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

**Mandatory Administrative Appeals Procedure**

As a condition precedent to all the benefits, terms and conditions of this 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.
What is eDocAmerica?
- Direct email access to eDocAmerica medical professionals
- Personal responses from, physicians psychologists, pharmacists, dietitians, and more...
- Weekly Health Tips written by physicians and delivered right to your email
- Healthy Lifestyle Assessment to help you monitor your current health status
- All services are FREE, unlimited, confidential, and cover the entire immediate family

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- A registered nurse will advise the caller as to the proper disposition for their situation
- English and Spanish speaking nurses

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1-866-842-5365

Access your FREE account
Step 1 - Visit www.edocamerica.com
Step 2 - Click the “Register Here” button
Step 3 - Choose “Arkansas Municipal League” from the drop-down menu
Step 4 - Follow the online instructions

Need Help? Have Questions?
1 (866) 525-3362 or info@edocamerica.com
Declaration of Trust

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

This Fund Booklet describes benefits available to you under the Fund. Consult your Employer to determine the Benefits available to you under the Fund.

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

The 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.
5. The exemption from these Federal requirements will be in effect for the 2019 plan year that begins on January 1, 2019, and ends on December 31, 2019.
6. The election may be renewed for subsequent plan years.

PATIENT PRIVACY

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

Mark R. Hayes
Plan Administrator
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Section 1: General Eligibility Information

General Eligibility Information

Eligibility Dates—If you are an employee 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.

Eligible Class—The Eligible Class of employees includes all full-time active employees of a Participating Employer who work an average of 30 hours per week (Class 5). Subject to election of a Participating Employer, employees in any of the following other classes can also be covered under the Fund and be part of the Eligible Class:

- Elected officials—Class 1
- Members of boards and commissions—Class 2
- Volunteer firefighters—Class 3
- 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 Fund, 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 and Mayor, City Manager or Chief Executive Officer.
- Certification must be submitted to the Fund each year on or before December 31.

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.

If you are a member of a class other than Class 5, consult your Employer to determine if you are a member of an Eligible Class.

Effective Date Requirements

To be covered under the Fund, you must enroll in the Fund as of your Eligibility Date and agree to make any required premium contributions. If you do not enroll yourself and your dependents before your Eligibility Date, you may not enroll or change your coverage election until January 1 of the following year or another Open Enrollment Period unless you have a Change in Status Event described below.
Requirements for Changing Your Coverage

Single Coverage
If you have single Coverage, family Coverage may be added during any Open Enrollment Period or on the first day of the Month coincident with or immediately following the occurrence of any of the following events (“Change of Status Events”):

New Eligible Dependents acquired via:
- Marriage
- Adoption

Regarding the birth of a baby, if you have single Coverage, family Coverage may be added during any Open Enrollment Period or during the month in which the birth of a baby occurs. To add a newborn to coverage, you must complete a Change of Status Form and provide supporting documentation within 30 days of the date of birth.

- Court Order to provide coverage for an eligible child; Child Support/Medical Support Order

Loss of Spouse's health coverage due to loss of their employment: must provide letter from 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.

In order to change your Coverage due to a Change of Status Event, you must complete a Change of Status Form (available from your Employer or the Fund) and provide a copy of supporting documentation of the Change of Status Event within 30 days of the date of the Change of Status Event.

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

Family Coverage
If you have family Coverage, an eligible newborn can be added to your Coverage on the newborn's date of birth. The newborn must be added within 60 days of their date of birth regardless if Social Security Number is received.

If the newborn is not added within 60 days of their date of birth the newborn may not be eligible for Coverage until the next Open Enrollment Period.

If you have family Coverage, an Eligible Dependent may be added to your coverage during any Open Enrollment Period or on the first day of the Month coincident with or immediately following the occurrence of a Change of Status Event. In order to add the Eligible Dependent due to a Change of Status Event, you must complete a Change of Status Form and provide a copy of supporting documentation of the Change of Status Event within 30 days of the date of the Change of Status Event.

If you do not add an otherwise Eligible 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.

Important Information

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

Members moving from one covered group to another without a lapse in Coverage do not have to meet the 60-day employment requirement. If this provision applies to you please contact the Fund 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 Fund will not credit premiums for failure to notify the Fund as required.

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

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

When Your Benefits Stop

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

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

- The last day for which your premium has been paid.
- When the Participating Employer fails to make the required premium payments.
- When the Participating Employer cancels Coverage under the Fund.

Your Eligible Dependents’ Coverage under the Fund will automatically terminate on the earliest of:

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

Eligibility as a Dependent will cease:

a. For any Dependent, on the date he or she becomes covered individually under the 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 Adult Dependent, the end of the month following the attainment of age 26.

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

Right to Continuation Coverage under COBRA

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health Coverage. It can also become available to other members of your family who are Covered under the Fund when they would otherwise lose their group health Coverage.
The COBRA notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of Coverage under the Fund. 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 Fund 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 Fund is lost because of a Qualifying Event. Under the Fund, 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 Fund 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 Fund 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 Fund 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 Fund as a “Dependent Child.”

When is COBRA Coverage Available?

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

Notice Must Be Given of Some Qualifying Events

For the other Qualifying Events (divorce or legal separation of the Employee and Spouse or a Dependent child losing eligibility for Coverage as a Dependent child), you must notify the Fund within 60 days after the Qualifying Event occurs. You must provide this notice to:
Section 1
Eligibility

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

How much does COBRA continuation coverage cost?

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

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

If you elect continuation coverage you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is postmarked, if mailed.) If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Fund. You are responsible for making sure that the amount of your first payment is correct. You may contact the employer or the 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 Fund, 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 Fund will continue for that coverage period without any break. The Fund 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 Fund 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 Fund.
Your first payment and all periodic payments for continuation coverage should be sent to the participating Employer for your group, or you may send them directly to the Fund address.

KEEP THE FUND INFORMED OF ADDRESS CHANGES—In order to protect you and your family’s rights, you should keep the Fund 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 Fund. Additionally, if you have changed marital status or you or your spouse have changed addresses, please notify the Fund in writing at the above address. Please note: If you have questions concerning your Fund or your COBRA continuation coverage rights, contact your Employer, or the Fund, Municipal Health Benefit Fund, P.O. Box 188, North Little Rock, AR 72115. For additional information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, visit the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

Retiree Coverage

Arkansas law requires municipalities to establish by ordinance, or otherwise, criteria for eligibility as a retiree. The Fund will provide retiree Coverage consistent with locally established criteria, provided a written copy of the ordinance or policy is furnished to the Fund by January 1 of the Fund year. If no ordinance or policy is provided, then the Fund 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 Fund.
- 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 Fund.

The retired employee or official may include his or her Eligible Dependents in the Fund provided the dependent premium is paid.
Section 2: Major Medical Benefits

Benefits

Major Medical Schedule of Benefits

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

*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.

****Sleep study must be completed in one night. The Fund will not cover a second night.
Preventative Care Benefits

The Fund will pay 100 percent of the reasonable and customary charges for In-Network, Preventative Care (as described further below under “Preventative Care Program”).

Physician Evaluation and Consultation Visit Copayment

You are responsible for a copayment of $20.00 for each visit for services that are billed by the medical provider under CPT Codes 99201 through 99215 (“Physician Visit Copayment”) performed in an office location.

Some examples of the types of visits for which the Physician Visit Copayment will apply are new patient consultations, evaluation and management of a chronic condition, or an examination for treatment of a cold or the flu.

The Physician Visit Copayment will not count toward your Calendar Year Deductible (as described further below under “Calendar Year Deductibles for Major Medical”). Any services or procedures rendered other than those billed under the CPT Codes listed above will be reimbursed as outlined in the Fund Booklet.

Calendar Year Deductibles for Major Medical

<table>
<thead>
<tr>
<th>Standard Individual Calendar Year Major Medical</th>
<th>$500, $1200 or $2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Deductible Maximum</td>
<td>$6000</td>
</tr>
</tbody>
</table>

Please consult your Employer for the amount of your Calendar Year Deductible. The Calendar Year Deductible shall be applied to the amount of Covered medical expenses that are incurred each calendar year. Each Covered Member shall satisfy the $500, $1200 or $2000 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 Calendar Year Deductible.

Emergency Ambulance Services (ground or air ambulance)

Annual | 2 each per year

Individual Coinsurance

The Covered person 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 person meets the Arkansas In-State, In-Network coinsurance maximum, the Fund 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 Fund 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.

<table>
<thead>
<tr>
<th>After the calendar year deductible(s) are met, the Fund will pay the following percentages for covered services:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PPO</strong></td>
</tr>
<tr>
<td>Emergency Room Services</td>
</tr>
<tr>
<td>PPO Providers (In-State or Out-of-State)</td>
</tr>
<tr>
<td>Non-PPO Providers (In-State or Out-of-State) (Except for Emergency Room Charges)</td>
</tr>
</tbody>
</table>
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 Fund deductible or copayment requirement. Emergency room copayments do not apply to the Fund 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. The Fund will reimburse emergency room services (whether or not rendered at an In-Network facility) pursuant to In-Network deductible requirements and benefit percentages for emergent and immediate care up to the Fund’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 Fund 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 Fund 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 Fund 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 Fund will not pay 100 percent of the emergency room service charges even though provider retains the patient for observation. The copayment may be waived for an inpatient hospital room admission (for Stop Loss for Prescription Drug Benefits, see “Important Fund Changes related to the Affordable Care Act (Healthcare Reform)” in Section 3 of this Booklet, page 28).

Covered Major Medical Charges

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

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

Emergency Room Charges—Charges for medically necessary emergency room services.
Family Planning—Benefits are provided for an elective vasectomy performed only in a physician's office. The Fund will also provide benefits for an elective tubal ligation.

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

Medical Supplies and Pharmaceutical Charges—The Fund 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 re-placement of artificial legs, arms, and eyes. Also included is the replacement of these devices when required by a change in your physical condition, as well as repairs to prosthetic devices. Precertification is required for purchase of all prosthetic/orthotic devices that exceed $2,000. Coverage for replacement of a prosthetic or orthotic device may, at a minimum, be one (1) time every three (3) years, unless it is medically necessary as indicated by medical criteria. However, these devices will not be covered if they are misused or lost. (See Exclusions.)

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

Rental or Purchase of Durable Medical Equipment—The Fund will pay for standard durable medical equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is only useful to a person with an illness or injury, and (d) is appropriate for use in the home. Additionally, the Fund will replace standard durable medical equipment that is no longer serviceable provided it meets the criteria above. The Fund 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 Fund 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 Fund reserves the right to establish a rental or purchase price based on the reasonable and customary charge for such equipment. The Fund 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 coding rules.

Pre-certification, Penalty Deductibles, and Utilization Review

It is the member’s responsibility to pre-certify the following services by calling 888-295-3591. A $1,500 penalty deductible will be assessed for failure to pre-certify any services requiring precertification, per occurrence. Pre-certification requirements apply even if the Fund is a secondary payer. A covered member must pre-certify the following services including but not limited to:

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

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

Non-Emergency Surgical Procedures — Annual Maximum of 2
(hospital or ambulatory surgery center)

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

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

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

Surgical Procedures

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

Utilization Review Program

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

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 Utilization Review Program where the Fund requires pre-certification.

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

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

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 pre-certify your care by calling the Utilization Review Program at 888-295-3591. Inform the Utilization Review Program that you are covered under the Fund and provide the Utilization Review Program with your doctor’s name and telephone number. Failure to notify the Utilization Review Program prior to admission will result in the assessment of a $1,500 penalty deductible.
If your admission is due to an emergency, you or your family or physician will have until 5:00 p.m. the next business day to notify the Utilization Review Program of that admission. Direct admissions from your physician's office are not considered emergencies and must be pre-certified by you or your physician within twenty-four (24) hours. **Failure to do so will result in the assessment of $1,500 penalty deductible.**

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

**Exception for Childbirth**

The Fund 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.

**Additional Utilization Review Program Information**

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

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

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

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

Services and supplies which are not Medically Necessary are not covered, except for 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 Fund. If Utilization Review Program determines that a service is not Medically Necessary before or after a participating PPO Provider renders it, we prohibit the Provider who rendered the service from billing you for those services, UNLESS you agreed in writing to be responsible for payment before the services were rendered. Charges for services or supplies rendered by non-PPO Providers that are not considered medically necessary by the Utilization Review Program will be the responsibility of the member receiving the services.

Appeals made by a provider as to medical necessity will be referred to a Medical Reviewer designated by the Plan Administrator. **The decision of the Plan Administrator's Medical Reviewer shall be final and binding to all parties.** Appeals made by covered members or their legal representative shall be done in accordance with the internal/external review process set out in Section 7, page 43, of this Booklet.

The Fund will not pay for services or supplies furnished after the date your coverage ends, even if the Fund pre-certifies 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 Fund where services with high expenses are expected or where such services are expected but are not available within the Preferred Provider Network see “Section 5”, page 37, for more information. 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 Fund'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 Fund, alternative benefits may be provided by the Fund in lieu of Major Medical Benefits. Alternative benefits shall be provided if, in the sole discretion of the Fund, 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 Fund’s percentage reimbursements.

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. eDoc America is a tool available to all members of the Fund and their Families and provides access to medical professionals. When you log in to your eDocAmerica account, you can choose who you want to contact. Physician answers are guaranteed in 24 hours with most responses arriving within 2-3 hours.

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.

A 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.

Preventative Care Program

The Fund will reimburse for Annual Routine Preventative Care Benefits at 100 percent of the allowable charge, subject to usual, reasonable and customary charges. Annual Routine Preventative Care Benefits are not subject to deductibles and benefit percentages. To be considered as an Annual Routine Preventative Care Benefit, the provider’s bill for the service must designate a routine preventative diagnosis code, with the proper CPT Code and diagnosis pointer to be considered as a preventative service. Claims received with diagnoses other than or in addition to routine preventative will be considered under the Major Medical Benefits and reimbursed accordingly. Preventative benefits are not payable when done at flu clinics, health fairs or other public or private venues; however, flu shots exclusively, when billed through the drug card benefit and administered by a participating pharmacy, may be covered.

The following list is an example of the types of services often considered as routine preventative services:

- 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 history and are 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 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

### 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)
- Rotavirus
- Zosatavax (Shingles Vaccine)

**PLEASE NOTE:** Allergy injections and expenses related to birth of a child are not considered part of this benefit. Other injectable medicines may be covered under the Prescription Drug Card Program. Please see the Prescription Drug Card section of this Fund Booklet (Section 3, page 27). Pharmacy copays will be assessed if the above are administered at your local pharmacy, except for Influenza.

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

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

### Special Limitations on Specific Types of Medical Treatments

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

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

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 Program. (For more information, see Coordination of Benefits.)

Average Wholesale Pricing (AWP)—The allowable amount determined by the Fund 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 Fund retains the right to review any and all claims for such products provided to its covered members. The Fund retains the right to reimburse providers at eighty-five (85%) percent of AWP for claims billed. The National Drug Code (NDC) is a unique product identifier used in the United States for drugs intended for human use. (For more information see Usual, Customary and Reasonable Charges (UCR).

Bariatric Weight Loss Program*—The Fund 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 as described below 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 Fund limitations. Under this provision, Eligible Morbid Obesity expenses include the pre-obesity evaluation, medical and surgical treatment for post obesity follow-up care including but not limited to treatment of any complications. The morbid obesity treatment must be performed at a Fund-designated Morbid Obesity Treatment Center and is an eligible benefit for covered individuals nineteen (19) years of age or older.

Non-Covered Nutrition—The Fund 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 Fund Year to requalify.

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 Fund. 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

1. Call your Fund Case Manager at 888-295-3591 and notify them that you are interested in the MBS-AQIP program.
2. 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.
3. After the application is completed and you have been approved for the program, you will then complete six months of physician supervised weight management.
4. Monthly updates are required to be sent to the Fund Case Manager by your physician or dietician.

How to Obtain Pre-Authorization for Bariatric Surgery

1. Call your Fund Case Manager and notify them that you have completed the six 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.

*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 Fund Chemical Dependency Treatment Center to be covered. You must contact Fund 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 Fund. An order by a court or state agency for psychiatric treatment is not an indication of eligibility under this benefit.

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

Hearing Aids—The Fund 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 and MHBF has received a signed delivery receipt.

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

**Hospice Care**—The Fund 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 have family coverage, an eligible newborn can be added to your coverage on the newborn’s date of birth. The newborn must be added within 60 days of their date of birth regardless if Social Security Number is received or not. The Fund’s annual inpatient hospital maximum applies to this benefit.

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

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

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

**Organ Transplant Benefit Charges**—Transplant benefits are all inclusive and limited to two per lifetime. All-inclusive means all charges for all services for an organ transplant, including but not limited to, testing prior to transplant and all post-operative treatment. Additionally, donor procurement, tissue typing, surgical procedure, along with storage and transportation costs are included in the annual benefit but must be billed inclusively under the covered member of the 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 pre-certify services. No benefits will be available for transplants performed at any facility which is not designated by the Fund. Travel and lodging expenses are not a covered benefit.

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

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

**Usual, Customary, and Reasonable Charges (UCR)**—To determine UCR charges billed by a medical provider for services and supplies, the Fund 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 Fund may set limits on a provider’s charges and fees at its discretion without giving notice to the provider. The Fund 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 Fund and is prescribed by and administered under the direct supervision of a licensed physician.

**Health Care Exclusions**

**General Information**—The Fund 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 Fund 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 Fund 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 Fund will not cover any services required for complications arising out of the member’s discharge from care contrary to medical advice.

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

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

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

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

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

**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 Fund 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 Fund, 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 Fund provisions or charges that are applied to the Fund’s deductible, coinsurance, or copayment provisions.

**Dental Care**—is not a covered benefit under the Major Medical Benefits of the Fund
Domestic Partners—The Fund 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 Fund.

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

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

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 Fund.

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 Fund with the exception of cancer diagnoses.

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

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

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 Fund 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 Fund.

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 Fund.

Medication Maintenance Agreements—The Fund 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 Fund. 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 Fund.

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

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 Fund liability or claim.

Routine Foot Care—The Fund 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 Fund.

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 Fund.

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 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 “Right of Reimbursement” terms on page 41.

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

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

Travel and Lodging—Travel and lodging expenses incurred as a result of obtaining treatment for a medical condition are not covered benefits.
**Unproven Medical Procedures/Treatment**—Any medical procedure or drug that falls under any of the following:

a. Not consistent with standards of good medical practice in the United States as evidenced by endorsement by national guidelines (such as those prepared by the NIH and/or NCCN);
b. Under study in clinical trials other than those clinical trials meeting criteria established by federal law;
c. Exceeds (in scope, duration or intensity) that level of care which is needed; or
d. Are given primarily for the personal comfort or convenience of the patient, the family, or the provider.

**Vision**—Eye refractions, eyeglasses, contact lenses, or the fitting of such items or exercises for the eyes, and charges for eye surgery to correct refractive errors including, but not limited to, Radial Keratotomy (RK), Photo Refractive Keratotomy (PRK), Automated Lamellar Keratoplasty (ALK), Lasik or any related kerato-refractive surgery to correct refractive errors are excluded under the Fund. See Vision Care coverage section of this Fund 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; competitive skateboarding; sky diving; competitive street BMX riding; wall climbing without safety equipment; zip lining; tight rope walking.

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

**Please note:** that medical complications occurring as a result of receiving services excluded under the Fund, including but not limited to, surgeries, procedures, or medications, are not covered by the Fund. For other policy provisions, explanation of services and limitations, please see Definitions, Section 8, page 52.

**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 Fund is not the primary plan.
- Subrogation, reimbursement, and third-party recovery rights of the Fund.
- 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 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 Fund.
- A covered person failing to provide requested documentation such as an accident claim form, multiple coverage inquiry, certificate of acceptance of plan provisions, 2-page accident and Injury questionnaire, etc.
- Services must be performed at an accredited, licensed, certified facility for the treatment received.
- For covered Members who decline to purchase the minimum medical and hospital benefits under their automobile insurance coverage, pursuant to Ark. Code Ann. § 23-89-202(1), the Fund will coordinate as if the covered member had purchased this coverage.
Section 3: Drug Benefits

Prescription Drug Coverage or Prescription Drug Card Program

General Coverage

Prescription Drug Charges—The Fund will provide coverage 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 Fund has received and processed your enrollment paper work.

Coordination of Benefits Rules do not apply to the Prescription Drug Card Program.

Fund program members will be provided with an ID Medical/Drug card that can be used in most pharmacies for Prescription Drug Charges. Member copayments are outlined below (per 30-day supply).

<table>
<thead>
<tr>
<th>Generic Drugs</th>
<th>Preferred Brand Name Drugs</th>
<th>Non-Preferred Brand Name Drugs</th>
<th>Drug Cost &lt; $1,000/30 days</th>
<th>Drug Cost &gt; $1,000/30 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10.00</td>
<td>$30.00</td>
<td>$50.00</td>
<td>$100.00</td>
<td>$200.00</td>
</tr>
</tbody>
</table>

To locate an OptumRx pharmacy go to www.optumrx.com, enter your address or zip code.

Fund Members have access to OptumRx’s on-line prescription tool at www.optumrx.com. On this site, you can compare medication costs at local pharmacies, and see savings between brand name and generic medications. If you have any questions regarding your prescription drug plan, please feel free to contact OptumRx Customer Service Center at 855-253-0846.

Effective January 1,2017, the Prescription Drug Card Program will no longer cover the following products:

- Prescription strength and over-the-counter (OTC) gastric acid reducers/ulcer medications, such as Nexium and Prilosec.
- Prescription strength and over-the-counter (OTC) antihistamines, such as Allegra or Claritin.
- Prescription strength and over-the-counter (OTC) nasal steroids, such as Flonase or Nasacort.

These medications are widely available over the counter. Members will be responsible for 100 percent of the cost of these medications.

Brands with a Generic Available—The Fund enforces a Mandatory Generic Policy for brand-name drugs that are available generically. In the event a brand-name drug is chosen for which a generic exist, the member will pay their generic co-payment PLUS the difference in cost between the generic and brand-name grug. Members are encouraged to choose generic drugs, whn possible, to reduce out-of-pocket cost.

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

Blood Glucose Monitoring—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, the Fund allows members with diabetes to receive one free blood glucose meter per year at no charge.
The following Accu-Chek and OneTouch blood glucose meters are currently available:

<table>
<thead>
<tr>
<th>LifeScan Inc., a Johnson &amp; Johnson company</th>
<th>Rouche Diagnostics</th>
</tr>
</thead>
<tbody>
<tr>
<td>ONETOUCH® UltraMiniTM Meter</td>
<td>ACCU-CHEK® Aviva system</td>
</tr>
<tr>
<td>ONETOUCH® Ultra*2 Meter</td>
<td></td>
</tr>
</tbody>
</table>

**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.

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

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

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

Beginning January 1, 2015, prescription drug expenditures applied to a separate prescription drug out-of-pocket maximum. It is important to know that this out-of-pocket maximum is separate from the major medical out-of-pocket maximum and only applies to prescription drugs that are covered by the Fund.

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 Fund’s reference pricing program are deemed excluded from coverage and do not apply to the out-of-pocket maximum.

Important information regarding specific prescription drug coverage will be available on the Fund’s website, www.arml.org.

**Preventive Services** — The Fund provides coverage for the following “preventive” medications/drug categories as required by the Affordable Care Act (ACA). These products will be available at $0 copayment 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.

<table>
<thead>
<tr>
<th>Drugs / Drug Categories</th>
<th>Coverage Parameters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin to Prevent Cardiovascular Disease</td>
<td>For members ≥ 45 years of age. Quantity Limit of 100</td>
</tr>
<tr>
<td>Iron Supplementation for Children</td>
<td>For children up to 1 year of age</td>
</tr>
<tr>
<td>Oral Fluorides for Children</td>
<td>For children ≥ 6 months and ≤ 6 years of age</td>
</tr>
<tr>
<td>Folic Acid Supplements</td>
<td>For female members ≤ 55 years of age. Quantity Limit of 100</td>
</tr>
<tr>
<td>Tobacco Cessation</td>
<td>For members &gt; 18 years of age. Annual Limit: 2 cycles of treatment (12 weeks/cycle)</td>
</tr>
<tr>
<td>Routine Vaccinations for Children &amp; Adults</td>
<td>See Preventative Benefits, page 17.</td>
</tr>
<tr>
<td>All FDA approved contraceptive methods</td>
<td>Coverage limited to The Fund’s custom list and is subject to change</td>
</tr>
<tr>
<td>Breast Cancer Prevention</td>
<td>Tamoxifen, raloxifene</td>
</tr>
<tr>
<td>Vitamin D Supplementation</td>
<td>For members ≥ 65 years of age</td>
</tr>
<tr>
<td>Cholesterol Reducers (Statins)</td>
<td></td>
</tr>
</tbody>
</table>
**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/OptumRx 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, Fund members may obtain their medications through MedVantx mail order pharmacy. The mail order co-payment 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 Fund's standard co-payment structure will apply to each 30-day supply of medication obtained through the mail service pharmacy. A maximum of a 90-day supply of medication may be obtained through the mail service pharmacy, however a copayment for each one month supply will be charged.

**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 (833) 339-8401. If approved, the authorization will be referred to Allcare Specialty Pharmacy. The member or physician will then be contacted to arrange for shipment of the medication.

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

The list of Specialty medications is available at www.optumrx.com.

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

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

**Drug Therapy Management Programs**

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

**NOTE:** Drugs may be added to the Fund’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 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 and thus requiring prior authorization is provided at www.arml.org.

**NOTE:** Drugs may be added to the Fund’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 Fund will select the Best-In-Class or Reference Drug for each drug class involved in Reference Pricing. The amount paid by the Fund per tablet or capsule for the Reference Drug will be the amount the Fund 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 Fund’s standard co-payment amount. For all other drugs in the same category, the member will pay the difference between the Total Cost of the drug being dispensed and the cost of the Reference Drug. This copayment can be substantial. Prescription drug expenses related to the Fund’s Reference Pricing program do not apply to the out-of-pocket maximum.

Members are encouraged to ask their doctor for a Reference Drug when appropriate in order to save money. A list of drugs included in the reference pricing program is available at www.arml.org.

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

Prior Authorization

To ensure appropriate medication use, prior authorization is sometimes necessary for certain medications. Consideration for coverage will be given for those medications listed on the Fund’s prior authorization list. Your doctor must contact EBRx (UAMS) at (833) 339-8401 to request and start the prior authorization process. A list of medications that require prior authorization is located at www.arml.org.

NOTE: Drugs and drug categories may be added to the Fund’s Prior Authorization list throughout the year without notice.

Provider Assistance

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

Member Assistance

Members having general questions about the Fund’s prescription drug coverage should call the OptumRx 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. Furthermore, we have incorporated an evidence-based process in evaluating drug therapies to be reimbursed by the Fund. As a result of this process, there are many drugs that the Fund will exclude from coverage. The listing of products or drug categories excluded from coverage is located at www.arml.org.

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 EBRx Pharmacy and Therapeutics Committee. If this committee, made up of practicing physicians and pharmacists, determines that a product should be covered, it will then be moved to the appropriate preferred or non-preferred copay tier on the 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 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 Fund for Employees and Dependents. Your out-of-pocket cost for these expenses, after the combined benefits, is no more than the Fund 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 OptumRx as the secondary carrier;
- You pay only the Fund co-payments for that medication.

Important Note:

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

OptumRx
Patient Reimbursement
P.O. Box 968022
Schaumburg, IL 60196-0822

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 OptumRx Call Center at 855-253-0846.
Section 4: Optional Benefits

Optional Benefits

A Member Employer may choose from the following list of 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

<table>
<thead>
<tr>
<th>Dental Calendar Year Deductible (covers all services below)</th>
<th>Annual</th>
<th>$50</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Procedures</td>
<td>Annual</td>
<td>$1200</td>
</tr>
<tr>
<td>Orthodontic</td>
<td>Lifetime</td>
<td>$1000</td>
</tr>
<tr>
<td>Temporomandibular Joint Dysfunction (TMJ)</td>
<td>Annual</td>
<td>$1000</td>
</tr>
</tbody>
</table>

Individual Coinsurance

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

- PPO Providers In-State or Out-of-State—80% of the Funds Usual and Customary Allowables for PPO Services
- Non-PPO Providers In-State or Out-of-State—50% of the Funds 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 Fund’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 Fund 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 bridge-work (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 Fund.
- 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 Fund.

**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 Fund 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**

Effective January 1, 2019, optional vision benefits are changing to a new program offered through EyeMed. Following is a summary of the benefit:

### Vision Care Services

<table>
<thead>
<tr>
<th>Member Cost In-Network</th>
<th>Member Cost Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exam (With dilation as necessary)</strong></td>
<td><strong>Member Cost In-Network</strong></td>
</tr>
<tr>
<td>$30 Copay</td>
<td>$40</td>
</tr>
</tbody>
</table>

**Frames**

| Any available frame at provider location | 0 Copay; $100 allowance and 20% off balance over $100 |

**Contact Lenses**

Contact Lens allowance includes materials only.

<table>
<thead>
<tr>
<th>Type</th>
<th>Member Cost In-Network</th>
<th>Out-of-Network Member reimbursement up to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conventional</td>
<td>$0 Copay; $100 allowance and 15% off balance over $100</td>
<td>$80</td>
</tr>
<tr>
<td>Disposable</td>
<td>$0 Copay; $100 allowance and plus balance over $100</td>
<td>$80</td>
</tr>
<tr>
<td>Medically Necessary</td>
<td>$0 Copay, Paid-In-Full</td>
<td>$210</td>
</tr>
</tbody>
</table>

**Standard Plastic Lenses**

<table>
<thead>
<tr>
<th>Type</th>
<th>Member Cost In-Network</th>
<th>Out-of-Network Member reimbursement up to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single Vision</td>
<td>$30 Copay</td>
<td>$40</td>
</tr>
<tr>
<td>Bifocal</td>
<td>$30 Copay</td>
<td>$60</td>
</tr>
<tr>
<td>Trifocal</td>
<td>$30 Copay</td>
<td>$80</td>
</tr>
<tr>
<td>Lenticular</td>
<td>$30 Copay</td>
<td>$100</td>
</tr>
<tr>
<td>Standard Progressive</td>
<td>$85 Copay</td>
<td>$60</td>
</tr>
<tr>
<td>Premium Progressive Tier 1</td>
<td>$115 Copay</td>
<td>$60</td>
</tr>
<tr>
<td>Premium Progressive Tier 2</td>
<td>$125 Copay</td>
<td>$60</td>
</tr>
<tr>
<td>Premium Progressive Tier 3</td>
<td>$140 Copay</td>
<td>$60</td>
</tr>
<tr>
<td>Premium Progressive Tier 4</td>
<td>$205 Copay</td>
<td>$60</td>
</tr>
</tbody>
</table>

**Covered Lens Options**

<table>
<thead>
<tr>
<th>Type</th>
<th>Member Cost In-Network</th>
<th>Out-of-Network Member reimbursement up to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard Anti-Reflective</td>
<td>$45 Copay</td>
<td>$5</td>
</tr>
<tr>
<td>Premium Anti-Reflective Tier 1</td>
<td>$57 Copay</td>
<td>$5</td>
</tr>
<tr>
<td>Premium Anti-Reflective Tier 2</td>
<td>$68 Copay</td>
<td>$5</td>
</tr>
<tr>
<td>Premium Anti-Reflective Tier 3</td>
<td>$85 Copay</td>
<td>$5</td>
</tr>
<tr>
<td>Standard Polycarbonate under age 19</td>
<td>$0 Copay</td>
<td>$5</td>
</tr>
</tbody>
</table>

**Additional Vision Care Services**

**Discounted Exam Services**

- **Retinal Imaging Benefit** | $Up to $39
Contact Lens Fit and Follow Up

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

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

Discounted Lens Options

<table>
<thead>
<tr>
<th>Option</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>Photochromic (Plastic)</td>
<td>$75</td>
</tr>
<tr>
<td>Tint (Solid &amp; Gradient)</td>
<td>$15</td>
</tr>
<tr>
<td>UV Treatment</td>
<td>$15</td>
</tr>
<tr>
<td>Standard Plastic Scratch Coating</td>
<td>$15</td>
</tr>
<tr>
<td>Standard Polycarbonate – age 9 and over</td>
<td>$40</td>
</tr>
</tbody>
</table>

Monthly Rate:

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Coverage</td>
<td>$4.58</td>
</tr>
<tr>
<td>Family Coverage</td>
<td>$11.70</td>
</tr>
</tbody>
</table>

If you are interested in adding the new vision benefit to your group coverage please contact the Fund at 501-978-6137. Once your group is enrolled, the vision benefit will be administered by EyeMed. You can reach EyeMed’s customer service support at 844-409-3401.

Life Coverage

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

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>Consult your Employer for amount</td>
</tr>
<tr>
<td>Spouse</td>
<td>$10,000</td>
</tr>
<tr>
<td>Child by Age at Death 2 weeks</td>
<td>$0</td>
</tr>
<tr>
<td>2 weeks but less than 6 months</td>
<td>$200</td>
</tr>
<tr>
<td>6 months but less than 19 years</td>
<td>$2,000</td>
</tr>
<tr>
<td>19 years or over</td>
<td>$0</td>
</tr>
</tbody>
</table>

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 Fund 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.

Important:

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

In this instance the term Child shall include:

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

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

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

### Option A (26 Week Benefit)

<table>
<thead>
<tr>
<th>Weekly Benefit</th>
<th>$105</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Benefit Day for Disability due to Accident</td>
<td>1st Day</td>
</tr>
<tr>
<td>Illness</td>
<td>8th Day</td>
</tr>
<tr>
<td>Maximum Number of Weeks Payable</td>
<td>26 Weeks</td>
</tr>
</tbody>
</table>

### Option B (52 Week Benefit)

<table>
<thead>
<tr>
<th>Weekly Benefit</th>
<th>$105</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Benefit Day for Disability due to Accident</td>
<td>183rd Day</td>
</tr>
<tr>
<td>Illness</td>
<td>183rd Day</td>
</tr>
<tr>
<td>Maximum Number of Weeks Payable</td>
<td>52 Weeks</td>
</tr>
</tbody>
</table>

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 Fund within 180 days of the first date of disability. The Disability Income Form is also available online at www.arml.org/services/mhbf. Timely filing guidelines for active members and when benefits stop apply to this benefit.

Disability Income Benefits Exclusions—Disability payments will not be made unless you are under the continuous care of a physician, or for any disability due to intentionally self-inflicted injury, or for any disability due to injury or illness arising out of or in the course of any employment for compensation or profit. The Exclusions provision of the Hospital or Major Medical Expense Benefits will, to the extent not inconsistent, also apply to these benefits.
Section 5: 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 Fund engages in a managed care program. Managed care encourages the employees and their dependents to use physicians, hospitals and other providers that have agreed to join the Network of Preferred Providers. The Fund developed and maintains its own Preferred Provider Network.

You may choose to use a PPO provider or a non-PPO provider. The Fund 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 Fund.

PPO hospitals and providers for medical, optional dental and optional vision services have agreed and contracted with the Fund to handle billing and collections for the patient, and to follow the Utilization Review Program utilized by the Fund. The Provider Directory, as well as a list of participating pharmacies is available at www.arml.org/services/mhbf or contact customer service at 501-978-6137, option 6.

<table>
<thead>
<tr>
<th>After the calendar year deductible(s) are met, the Fund will pay the following percentages for covered services:</th>
<th>PPO</th>
<th>Non-PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Room Services</td>
<td>80% of the Fund's Usual and Customary PPO Allowables</td>
<td>80% of the Fund's Usual and Customary PPO Allowables</td>
</tr>
<tr>
<td>PPO Providers (In-State or Out-of-State)</td>
<td>80% of the Fund's Usual and Customary Allowables</td>
<td>50% of the Fund's Usual and Customary Allowables (See Usual and Customary Charges under Definitions)</td>
</tr>
<tr>
<td>Non-PPO Providers (In-State or Out-of-State) (Except for Emergency Room Charges)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The Fund will utilize its wrap-around network for out-of-state providers to ensure that benefits are paid as in-network whenever possible. Even though a provider is not listed in the Fund’s PPO network, it may be a part of the wrap-around network. Please contact the Fund at 501-978-6137 if you have any questions regarding a provider.
Section 6: Coordination of Benefits

Coordination of Benefits (COB)

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

*Please note: For covered Members who decline to purchase the minimum medical and hospital benefits under their automobile insurance coverage, pursuant to Ark. Code Ann. § 23-89-202(1), the 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 Fund will not exceed 100 percent of the annual eligible benefits when combined with all other plans.

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

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

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

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

How Coordination of Benefits (COB) Works

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

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

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

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

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

3. Guidelines to Determine Primary and Secondary Plans for Medicare Recipients:
   A. If your Employer has less than 20 employees, Medicare is primary for covered members eligible for Medicare due to age.
   B. If your Employer has less than 100 employees, Medicare is primary for covered members eligible for Medicare due to disability.
   C. If your Employer has more than 100 employees, the Fund 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 Fund as primary for a 30-month waiting period.

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

Notice and Proof of Claim

Filing a Claim—All claims are to be filed with the Fund and mailed to Municipal Health Benefit Fund, 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 Fund office or by the Fund within 180 days of the date the claim was incurred, unless defined otherwise in this section. Please note that the timely filing guidelines also apply to secondary payer rules (COB, as outlined within this booklet.) If an entire group or individual member is terminating coverage, any incurred claim for benefits, along with supporting information/documentation, must be filed within 60 days of the last day of membership in the Fund, 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 Fund may provide forms to facilitate a claims determination. If a form or supplemental information is requested by the Fund, 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 Fund prior to 90 days after proof of claim has been filed with the Fund Administrator. If the time for beginning legal action is less than that permitted by law of the jurisdiction in which the Fund is domiciled, such limit is extended to the minimum period permitted by such law.
Payment of Benefits—Benefit payments for Allowable Expenses will be paid to you promptly upon receipt of due written proof of claim. The Member is responsible for reimbursement to the Fund to the extent of any overpayment that is in excess of the amount payable under the Fund. If any benefit remains unpaid at your death, or if you are a minor or, in the opinion of the Fund, are legally incapable of giving a valid receipt and discharge for any benefit, the Plan Administrator, may at his option, pay all or any part of such benefit (a) to your guardian or your estate, (b) to any institution or individual toward satisfaction of whose charges payment of such benefit is based, or (c) to any one or more persons among the following relatives: your spouse, parents, children, brothers, or sisters. The Plan Administrator’s obligations will be completely discharged to the extent of such payment, and the Plan Administrator will not be required to see the application of the payment.

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

Overpayments: Right of Recovery

As discussed more fully herein, the Fund 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 Fund for such medical expenses. However, the Fund, at its sole discretion, may provide benefits according to Fund terms provided that the participant agrees, in writing:

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

**Right of Reimbursement**

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

Without limiting the Fund’s rights in any way, it is the intention of the parties that the Fund 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 Fund that the member grant the Fund 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 Fund’s expenditures, so that every such dollar of any such proceeds will be paid to the Fund, beginning with the first dollar and continuing until the Fund 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 Fund first. The Fund’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 Fund’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 Fund 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 Fund under these provisions within a reasonable amount of time after receiving proceeds (including any form of consideration) from any third party, the Fund 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 Fund shall retain all rights provided for in those parts that remain enforceable, including without limitation the Fund’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 Fund 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 Fund, though not expressly designated as such, which determination shall be made at the sole discretion of the Fund.
In order to obtain reimbursement, the Fund will take such actions as the Board of Trustees, in its discretion, feels would best serve the Fund. The Fund may seek to have any payment by a third party made payable to the Fund 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 Fund, the member will assign to the Fund 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 Fund’s expenditures. If the Fund pursues any such action or claim, the member shall cooperate and assist the Fund and shall be prohibited from taking any action that would prejudice the Fund's rights or in any way diminish its prospects for a recovery.

In addition, the participant must execute a lien in favor of the Fund for the amount to which the Fund is entitled. However, even if the participant or insured does not give the Fund a lien, the participant is liable to the Fund 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 Fund 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 Fund'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 Fund. 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 Fund.

Furthermore, notwithstanding the above provisions, the Fund reserves the right to seek reimbursement for any and all overpayments 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: 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 Fund 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.

Provider Appeals:

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

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

Member Appeals:

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

The 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.

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 Review Team, 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, a Claims Review Team Representative will respond to you in writing with a determination regarding your appeal. If your claim is denied the response will reference the Fund provision upon which the denial was based and will provide you with an explanation of additional appeals you may make. If the Fund needs time to investigate the facts, you will be notified.
**Final Internal Written Appeal**—If the decision rendered by the Claims Review Team is not satisfactory you or a duly authorized representative may appeal from that denial to the Board of Trustees for the Municipal Health Benefit Fund within 60 days of having received a denial notice from the Claims Review Team. To do so, write to the Plan Administrator, P.O. Box 188, North Little Rock, AR 72115. In your request for a review of the denial specifically state why you believe the denial was incorrect. In connection with your request, you may submit documents supporting your claim. Your appeal will be reviewed by the Board at the quarterly meeting of the Board of Trustees along with documents pertinent to the administration of the Fund. 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 Fund 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 Fund;
   - 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 Fund 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 9(j) 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 Fund’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 Fund 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 9(j).
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 Fund. 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 Fund’s benefit determination as soon as possible, but in no case later than forty-eight (48) hours after the earlier of:

The Fund’s receipt of the specified information, or
The end of the period afforded the claimant to provide the specified additional information.

4. Concurrent care decisions.
If the 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 9 of this section and the appeal shall be governed by paragraph 10 of this section, as appropriate.

5. Other claims.
In the case of a claim not described above the 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 Fund. This period may be extended one time by the Fund 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 Fund 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 11.

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 determines 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 Fund 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 11.

8. Calculating time periods.

The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed in accordance with 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; and

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 Fund 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 Fund 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 Fund 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 11 of this section to give the claimant a reasonable opportunity to respond prior to that date; and before issuing a final internal adverse benefit determination based on a new or additional rationale, the 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 11 of this section to give the claimant a reasonable opportunity to respond prior to that date.

11. Timing of notification of benefit determination on review.

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A. **Urgent care claims.** In the case of a claim involving urgent care, the Fund shall notify the claimant of the Fund'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 Fund 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 Fund, 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 Fund'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 Fund 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 number 9 on page 46.

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 Fund and shall be entitled to pursue an external review on the basis that the Fund 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:

c. 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
d. A rescission, which is a retroactive cancellation or discontinuance of coverage.

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

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

- You have requested an expedited internal appeal but the time frame for completion of the expedited internal appeal would seriously jeopardize your life, your health, or your ability to regain maximum function; or
- The time frame for completion of a standard external review would seriously jeopardize your life, your health, or your ability to regain maximum function; or
- The ABD concerns an admission, availability of care, continued stay or health care service for which you received emergency services, but have not been discharged from a facility.

Notification of External Review

Rights and Assignment to Independent External Review Organization

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

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

You must provide the following information:

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

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### Section 8: Definitions

**Definitions**

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

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

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

**Adverse Benefit Determination (ABD)** means a denial, reduction or termination (in whole or in part) of payment for a benefit. See Section 7: Appeals, page 43, for a complete definition.

**Allowable Expenses** means the Usual, Customary and Reasonable Charges, including the average wholesale price (AWP), 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 a claim is made based upon such UCR charges and AWP, as adjusted by any agreements between the Fund and providers. These charges will be considered Allowable Expenses and a benefit paid based upon the terms of the Fund. Allowable Expenses do not include charges used to satisfy the deductibles, copayments or coinsurance assessed under the Prescription Drug Card Plan.

**Average Wholesale Pricing (AWP)** means the allowable amount determined by the Fund 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 Fund retains the right to reimburse providers at eighty-five (85%) percent of AWP. The National Drug Code (NDC) is a unique product identifier used in the United States for drugs intended for human use. (For more information see Usual, Customary and Reasonable Charges (UCR).

**Benefit** means the benefit provided to Members of the Fund.  
**Employee Benefit** means the Benefit provided for eligible Employees.  
**Dependent Benefit** means the Benefit provided for Eligible Dependents of eligible Employees.

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

**Certificate of Creditable Coverage** means a written certificate issued by the Fund, 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 Fund, when you are entitled to elect COBRA continuation coverage or when you lose COBRA continuation coverage. A certificate will also be provided free of charge upon request while you have health coverage or within 24 months after your coverage ends.

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

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

A. characteristic withdrawal syndrome for the substance,
B. use of the substance or closely related substance is taken to relieve or avoid withdrawal symptoms.

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

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

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

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

Copayment means an amount required to be paid by a Covered Person each time a specific covered service is accessed. The copayments are set forth in the Schedule of Benefits in Section 2: Benefits, page 12.

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

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

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

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

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

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

Eligible Class means an employee classification whose members may be eligible for Employee Benefits under the Fund if their Employer becomes a Participating Employer and all service requirements, if any, are met. The employee classifications that may constitute an Eligible Class are described in Section 1: General Eligibility Information, page 5, this Fund Booklet.

Eligible Dependent—An Eligible Dependent is a Dependent of an Employee who is eligible for Benefits under the Fund and includes the following:

- An Employee’s Spouse—not legally separated or divorced from the Employee
- An Employee’s Adult Dependent—a Dependent (other than the Employee’s spouse) who is between age 19 to age 26
- An Employee’s Child—under the age of 19 years
- The term Child shall include:
  a. An Employee’s natural child from birth until 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 legal custody of the Employee 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 Fund.

**Employee**—See Member/Employee.

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

The terms **Experimental and Investigative** apply to a medical device, medical treatment or pharmaceutical treatment that cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA). The Fund 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 Fund will be considered final and binding on all parties.

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

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

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

The Fund 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 Fund.

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

**Fund Booklet** means the Fund Document which sets out the Fund’s terms and conditions as included herein. No contract, agreement or financial arrangement other than the Declaration of Trust, as amended from time to time, supersedes the terms, conditions, limitations and exclusions set forth in the most current Municipal Health 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** means services provided in order for a person to attain and maintain a skill or function that was never learned or acquired and is due to a disabling condition.


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

**Home Office** means the Home Office of the Plan Administrator.

**Home Setting** means medical care provided in the home.
Hospice Care means medical care of dying persons while allowing them to remain at home under professional medical supervision.

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

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

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

Illness means illness or disease and related medical conditions.

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

Injury means a bodily injury sustained accidentally by external means.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Non-PPO**—out-of-network provider that does not participate in the Fund’s preferred provider network.

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

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

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

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

**Out-of-Network** means a provider that is not a member of the Municipal Health Benefit Fund’s Preferred Provider Network.

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

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

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

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

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

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

**Plan (other than the 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.

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

**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 Person.

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

**Provider**—person or business that provides health care services to covered members.

**Out-of-State**—outside the state of Arkansas.

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

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

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

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

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

**Usual, Customary and Reasonable Charges (UCR)** means charges billed by a medical provider for services and supplies that comply with health care industry standards. The Fund 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 to determine UCR charges. The Fund may set limits on a provider’s charges and fees at its discretion without giving notice to the provider. The Fund will not pay 100 percent of a provider’s billed charges.

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

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

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

A glossary of commonly used Health Coverage & Medical Terms is available at www.arml.org/services/mhbf or by calling Customer Service at 501-978-6137.
Section 9: Forms

Participation Agreement in the Municipal Health Benefit Fund

THIS AGREEMENT, entered into this ______ day of ____________________, 2019, effective as of _________________________ (hereinafter called the “Effective Date”) by and between the City of ____________________, Arkansas (the “City”) and the Municipal Health Benefit Fund (the “Fund”).

WITNESSETH

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

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

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

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

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

   Medical Coverage
   _____ $500 Deductible
   _____ $1,200 Deductible
   _____ $2,000 Deductible

   _____ Dental Coverage
   _____ Vision Coverage
   _____ Life Insurance
   _____ Disability Income Benefits
   _____ Option A
   _____ Option B

2. By execution of this Participation Agreement, the City adopts and agrees to be bound by all of the terms and provisions of the Fund, as amended from time to time. The City further agrees to timely make all required premium payments to the Fund in accordance with the Fund’s procedures.

3. The City acknowledges receipt of the proposal dated __________, 20__. In accordance with the eligibility provision outlined in the proposal, the City hereby certifies and agrees that it will at all times while a Participating Employer in the Fund comply with the Eligibility Requirements of the Fund as set forth in Exhibit A attached hereto and incorporated herein. The City acknowledges that its participation in the Fund is contingent upon its compliance with the Eligibility Requirements.

4. By signature below, the City agrees to and does become a party to the Fund as a Participating Employer. The City hereby acknowledges receipt of a copy of the Declaration of Trust and the Municipal Health Benefit Fund Booklet.
5. By execution of the Participation Agreement by the Plan Administrator, the Fund accepts the City as a party to the Fund pursuant to the authority vested in the Plan Administrator by the Declaration of Trust. The Fund agrees to receive the City's premiums and to hold, administer and invest such funds and to pay claims to Employees in accordance with the terms and provisions of the Fund, as amended from time to time.

6. The terms of the Fund as in effect from time to time, shall fully apply to the City as of the Effective Date, with the imposition of any additional terms or conditions set forth in this Agreement.

7. The City acknowledges that, pursuant to the Declaration of Trust, the Fund may be terminated by giving written notice to member cities and other public entities at their regular business addresses. Pursuant to the Fund Booklet, the Fund agrees to provide such written notice by regular mail sixty (60) days prior to termination. The Fund’s Trustees may also amend the terms of the Fund. It is the responsibility of the City to notify its Employees of any amendments or changes to the Fund.

8. All capitalized terms used in this Participation Agreement and all Exhibits hereto shall have the same meanings given to them in the Municipal Health Benefit Fund Booklet, unless otherwise defined in this Agreement.

IN WITNESS WHEREOF, the parties have caused this Participation Agreement to be executed on their behalf on the date first written above.
Municipal Health Benefit Fund Participation Agreement Signature Page

CITY: ________________________________
By: ________________________________
Its: ________________________________

MUNICIPAL HEALTH BENEFIT FUND:
By: ________________________________
    Mark R. Hayes, Plan Administrator
EXHIBIT A
ELIGIBILITY REQUIREMENTS

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

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

Class 1 – Active elected officials
Class 2 – Members of boards and commissions
Class 3 – Volunteer firefighters (See below for further details)
Class 4 – Auxiliary police
Class 5 – All full-time active employees of the City who work at least thirty (30) hours per week.
Class 6 – Retired members age 55 or over (See Retiree Coverage for further details)

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

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

Volunteer Firefighters (Class 3)—to qualify for Coverage under the Fund, 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 Fund each year on or before December 31.

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

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

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

Active elected officials (Class 1) who are on Medicare are eligible for dental, vision, drug card and hearing aid Coverage. However, enrollment in all parts of Medicare, Parts A, B and D, is required for active elected officials (Class 1) choosing to continue Coverage under the dental, vision, drug card and hearing aid Coverage benefits. However, seventy-five percent (75%) of each participating class (2, 3, 4 or 5) must participate for Coverage to continue.
MUNICIPAL HEALTH BENEFIT 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 Fund 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 Fund or their lawyers when the law provides the Fund with the right to contest a claim made under Fund 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 Fund. 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 Fund'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 Fund or their lawyers when the law provides the Fund the right to contest a claim incurred while I was a covered member under the Fund.

Signature: _____________________________  Date: _____________________________

Witnessed by __________________________________________________________________________

________________________    Date: _____________________________

Print Name
# MHBF Change of Address Form

**CHANGE OF ADDRESS**

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<th>Name of City/Entity</th>
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<th>Name of Member / Employee</th>
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**Old Mailing Address**

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<th>City</th>
<th>State</th>
<th>Zip</th>
<th>Phone Number</th>
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**New Mailing Address**

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<th>City</th>
<th>State</th>
<th>Zip</th>
<th>Phone Number</th>
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Do you need additional combination Medical ID/ Prescription Cards?  □ Yes  □ No

Member/Employee Signature ________________________________  Date ______________________

Please send this form to MHBF at the above address or fax number.
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
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.)