or intends to pursue an action against, or to seek recovery from, any third party for damages, indemnity, recovery, insurance, or other payment of any kind whatsoever in connection with the accident, injury, or other event giving rise to the Program’s obligations to make expenditures to or on behalf of the member, so that the Program can protect its rights to recover.
- Nothing in this section shall be deemed to waive or otherwise diminish any rights to reimbursement, subrogation, assignment, or other recovery available to the Program under applicable common or statutory laws.
- That the Program will be treated as subrogated to the extent of benefits paid and any rights of recovery that the participant may have against a third party.
- As a condition to receiving benefits from the Program, each participant, former participant or other person having an interest in or eligibility under the Program (“Member”) agrees that the Program will be treated as subrogated to the extent of benefits paid and any rights of recovery that the participant may have against a third party, and that, in the implementation of such subrogation right, the Program may directly pursue recovery against such third party and can treat the participant (and such individual’s attorney) as acting as the Program’s agent with respect to the prosecution of any claim and the recovery of any amount, and that the participant will execute such further documents as may be necessary to effectuate the Program’s subrogation right.
- To reimburse the Program in accordance with these provisions.
- Notwithstanding and in addition to the above, in the event you receive a benefit payment that exceeds the amount you have a right to receive, the Program retains the right to require you to return the overpayment or to reduce any future benefit payments made to you or your dependents by the amount of the overpayment. This right does not affect any other right of recovery with respect to such overpayment. You are required to produce any instruments or papers necessary to ensure this right of recovery.

- As a condition to receiving benefits from the Program, each participant, former participant or other person having an interest in or eligibility under the Program (“member”) shall provide the Program with a Right of Reimbursement and an Assignment of Rights, as described below. These rights enable the Program to recover the amount it has expended to provide the benefits to the member from any proceeds the member receives from a third person in connection with the accident or injury.
- The Program will refuse to provide the participant or other covered members of the participant’s family any benefits under the Program if the participant refuses to execute an agreement agreeing to reimburse the Program, fails to reimburse the Program, or fails to cooperate in helping the Program collect reimbursement from the participant or a third party.

Right of Reimbursement

As a condition to receiving benefits from the Program and by their receipt of said benefits, all participants and insureds grant the Program the right to recover from any proceeds, including any form of consideration whatsoever, that the participant/insured receives from a third party, via judgment, settlement, or otherwise in connection with the accident, injury or other event that resulted in the Program’s expenditures, dollar for dollar beginning with the first dollar received by the member from the third party, regardless of how those proceeds are characterized or labeled (e.g., payment of medical expenses, pain and suffering damages, compensatory damages, punitive damages, or any other type of non-economic or economic damages), in an amount equal to the expenditures made by the Program in providing benefits to the member.

Without limiting the Program’s rights in any way, it is the intention of the parties that the Program is entitled to recover from any proceeds that the member receives from a third party, regardless of how those proceeds are characterized or labeled or how they are obtained; i.e., judgment rendered by a court, jury, or other judicial tribunal; awards given or reached in arbitration, mediation, or any other form of dispute resolution, whether said awards were given by the person deciding the outcome of the dispute resolution or by the parties to that process; settlement, or any other arrangement.

It is an additional condition to receiving benefits under the Program that the member grant the Program a first lien with respect to any proceeds that the member receives from a third party in connection with the accident, injury, or other event that gave rise to the Program’s expenditures, so that every such dollar of any such proceeds will be paid to the Program, beginning with the first dollar and continuing until the Program has been paid an amount equal to the amount it expended to provide benefits to the member, regardless of how that payment is labeled or characterized, regardless of any purported allocation or itemization of such recovery to specific types of injuries, and regardless of the injury or loss ostensibly redressed by the payment or the apparent cause or inducement for such payment. If the recovery is for damages other than for medical or dental care expenses, such as pain and suffering, the participant will still be required to reimburse the benefits paid by the Program first. The Program’s right of reimbursement will apply to the first dollar recovered from the third party, before attorneys’ fees and even if the recovery is less than the amount needed to reimburse the participant fully. The Program’s right of reimbursement will apply to all amounts received from or on behalf of the third party, whether directly or indirectly, including, without limitation, payments to an account or trust on the participant’s behalf.

The parties hereby specifically disavow and waive the “made whole” doctrine or any other principle of law that would require that the member be fully compensated before payment is made to the Program under its Right of Reimbursement or any of its other rights to recovery, whether contractual, legal, or equitable.

In the event a participant or insured fails to provide reimbursement to the Program under these provisions within a reasonable amount of time after receiving proceeds (including any form of consideration) from any third party, the Program reserves the right to offset future payments to or on behalf of the participant or other covered members of the participant’s family to collect a reimbursement, until it has been fully reimbursed for the expenditures it has made.

In the event a court of competent jurisdiction determines that any part of the foregoing Right to Reimbursement is unenforceable for any reason, it is the intent of the parties that the Program shall retain all rights provided for in those parts that remain enforceable, including without limitation the Program’s right to recover the expenditures it has made to provide benefits to the member, to the extent that any portion of the proceeds paid to the member by any third party is designated as compensation for medical expenses or for other expenses paid by the Program to or on behalf of the member, or which are intended as, or can reasonably be attributed to, compensation for medical expenses or other expenses paid by the Program, though not expressly designated as such, which determination shall be made at the sole discretion of the Program.

In order to obtain reimbursement, the Program will take such actions as the Board of Trustees, in its discretion, feels would best serve the Program. The Program may seek to have any payment by a third party made payable to the Program in lieu of, or in addition to, the participant or his/her assigns or representatives.

Assignment of Rights

In addition to providing the Right of Reimbursement described above, and as an additional condition to receiving benefits from the Program, the member will assign to the Program any and all rights to pursue an action or claim against any third party in connection with the accident, injury or other event that gave rise to the Program's expenditures. If the Program pursues any such action or claim, the member shall cooperate and assist the Program and shall be prohibited from taking any action that would prejudice the Program's rights or in any way diminish its prospects for a recovery.

In addition, the participant must execute a lien in favor of the Program for the amount to which the Program is entitled. However, even if the participant or insured does not give the Program a lien, the participant is liable to the Program for reimbursement under these provisions:

- To ensure that any amounts received from or on behalf of a third party are kept separate and are not commingled with any other funds.
- To notify the Program within 10 days after receiving any recovery from or on behalf of a third party.

NOTE: *The foregoing provisions are not intended and shall not be deemed to constitute a waiver of the Program's right to deny Coverage for any illness or injury for which a third party may be liable or legally responsible, as discussed above, or for any other illness or injury that is excluded under the terms of the Program. In no event shall the foregoing language be deemed to vest a participant or other Covered Member of a participant's family with the right to receive Coverage for claims that are specifically excluded under the Program.*

Furthermore, notwithstanding the above provisions, the Program reserves the right to seek reimbursement for any and all overpayments which it may make by offsetting future payments to or on behalf of the participant or other covered members of the participant's family, until it has been fully reimbursed for the expenditures it has made.

Section 7: Appeals

Claims Reviews and Appeals Procedure

Getting Help with your Claim for Benefits

If you have a question about your claim payment or how the Program works, we urge you to call and visit with a Municipal Health Benefit Program customer service representative at **501-978-6137, Option 4**.

Generally, a denial of a claim for benefits will be explained in writing setting forth a specific reason for the denial. The explanation may also provide a description of additional information you might be required to provide for reconsideration of your claim and an explanation of why it is needed. If a claims or benefit question cannot be resolved through Customer Service, it may be resolved through an appeals procedure as set out below.

Claims and Appeals Procedures Generally

Claims and appeal processes are governed by the Patient Protection and Affordable Care Act (PPACA) as well as the regulations pertinent to the Act. As such, Federal law requires the Program to use reasonable procedures with respect to requests, also known as a claim, for a plan benefit or benefits. Claims procedures address the filing of claims, notification of benefit determinations, and appeals from benefit determinations and also deal with preauthorization requirements, utilization reviews and applicable time frames. These requirements and procedures are set out in more detail in the **Internal Claims and Appeal Reviews and the Independent External Claims Review** sections found on the following pages.

Provider Appeals:

Providers seeking to appeal any denial or reduction in benefit payments are not governed by the PPACA but must make their appeal within 60 days from the denial or reduction in payment.

Internal Written Appeal—Within 60 days of having received a claims denial notice, write to the Claims Review Team, at Municipal Health Benefit Program, P.O. Box 188, North Little Rock, AR 72115. In your request for a review of the denial specifically state why you believe the denial was incorrect.

Within 60 days the receipt of your request, a Claims Review Team Representative will respond to you in writing with a determination regarding your appeal. If your claim is denied, the response will reference the Program provision upon which the denial was based and will provide you with an explanation of additional appeals you may make. If the Program needs time to investigate the facts, you will be notified.

Member Appeals:

Before filing a law suit you must exhaust your administrative rights and remedies

The Program requires an employer member and its employee members must exhaust all of their administrative remedies including, but not limited to, the claims procedures, the internal review procedures, including the review by the Board of Trustees, and, to the extent available, Federal external review processes, before any legal action is brought in any court.

Your rights and responsibilities are set out in complete detail in the Internal and External Review sections; however the “First Internal Written Appeal” and “Final Internal Written Appeal” immediately following this paragraph provides a simplified and non-exhaustive overview of the internal review process. More particular information is to be found in the Internal Claims and Appeal Reviews and the Independent External Claims Review sections found on the following pages.

First Internal Written Appeal—Within 60 days of having received a claims denial notice, write to the Claims Review Team, at Municipal Health Benefit Program, P.O. Box 188, North Little Rock, AR 72115. In your request for a review of the denial specifically state why you believe the denial was incorrect.

Within 60 days the receipt of your request, a Claims Review Team Representative will respond to you in writing with a determination regarding your appeal. If your claim is denied the response will reference the Program provision upon which the denial was based and will provide you with an explanation of additional appeals you may make. If the Program needs time to investigate the facts, you will be notified.

Final Internal Written Appeal—If the decision rendered by the Claims Review Team is not satisfactory, you or a duly authorized representative may appeal from that denial to the Board of Trustees for the Municipal Health Benefit Program

within 60 days of having received a denial notice from the Claims Review Team. To do so, write to the Plan Administrator, P.O. Box 188, North Little Rock, AR 72115. In your request for a review of the denial specifically state why you believe the denial was incorrect. In connection with your request, you may submit documents supporting your claim. Your appeal will be reviewed by the Board at the quarterly meeting of the Board of Trustees along with documents pertinent to the administration of the Program. You may attend the Board meeting and present your case to the Board and may have representation throughout this review procedure though you need not make an appearance at the Board meeting.

The Board will reach a decision on your claim no later than 180 days after receipt of the request for the Board's review. If there are special circumstances, the decision shall be rendered as soon as reasonably possible. The Board's decision shall be in writing and shall include specific reference to the pertinent Program provisions on which the decision was based.

Internal Claims and Appeal Reviews

1. Definitions

Some definitions helpful to an understanding of claims procedures are set out below.

- A. **Adverse benefit determination**—The term “adverse benefit determination” means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for:
- A benefit;
 - A benefit based on a determination of whether a participant or beneficiary is eligible to participate in the Program;
 - A benefit resulting from the application of any utilization review; as well as
 - Failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; or

Any rescission of Coverage, regardless of whether there is an adverse effect on any particular benefit at that time.

- A. **Appeal (or internal appeal)**—The term “appeal or internal appeal” means a review by the Program.
- B. **Claim involving urgent care**—The term “claim involving urgent care” is 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, as determined by an individual acting on behalf of the Program applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine; or
 - A physician with knowledge of the claimant's medical condition opines that without the care or treatment that is the subject of the claim the claimant would be subjected to severe pain that cannot be adequately managed; unless
 - Any claim that a physician with knowledge of the claimant's medical condition determines is a “claim involving urgent care” shall be treated as a “claim involving urgent care.”
- C. **Claimant**—The term “claimant” means a person covered by the Program who makes a claim under this section. References to a claimant include a claimant's authorized legal representative.
- D. **External review**—The term “external review” means a review of an adverse benefit determination (including a final internal adverse benefit determination) conducted pursuant to the federal external review process.
- E. **Final external review decision**—The term final external review decision means a determination by the independent review organization at the conclusion of an external review.
- F. **Final internal adverse benefit determination**—The term “final internal adverse benefit determination” means an adverse benefit determination that has been upheld by the Program at the completion of the internal appeals process or when the internal appeals process is deemed exhausted under federal law.
- G. **Health care professional**—The term “health care professional” means a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.
- H. **Notice or notification**—The term “notice” or “notification” means that the delivery or furnishing of information to an individual shall be done in a manner that is reasonably calculated to ensure actual receipt of the material by Program participants, beneficiaries and other specified individuals. See 9(j) for more information on notice to non-English literate persons covered by the Program.

- I. **Post-service claim**—The term “post-service claim” means any claim for a benefit under a group health plan that is not a pre-service claim.
- J. **Pre-service claim**—The term “pre-service claim” means any claim for a benefit under a group health plan, with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.
- K. **Rescission**—The term “rescission” is a cancellation or discontinuance of Coverage that has retroactive effect. For example, a cancellation that treats Coverage as void from the time of the individual’s or group’s enrollment is a rescission. As another example, a cancellation that voids benefits paid up to a year before the cancellation is also a rescission for this purpose. A cancellation or discontinuance of Coverage is not a rescission if:
 - The cancellation or discontinuance of Coverage has only a prospective effect; or
 - The cancellation or discontinuance of Coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of Coverage.
- L. **Relevant**—The term “relevant” means that a document, record, or other information shall be considered “relevant” to a claimant’s claim if such document, record, or other information:
 - Was relied upon in making the benefit determination;
 - 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; or
 - Demonstrates compliance with required administrative processes and safeguards in making the benefit determination.

These claims procedures do not preclude an authorized representative of a claimant from acting on behalf of a claimant in pursuing a benefit claim or appeal of an adverse benefit determination. Nevertheless, the Program has established reasonable procedures for determining whether an individual has been authorized to act on behalf of a claimant. Also, in the case of a claim involving urgent care, a health care professional, with knowledge of a claimant’s medical condition shall be permitted to act as the authorized representative of the claimant.

If a claimant or an authorized representative of a claimant fails to follow the Program’s procedures filing a pre-service claim, the claimant or representative shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification shall be provided to the claimant or authorized representative, as appropriate, as soon as is possible, but not later than five (5) days (24 hours in the case of a failure to file a claim involving urgent care) following the failure. Notification may be oral, unless written notification is requested by the claimant or authorized representative. If claims procedures are not followed in the filing of a claim for benefits notice by the Program shall be provided only in the case of a failure that is a communication by a claimant or an authorized representative of a claimant that is received by a person or organizational unit customarily responsible for handling benefit matters; and is a communication that names a specific claimant; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.

2. Denials

Except as provided below in this section, (see Urgent Care, Concurrent Care, Pre-service and Post-service claims) if a claim is wholly or partially denied, the Program shall notify the claimant of the Program’s adverse benefit determination within a reasonable period of time, but not later than ninety (90) days after receipt of the claim by the Program, unless the Program determines that special circumstances require an extension of time for processing the claim. If so, written notice of the extension shall be furnished to the claimant prior to the termination of the initial ninety (90) day period. In no event shall such extension exceed a period of ninety (90) days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Program expects to render the benefit determination. During the appeal process, the Program will provide continued Coverage pending the outcome of the appeal. Notification of any adverse benefit determination pursuant to this paragraph shall be made in accordance with paragraph 9(J).

3. Urgent care

In the case of a claim involving urgent care, the Program shall notify the claimant of the benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the claim by the Program, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Program. In the case of such a failure, the Program shall notify the claimant as soon as possible, but not later than twenty-four (24) hours after receipt of the

claim by the Program, of the specific information necessary to complete the claim. The claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. The Program shall notify the claimant of the Program's benefit determination as soon as possible, but in no case later than forty-eight (48) hours after the earlier of:

- The Program's receipt of the specified information, or
- The end of the period afforded the claimant to provide the specified additional information.

4. Concurrent care decisions

If the Program has approved an ongoing course of treatment to be provided over a period of time or number of treatments:

Any reduction or termination by the Program of such course of treatment (other than by amendment of the Program's plan or termination of the plan) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. The Program shall notify the claimant of the adverse benefit determination 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 adverse benefit determination before the benefit is reduced or terminated.

Any request by a claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible, taking into account the medical exigencies, and the Program shall notify the claimant of the benefit determination, whether adverse or not, within twenty-four (24) hours after receipt of the claim by the Program, provided that any such claim is made to the Program at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments.

Notification of any adverse benefit determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in accordance with paragraph 9 of this section and the appeal shall be governed by paragraph 10 of this section, as appropriate.

5. Other claims

In the case of a claim not described above the Program shall notify the claimant of the Program's benefit determination as set out above, as appropriate.

6. Pre-service claims

In the case of a pre-service claim, the Program shall notify the claimant of the Program's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the claim by the Program. This period may be extended one time by the Program for up to fifteen (15) days, provided that the Program both determines that such an extension is necessary due to matters beyond its control and notifies the claimant, prior to the expiration of the initial fifteen (15) day period, of the circumstances requiring the extension of time and the date by which the Program expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least forty-five (45) days from receipt of the notice within which to provide the specified information.

During the appeal process, the Program will provide continued Coverage pending the outcome of the appeal. Notification of any adverse benefit determination pursuant to this paragraph shall be made in accordance with paragraph 11.

7. Post-service claims

In the case of a post-service claim, the Program shall notify the claimant of the Program's adverse benefit determination within a reasonable period of time, but not later than thirty (30) days after receipt of the claim. This period may be extended one time by the Program for up to fifteen (15) days, provided that the Program that such an extension is necessary due to matters beyond the control of the Program and notifies the claimant, prior to the expiration of the initial thirty (30) day period, of the circumstances requiring the extension of time and the date by which the Program expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the

claimant shall be afforded at least forty-five (45) days from receipt of the notice within which to provide the specified information.

During the appeal process, the Program will provide continued Coverage pending the outcome of the appeal. Notification of any adverse benefit determination pursuant to this paragraph shall be made in accordance with paragraph 11.

8. Calculating time periods

The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed in accordance with Program procedures, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended as permitted due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

9. Form, manner and content of notification of benefit determination

Except for required oral notification, the Program shall provide a claimant with written or electronic notification of any adverse benefit determination. Any electronic notification shall comply with federal regulatory authority and the notification shall set forth, in a manner calculated to be understood by the claimant:

- A. Information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of diagnosis and treatment codes and corresponding meanings;
- B. Any denial code along with its corresponding meaning, and a description of the Program's standard, if any, that was used in denying the claim;

The specific reason or reasons for the adverse determination, including any final internal adverse benefit determination;

- C. Reference to the specific plan provisions on which the determination is based; and
- D. 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.
- E. If requested, the Program will provide to participants and beneficiaries, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse benefit determination or final internal adverse benefit determination. The Program will not consider a request for diagnosis and treatment information, in itself, to be a request for an internal or external appeal.
- G. The Program will provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal.
- F. In the case of a notice of final internal adverse benefit determination, the description will include a discussion of the decision.
- G. The Program will also disclose the availability of, and contact information for the Arkansas Insurance Department's Consumer Assistance Program, *i.e.*:
Telephone: 800-852-5494 or 501-371-2640
Fax: 501-371-2749
Email: insurance.consumers@arkansas.gov
- H. In the case of an adverse benefit determination by the Program concerning a claim involving urgent care, a description of the expedited review process applicable to such claims.
- I. In the case of an adverse benefit determination by the Program concerning a claim involving urgent care, the information provided by the Program to the claimant may be given to the claimant orally within prescribed time frames given that a written or electronic notification is furnished to the claimant not later than seventy-two (72) hours after the oral notification.

The Program will provide relevant notices in a culturally and linguistically appropriate manner to those Program participants who reside at an address in a county where 10 percent or more of the population residing in the participant's county, as determined by Federal law, and who are literate only in the same non-English language. The Program will also provide applicable non-English oral language services, such as a telephone customer-assistance hotline that includes answering questions in any applicable non-English language as well as assistance in filing claims and appeals (including external review).

10. Appeal of adverse benefit determinations

A claimant covered by the Program shall have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the Program, and under which there will be a full and fair review of the claim and the adverse benefit determination. As such, the Program will allow a claimant to review the claim file and to present evidence and testimony as part of the internal claims and appeals process.

A full and fair review also includes the procedures set out below.

The Program will:

- A. Provide claimants at least 180 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;
- B. Provide claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
- C. Provide a claimant, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
- D. Provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;
- E. Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Program who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
- F. Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard 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 has appropriate training and experience in the field of medicine involved in the medical judgment;
- G. Provide for the identification of medical experts whose advice was obtained on behalf of the Program in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;
- H. Provide that the health care professional engaged for purposes of a consultation shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and
- I. Provide, in the case of a claim involving urgent care, for an expedited review process pursuant to which—
 - a. A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and
 - b. All necessary information, including the Program's benefit determination on review, shall be transmitted between the Program and the claimant by telephone, facsimile, or other available similarly expeditious method.
- J. The Program will provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Program (or at the direction of the Program) in connection with the claim as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided under paragraph 11 of this section to give the claimant a reasonable opportunity to respond prior to that date; and before issuing a final internal adverse benefit determination based on a new or additional rationale, the Program will provide to the claimant, free of charge, the rationale as soon as is possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided under paragraph 11 of this section to give the claimant a reasonable opportunity to respond prior to that date.

11. Timing of notification of benefit determination on review

- A. **Urgent care claims**—In the case of a claim involving urgent care, the Program shall notify the claimant of the Program's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the claimant's request for review of an adverse benefit determination by the Program.
- B. **Pre-service claims**—In the case of a pre-service claim, the Program shall notify the claimant of the Program's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. Because the Program provides for two appeals of an adverse determination, such notification shall be provided, with respect to any one of such two (2) appeals, not later than fifteen (15) days after receipt by the Program of the claimant's request for review of the adverse determination.
- C. **Post-service claims**—In the case of a post-service claim, except as provided for in appeals to the Board of Trustees, the Program shall notify the claimant of the Program's benefit determination on review within a reasonable period of time. Because the Program provides for two appeals of an adverse determination, such notification shall be provided, with respect to any one of such two appeals, not later than thirty (30) days after receipt by the Program of the claimant's request for review of the adverse determination.

12. Calculating time periods

For purposes of an appeal, the period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the reasonable procedures of a Program, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

13. Furnishing documents

In the case of an adverse benefit determination on review, the Program shall provide such access to, and copies of, documents, records, and other information.

14. Manner and content of notification of benefit determination on review

The Program will provide a claimant with written or electronic notification of a Program's benefit determination on review. Any electronic notification shall comply with the standards established by Federal law. In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by the claimant:

- A. The specific reason or reasons for the adverse determination;
- B. Reference to the specific Program provisions on which the benefit 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 claimant's claim for benefits.

For additional information on the manner and content of notification of benefit determination, see paragraph I on page 56.

15. Failure to establish and follow reasonable claims procedures

In the case of the Program's failure to establish or follow claims procedures consistent with the requirements Federal law, a claimant shall be deemed to have exhausted the administrative remedies available under the Program and shall be entitled to pursue an external review on the basis that the Program has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

Independent External Claims Review

The Municipal Health Benefit Program (Program) gives you the opportunity to seek review of certain claim denials by an independent external review organization. If you disagree with the Program's final determination on internal appeal, you can seek review within four months of the decision.

Your claim is eligible for external review if either:

- The Program or its designee does not strictly adhere to all claim determination and appeal requirements under federal law (other than minor violations); or
- You have exhausted the standard levels of appeal and your appeal relates to:
 - a. An adverse benefit determination (ABD) by the Program, including a final internal ABD, that involves medical judgment (including, but not limited to those based on the Program's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or, its determination that a treatment is experimental or investigational), as determined by the external reviewer; or
 - b. A rescission, which is a retroactive cancellation or discontinuance of Coverage.

Claims based on solely on (a.) legal or contractual disputes or (b.) issues regarding your eligibility are not eligible for external review.

Your claim is eligible for an expedited external review if you have a medical condition and:

- You have requested an expedited internal appeal but the time frame for completion of the expedited internal appeal would seriously jeopardize your life, your health, or your ability to regain maximum function; or
- The time frame for completion of a standard external review would seriously jeopardize your life, your health, or your ability to regain maximum function; or

The ABD concerns an admission, availability of care, continued stay or health care service for which you received emergency services, but have not been discharged from a facility.

Notification of External Review

Rights and Assignment to Independent External Review Organization

If your final internal appeal is denied, you may request an External Review by an Independent External Review Organization.

You may submit a standard external review request via mail or fax within four months after you received the final internal adverse benefit determination notice or within four months after notice that the request does not meet the criteria for an expedited review.

You must provide the following information:

- Name
- Address
- Phone
- Email address
- Whether the request is urgent
- Patient's signature if person filing the appeal is not the patient
- A brief description of the reason you disagree with your Program's denial decision

You may use an HHS Federal External Review Request Form to provide this and other additional information. In addition, you may submit additional information for consideration of your external review request.

For example, you may provide:

- Documents to support the claim, such as physicians' letters, reports, bills, medical records, and explanation of benefits (EOB) forms;
- Letters sent to the Program about the denied claim; and
- Letters received from the Program.

Instructions for Sending Your External Review Request

You may call, toll free, 1-888-866-6205, to request an external review request form and send your request for an external review to the address listed on your final adverse benefit determination (denial) letter from the Program, or you may send your external review request: **By Mail:**

MAXIMUS Federal Services
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534

By Fax: 1-888-866-6190

NOTE: *There is no charge for submitting the external review request.*

Preliminary Review

When the external review examiner receives the external review request the examiner will contact the Program to provide notification that it must forward any information considered in making the ABD or final internal ABD within five days.

This includes:

- Your certificate of Coverage or benefit;
- A copy of the ABD;
- A copy of the final internal ABD;
- A summary of the claim;
- An explanation of the Program's ABD;

All documents and information considered in making the ABD or final internal ABD including any additional information provided to the Program relied on during the internal appeals process;

- The external review examiner will review the information provided by the Program and may request additional information;
- The external review examiner will notify you and Program in writing if it determines that the claim is not eligible for an external review;
- The examiner will review all of the information timely received and consider the claim without being bound by any decision reached during the Program's internal claims and appeals process;
- Upon request by the Program, the examiner will forward all documents submitted by you to the Program. Upon receipt of any such information, the Program may reconsider its ABD or final internal ABD. This reconsideration must not delay review. The external review may be terminated if the Program decides to reverse its decision and provide Coverage or payment after reconsideration. The Program must provide written notice to you and the examiner within one business day after making the decision to reverse. The examiner must terminate the external review upon receipt of the notice from the Program.

The examiner must provide written notice of a final determination on the external review to you and the Program as expeditiously as possible, but no later than 45 calendar days from the date of receipt of the request for external review.

The final external review decision notice will contain:

- A description of the reason for the requested external review with sufficient information to identify the claim;
- The date the examiner received the external review assignment;
- References to evidence or documentation considered in decision;
- Discussion of the reasoning for the decision including rationale and any evidence-based standards relied upon;
- A statement that the decision is binding except to the extent that other remedies may be available under state or federal law to you and the Program;
- A statement that judicial review may be available to you;
- Current contact information for any applicable health insurance consumer assistance or ombudsman;
- The examiner must maintain records of all claims and notices associated with the external review process for six years and make the records available for examination by you or the Program upon request;
- Upon receipt of a final external review decision reversing the ABD or final internal ABD, the Program must immediately provide Coverage or payment for the claim.

Expedited Reviews

- An expedited timeline is followed in cases where you have filed a request for an expedited internal appeal and meets the conditions for an expedited review. (See above.)
- The examiner will contact the Program once the examiner receives a request for expedited review and request all documents and information required under a standard review.
- The examiner will review all information received from the Program and may request additional information that it deems necessary to the external review.
- The examiner will notify you and the Program as expeditiously as possible if the examiner determines that you are not eligible for external review.
- The examiner will review all of the information timely received and then consider the claim without being bound by any decision reached during the plan or issuer's internal claims and appeals process.

The examiner will forward all documents submitted by you to the Program. Upon receipt of the information the Program may reconsider its ABD or final internal ABD. This reconsideration must not delay review. The external review may be terminated if the Program decides to reverse its decision and provide Coverage or payment after reconsideration. The Program must immediately provide notice to you and the examiner after making the decision to reverse. This notice may be oral but must be followed up with written notice within 48 hours. The examiner must terminate the external review upon receipt of initial notice from the Program.

- The reviewer shall make a final determination on the external review and communicate it to you and the Program within 72 hours from the time of receipt of the request or sooner depending on medical circumstances of the case.
- If you are notified orally, the reviewer will follow-up with written notice within 48 hours after delivery of the oral notice.
- The examiner's final external review decision and records maintenance must comply with the same requirements as for final external review decisions in standard external review.
- Upon receipt of a final external review decision reversing the ABD or final internal ABD, the Program must immediately provide Coverage or payment for the claim.

Technical Assistance is available by calling toll-free: 1-888-866-6205

- Available 24 hours a day, 7 days a week
- You may leave messages and receive instructions on submitting expedited external review requests • TTY for hearing impaired
- Interpreter through the AT&T language line

Translated brochures are available upon request, under CLAS standards

Section 8: Definitions

Definitions

Actively Working means the active expenditure of time and energy by the Employee performing each and every duty pertaining to the job in the place where and the manner in which such job is normally performed. For an Employee to be actively working, he or she must work an average of 30 hours per week on a regular basis and receive a payroll check for such service. If the Employee is not receiving a payroll check, he or she will be considered inactive, and his or her benefits will be terminated as defined in the Program.

Acupuncture means puncture treatment or therapy with long, fine needles.

Advanced Practice Nurse (APN) means a person who is licensed as a registered professional nurse under the state in which they are practicing, meets the requirements for licensure as an advanced practice nurse and has a written collaborative agreement with a collaborating physician in the diagnosis of illness and management of wellness and other conditions as appropriate to the level and area of his or her practice.

Adverse Benefit Determination (ABD) means a denial, reduction or termination (in whole or in part) of payment for a benefit. See Section 7: Appeals, page 51, for a complete definition.

Allowed Amount is the maximum amount deemed by the Program, in its sole discretion, to be reasonable payment for a Covered Service. Benefits under the Program will always be limited by the Allowed Amount. This means that regardless of how much a health care provider may bill for any service, drug, medical device, equipment, or supplies, the benefits under this Program will be limited to the Allowed Amount.

The Program calculates and pays Program benefits on the basis of the Allowed Amount, an amount that may vary substantially from the amount a provider chooses to bill.

The Allowed Amount for Preferred Providers means the amount Preferred Providers have agreed to accept as payment in full for Covered Services. For Out-of-Network Providers, the Allowed Amount means charges equivalent to 150% of Medicare, and as established by the Board of Trustees on an annual basis, or charges as established by the Program's utilization of health care cost management services (i.e. Fair Market Pricing), less any adjustments applied according to the Program's Utilization Review Program, or the Program's AWP provision (see below). Out-of-Network Providers are not under any obligation to accept the Program's Allowed Amount as payment in full and may bill Covered Members up to the billed charge after the Program has paid its portion. Covered Members will be responsible for all amounts billed by Out-of-Network Providers in excess of the Allowed Amount (in addition to the Covered Member's applicable cost share of the Allowed Amount).

The Allowed Amount does not include charges used to satisfy the Member's Calendar Year Deductibles or copayment assessed under the Program's Major Medical Benefit or the Prescription Drug Card Program. Charges used to satisfy the Member's applicable Calendar-Year Deductible or copayment will be deducted from the Allowed Amount.

Average Wholesale Pricing (AWP)—The charge determined by the Program for drug products provided to Covered Members, employing the most current Average Wholesale Price (AWP) of the drug product or other industry-accepted benchmarks as set forth by Medispan, First Databank, or other industry-accepted databases. The Program has the right to review all claims for such drug products provided to its Covered Members and will reimburse providers at eighty-five (85%) percent of AWP for claims billed. The National Drug Code (NDC) is a unique product identifier used in the United States for drugs intended for human use.

Benefit means the benefit provided to Members of the Program.

Employee Benefit means the Benefit provided for eligible Employees.

Dependent Benefit means the Benefit provided for Eligible Dependents of eligible Employees.

Case Manager means the individual who coordinates process of assessment, planning, facilitation, care coordination and evaluation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality and cost-effective outcomes.

Certificate of Creditable Coverage means a written certificate issued by the Program, or another health insurance issuer, that shows your prior health Coverage (creditable Coverage). A certificate will be issued automatically and free of charge when you lose Coverage under the Program, when you are entitled to elect COBRA continuation Coverage or when you lose COBRA continuation Coverage. A certificate will also be provided free of charge upon request while you have health Coverage or within 24 months after your Coverage ends.

Chemical Dependency Treatment is treatment for the use of alcohol, cannabis, hallucinogens, inhalants, opioids, sedative hypnotic, or anxiolytics, stimulants, and tobacco where there is a problematic pattern of substance use leading to clinically significant impairment or distress as manifested by at least two of the following occurring in a 12-month period where:

1. The substance is often taken in larger amounts or over a longer period of time than was intended;
2. There is a persistent desire or unsuccessful efforts to cut down or control substance use;
3. There is a great deal of time spent in activities necessary to obtain the substance, use the substance, or recover from its effects, craving or strong desire to use the substance;
4. There is a problematic pattern of substance use leading to clinically significant impairment or distress as manifested by at least two of the following occurring in a 12-month period:
 5. There is a recurrent use resulting in failure to fulfill major role obligations at work, school, home;
 6. There is continued substance use despite having persistent or recurrent social or interpersonal problems;
 7. Important social, occupational, or recreational activities are given up or reduced because of substance use;
 8. There is recurrent substance use in situations in which it is physically hazardous;Substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance;
9. Tolerance, as defined by either of the following:
 - A. A need for markedly increased amounts of the substance to achieve intoxication or desired effect,
 - B. A markedly diminished effect with continued use of the same amount of substance.
10. Withdrawal, as manifested by either of the following:
 - A. Characteristic withdrawal syndrome for the substance,
 - B. Use of the substance or closely related substance is taken to relieve or avoid withdrawal symptoms.

Clean Claim is a properly completed billing form UB 94, HCFA 1500, or their successor form(s), or one providing equivalent information with complete and current CPT or ICD coding, which needs no additional information or clarification from the health care provider or Covered Person for payment to be made properly, i.e., medical records, detailed billing, invoices, or any other such like information.

Code refers to a medical billing code (i.e., ICD-9, ICD-10, CPT)

Coinsurance means the ratio (percentage) of splitting the bill between the Program and the Covered Person.

Example: 80 percent for the first \$5,000 of eligible charges means the Program will pay \$4,000 and the Covered Person is responsible for the remaining \$1,000.

Copayment means an amount required to be paid by a Covered Person each time a specific covered service is accessed. The copayments are set forth in the Schedule of Benefits. See Section 2: Benefits, page 13.

Cover or Coverage means that a Member or Eligible Dependent has satisfied all applicable Program requirements and is receiving Benefits under the Program.

Covered Person, Covered Individual or Covered Member means a Member or Eligible Dependent Covered by the Program provision in which the term is used, but only while under such provisions.

CPT Code means the current code for a medical procedure to be used for billing purposes as set forth in the applicable Current Procedural Terminology established and maintained by the American Medical Association.

Custody means the care, control and maintenance of a child that may be awarded by a court to one of the parents of the child or a Guardian.

Dentist means any physician as otherwise defined in this booklet practicing within the scope of their respective profession who performs a dental procedure covered by the Program.

Dependent means any individual who qualifies as a dependent under Code Section 152 (as modified by Code Section 105(b)). “Dependent” shall include an Employee’s natural child, stepchild, foster child, adopted child, or a child placed with the Employee for adoption until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person.

Eligible Class means an employee classification whose members may be eligible for Employee Benefits under the Program if their Employer becomes a Participating Employer and all service requirements, if any, are met. The employee classifications that may constitute an Eligible Class are described in Section 1: General Eligibility Information, page 7.

Eligible Dependent means a dependent of an Employee who is eligible for Benefits under the Program and includes the following:

- **An Employee’s Spouse**—Not legally separated or divorced from the Employee;
- **An Employee’s Adult Dependent**—A Dependent (other than the Employee’s spouse) who is between age 19 to age 26;
- **An Employee’s Child**—Under the age of 19 years; the term Child(ren) shall include:
 - a. An Employee’s natural child(ren) from birth until less than 19 years of age.
 - b. An Employee’s stepchild(ren), foster child(ren), adopted child(ren), or child(ren) under legal guardianship or legal custody, if such child depends primarily on the Employee for support and maintenance and lives with the Employee in a regular parent-child relationship.
 - c. Adopted children and stepchildren ages 19 to 26 must have met the above requirements at the time the Child turned 19 to be considered an Eligible Dependent. Copies of supporting documentation will be required for these Dependents.

Employee—See Member/Employee.

Employer means the Program or a municipality who in either instance participates in the Coverage offered by the Program for the benefit of its eligible employees.

The terms **Experimental and Investigative** apply to a medical device, medical treatment or pharmaceutical treatment that cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA). The Program may select a medical review professional to help determine whether a specific treatment is Experimental or Investigative, but in any event, the decision of the Program will be considered final and binding on all parties.

After all other provisions of the Program have been complied with, the following criteria and guidelines will be used by the Program in determining whether medical devices, medical treatments and pharmaceutical treatments are to be considered Experimental or Investigative and whether they will or will not be covered by the Program.

If FDA approval for use of a drug to treat a specifically diagnosed condition has not been given at the time of treatment, such use shall be known as “off-label” use and will not be covered by the Municipal Health Benefit Program, with the exception for the diagnosis of cancer, which will be reviewed on a case-by-case basis utilizing standards set forth in the Milliman Care Guidelines.

The Program will not provide Coverage for medical services that are subject to ongoing clinical trials or research except as required by federal law.

The Program will not provide Coverage for medical devices unless all of the following criteria are met:

- a. The FDA has approved the device for marketing.
- b. The device is being used to treat a condition specifically recognized and authorized by the FDA marketing approval.
- c. The device has been recognized for its clinical effectiveness in treating the condition according to the nationally accepted medical guidelines utilized by the Program.

Program means the Municipal Health Benefit Program, as presented in the Program Booklet as approved by the Board of Trustees.

Program Booklet means the Program Document which sets out the Program’s terms and conditions as included herein. No contract, agreement or financial arrangement other than the Declaration of Trust, as amended from time to time, supersedes the terms, conditions, limitations and exclusions set forth in the most current Municipal Health Program Booklet.

Program Month means a period of one month beginning on the date regular monthly premiums became due under the Municipal Health Benefit Program.

Guardian means a person lawfully invested with the power and charged with the duty of taking care of a child and managing the property and rights of that child.

Habilitative Services means services provided in order for a person to attain and maintain a skill or function that was never learned or acquired and is due to a disabling condition.

HIPAA Privacy Rule means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as amended.

Homebound means that leaving home is a major effort; you are normally unable to leave home unassisted and you are unable to go to work; when you leave home, it must be to get medical care, or for short, infrequent non-medical reasons such as a trip to get a haircut, or to attend religious services.

Home Office means the Home Office of the Plan Administrator.

Home Setting means medical care provided in the home.

Hospice Care means medical care of dying persons while allowing them to remain at home under professional medical supervision.

Hospital means an institution operated according to law that regularly provides continuous room and board and nursing service for its patients; has a staff including one or more physicians available at all times; is equipped with organized facilities on its own premises for diagnosis, therapy and/or major surgery; and is not primarily a clinic, outpatient surgery center, nursing, residential treatment or convalescent facility, or an institution for treatment of alcoholism or drug abuse.

Hospital Care Period means successive periods of Inpatient care in a Hospital setting for illness or injuries due to the same or related causes unless such periods of Hospital care are separated by at least 60 consecutive days or, in the case of an Employee, by at least one day of active work with the Employer.

Hyperbaric Oxygen Treatment means a medical treatment that allows patients to utilize pure oxygen inside a pressurized chamber.

Illness means illness or disease and related medical conditions.

Immediate Relative means your spouse, parents, children, brother, sister, grandparents, uncles, aunts, nieces, nephews or legal Guardian of the Covered Person who received the services for which a claim has been submitted to the Program.

Injury means a bodily injury sustained accidentally by external means.

In-Network means that a health care provider is a member of the Program's Preferred Provider Network.

Inpatient means a Member who is a patient using and being charged for the daily room and board facilities of a Hospital or approved facility, or a Member who remains under medical observation longer than 23 hours.

Licensed Certified Social Worker means a person who has a Master's Degree from an accredited social work program in an accredited institution approved by the state in which the individual is licensed to practice. This definition shall also extend to licensed certified counselors. To qualify for a Benefit for services provided by a Licensed Certified Social Worker, the Program Member must have been referred to the Licensed Certified Social Worker by a licensed Physician.

Long-Term Care (LTC) means the provision of medical, social, and personal care services on a recurring or continuing basis to persons with chronic physical or mental disorders. The care may be provided in environments ranging from institutions to private homes. Long-Term Care services usually include symptomatic treatment, maintenance, and rehabilitation for patients of all age groups.

Maintenance Therapy means a therapeutic regimen intended to preserve the patient's functionality so that the patient continues in good health practices without supervision, incorporating them into a general lifestyle.

Major Medical Benefits means Coverage designed to compensate for particularly large medical expenses due to a severe or prolonged illness, usually by paying a percentage of medical bills above a certain amount.

Medically Necessary means services that, unless otherwise stated in the Program booklet, are medically necessary if, under generally accepted principles of good medical practice and professionally recognized standards, that are required for and consistent with the diagnosis, care, and treatment of a condition, disease, ailment or injury that is covered (eligible for payment) under the Program. A service is not Medically Necessary if it is provided solely for the convenience either of the covered individual or any provider. Services that may otherwise be Medically Necessary may not be Covered Services if they are excluded or limited in their Coverage by the Program, or if the requirement of the Utilization Review Program are not met.

Medicare Eligibility means that an individual has met certain criteria that qualify him or her to apply for and receive Medicare benefits, such as turning 65 or becoming disabled.

Medicare Entitlement means that an individual eligible for Medicare benefits has actually applied to begin Social Security income payments or filed an application for hospital insurance benefits under Part A of Medicare and is therefore entitled to begin receiving Medicare benefits.

Member or Employee means an eligible person or their Dependents who has submitted an enrollment form and has been accepted as a member of the Municipal Health Benefit Program and remains a member in good standing according to the policy provisions of the Program. In addition to full-time active employees who work at least 30 hours per week for a participating employer, those eligible for membership also include elected officials, members of a board or commission, volunteer firefighters, auxiliary police or retirees.

Month means the period of time from the beginning of a numbered calendar day of a calendar month to, but not including, the same numbered day of the following calendar month.

Morbid Obesity means a condition in which a Covered Person's weight exceeds his or her ideal weight, defined as having a Body Mass Index (BMI) of greater than 35 to 40.

Municipal means pertaining to a local governmental unit or political subdivision, such as incorporated cities and towns of Arkansas and Arkansas counties and their agencies or instrumentalities, including limited service members of the League.

Non-Emergency Procedure means a medical procedure to improve health or quality of life when the medical condition is not considered immediately life-threatening. Non-emergency procedures are pre-scheduled to a specific date and are not considered emergent in nature.

Non-PPO means an out-of-network provider that does not participate in the Program's preferred provider network.

Nutritional is defined as (1) the process of nourishing or being nourished, especially via the process by which a living organism assimilates food and uses it for growth and for replacement of tissues; or (2) the science or study that deals with food and nourishment, especially in humans; or (3) a source of nourishment, food; and (4) the provision to cells and organisms of the materials necessary in the form of food to support life.

Occupational Therapist means a person who has a Master's Degree in Occupational Therapy from an accredited institution approved by the state in which the individual is licensed to practice who helps patients to develop skills in carrying out activities of daily living, vocational skills and fine motor hand skills. They also make and apply orthoses and treat psychologically impaired patients.

Occupational Therapy means a therapeutic use of self-care activities to increase independent function, enhance development and prevent disability.

Open Enrollment Period means the period of time immediately preceding the beginning of each calendar year as established by the Board of Trustees, such period to be applied on a uniform and consistent basis for all Employers and Employees, during which an Employee may enroll or change his or her Coverage selections under the Program. At times, the Board of Trustees may recommend a mid-year Open Enrollment Period. If approved, the mid-year enrollment period will be the period of time immediately preceding July of each calendar year.

Out-of-Network means a provider that is not a member of the Municipal Health Benefit Program's Preferred Provider Network.

Outpatient means services or treatment for care of illness or injury provided to a Member in a Hospital or other licensed facility that does not require the Member to stay in such facility for longer than twenty-three (23) consecutive hours for such services or treatment.

Participating Employer means a municipality who is a member of the Arkansas Municipal League that has been admitted as a party to the Program and has agreed, by entering into a Participation Agreement with the Trustees or otherwise, to make contributions to the Program on behalf of its Eligible Class of Employees.

PHI means Personal Health Information, as defined in the HIPAA Privacy Rule.

Physical Therapist means a doctor or an individual licensed by the proper authority or certified by the American Physical Therapy Association.

Physical Therapy is a rehabilitation treatment that improves further deterioration of a bodily function that has been lost or impaired through a disease or injury. This treatment involves physical contact with the impaired area such as massage, manipulation, heat or hydrotherapy.

Physician means a licensed doctor of medicine (M.D.), doctor of osteopathy (D.O.) duly licensed and qualified to practice medicine and perform surgery at the time and place service is rendered. Physician also means a licensed doctor of podiatry (D.P.M.), a licensed chiropractor (D.C.), a licensed psychologist (Ph.D.), a licensed oral surgeon (D.D.S. or D.M.D.), a licensed doctor of optometry (O.D.) and a licensed doctor of psychiatry (M.D. Psychiatrist).

Plan (other than the Program) means any group insurance or group prepaid arrangement of Coverage, whether on an insured or uninsured basis, which provides benefits or services for, or by reason of medical, dental, or vision care or treatment, or any Coverage required or provided under, or by any government program or law, including Medicare. Hospital indemnity benefits (provided on a non-expense incurred basis) of \$30 per day or less are not included within the meaning of "Plan." Each policy, contract or other arrangement for providing benefits or services will be considered a separate Plan. If only a part of such policy, contract or other arrangement is subject to a provision similar to this provision, that part will be treated as one Plan and the remainder will be treated as a separate Plan.

PPO is a preferred provider organization. A managed care organization of medical doctors, hospitals and other health care providers who have agreed to do business with the Program.

Pre-Determination means to determine in advance that a Member is eligible to participate in a covered program.

Precertification means PRIOR notification to the Utilization Review Program before any of the service types listed in the Program Booklet are received by the Covered Person.

Pregnancy means the state of a female after conception until delivery and/or until termination of gestation.

Provider means a person or business that provides health care services to covered members.

Out-of-State means outside the state of Arkansas.

Room and Board Charges means charges incurred by an Inpatient for room and board and other services and supplies necessary for the care and treatment of illness or injury, except fees for professional services that are customarily made by a Hospital at a daily or weekly rate determined solely by the class of accommodations occupied.

Satisfactory Evidence of Coverage means evidence that is approved by the Program in the Home Office and is furnished without expense to the Program.

Speech Pathologist means a person who has been educated, trained and licensed to plan, conduct and evaluate speech therapy programs.

Stop Loss means a limit on the coinsurance required from the Covered Person.

Surrogate Pregnancy means acting as a substitute mother by becoming pregnant for the purposes of bearing a child on another's behalf.

Utilization Review Program is the critical examination of healthcare services to patients to evaluate the medical necessity, appropriateness, and efficiency of the use of healthcare services, procedures, and facilities under the provisions of the health benefit plan. The Utilization Review Program is provided directly by the Program which is a licensed review agent. The Utilization Review Program can include, but is not limited to pre-admission review, preauthorization/precertification, concurrent review, retrospective review, case management, and discharge planning. All claims are subject to the Utilization Review Program.

Wound Care means comprehensive care for wounds to prevent complications and preserve function. Debridement or surgical procedures require precertification.

You and Your means an Employee/Member covered by or in an Eligible Class for Employee Benefits.

A glossary of commonly used Health Coverage & Medical Terms is available at www.arml.org/mhbp or by calling Customer Service at 501-978-6137.

Section 9: Forms

Participation Agreement in the Municipal Health Benefit Program

THIS AGREEMENT, entered into this _____ day of _____, 2020, effective as of _____ (hereinafter called the “Effective Date”) by and between the City of _____, Arkansas (the “City”) and the Municipal Health Benefit Program (the “Program”).

WITNESSETH

WHEREAS, the Program is a multi-employer, self-funded trust fund created by Declaration of Trust dated November 16, 1981, as amended (the “Declaration of Trust”), to provide health and welfare benefits to employees of participating municipalities who are members of the Arkansas Municipal League; and

WHEREAS, the City wishes to become a Participating Employer in the Program to provide health and welfare benefits to its eligible Employees; and

WHEREAS, by virtue of the authority granted to it in the Declaration of Trust, the Program agrees to accept the City as a Participating Employer in the Program.

NOW, THEREFORE, for and in consideration of the promises and of the mutual covenants herein contained, the parties hereby agree as follows:

1. Beginning on the Effective Date, the City agrees to become a Participating Employer in the Program and to make payments to the Program on behalf of its eligible Employees to provide the following benefits for the following premium amounts:

Medical Coverage

_____ \$500 Deductible

_____ \$1,200 Deductible

_____ \$2,000 Deductible

_____ Dental Coverage

_____ Vision Coverage

_____ Life Insurance

_____ Disability Income Benefits

_____ Option A

_____ Option B

2. By execution of this Participation Agreement, the City adopts and agrees to be bound by all of the terms and provisions of the Program, as amended from time to time. The City further agrees to timely make all required premium payments to the Program in accordance with the Program’s procedures.
3. The City acknowledges receipt of the proposal dated _____, 20___. In accordance with the eligibility provision outlined in the proposal, the City hereby certifies and agrees that it will at all times while a Participating Employer in the Program comply with the Eligibility Requirements of the Program as set forth in Exhibit A attached hereto and incorporated herein. The City acknowledges that its participation in the Program is contingent upon its compliance with the Eligibility Requirements.
4. By signature below, the City agrees to and does become a party to the Program as a Participating Employer. The City hereby acknowledges receipt of a copy of the Declaration of Trust and the Municipal Health Benefit Program Booklet.

Participation Agreement In The Municipal Health Benefit Program

5. By execution of the Participation Agreement by the Plan Administrator, the Program accepts the City as a party to the Program pursuant to the authority vested in the Plan Administrator by the Declaration of Trust. The Program agrees to receive the City's premiums and to hold, administer and invest such funds and to pay claims to Employees in accordance with the terms and provisions of the Program, as amended from time to time.
6. The terms of the Program as in effect from time to time, shall fully apply to the City as of the Effective Date, with the imposition of any additional terms or conditions set forth in this Agreement.
7. The City acknowledges that, pursuant to the Declaration of Trust, the Program may be terminated by giving written notice to member cities and other public entities at their regular business addresses. Pursuant to the Program Booklet, the Program agrees to provide such written notice by regular mail sixty (60) days prior to termination. The Program's Trustees may also amend the terms of the Program. It is the responsibility of the City to notify its Employees of any amendments or changes to the Program.
8. All capitalized terms used in this Participation Agreement and all Exhibits hereto shall have the same meanings given to them in the Municipal Health Benefit Program Booklet, unless otherwise defined in this Agreement.

IN WITNESS WHEREOF, the parties have caused this Participation Agreement to be executed on their behalf on the date first written above.

Municipal Health Benefit Program Participation Agreement Signature Page

CITY: _____

By: _____

Its: _____

MUNICIPAL HEALTH BENEFIT PROGRAM:

By: _____

Mark R. Hayes, Plan Administrator

EXHIBIT A

ELIGIBILITY REQUIREMENTS

Since all eligible employees must be offered coverage, the City's participation in the Program is expressly contingent upon the City's continued compliance with the following Eligibility Requirements:

The Eligible Class of employees who may be Covered under the Program includes all employees of the City in any of the following classes. The City **must** include employees in Class 5, and **may elect** to include employees in the other classes, as part of the Eligible Class.

- **Class 1**—Active elected officials (including those appointed to an elected office)
- **Class 2**—Members of boards and commissions
- **Class 3**—Volunteer firefighters
- **Class 4**—Auxiliary police
- **Class 5**—Full-time employees of a Participating Employer
- **Class 6**—Retired members age 55 or over (See Retiree Coverage for further details.)

For each class to which it offers benefits, the City must meet the following criteria:

1. All eligible Employees have been offered Coverage, and
2. A list of all eligible Employees accepting Coverage has been submitted to the Program, during an Open Enrollment Period and/or in the event of a Change of Status Event such as new hire, birth of a child, or divorce; and
3. Seventy-five percent (75%) of all eligible Employees elect Coverage under the Program, and
4. A list of all eligible Employees opting out of Coverage, along with proof of Coverage through a Spouse, Medicare and/or another carrier has been submitted to the Program during an Open Enrollment Period or at the time of qualifying Change of Status Event.

If the City offers Coverage to any of the Classes 1 through 4, then the Coverage must be offered to all members of the class. When Coverage is offered to a class, the City shall require all members of that class to sign up for the Coverage or submit a refusal form. A minimum of seventy-five percent (75%) of classes 2, 3 and 4 must sign up for Coverage, or none of the class may be Covered. Those persons in Classes 2, 3 and 4 who are eligible for Medicare are excluded from the seventy-five percent (75%). The City must maintain Coverage on seventy-five percent (75%) of each participating class (2, 3, 4 or 5) for Coverage to continue.

If the City offers Coverage to any of the Classes 1 through 4, then the Coverage must be offered to all members of the class. When Coverage is offered to a class, the City shall require all members of that class to sign up for the Coverage or submit a refusal form. A minimum of seventy-five percent (75%) of classes 2, 3 and 4 must sign up for Coverage, or none of the class may be Covered. Those persons in Classes 2, 3 and 4 who are eligible for Medicare are excluded from the seventy-five percent (75%). The City must maintain Coverage on seventy-five percent (75%) of each participating class (2, 3, 4 or 5) for Coverage to continue.

The City must offer medical Coverage to all eligible Employees working thirty (30) hours or more a week and must ensure that the Employee's share of the premium is affordable. The City may use one of three "safe harbors" allowed by IRS regulation to determine affordability. The W-2 wages safe harbor is most frequently used. It is satisfied if the City ensures that the Employee's share of the premium does not exceed 9.5 percent of the Employee's current W-2 wages for the cost of employee only (single) coverage for full-time active employees. Other safe harbors are (1) the rate of pay safe harbor, and (2) the federal poverty line safe harbor. If the City meets the requirements of the safe harbor, the offer of coverage is deemed affordable for purposes of Code section 4980H(b) regardless of whether it is affordable to the Employee under section 36B of the Code.

Classes 1 through 4 are not eligible for the medical Coverage provided under the Program if they are eligible for Medicare.

Active elected officials (Class 1) who are on Medicare are eligible for dental, vision, drug card and hearing aid Coverage. However, enrollment in all parts of Medicare, Parts A, B and D, is required for active elected officials (Class 1) choosing to continue Coverage under the dental, vision, drug card and hearing aid Coverage benefits. However, seventy-five percent (75%) of each participating class (2, 3, 4 or 5) must participate for Coverage to continue.

MUNICIPAL HEALTH BENEFIT PROGRAM
Authorization to Disclose Health Information
P.O. BOX 188, NORTH LITTLE ROCK, AR 72115
Fax: 501-537-7252

This form is **OPTIONAL**. By completing this form, a covered individual may allow someone other than themselves or their providers access to their Private Health Information (PHI). **PLEASE PRINT**

Name of Policy Holder: _____ ID#/SSN: _____

Group/Employer Name: _____

I _____ (name), do hereby give authorization to the Municipal Health Benefit Program (Plan) permission to disclose any and all Private Health Information (PHI) to the individual name below:

_____/_____
Print Name Relationship to Member

(1) I understand that I have the right to revoke this authorization at any time in writing and present my written revocation to the Program at the address listed above. I understand that the revocation will not apply to information already released in response to this authorization. I understand the revocation will not apply to the Program or their lawyers when the law provides the Program with the right to contest a claim made under Program coverage. Unless revoked, this authorization will expire on the following date, event, or condition: _____, or at the termination of my employment.

(2) I understand that this form is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment or proper claims payment while I am covered under the Program. I understand that I may inspect or copy the information to be used or disclosed as provided in CFT164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by the federal confidentiality rules. If I have questions regarding the disclosure of my health information, I may contact the Program's designated representative.

Signature: _____

Date: _____

Witnessed by: _____

Date: _____

Print Name

MUNICIPAL HEALTH BENEFIT PROGRAM

Revocation of Authorization to Release Health Information

P.O. Box 188, North Little Rock, AR 72115

Fax: 501-537-7252

Name of Policy Holder: _____ ID#/SSN: _____

Address: _____

Group/Employer Name: _____

I _____, hereby revoke any and all authorizations to release health information to:

_____/_____

Print Name

Relationship to Member

I understand this revocation will not apply to information already released in response to the Authorization to Disclose Health Information previously submitted. I also understand this revocation does not apply to the Program or their lawyers when the law provides the Program the right to contest a claim incurred while I was a covered member under the Program.

Signature: _____

Date: _____

Witnessed by: _____

Date: _____

Print Name

MUNICIPAL HEALTH BENEFIT PROGRAM
Change of Address Form
P.O. BOX 188, NORTH LITTLE ROCK, AR 72115
Fax: 501-537-7265

PLEASE PRINT

Name of City/Entity: _____ Group Number: _____

Name of Policy Holder: _____ ID#/SSN: _____

PREVIOUS INFORMATION

Mailing Address: _____

City: _____ State: _____ ZIP: _____ Phone Number: _____

CURRENT INFORMATION

Mailing Address: _____

City: _____ State: _____ ZIP: _____ Phone Number: _____

Do you need additional Medical ID/Prescription Cards? Yes No

Signature: _____ Date: _____

Please send this form to MHBP at the address or fax number listed above.

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SIMPLIFY YOUR EMPLOYEE BENEFITS

JTS Financial has partnered with the **Municipal Health Benefit Program** to assist cities with:

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- Bill Reconciliation Systems
- Employee Benefit Booklets
- Customized Smart Phone Apps
- Wellness Programs
- Customer Advocacy
- HR Consulting



Charles Angel

VP of Employee Benefits Programs

501-690-2532

charles.angel@jtsfs.com

www.jtsfs.com | 1616 Brookwood Drive, Little Rock, AR 72202



PLAN ADMINISTRATION: Enrollment and Premiums

Municipal Health Benefit Program Premium

P.O. Box 880

Conway, AR 72033

Phone: 501-978-6137 Fax: 501-537-7252

www.arml.org/mhbp

CLAIMS ADMINISTRATION: Claims and Benefits

Municipal Health Benefit Program

P.O. Box 188

North Little Rock, AR 72115

Phone: 501-978-6137 Fax: 501-537-7252

www.arml.org/mhbp

For Precertification, please call:

1-888-295-3591

(Precertification does not provide Benefit Information.)