Municipal Health Benefit Fund

Effective December 1, 1981 (As Amended January 1, 2015)

The Municipal Health Benefit Fund is not insurance, and the Fund is not under the Rules and Regulations of the Insurance Department of the State of Arkansas.

Mandatory Administrative Appeals Procedure

As a condition precedent to all the benefits, terms and conditions of this contract, an employer member and its employee members must agree to exhaust all of 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.

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

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MUNICIPAL HEALTH BENEFIT FUND (Health Fund No. 1)

Effective December 1, 1981 (As Amended January 1, 2015)

Declaration of Trust

The provisions of this Municipal Health Benefit Fund Booklet are subject to the terms and conditions of the Declaration of Trust as amended.

This booklet describes benefits available to you under the Municipal Health Benefit Fund. Consult your Employer to determine the amount of your Life Benefits and to determine if your group has Disability Income Benefits. The self-funded Municipal Health Benefit Fund may be amended or discontinued by giving sixty (60) days' notice by regular mail to member cities and other public entities at their regular business addresses. It is the responsibility of the Participating Employer to notify its employees of any amendments or changes of the Municipal Health Benefit Fund.

Group health plans sponsored by state and local governmental employers must generally comply with Federal law requirements in title XXVII of the Public Health Service Act. 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 Municipal Health Benefit Fund has elected to exempt the Fund 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.

The exemption from these Federal requirements will be in effect for the 2015 plan year that begins on January 1, 2015, and ends on December 31, 2015.

The election may be renewed for subsequent plan years.

PATIENT PRIVACY

The Plan does not sell, market or otherwise distribute your medical and personal health care information. However, the Plan 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 Plan are contained in the following pages.

Plan Administrator

MHBF Director

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Section 1:
General Eligibility Information

General Eligibility Information

Eligibility Dates—If you are an employee in an Eligible Class, you will become eligible for Employee 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.

The eligibility requirements for employees also apply to Classes 1-5, subject to the provisions below.

Eligible Class—The Eligible Class of employees includes all full-time active employees (Class 5) who work an average of 30 hours per week for a Participating Employer. Any of the following classes can be covered when the following criteria are met:

Since all eligible employees must be offered coverage, the Plan will require the following:

1. All eligible employees have been offered coverage, and
2. A list of all eligible employees taking coverage has been submitted to the Plan, and
3. Seventy-five (75%) percent of all eligible employees elect coverage under the Plan, 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 Plan.

Classes 1 through 4 are not eligible for the medical coverage if they are eligible for Medicare. Active elected officials 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. However, 75% of each participating class (2, 3, 4 or 5) must participate for coverage to continue.

- Elected officials—Class 1
- Members of boards and commissions—Class 2
- Volunteer firefighters—Class 3 (See below for further details.)
- Auxiliary police—Class 4
- Full-time employees—Class 5
- Retired members age 55 or over—Class 6 (See Retiree Coverage for further details.)

Members in Class 3—to qualify for coverage under the Plan, volunteer firefighters must actively participate in more than:

- 50 percent of fire calls.
- 50 percent of training sessions.
- Verification of participation must be certified in writing under penalty of perjury by the Fire Chief.
- Certification must be submitted to the Plan each year on or before December 31.

If the Employer/Group 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 Participating Employer shall require all members of that class to sign up for the coverage or submit a refusal form. A minimum of 75 percent of classes 2 through 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 75 percent. A group must maintain coverage on 75 percent of each participating class (2, 3 or 4) for coverage or for coverage to continue.

A Participating Employer must offer coverage to all eligible employees working thirty (30) hours or more a week and must ensure 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 the employee only (single) coverage for full-time active employees.

Effective Date Requirements

To be covered you must enroll in the Plan when eligible and agree to make any required premium contributions. If you do not enroll yourself and your dependents before the date you become eligible, you may not enroll until January 1 of the following year or another Open Enrollment period.

If you have single coverage, family coverage may be added on the first day of the month after any of the following Qualifying Events:

1. New dependents acquired via:
   - Marriage
   - Birth
   - Adoption
   - Court Order to provide coverage for an eligible child; Child Support/Medical Support Order
2. Loss of Spouse's health coverage due to loss of their employment -must provide letter from both spouse's former employer showing date employment ended and provide a letter from the spouse's former insurance company showing date employment ended and date health coverage ended. **It is the loss of health coverage, not the loss of employment that makes this a qualifying event**.

If you are married with family coverage, an eligible newborn can be added to your coverage on the newborn's date of birth. The newborn must be added within 30 days of their date of birth regardless if Social Security Number is received or not.

Change of Status form and copy of supporting documentation of the Qualifying Event is required within 30 days of the date of the Qualifying Event.

If you do not add the newly acquired dependent(s) by submitting a completed Change of Status Form within 30 days of when they become eligible, you may not enroll them until January 1 of the next year or the next Open Enrollment period.

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 Municipal Health Benefit Fund (MHBF) 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 Plan will not credit premiums for failure to notify the Plan as required.

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

COBRA—The Plan recognizes and complies with all extended coverage benefits for employees and dependents provided for by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Benefits do not include Life and/or disability income.

Certificate of Group Health Plan Coverage—Under the 1996 HIPAA regulations, the Plan 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 an employee's employment or salary ceases, the employee's coverage also ends, albeit on the last day of the month in which the employment or salary ceases, whichever is the earlier date. Coverage ends whether you leave your employment, retire, die or go on unpaid leave of absence. If you become a member of an ineligible class, coverage will end on the last day of the month in which you became a member of an ineligible class.

In addition to the above, coverage is also terminable for failure to make premium payment. Coverage for you will stop 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.
- When the participating Employer cancels coverage under the Municipal Health Benefit Fund.
- The last day of the month you cease to meet the eligibility requirements as defined herein.

Your Dependents' Benefits will automatically terminate on the earliest of:

- The date your personal benefits terminate.
- The last day for which your dependent's premium has been paid.
- The last day of the month following your termination from the payroll of the city.
- The date coverage for dependents is terminated under the Municipal Health Benefit Fund.
- For any dependent, the last day of the month 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 Municipal Health Benefit Fund, 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 child, the end of the month following the attainment of the applicable maximum age limit.

However, if your child is incapable of sustaining employment by reason of mental retardation or physical handicap following attainment of age 26 and if covered hereunder up to that time, will continue to be eligible as a dependent so long as he or she remains continuously in that condition, provided the member/employee notifies the MHBF Director and such condition actually exists. If there is a conflict between dates when coverage could end, the earliest date governs. Additionally, the Plan will not pay for services or supplies furnished after the date coverage ends, even if the Municipal Health Benefit Fund precertifies 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 Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the most current Fund Booklet or contact the MHBF Director.

The COBRA notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. 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 Plan 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 Plan is lost because of a qualifying event. Under the Plan, 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 Plan 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 Plan 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 Plan 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 Plan as a "dependent child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the MHBF Director has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee or the employee becomes entitled to Medicare benefits (under Part A, Part B or both), the Employer must notify the MHBF Director 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 is losing eligibility for coverage as a dependent child), you must notify the MHBF Director within 60 days after the qualifying event occurs. You must provide this notice to:

MHBF Director

Municipal Health Benefit Fund

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 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 dependent children 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 of 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 Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the employer or the Municipal Health Benefit Fund 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 Plan, 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 Plan will continue for that coverage period without any break. The Plan 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 Plan 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 Plan.

Your first payment and all periodic payments for continuation coverage should be sent to the participating Employer for your group. Please do not send them direct to the Municipal Health Benefit Fund address. Payments mailed directly to this address will be returned unless previous arrangements have been made.

KEEP THE PLAN INFORMED OF ADDRESS CHANGES—In order to protect your family's rights, you should keep the MHBF Director 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 MHBF Director. Additionally, if you have changed marital status or you or your spouse have changed addresses, please notify the MHBF Director in writing at the above address. Please note: If you have questions concerning your Plan or your COBRA continuation coverage rights, contact your Employer, or the MHBF Director, Municipal Health Benefit Fund, P.O. Box 188, North Little Rock, AR 72215. 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.

Retiree Coverage

Arkansas law requires municipalities to establish by ordinance, or otherwise, criteria for eligibility as a retiree. The Plan will provide retiree coverage consistent with locally established criteria provided a written copy of the ordinance or policy is furnished to the Plan by January 1 of the Plan year. If no ordinance or policy is provided, then the Plan will provide retiree coverage if the retiring municipal official or employee:

- is age 55 or older and has completed 20 years of service with a participating Employer.
- 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 health care plan.
- is not covered at any time during retirement by another health care plan.
- notifies the Employer within 30 days of the official date of retirement of their intent to participate in the health care plan of the municipality. The retired employee or official may include his or her dependents in the retiree's health care plan provided the dependent premium is paid.

Section 2:
Major Medical Benefits

Benefits

Major Medical Schedule of Benefits

Individual Medical Coverage	Lifetime	No Maximum Dollar Limit
Acute Inpatient Habilitation/Rehabilitation	Annual	30 Days
Sub-Acute Inpatient Habilitation/Rehabilitation		15 Days
Habilitative Services		15 Days
Bariatric Weight Loss Program*		
Chemical Dependency Treatment	Lifetime	1 Treatment Plan **
Chiropractic Services	Annual	12 Visits
Diabetic Training	Annual	1 Day Session
Elective Surgical Procedures (Hospital or Ambulatory Surgery Center)	Annual	2
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, and Habilitative Therapy (Combined Benefit)	Annual	30 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

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

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

****Transplants must be performed at MHBF Designated Transplant Centers to be covered.*
For more information call 888-295-3591.

Preventative Care/Wellness Benefits

The Plan will pay 100% of the reasonable and customary charges for In-Network, Preventative Care. For services to be considered under this benefit, the Provider's claim must designate a Preventative Diagnosis and CPT Code only.

Wellness benefits are not payable when done at Flu Clinics, Health Fairs or other such like public or private venues.

Physician Evaluation and Consultation Visit Copayment

$20.00 each visit for Current Procedural Terminology Codes 99201 through 99215

The Physician Visit Copayment will not count toward your Calendar Year Deductible and any services or procedures rendered other than the CPT codes listed above will be reimbursed as outlined in the Fund Booklet.

Major Medical Deductibles

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

Family Deductible Maximum $6,000

Emergency Ambulance Services (ground or air ambulance)

Annual 2 each per year

Individual Coinsurance

The covered individual pays coinsurance for the first $20,000 of Arkansas In-State, In-Network Provider covered expenses after the calendar year deductible(s). Once the covered individual meets the Arkansas In-State, In-Network coinsurance maximum, the Plan will reimburse 100 percent of all covered Arkansas In-State, In-Network services for the remainder of the calendar year.

The covered family pays coinsurance for the first $40,000 of Arkansas In-State, In-Network Provider covered expenses after the calendar year deductible(s). Once the covered family meets the Arkansas In-State, In-Network coinsurance maximum, the Plan will reimburse 100 percent of all covered Arkansas In-State, In-Network services for the remainder of the calendar year.

The Stop Loss provision, or out-of-pocket maximum, does not apply to non-emergent Out-of-State In-Network or Non-PPO provider services and the individual will be responsible for coinsurance for all covered expenses from Out-of-State In-Network or Non-PPO providers. Emergency Room copayments (access fees) and Prescription Drug copayments are not included within the Stop Loss provision or out-of-pocket maximum.

After the calendar year deductible(s) are met, the Plan will pay the following percentages for covered services:		
	PPO	**Non-PPO**
Emergency Room Services	80% of the Plan's Usual and Customary PPO Allowables	80% of the Plan's Usual and Customary PPO Allowables
PPO Providers (In-State or Out-of-State)	80% of the Plan's Usual and Customary Allowables	
Non-PPO Providers (In-State or Out-of-State) (Except for Emergency Room Charges)		50% of the Plan's Usual and Customary Allowables (See Usual and Customary Charges under Definitions)

Emergency Room Services

Outpatient Emergency Room visits will require a $250 copayment (access fee) made by the covered member for each visit. This $250 copayment is in addition to any other Plan deductible or copayment requirement. Emergency Room copayments do not apply to the Plan deductible or towards the coinsurance maximum. When an emergency room visit results in inpatient hospital admittance (excluding observation stays), the $250 emergency room copayment will be waived. However, this does not apply when you are admitted to a different hospital than where you received emergency services. Non-PPO emergency room services will be reimbursed at the same PPO deductible requirements and benefit percentages for emergent and immediate care only and up to the Plan's reasonable and customary allowables for such services.

Explanation of Benefits and Benefit Limitations

Stop Loss for Major Medical

When In-State, In-Network covered charges reach $20,000 for the covered individual or $40,000 for the covered family and the calendar year deductible(s) are met, the Plan will pay 100 percent of all covered services above that amount for the remainder of the calendar year, unless excluded or modified by other portions of this benefit booklet. This is called a Stop Loss Provision or Out-of-Pocket Maximum. Out-of-State In-Network Provider and Non-PPO provider charges do not count toward the Out-of-Pocket Maximum (s) and the Plan will not pay 100 percent of Out-of-State In-Network Provider and Non-PPO provider charges. In addition, penalty deductible(s), and the Emergency Room Services copayments, and Prescription Drug copayments do not count toward the Out-of-Pocket Maximum(s). The Plan will not pay 100 percent of the Emergency Room Service charges even though provider retains the patient for observation. The copayment maybe waived for an inpatient hospital room admission (for Stop Loss for Prescription Drug Benefits, see page "Stop-loss or Out of Pocket Maximums for the Prescription Drug Benefit is:" on page 30).

Calendar Year Deductibles for Major Medical

A Calendar Year Deductible of $500, $1,200 or $2,000 (please consult your Employer for the amount of your deductible) shall be applied to the amount of covered medical expenses that are incurred each calendar year. Each covered member shall satisfy the $500, $1,200 or $2,000 calendar year deductible up to a Family Maximum Deductible of $6,000, if and when the covered member(s) incurs and submits covered medical expenses in an amount equal to the deductible.

Covered Major Medical Charges

Covered 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 as determined by the Plan in accordance with health care industry standards for the area in which the services and supplies are furnished, and (e) are deemed necessary by the Utilization Review Program. A charge is considered to be incurred on the date a covered member receives the services or supplies for which the charge is made. (For more information see Medically Necessary under Important Information on page 17.)

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 6 months of the initial injury or accident, unless otherwise agreed to in writing by the Plan. Any injury to teeth while eating is not covered in this provision.

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

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 Plan, 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 under the usual and customary fees allowed by the Plan. Any additional glasses and/or lenses may be covered under the optional Vision Care Benefits coverage.

Chiropractic Services—Are covered only for an eligible member five (5) years and older. Payment for covered services performed by a Chiropractor, including visits, adjustments and other covered charges, is limited to 12 visits per calendar year.

NOTE: Temporomandibular Joint Dysfunction (TMJ) is not a covered benefit under Chiropractic Services .TMJ is addressed under the optional Dental 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 Plan will also provide benefits for an elective tubal ligation.

Inpatient Hospital Charges—the Plan 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 Plan will consider 90 percent of the private room charge as the covered charge.

Medical Supplies and Pharmaceutical Charges—The Plan 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. For more information, please see Usual, Customary and Reasonable Charges (UCR).

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 replacement 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 Plan 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 not useful to a person in the absence of an illness or injury, and (d) is appropriate for use in the home. Additionally, the Plan will replace standard durable medical equipment that is no longer serviceable provided it meets the criteria above. The Plan 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 Plan 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 Plan reserves the right to establish a rental or purchase price based on the reasonable and customary charge for such equipment. The Plan will never pay more than the purchase price for any durable medical equipment.

Precertification is required when any durable medical equipment is purchased, rented or leased if the retail purchase price or annual rental cost will exceed $2,000. Benefits will not be considered until the Utilization Review Program has precertified and/or certified the equipment.

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 (Current Procedural Technology) coding rules.

Precertification, Penalty Deductibles and Utilization Review

It is the member's responsibility to precertify by calling 888-295-3591. A $1,500 penalty deductible will be assessed for failure to precertify any services requiring precertification, per occurrence.

- Ambulatory Surgical Procedures (whether they are performed in a Hospital, Ambulatory Surgery Center or doctor's office)
- Bariatric Weight Loss Program
- Chemical Dependency Treatment
- Durable Medical Equipment (if purchase price or annual rental cost exceeds $2,000)
- Home Health Care Services (care in a home setting)
- Hospice Care
- Inpatient Hospital Confinements
- 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

Elective Surgical Procedures — Annual Maximum of 2

(Hospital or Ambulatory Surgery Center)

For a comprehensive list of elective 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.

Utilization Review Program

The Municipal Health Benefit Fund has adopted a Utilization Review Program. In certain cases, the Review Program requires certification prior to treatment, as well as concurrent review, discharge planning, cost effectiveness and medical case management. A $1,500 penalty deductible will be assessed for failure to precertify with the Review Program where the Plan requires precertification.

Once a service has been precertified, the services must be rendered within 30 days of the precertified date of service. If the services are not rendered within the 30 day time period, the precertification process must be started again.

You or your doctor must precertify by calling the Utilization Review Program at 888-295-3591. The ultimate responsibility to precertify rests with the covered member.

Inpatient Admission

You must notify the Utilization Review Program of a scheduled admission prior to the date of service. As soon as you know you will be hospitalized, you or your physician must precertify your care by calling the Utilization Review Program at 888-295-3591. Inform the Utilization Review Program that you are covered under the Municipal Health Benefit Fund and provide the 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 will have until 5:00 p.m. the next business day to notify Utilization Review of that admission. Direct admissions from your physician's office are not considered emergencies and must be precertified by you or your physician. Failure to do so will result in the assessment of $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.

Surgical Procedures

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

PET Scans

Precertification is required for all PET Scans.

Hospice and Home Health Care

Hospice and care provided in a home setting also require precertification.

Durable Medical Equipment and Prosthetic Devices

Standard durable medical equipment purchases and rental and purchases of prosthetic devices retailing $2,000 or higher must be precertified. See the topic Rental of Durable Medical Equipment under Covered Medical Charges.

Exception for Childbirth

The Plan 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 in excess of 48 hours or 96 hours at 888-295-3591.

Important Information

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

Medically Necessary means services or charges submitted to the Plan must meet the conditions of being medically necessary to be considered for payment. The Plan will generally consider care of 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 preventative 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 Plan. If Utilization Review 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 8 of this Booklet.

The Plan will not pay for services or supplies furnished after the date your coverage ends, even if the Municipal Health Benefit Fund precertifies or provides benefit information for a treatment plan submitted before the end of your coverage.

Special Benefits

Case Management

Case Management should be utilized by the member of the Plan where services with high expenses are expected or where such services are expected but are not available within the Preferred Provider Network. The Case Manager will work with the 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 Plan'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 MHBF Director, alternative benefits may be provided by the Plan in lieu of Major Medical Expense benefits. Alternative benefits shall be provided if, in the sole discretion of the MHBF Director, 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 Plan's percentage reimbursements.

Preventative Care Program/Wellness Program

Annual Exam Benefits

Annual Routine Wellness Benefits are reimbursable at 100 percent of allowable, subject to usual, reasonable and customary charges and are not subject to deductibles and benefit percentages. To be considered as a preventative care benefit the provider's bill must designate a routine wellness diagnosis code only. Claims received with diagnoses other than or in addition to routine wellness will be considered under the Major Medical Benefits and reimbursed accordingly. The following list is an example of the types of services often considered as routine wellness:

- 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 fifty (50) years of age or older or for covered individuals who are less than fifty (<50) years of age that have a family or personal history and at normal risk for developing colon polyps or colon cancer for Eligible Benefits incurred while conducting a medically-recognized screening examination for the detection of colorectal cancer. This includes annual fecal occult blood tests and a colonoscopy and/or flexible sigmoidoscopy (examination of the large intestine) performed every five (5) years with a family or personal history of colon polyps, colon cancer or a colonoscopy performed every ten (10) years. This Benefit excludes coverage for virtual colonoscopies. This benefit will include routine and diagnostic colon-rectal examinations.
- General Health Panel
- TB
- Chest X-Ray (front and lateral)
- Well Baby Care/Well Child Care
- Carotid Screening

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
- Zosatavax (Shingles Vaccine)

Please note: Allergy injections and expenses related to routine newborn care are not considered part of this benefit. Other injectable medicines may be covered under the Drug Card Program. Please see the Prescription Drug Card section of this booklet. Pharmacy copays will be assessed if the above are administered at your local pharmacy, except for Influenza.

eDocAmerica—All eDocAmerica services are at no extra cost, confidential, and unlimited for covered employees and all family members. Contact eDocAmerica at 866-842-5365 or visit www.edocamerica.com to set up or access your free account.

eDocAmerica gives you email access to physicians, psychologists, pharmacists, dentists, dietitians, and fitness trainers:

Ask whatever you want, whenever you want, and get personal answers. When you log in to your eDocAmerica account, you can choose who you want to contact. There are no fees or copays of any kind. With eDocAmerica you and your immediate family have unlimited access to your very own medical team. Physician answers are guaranteed in 24hrs with most responses arriving within 2-3 hours.

Telephone access to the eDocAmerica medical team:

With eDocVoice you can access our medical team through our telephonic platform. Call the phone number and record your question. Once the medical team has answered your question, the system will automatically call you back and play their response. No Internet needed.

iPhone App and Droid App:

The era of Smartphones is here and eDocAmerica is bringing our team of medical experts directly to your hand-held device. Download the free app and get the personal medical attention you need for your on-the-go life. Want to send in a picture? Use the camera on your phone and attach the picture directly to your question. The App will also allow you access to your eDocVoice number, nurse line number, weekly health tips, and more.

24 hour Registered Nurse Advice Line:

The nurse line is available 24 hours per day, 7 days per week and 365 days per year. At the start of each call the caller is offered the opportunity to communicate in either English or Spanish.

The registered nurse will advise the caller as to the proper disposition for his/her stated medical concern or problem. These dispositions will range from home care advice to recommended emergency care immediately.

The 24/7 Registered Nurse Advice Line is available at 866-842-5365 or you may call eDoc at 866-525-3362 for assistance.

Additional included services:

eDocAmerica users enjoy a physician-written weekly Health Tip delivered right to your email, a Health Risk Assessment that helps you gain a snapshot of your current health status, a 3D Video Library with access to 250+ medical topics, and more. Take a moment to log in to your eDocAmerica account and scroll through the icons to see the additional services included in your account.

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.

Allowable Expenses—The usual, customary and reasonable charges, including the average wholesale price (AWP) made for necessary health care services, medications and supplies, a portion of which is covered by at least one of the plans covering the member for whom the claim is made. These covered services will be considered Allowable Expenses and a benefit paid. Allowable Expenses do not include charges used to satisfy the deductibles, copayments or coinsurance assessed under the Prescription Drug Card Plan. (For more information, see Coordination of Benefits.)

Average Wholesale Pricing (AWP)—The allowable amount determined by the Plan for products provided to the covered members, employing the most current Average Wholesale Price (AWP) or another industry-accepted benchmark as set forth by Medispan, First Databank, or other industry-accepted database. The Plan retains the right to review any and all claims for such products provided to its covered members. The Plan retains the right to reimburse providers at eighty-five (85%) percent of AWP for claims billed with NDC numbers. The National Drug Code (NDC) is a unique product identifier used in the Unites States for drugs intended for human use. (For more information see Usual, Customary and Reasonable Charges (UCR).

Bariatric Weight Loss Program

Bariatric Weight Loss Program*—MHBF will provide coverage for bariatric surgery to include:

a. Adjustable gastric banding surgery
b. Gastric Bypass surgery
c. Sleeve Gastrectomy surgery or
d. Duodenal switch biliopancreatic diversion.

A pre-determination is required in order to proceed with the Notification Review and is required to review the eligibility for a surgical procedure. To qualify to be eligible requires documentation of six (6) consecutive months of physician-supervised weight management program that may include but is not limited to nutritional education and a physical activity program. The covered individual, treating physician or family member must provide information for the Medical Care Management pre-determination review. Failure to do so will result in no benefit coverage for morbid obesity services.

Eligible Morbid Obesity expenses incurred will be covered subject to Medical Case Management approval and Plan limitations. Under this provision, Morbid Obesity includes the pre-obesity evaluation, medical and surgical treatment for post obesity follow-up care including but not limited to treatment of any complications. The Morbid Obesity treatment must be

performed at a Plan-Designated Morbid Obesity Treatment Center and is an eligible benefit for covered individuals nineteen (19) years of age or older.

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

Non-Designated Morbid Obesity Center—If the Morbid Obesity treatment is performed at a Non-Designated Morbid Obesity Treatment Center or if Medical Case Management is refused, the pre-obesity, obesity and post obesity care 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 Plan Year to re-qualify.

Claims Consideration—All claims related to MBS-AQIP must have the pre-determination or pre-authorization number on each claim to be considered for payment.

Any Obesity related charges for services not rendered under this program will not be covered by the Plan. Furthermore, Morbid Obesity treatment procedures will not be paid if the procedure is an Experimental and Investigative Medical Procedure as defined in this booklet.

How to Obtain a Pre-Determination

3. Call your MHBF nurse case manager at 888-295-3591 and notify them that you are interested in the MBS-AQIP program.
4. Once pre-determination is completed the member will then contact the MBS-AQIP physician's office for program registration. This must be done at www.obesity-surgery.net. You must fill out the new patient application online.
5. After the application is completed and you have been approved for the program, you will then complete 6 months of physician supervised weight management.
6. Monthly updates are required to be sent to the MHBF nurse case manager by your physician or dietician.

How to Obtain Pre-Authorization for Bariatric Surgery

1. Call your MHBF case manager and notify them that you have completed the 6 months of physician supervised weight management and are ready to proceed with surgery.
2. Your case manager will contact the MBS-AQIP physician's office and proceed with prior-authorization.

The Plan criteria used for prior-authorization can be obtained by contacting your MHBF Nurse Case Manager at 888-295-3591.

**These services will be covered exclusively through the Metabolic & Bariatric Surgery Accreditation & Quality Improvement Program (MBS-AQIP). All services require a pre-determination and a pre-authorization. Retro Determination or Retro Authorizations will not be considered. Participation in this program must be performed at a MBS-AQIP designated Treatment Center.*

Chemical Dependency Treatment—These services are limited to one treatment plan per lifetime. Services must be rendered at the MHBF Chemical Dependency Treatment Center to be covered. You must contact MHBF 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 Plan. An order by a court or state agency for psychiatric treatment is not an indication of eligibility under this benefit.

Chiropractic Services—Are covered only for an eligible member five (5) years and older. Payment for covered services performed by a Chiropractor, including visits, adjustments and other covered charges, is limited to 12 visits per calendar year. Please note that Temporomandibular Joint Dysfunction (TMJ) is not a covered benefit under Chiropractic Services. TMJ is addressed under the optional Dental Care Benefit provisions of the Plan.

Diabetic Education or Training—The Plan 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 Plan 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 Plan will cover enteral feeds when it is the member's only means of nutrition.

Fund Booklet—The Plan Document which sets out the Plan's terms and conditions as included herein. No contract, agreement or financial arrangement supersedes the terms, conditions, limitations and exclusions set forth in the most current Municipal Health Fund Booklet.

Hearing Aids—The Plan 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.) 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.

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 Definitions.)

Hospice Care—The Plan 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 for additional information.)

Maternity Benefits and Newborn Child Care—If you are married with family coverage, an eligible newborn can be added to your coverage on the newborn's date of birth. The newborn must be added within 30 days of their date of birth regardless if Social Security Number is received or not. The Plan'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.)

Organ Transplant Benefit Charges—Transplant benefits are all inclusive and limited to 2 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 Fund to be considered. Eligible procedures are: heart, lung, liver, kidney, pancreas, cornea and bone marrow.

All transplants must be performed at one of the MHBF Designated Transplant Centers to be covered. You must contact MHBF Case Management at 888-295-3591 who will direct your care and precertify services. No benefits will be available for transplants performed at any facility which is not designated by the Plan.

Outpatient Clinical Setting
Physical Therapy, Speech Therapy, Habilitative and Occupational Therapy Services—These therapeutic services, when provided in an outpatient clinical setting, will be combined to allow for an annual maximum of 30 visits. The services of a Licensed or Registered Therapist, are covered if the treatment meets all of the following:

- Is part of a documented treatment plan;
- Is medically necessary;
- Is for a condition that is the result of a disease or injury; and
- Is not excluded elsewhere in the policy;
- Is prescribed by a licensed physician.

Usual, Customary and Reasonable Charges (UCR)—To determine UCR charges billed by a medical provider for services and supplies, the Plan reserves the right to use national tables (including, but not limited to, RBRVS, ADP and MDR, Medispan, First Databank) and methods in accordance with health care industry standards. The Plan may set limits on a provider's charges and fees at its discretion without giving notice to the provider. The Plan will not pay 100 percent of a provider's billed charges.

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 Plan and is prescribed by and administered under the direct supervision of a licensed physician.

Health Care Exclusions

General Information—The Plan 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 Plan 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.

Abortion—The Plan 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 Plan 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—Services and supplies including, but not limited to drugs, office visits, surgical centers and/or treatments and diagnostic procedures received in or out of a hospital setting outside the United States of America are not covered under the Plan, unless defined elsewhere in this booklet.

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 Plan.

Benign Gynocomastia (abnormal breast enlargement in males)—Services and procedures to treat this condition will not be covered by the Plan.

Blood—Blood, blood plasma, blood derivatives as these can be donated or replaced by the member or family. Additionally, fees to cover blood donations or blood storage are not covered.

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 Plan or (2) for the reconstruction of both breasts due to cancer.

Counseling Services—Outpatient counseling services (marriage, family, career, children, social adjustment, pastoral, financial or any form of group counseling) will not be covered by the Plan, 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 Municipal Health Benefit Plan provisions or charges that are applied to the Plan's deductible, coinsurance or copayment provisions.

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

Domestic Partners—The Plan 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 Plan.

Eating Disorders—Anorexia Nervosa, Bulimia and services related to eating disorders are not covered, except as covered under the Mental Health provisions of the Plan.

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

Free Flu Clinics/Health Fairs—Charges for services that are free or that a covered member is not required to pay, or would not otherwise be made if coverage did not exist are not covered under the Plan.

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 not covered under the Plan with the exception of cancer diagnoses.

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

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

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 of this booklet or who ordinarily resides in your home.

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 Plan 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 Plan.

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, are not covered by the Plan.

Medication Maintenance Agreements—The Plan will not cover testing for drug compliance of members seeking treatment for pain management under these types of agreements with their physicians/providers.

Midwifery—services and providers of midwifery are not covered under the Plan. 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 non-reimbursable reportable events/conditions which are considered unacceptable and eminently preventable.

Obesity or Weight Reduction—Charges for services and/ or over the counter and prescription drugs for the treatment of obesity and/or weight reduction, except as outlined under the Bariatric Weight Loss Program.

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

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

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 Plan liability or claim.

Routine Foot Care—The Plan 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 Plan.

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 Plan.

Third Party Injuries—Treatment, services and supplies for injury or illness for which, as determined by the Fund, 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 Fund pay for treatment, services and supplies required by school-based programs, federally mandated programs, Medicare, employment physicals, tests, and exams and exams requested or directed by a court of law.

If benefits are paid or provided by the Fund whenever this exclusion applies, the Fund reserves all rights to recover the reasonable value of such benefits, as provided in the Fund Booklet under the "Rights of Reimbursement" terms on page 45.

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.

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 as the control arm of a randomized phase III/IV trial for the specific illness;
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 Plan. See Vision Care coverage section of this Plan 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 Fund 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 Fund 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; skateboarding; sky diving; 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 Fund.

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 Wellness Benefits portion of the plan.

Please note: that medical complications occurring as a result of receiving services excluded under the Plan, including but not limited to, surgeries, procedures, or medications, are not covered by the Plan. For other policy provisions, explanation of services and limitations, please see Definitions, Section 7 beginning on page 47.

Section 3: Prescription Drug Benefits

Prescription Drug Coverage

General Coverage

Prescription Drug Charges—for drugs and medicines obtainable only on a physician's written prescription, except as defined under Drug Card Quantity Limitations.

- Prescription/Medical ID cards should be delivered within 30 days from the date the Plan has received and processed your enrollment paper work.
- The Rules for the Coordination of Benefits do not apply to the Drug Card Program.

Prescription Drug Card Program

Municipal Health Benefit Fund program members will be provided with an ID Medical/Drug card that can be used in most drug stores in the state and nationwide. Member copayments are outlined below (per up to a 30-day supply).

Type of Drug Copayment

Pharmacy Type	Day Supply	OTC	Generic	Preferred Brand	Non-Preferred Brand
Align Pharmacies	30 days	$0	$4	$30	$50
All Other Pharmacies (retail*/mail)	30 days	$5*	$10	$30	$50

To locate a Restat Pharmacy go to www.restat.com > For Members > Pharmacy Locator, enter your address or zip code. You can then toggle between the Align pharmacies or National network.

How can you take advantage of Align program savings?

If you currently purchase your prescriptions at one of the Align pharmacies listed:	If you currently do not use an Align pharmacy:
Simply present your new Municipal Health Benefit Fund Medical/Prescription ID card on or after January 1, 2015. You will automatically be charged the lower generic copay as of January 1, 2015.	Switch to an Align pharmacy. Call the pharmacy or bring your current prescription packaging to the Align pharmacy of your choice.

If you have any questions regarding your prescription drug plan, please feel free to contact Restat's Customer Service Center at **855-253-0846**.

Covered OTC products at retail pharmacies (with written prescription):

Anti Ulcer Medications (including generics)

- Axid AR
- Nexium OTC
- Pepcid AC OTC
- Prevacid OTC
- Prilosec OTC
- Tagamet HB OTC
- Zantac-150 OTC
- Zegerid OTC

Non and Low Sedating Antihistamines (including generics)

- Allegra OTC
- Allegra-D OTC
- Claritin OTC
- Claritin-D OTC
- Zyrtec OTC
- Zyrtec-D OTC

Obtaining Benefits for Covered OTC Products—A written prescription is required for these OTC (over-the-counter) products. Once this is obtained, simply present the prescription and your Medical/Drug ID card to your retail pharmacy. The purchase will be processed in the same manner as a prescription drug purchase is processed.

Brands with a Generic Available—In most cases, brand-name drugs that have generic equivalents will be excluded from coverage.

Covered Prescriptions—Injectable and non-injectable drugs requiring a prescription, except as specifically excluded, are considered covered.

Blood Glucose Monitoring Program

Blood glucose meters allow members with diabetes to become an active participant in the management of their diabetes by allowing them to detect and treat changes in their blood sugar. In an effort to help members effectively self-manage their diabetes, Restat has created a blood glucose monitoring program that allows members with diabetes to receive a free blood glucose meter kit at no charge.

How the Blood Glucose Monitoring Program Work—The supplies needed for blood sugar monitoring are (1) blood glucose meter, (2) blood glucose monitoring strips, and (3) lancets. While the blood glucose strips and lancets will be obtained at your local pharmacy, the meter must be ordered separately. You may order the free meter by phone or on-line. (Details provided below) When you place an order you will receive a free glucose meter kit shipped directly to the address of your choice within two to four weeks. The kit contains everything you need to get started; (1) a meter, (2) test strips, (3) lancet device, (4) lancets, and (5) user's manual.

It's important to provide the correct order code and company name when requesting a free meter, refer to the chart below for details.

The following Accu-Chek and OneTouch blood glucose meter kits are currently available:

LifeScan Inc., a Johnson & Johnson company	Roche Diagnostics
ONETOUCH® UltraMini™ Meter Just the basics of testing. ONETOUCH® Ultra®2 Meter See how food affects your blood glucose.	ACCU-CHEK® Aviva System (Meter includes the ACCU-CHEK® Connect tool kit guide and video)
COMPANY NAME: RESTAT ORDER CODE: 574RET001 ONLINE ORDER: www.onetouch.orderpoints.com TOLL FREE NUMBER: 1-800-991-2652	COMPANY NAME: RESTAT ORDER CODE: RESTAT11 ONLINE ORDER: meters.accu-chek.com TOLL FREE NUMBER: 1-888-355-4242

Free Diabetic Supplies—You can receive your blood glucose strips and lancets at your local pharmacy. These supplies are available for a $0 co-payment 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.

Important Plan Changes related to the Affordable Care Act (Healthcare Reform)

Beginning on 1/1/2015, prescription drug expenditures will apply to a separate prescription drug out-of-pocket maximum. It is important to know that these out-of-pocket limits operate separately from the major medical benefits and this limit only applies to prescription drug services that are considered covered by the Plan.

Stop-loss or Out of Pocket Maximums for the Prescription Drug Benefit is:

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

Also note that expenses related to prescription drugs involved in the Plan's reference pricing program or deemed excluded from coverage do not apply to the out-of-pocket limit.

Important information regarding specific prescription drug coverage will be available on the Plan's website @ www.arml.org/services/mhbf/.

Preventive Services

The Plan provides coverage for the following "preventive" medications / drug categories as required by the Affordable Care Act (ACA). These products will be available at $0 co-payment 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	
All FDA approved contraceptive methods	Coverage limited to The Plan's custom list and is subject to change
Breast Cancer Prevention	Tamoxifen, raloxiphene
Vitamin D Supplementation	For members ≥ 65 years of age

Medicare Retirees and Medicare Eligible Members (MEDICARE PART B & PART D)

Medicare Retirees and those Medicare Eligible Members whose primary insurance is Medicare must purchase their diabetic supplies under Medicare Part B. It is required that you have your pharmacy electronically bill Medicare as primary and then bill MHBF/Restat as secondary. If you purchase your diabetic supplies within 100 days of your insulin or diabetic medication, you will have a $0 copayment on your supplies.

Mail-Order Pharmacy

In addition to the traditional retail pharmacy network, plan members may obtain their medications through **MedVantx** mail order pharmacy. The mail order copayment structure is the same as that for retail. Information and instructions on how to use the mail order pharmacy may be obtained by calling **MedVantx at 866-744-0621** or by visiting www.MedVantxRx.com. The Plan's standard copayment 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.

Specialty Pharmacy

Very expensive medications (many of which are injectables) are 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 for prior authorization by calling **866-785-7935.** 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 authorized by the physician. Specialty medications are limited to a maximum of 30 days per prescription.

Complete list of Specialty medications is available at www.restat.com > For Clients > Specialty Pharmacy.

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

Specialty Pharmacy Copayment: If the total cost of the medication is between $0.01 and $1000.00, the member will be responsible for a $50 copayment; if the total cost of the medication is over $1000.01, the member will be responsible for $100 copayment.

Drug Therapy Management Programs

In an effort to ensure that prescription coverage remains affordable for the Plan'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 Plan to ensure safe and effective drug usage. These guidelines are consistent with the FDA-approved labeling and limit the amount of a particular medication that can be dispensed (1) per prescription, (2) per day, or (3) per timeframe. A listing of drugs managed by quantity limits is provided at www.arml.org/services/mhbf/

NOTE: Drugs may be added to the Plan'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 drugs are tried before other and more expensive 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. A listing of drugs/drug categories affected by Step Therapy is provided at www.arml.org/services/mhbf/

NOTE: Drugs may be added to the Plan'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 Plan will select the Best-In-Class or Reference Drug for each drug class involved in Reference Pricing. The amount paid by the Plan per tablet or capsule for the Reference Drug will be the amount the Plan 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 Plan'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 co-payment can be substantial.

Members are encouraged to ask their doctor for a Reference Drug when appropriate in order to save money. A listing of drugs included in the reference pricing program can be found at www.arml.org/services/mhbf/.

NOTE: Drugs and drug categories may be added to the Plan's reference pricing list throughout the year without notice.

Prior Authorization

To ensure appropriate medication use, it is sometimes necessary to require prior authorization for some medications. Consideration for coverage will be given for those medications listed on the Plan's prior authorization list. Your doctor must contact the University of Arkansas College of Pharmacy (UAMS), Evidence-Based Prescription Drug Program (EBRx) to provide justification for the use of the medication. A listing of medications requiring prior authorization is located at www.arml.org/services/mhbf/

Provider Assistance (Physicians and Pharmacists only)

The University of Arkansas for Medical Sciences College of Pharmacy, Evidence-Based Prescription Drug Program (EBRx), will handle the prior authorization management for selected medications and will address questions from providers (physicians and pharmacists) pertaining to these drugs. EBRx's hours of operation are Monday-Friday, 9:00 a.m.-5:00 p.m. CST. Your physician or pharmacist may obtain EBRx's contact information by calling the EBRx call center at (866) 785-7935.

NOTE: All Member calls must be directed to the Restat call center at (855) 253-0846 available 24/7.

Drug Card Exclusions

In an effort to keep health benefits affordable for members, it is imperative that we provide coverage for the most cost-effective products for the range of treatable conditions established by the Plan. Furthermore, we have incorporated an evidence-based process in evaluating drug therapies to be reimbursed by the Plan. As a result of this process, there are many drugs that the Plan will exclude from coverage. The listing of products or drug categories excluded from coverage is located at www.arml.org/services/mhbf/

New Drugs Entering the Market

All new drugs entering the market will automatically be excluded from coverage. These drugs will remain excluded until evaluated by the 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 co-pay tier on the formulary. Otherwise, it will remain excluded from coverage.

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

A benefit is provided by the Municipal Health Benefit Fund 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 Municipal Health Benefit Fund for Employees and Dependents. Your out-of-pocket cost for these expenses, after the combined benefits, is no more than the Plan copays.

Steps to Receive Medicare Part D Benefits:

- Enroll in a Medicare Part D Plan that you select, and pay the monthly premium;
- Instruct the pharmacist to submit the prescription drug expense to your Medicare D Plan as the primary carrier and then submit to Restat as the secondary carrier;
- You pay only the Plan co-payments for that medication.

Important Note:

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

Restat

Patient Reimbursement

11900 W. Lake Park Drive

Milwaukee, WI 53224

Attach copies of prescription receipts showing the following information:

Pharmacy Name and Address, Patient Name, Prescription Number, Fill Date, Drug Name and Strength, Quantity & Days supply, Drug Cost, and the amount Paid. Please allow 4-6 weeks for processing.

Status of these claims can be obtained by calling the Restat Call Center at (855) 253-0846.

Section 4: Optional Benefits

Optional Benefits

Dental Benefits

Benefits Payable—Dental Benefits are payable if a covered member incurs dental expenses and has satisfied the Dental Calendar Year Deductible of $50 for the year in which the expenses are incurred. Benefits are payable in an amount equal to the appropriate Covered Percentage of such expenses as set out in the Schedule of Benefits. 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.

Dental Care Coverage Maximums and Deductible

Calendar Year Deductible (covers all services below)	Annual	$50
Dental Procedures	Annual	$1200
Orthodontic	Lifetime	$1000
Temporomandibular Joint Dysfunction (TMJ)	Annual	$1000

Individual Coinsurance

After the Calendar Year Deductible the Plan will pay the following percentages up to the Annual Maximums:

PPO Providers In-State or Out-of-State	80% of the Plans Usual and Customary Allowables for PPO Services
Non-PPO Providers In-State or Out-of-State	50% of the Plans Usual and Customary Allowables for Non-PPO Services

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 Plan's usual and customary charges 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 Fund 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 Fund 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 MHBF Director 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 Plan.
- 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 Plan.

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.
  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 the "Definitions" sections of this booklet or who ordinarily resides in your home.

Eligibility—Any Member of a Covered Group offering Dental Care Benefits must be enrolled in the MHBF Major Medical Benefits to be eligible.

Please Note: The Plan 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

Benefits Payable—Vision benefits are payable up to an amount of $150 if a covered member incurs covered vision expenses in a calendar year in excess of a $50 vision calendar year deductible.

Covered Vision Expense—Covered Vision Expenses are charges for necessary vision care as listed below:

- Eye examinations by Optometrist or Ophthalmologist.
- The purchase of eyeglasses, tints, coatings, and contact lenses as a result of an examination for which a benefit is payable.

Routine Vision Care—Routine vision care benefits are payable if a member satisfies the Routine Vision Calendar Year Deductible of $50 for the year in which the expenses are incurred. Benefits are payable in an amount equal to the appropriate Covered Percentage listed below. However the total amount payable for all covered routine vision charges incurred by a covered member during a calendar year will not exceed the Annual Maximum of $150 defined in the Schedule of Benefits listed below:

Routine Vision Care and Deductible

Calendar Year Deductible:	Annual	$50
Routine Exam, Eye Glasses, Contact Lenses	Annual	$150

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 under the usual and customary fees allowed by the Plan. Any additional glasses and/or lenses may be covered under the optional Vision Care Benefits coverage.

Individual Coinsurance

After the Calendar Year Deductible the Plan will pay the following percentages up to the Annual Maximums:

PPO Providers In-State or Out-of-State	80% of the Plans Usual and Customary Allowables for PPO Services
Non-PPO Providers In-State or Out-of-State	50% of the Plans Usual and Customary Allowables for Non-PPO Services

Covered Vision Expense—Covered Vision Expenses are charges for necessary vision care as listed below:

- Routine eye examinations performed by a licensed Optometrist or Ophthalmologist.
- The purchase of eyeglasses, tints, coatings, and contact lenses as a result of an examination for which a benefit is payable.

Vision Care Limitations and 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. Examination, lenses or frames received in or from an institution owned or operated by the federal government where there is no obligation to pay in the absence of coverage.
  b. Sun glasses.
  c. Repair to frames.

Medical Eye Care—Eye disease and other medical treatment of the eye is not a covered benefit under the Routine Vision Benefits. Please see the separate Covered Major Medical Benefits section of this booklet for further information.

Eligibility—Any Member of a Covered Group offering Vision Care Benefits must be enrolled in the MHBF Major Medical Benefits to be eligible.

Life Coverage

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

Employee	Consult your Employer for amount
Spouse	$5,000
Child by Age at Death 2 weeks	Nil
2 weeks but less than 6 months	$200
6 months but less than 19 years	$2,000
19 years or over	Nil

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 Plan 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.

Disability Income Benefits

Optional Coverage for Full-Time Employees Only

Each group has the option to enroll in the disability income benefit. Check with your Employer to see if you are covered.

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 Plan reserves the right to request a determination of disability by a physician selected by the Plan. This benefit is not assignable.

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

Option B (52 Week Benefit)	
Weekly Benefit	$105
First Benefit Day for Disability due to Accident	183rd Day
Illness	183rd Day
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 MHBF Director within 180 days of the first date of disability. The Disability Income Form is also available online at www.arml.org/services/mhbf/.

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

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

Section 5: MHBF Preferred Provider Network/PPO

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

In an effort to better control costs and provide quality service, the Plan is participating in a managed care concept. The concept encourages the employees and their dependents to use physicians, hospitals and other providers that have agreed to join the Network of Preferred Providers. The Municipal Health Benefit Fund has developed and maintains its own Preferred Provider Network.

You may choose to use a PPO provider or a non-PPO provider. The Plan will pay a higher benefit if you choose to use a PPO provider. It will be the member's responsibility to inquire whether a provider is in the PPO Network before services are rendered. Your personal identification card will notify the provider of your membership in the Plan.

PPO hospitals and providers for medical, optional dental and optional vision services have agreed and contracted with the Plan to handle billing and collections for the patient, and to follow the Utilization Review Program utilized by the Plan. The Provider Directory, as well as a list of participating pharmacies is available at www.arml.org/services/mhbf/

#1. To request a full copy of the most current PPO Directory, please call MHBF Customer Service at 501-978-6137.

After the calendar year deductible(s) are met, the Plan will pay the following percentages for covered services:		
	PPO	**Non-PPO**
Emergency Room Services	80% of the Plan's Usual and Customary PPO Allowables	80% of the Plan's Usual and Customary PPO Allowables
PPO Providers (In-State or Out-of-State)	80% of the Plan's Usual and Customary Allowables	
Non-PPO Providers (In-State or Out-of-State) (Except for Emergency Room Charges)		50% of the Plan's Usual and Customary Allowables (See Usual and Customary Charges under Definitions)

Section 6: Coordination of Benefits

Coordination of Benefits (COB)

You or your family members may have coverage under more than one health plan. This Plan contains a coordination of benefits provision which eliminates duplication of payment for services received while covered under this Plan. The benefits payable under this Plan for medical, dental or vision expenses will be coordinated with group insurance and health benefit plans providing benefits for such expenses to cover up to 100 percent of Allowable Expenses incurred, after the deductible has been satisfied. Benefits payable under the Plan will also be coordinated with applicable medical payment coverages, including, but not limited to, travelers, auto* and homeowners coverages. The Municipal Health Benefit Fund will follow the usual rules of coordination of benefits.

***Please note: For covered members who decline to purchase the minimum medical coverage under their auto insurance, the Municipal Health Benefit Fund 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 Plan will not exceed 100 percent of the annual eligible benefits when combined with all other plans.

When Medicare pays as the Primary Coverage, 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 Plan for consideration of Secondary coverage.

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 Municipal Health Benefit Fund will coordinate with Part A, Part B and Part D of Medicare the same as if the covered member had Part A, Part B and Part D of Medicare when Medicare is the Primary Carrier. This means that the Plan will reimburse only 20 percent of the eligible charge and you will be responsible for the deductible and 80 percent of the eligible charge.

The Plan'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

3. This is how COB Works: 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; this Plan provides payments towards the balance of the cost of covered services.
   B. Your Secondary Plan is the plan paying second or after the Primary Plan has paid; this Plan provides payments toward the balance of the cost of covered services.
4. This is how to determine which is the Primary and Secondary Plan:
   A. The plan covering the employee is primary. The plan covering the employee as a dependent is secondary.
   B. If both the mother and father's plan cover the child, the plan of the parent whose birthday is earlier in the year is the primary plan.
   C. Children of divorced or separated parents benefits 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 dependent has primary coverage but do not follow the Plan benefit requirements of that coverage, Plan's payment will be reduced by 80 percent. In other words, the maximum the Plan will pay is 20 percent of the allowable amount on the claim.

5. Guidelines to Determine Primary and Secondary Plans for Medicare Recipients:
   A. If your Group has less than 20 employees, Medicare is primary for covered members eligible for Medicare due to age.
   B. If your Group has less than 100 employees, Medicare is primary for covered members eligible for Medicare due to disability.
   C. If your group has more than 100 employees, this Plan is primary over Medicare for covered members eligible for Medicare due to age or disability.
   D. A Member eligible for Medicare based solely on end stage renal disease is entitled to receive benefits of this Plan as primary for a 30 month waiting period.
6. COB Allowable Expense: Allowable Expense is a health care expense (including deductible, coinsurance or copayments) covered in full or in part by the Plan. This means an expense or service not covered by any of the Plans is not an Allowable Expense.

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 Plan is not the primary plan.
- Subrogation, reimbursement and third party recovery rights of the Plan.
- Reductions when private hospital rooms are used.
- Reductions for certain multiple surgical procedures.
- Reductions for charges that exceed usual and customary allowances or negotiated fee allowables.
- Reductions and/or denials for services which are not medically necessary or generally accepted as inappropriate and/or are considered as overutilization.
- Denial for services for anyone currently residing outside the United States or Canada, except for emergency services.
- Denial for anyone already covered under the Municipal Health Benefit Fund 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 Plan.

Notice and Proof of Claim

Filing a Claim—All claims are to be filed with the MHBF Director and mailed to Municipal Health Benefit Fund (MHBF), 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 Municipal Health Benefit Fund office or by the MHBF Director within 180 days of the date the claim was incurred, unless defined otherwise in this section. Please note that the timely filing guidelines also applies 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 must be filed within 60 days of the last day of membership in the Plan, 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 MHBF Director may provide forms to facilitate a claims determination. If a form or supplemental information is requested by the MHBF Director, 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 Plan prior to 90 days after proof of claim has been filed with the Plan Administrator. If the time for beginning legal action is less than that permitted by law of the jurisdiction in which the Municipal Health Benefit Fund is domiciled, such limit is extended to the minimum period permitted by such law.

Payment of Benefits—Benefits will be paid to you promptly upon receipt of due written proof of claim. The member is responsible for reimbursement to the Plan to the extent of any overpayment that is in excess of the amount payable under the Plan. If any benefit remains unpaid at your death, or if you are a minor or, in the opinion of the MHBF Director, are legally incapable of giving a valid receipt and discharge for any benefit, the 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 Administrator's obligations will be completely discharged to the extent of such payment, and the 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 Plan 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 Plan for such medical expenses. However, the Fund, at its sole discretion, may provide benefits according to Plan terms provided that the participant agrees, in writing:

- To give the Plan 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 MHBF Director 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 Plan's obligations to make expenditures to or on behalf of the member, so that the Plan 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 Plan under applicable common or statutory laws.
- That the Plan 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 Municipal Health Benefits Plan, each participant, former participant or other person having an interest in or eligibility under the Plan ("member") agrees that the Plan 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 Plan may directly pursue recovery against such third party and can treat the participant (and such individual's attorney) as acting as the Plan'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 Plan's subrogation right.
- To reimburse the Plan 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 Plan 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 Municipal Health Benefits Plan, each participant, former participant or other person having an interest in or eligibility under the Plan ("member") shall provide the Plan with a Right of Reimbursement and an Assignment of Rights, as described below. These rights enable the Plan 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 Plan will refuse to provide the participant or other covered members of the participant's family any benefits under the Plan if the participant refuses to execute an agreement agreeing to reimburse the Plan, fails to reimburse the Plan, or fails to cooperate in helping the Plan collect reimbursement from the participant or a third party.

Right of Reimbursement

As a condition to receiving benefits from the Plan and by their receipt of said benefits, all participants and insureds grant the Plan 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 Plan'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 Plan in providing benefits to the member.

Without limiting the Plan's rights in any way, it is the intention of the parties that the Plan 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 Plan that the member grant the Plan 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 Plan's expenditures, so that every such dollar of any such proceeds will be paid to the Plan, beginning with the first dollar and continuing until the Plan 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 Plan first. The Plan'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 Plan'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 Plan 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 Plan under these provisions within a reasonable amount of time after receiving proceeds (including any form of consideration) from any third party, the Plan 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 Plan shall retain all rights provided for in those parts that remain enforceable, including without limitation the Plan'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 Plan 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 Plan, though not expressly designated as such, which determination shall be made at the sole discretion of the MHBF Director.

In order to obtain reimbursement, the Plan will take such actions as the Board of Trustees, in its discretion, feels would best serve the Plan. The Plan may seek to have any payment by a third party made payable to the Plan 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 Plan, the member will assign to the Plan 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 Plan's expenditures. If the Plan pursues any such action or claim, the member shall cooperate and assist the Plan and shall be prohibited from taking any action that would prejudice the Plan's rights or in any way diminish its prospects for a recovery.

In addition, the participant must execute a lien in favor of the Plan for the amount to which the Plan is entitled. However, even if the participant or insured does not give the Plan a lien, the participant is liable to the Plan 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 Plan 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 Plan'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 Plan. In no event shall the foregoing language be deemed to vest a participant or other covered members of a participant's family with the right to receive coverage for claims that are specifically excluded under the Plan.

Furthermore, notwithstanding the above provisions, the Plan reserves the right to seek reimbursement for any and all over-payments which it may make by, inter alia, 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: 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, they will be required to 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, they will be considered inactive, and their benefits will be terminated as defined in the Plan.

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.

Allowable Expenses means the usual, customary and reasonable charges, including the average wholesale price (AWP) made for necessary health care services, medications and supplies, a portion of which is covered by at least one of the plans covering the member for whom the claim is made. These covered services will be considered Allowable Expenses and a benefit paid. Allowable Expenses do not include charges used to satisfy the deductibles, copayments or coinsurance assessed under the Prescription Drug Card Plan. (For more information, see Coordination of Benefits.)

Average Wholesale Pricing (AWP) means allowable amount determined by the Plan for products provided to the covered members, employing the most current Average Wholesale Price (AWP) or another industry-accepted benchmark as set forth by Medispan, First Databank, or other industry-accepted database. The Plan retains the right to review any and all claims for such products provided to its covered members. The Plan retains the right to reimburse providers at eighty-five (85%) percent of AWP for claims billed with NDC numbers. The National Drug Code (NDC) is a unique product identifier used in the Unites States for drugs intended for human use. (For more information see Usual, Customary and Reasonable Charges (UCR).

Benefit means the benefit provided under the Municipal Health Benefit Fund.

Employee Benefit means the benefit provided for eligible employees.

Dependent Benefit means the benefit provided for dependents of eligible employees.

Certificate of Creditable Coverage means a written certificate issued by the Plan, 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 Plan, 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.

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 Provider or Covered Individual for payment to be made properly, i.e., medical records, detailed billing, invoices, or any other such like information.

Coinsurance means the ratio (percentage) of splitting the bill between the Plan and the covered member.

> **Example: 80 percent for the first $5,000 of eligible charges means the Plan will pay $4,000 and the covered member is responsible for the remaining $1,000.**

Copayment means an amount required to be paid by a covered member each time a specific covered service is accessed. The copayments are set forth in the Schedule of Benefits.

Covered Person means a member covered by the Municipal Health Benefit Fund provision in which the term is used, but only while under such provisions.

Custody means the care, control and maintenance of a child that may be awarded by a court to one of the parents 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 Municipal Health Benefit Fund.

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

Eligible Dependent—An Eligible Dependent is as follows:

- Spouse—not legally separated or divorced
- Adult Dependent—a covered dependent (other than your spouse) age 19 to 26
- Child—under the age of 19 years
- 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. A divorce decree is required to note legal custody and insurance maintenance at enrollment of said child.
  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.
  d. An employee's grandchild who is under legal guardianship or custody of the employee and may be enrolled under the Dependent Only coverage if the employee submits documentation of custody and/or guardianship and pays an additional monthly premium as determined by the Plan.
- Adult Dependent—a covered dependent (other than your spouse) age 19 to 26. Coverage for adult dependents (other than your spouse) age 19 through the last day of the month in which they reach age 26 can be covered, at the employee's request, under the Major Medical and Prescription Drug, optional Dental, and Vision Benefits offered by the Plan.

Employee—See member/employee.

Employer means only the Plan or a participating affiliate of the Plan who in either instance participates in the Plan as a participating Employer.

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 MHBF Director 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 MHBF Director will be considered final and binding on all parties.

After all other provisions of the Plan have been complied with, the following criteria and guidelines will be used by the Plan 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 Plan.

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 Municipal Health Benefit Fund, with the exception for the diagnosis of cancer, which will be Case Managed utilizing Evidence Based Cancer Guidelines.

The Plan will not provide coverage for medical services that are subject to ongoing clinical trials or research.

The Plan 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 Plan.

Fund Booklet means the Plan Document which sets out the Plan's terms and conditions as included herein. No contract, agreement or financial arrangement supersedes the terms, conditions, limitations and exclusions set forth in the most current Municipal Health Fund Booklet.

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

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—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.

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 MHBF Director.

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, nursing, residential treatment or convalescent facility, or an institution for treatment of alcoholism or drug abuse.

Hospital Care Period means successive periods of hospital care 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 member who received the services.

Injury means a bodily injury sustained accidentally by external means.

Inpatient means a member who is a patient using and being charged for the daily room and board facilities of a hospital or a member who remains in 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 they are licensed to practice. This definition shall also extend to licensed certified counselors. To qualify for benefits, the Plan member must have been referred to the social worker by a licensed medical 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.

Medicare Eligibility means when an individual meets certain criteria that will enable him or her to apply for and receive Medicare benefits, such as turning 65 or becoming disabled.

Medicare Entitlement means when an individual becomes entitled to Medicare once they actually apply to begin Social Security income payments or file an application for hospital insurance benefits under Part A of Medicare.

Member/Employee means an eligible person or their dependent who has submitted an enrollment form and has been accepted as a member of the Municipal Health Benefit Fund, and remains a member in good standing according to the policy provisions of the Plan. 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 is defined as a condition for which a Covered Individual is over their ideal weight with 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.

Nutritional is defined as (1) the process of nourishing or being nourished, especially via the process by which a living organism assimilated 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. Many common health problems can be prevented or alleviated with a healthy diet.

Occupational Therapist means a person 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.

Outpatient means a member receiving services or treatment for care of illness or injury in a hospital or other licensed facility.

PHI means Personal Health Information.

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 is defined as the **Municipal Health Benefit Fund (Fund)**, as presented in the Employees' booklet as approved by the Board of Trustees.

> ***Plan other than the Municipal Health Benefit Fund (Fund)*** 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.

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 Fund Booklet are received by the covered individual.

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

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 MHBF Director in the Home Office and is furnished without expense to the MHBF Director.

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

Stop Loss is a limit on the coinsurance required from the Covered Member.

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

Usual, Customary and Reasonable Charges (UCR) To determine UCR charges billed by a medical provider for services and supplies, the Plan reserves the right to use national tables (including, but not limited to, RBRVS, ADP and MDR, Medispan, First Databank) and methods in accordance with health care industry standards. The Plan may set limits on a provider's charges and fees at its discretion without giving notice to the provider. The Plan will not pay 100 percent of a provider's billed charges.

You and Your means an employee/member covered by or in a class eligible for Employee Benefits.

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

Section 8: 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 Plan works, we urge you to call and visit with a Municipal Health Benefit Fund 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 Fund 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 below.

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

The Fund requires that as a condition precedent to all the benefits, terms, and conditions of this contract, 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.

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.

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 below.

First Internal Written Appeal—Within 60 days of having received a claims denial notice, write to the Claims Supervisor, at Municipal Health Benefit Fund, 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 the Claims Supervisor will respond to you in writing with a determination regarding your appeal. If your claim is denied the response will reference the Plan provision upon which the denial was based and will provide you with an explanation of additional appeals you may make. If the Plan needs time to investigate the facts, you will be notified.

Final Internal Written Appeal— If the decision rendered by the Claims Supervisor is not satisfactory you or a duly authorized representative may appeal from that denial to the Board of Trustees for the Municipal Health Benefit Fund within 60 days of having received a denial notice from the Claims Supervisor. 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 Plan. 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 Plan 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 plan;
- 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.

B. **Appeal (or internal appeal).** The term "appeal or internal appeal" means a review by the Fund.

C. **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 plan 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."

D. **Claimant.** The term "claimant" means a person covered by the Fund who makes a claim under this section. References to a claimant include a claimant's authorized legal representative.

E. **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.

F. **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.

G. **Final internal adverse benefit determination.** The term "final internal adverse benefit determination" means an adverse benefit determination that has been upheld by the Fund at the completion of the internal appeals process or when the internal appeals process is deemed exhausted under Federal law.

H. **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.

I. **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 Fund participants, beneficiaries and other specified individuals. See below at (i)(4) for more information on notice to non-English literate persons covered by the Fund.

J. **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.

K. **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.

L. **Rescission.** A 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.

M. **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 Fund 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 Fund'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 Fund 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 Fund shall notify the claimant of the plan's adverse benefit determination within a reasonable period of time, but not later than ninety (90) days after receipt of the claim by the Fund, unless the Fund 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 plan expects to render the benefit determination. During the appeal process, the Fund 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 (i) below.

3. Urgent Care.

In the case of a claim involving urgent care, the Fund 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 Fund, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan. In the case of such a failure, the Fund shall notify the claimant as soon as possible, but not later than twenty-four (24) hours after receipt of the claim by the Fund, 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 Fund shall notify the claimant of the plan's benefit determination as soon as possible, but in no case later than forty-eight (48) hours after the earlier of—

A. The Fund's receipt of the specified information, or

B. The end of the period afforded the claimant to provide the specified additional information.

4. Concurrent care decisions.

If the Fund 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 Fund of such course of treatment (other than by amendment of the Fund'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 Fund 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 Fund shall notify the claimant of the benefit determination, whether adverse or not, within twenty-four (24) hours after receipt of the claim by the Fund, provided that any such claim is made to the Fund 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 (i) of this section and the appeal shall be governed by paragraph (k) of this section, as appropriate.

5. Other claims.

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

6. Pre-service claims.

In the case of a pre-service claim, the Fund shall notify the claimant of the Fund'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 plan. This period may be extended one time by the plan for up to fifteen (15) days, provided that the Fund 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 plan 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 Fund 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 (i) below.

7. Post-service claims.

In the case of a post-service claim, the Fund shall notify the claimant of the Fund'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 Fund for up to fifteen (15) days, provided that the Fund that such an extension is necessary due to matters beyond the control of the Fund 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 plan 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 Fund 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 (i) below.

8. Calculating time periods.

The period of time within which a benefit determination is required to be made shall bgin at the time a claim is filed in accordance with Fund 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 Fund 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 Fund's standard, if any, that was used in denying the claim.

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

D. Reference to the specific plan provisions on which the determination is based;

E. 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;

F. If requested, the Fund 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 Fund will not consider a request for diagnosis and treatment information, in itself, to be a request for an internal or external appeal.

G. The Fund will provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal.

H. In the case of a notice of final internal adverse benefit determination, the description will include a discussion of the decision.

I. The Fund 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**

J. In the case of an adverse benefit determination by the Fund concerning a claim involving urgent care, a description of the expedited review process applicable to such claims.

In the case of an adverse benefit determination by the Fund concerning a claim involving urgent care, the information provided by the Fund 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 Fund will provide relevant notices in a culturally and linguistically manner to those Fund 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 Fund 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 Fund shall have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the Fund, and under which there will be a full and fair review of the claim and the adverse benefit determination. As such, the Fund 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 Fund 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 plan 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 plan 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 Fund's benefit determination on review, shall be transmitted between the plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

J. The Fund will provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Fund (or at the direction of the Fund) 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 (k) 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 Fund 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 (k) 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 Fund shall notify the claimant of the plan'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 Fund.

B. **Pre-service claims.** In the case of a pre-service claim, the Fund shall notify the claimant of the Fund's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. Because the Fund 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 Fund 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 Fund shall notify the claimant of the Fund's benefit determination on review within a reasonable period of time. Because the Fund 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 plan 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 plan, 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 Fund 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 Fund will provide a claimant with written or electronic notification of a plan'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 plan 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 (9.) above.

15. Failure to establish and follow reasonable claims procedures.

In the case of the Fund'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 plan and shall be entitled to pursue an external review on the basis that the plan 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 Fund (Fund) gives you the opportunity to seek review of certain claim denials by an independent external review organization. If you disagree with the Fund'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 Fund 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 Fund, including a final internal adverse benefit determination, that involves medical judgment (including, but not limited to those based on the Fund'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 timeframe for completion of the expedited internal appeal would seriously jeopardize your life, your health, or your ability to regain maximum function; or
- The timeframe 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 plan'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 Fund about the denied claim; and
- Letters received from the Fund.

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 Fund, or you may send your external review request:

By Postal Mail:

MAXIMUS Federal Services

3750 Monroe Avenue, Suite 705

Pittsford, NY 14534

By Fax to:

(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 Fund 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 Fund's ABD;
- All documents and information considered in making the ABD or final internal ABD including any additional information provided to the Fund relied on during the internal appeals process;
- The external review examiner will review the information provided by the Fund and may request additional information;
- The external review examiner will notify you and Fund 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 Fund's internal claims and appeals process;
- Upon request by the Fund, the examiner will forward all documents submitted by you to the Fund. Upon receipt of any such information, the Fund may reconsider its ABD or final internal ABD. This reconsideration must not delay review. The external review may be terminated if the Fund decides to reverse its decision and provide coverage or payment after reconsideration. The Fund 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 Fund.

The examiner must provide written notice of a final determination on the external review to you and Fund 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 Fund;
- 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 Fund upon request.
- Upon receipt of a final external review decision reversing the ABD or final internal ABD, the Fund 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 Fund 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 Fund and may request additional information that it deems necessary to the external review.
- The examiner will notify you and the Fund 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 Fund. Upon receipt of the information the Fund may reconsider its ABD or final internal ABD. This reconsideration must not delay review. The external review may be terminated if the Fund decides to reverse its decision and provide coverage or payment after reconsideration. The Fund 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 Fund.
- The reviewer shall make a final determination on the external review and communicate it to you and the Fund 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 Fund must immediately provide coverage or payment for the claim.

Technical Assistance is available by calling Toll-Free Telephone:

1-888-866-6205

- Available 24 hours/7 days per 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 9: Forms

MUNICIPAL HEALTH BENEFIT FUND

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 Fund (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 Plan 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 Plan or their lawyers when the law provides the Plan with the right to contest a claim made under Plan 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 Plan. 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 Plan's designated representative.

Signature: _____ Date: _____

Witnessed by _____ Date: _____

_____
PRINT NAME

Municipal Health Benefit Fund
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 Plan or their lawyers when the law provides the Plan the right to contest a claim incurred while I was a covered member under the Plan.

Signature: _____ Date: _____

Witnessed by _____ Date: _____

_____

PRINT NAME

Manage Costs by Maximizing Your Tax Savings.

We offer Expense Management Services for you and your employees.

American Fidelity provides a suite of expense management services that can help you and your employees maximize your tax savings and manage costs associated with various benefits. We specialize in providing employer administrative services for all of our services, which can easily coordinate with existing plans.

Our expertise and experience in offering expense management services allows us to make recommendations on the programs that will work best in your situation. Also, we explain how we can implement these cost-saving programs for you and your employees.

Our Expense Management Services

- Section 125 Plans
- Flexible Spending Accounts
- Health Savings Accounts
- Health Reimbursement Arrangements
- Dependent Verification Reviews
- Enrollment Solutions

To learn more about what American Fidelity can do for your organization, contact:

Charles Angel
Senior Account Executive

800-450-3506, ext. 3132
charles.angel@americanfidelity.com

American Fidelity Assurance Company

Our Family, Dedicated To Yours.®

SB-25306-0312

PLAN ADMINISTRATION: Enrollment and Premiums

Municipal Health Benefit Fund Premium
P.O. Box 880
Conway, AR 72033
Phone: 501-978-6137 Fax: 501-537-7252
www.arml.org/services/mhbf

CLAIMS ADMINISTRATION: Claims and Benefits

Municipal Health Benefit Fund
P.O. Box 188
North Little Rock, AR 72115
Phone: 501-978-6137 Fax: 501-537-7252
www.arml.org/services/mhbf

For Precertification, please call:

1-888-295-3591
(Precertification does not provide Benefit Information.)