Bylaws of the Municipal Health Benefit Program

EFFECTIVE DECEMBER 1, 1981 (AS AMENDED JANUARY 1, 2026)

The Municipal Health Benefit Program is a self-funded trust of municipalities. Municipal Health 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.

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

Declaration of Trust

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

The terms of this Program may be amended or terminated at any time by the Board of Trustees as set forth in the Trust Agreement.

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

Group health plans sponsored by state and local governmental employers must generally comply with federal law requirements.

Patient Privacy

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

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

Mark R. Hayes
Plan Administrator

Section 1: General Eligibility Information

General Eligibility Information

Eligibility Dates—If you are a member of an Eligible Class, as described below, you will become eligible for benefits on (a) the date your Employer becomes a Participating Employer, (b) a date consistent with the Participating Employer's established criteria, provided a written copy of the ordinance or policy is furnished to the Program by January 1 of the Program year; or (c) if no ordinance or policy is provided, then on the first day of the calendar month following the date you have continuously been a member of such class for 60 consecutive days, whichever is later. For members of Class 1, you will become eligible on the first day of your term of office.

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

Eligible Classes include the following:

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

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

Special Provisions related to individual Eligible Classes:

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

Class 1—Active elected officials and their Eligible Dependents (i.e. spouse) who are on Medicare are eligible for dental, vision, 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, and hearing aid Coverage benefits.

Eligibility Requirements

If you are a member of an Eligible Class, to become a Member and be covered under the Program, you must enroll in the Program as of your Eligibility Date and agree to make any required premium contributions. If you do not enroll yourself and your Eligible Dependents before your Eligibility Date,

you may not enroll or change your Coverage election until the next Open Enrollment Period unless you have a Qualifying Event described in this Booklet.

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

- **An Employee's Spouse**—Not legally separated or divorced from the Employee;

- **An Employee's Child**—A Child (other than the Employee's spouse) who is under the age of twenty-six (26) years; the term Child(ren) shall include:

  a. An Employee's natural child(ren).
  b. An Employee's stepchild(ren), foster child(ren), adopted child(ren), or child(ren) under legal guardianship or legal custody

  Documentation supporting an individual's Dependent status may be required to be submitted to the Plan.

Open Enrollment

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

Special Enrollment Periods/Qualifying Event

There are certain life events that will require you to change your Coverage outside of the Program's Open Enrollment period. These are called "Qualifying Events." Except as otherwise provided below, you must apply for or request a change of Coverage within 60 days from the date of the Qualifying Event and provide any requested supporting documentation. **Except for the birth or the adoption of a child, the effective date of Coverage related to the Qualifying Event will be the first day of the month coincident with or immediately following the occurrence of the Qualifying Event.**

Qualifying Events:

1. You gain or lose an Eligible Dependent through marriage or divorce. You must provide a copy of the marriage license, and/or divorce decree with settlement agreement instructing which party is to cover dependents (if available, otherwise Coordination of Benefits Rules sill apply).
2. You gain or lose an Eligible Dependent through birth or adoption, or through legal guardianship or custody. New Coverage for you and your Eligible Dependent will be effective on the date of the birth or adoption. However, the effective date for an Eligible Dependent acquired through legal guardianship or custody will be the first day of the month coincident with or immediately following the date of the legal guardianship or custody. You must provide a copy of the birth certificate, certificate of record of live birth, or adoption decree, or in the case of legal guardianship or custody, a copy of the court order bestowing legal guardianship or legal custody of the Eligible Dependent upon the Employee.
3. You or your Eligible Dependent loses their other health coverage. The loss of the other coverage must be as a result of loss of eligibility for the coverage or termination of employer contributions towards the coverage or if the other coverage is COBRA coverage, as a result of

exhausting COBRA coverage. Loss of other coverage for failure to pay premiums does not give rise to a Qualifying Event. You must provide proof of loss of the previous health Coverage showing the date health Coverage terminated.

4, You or your Eligible Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act (Medicaid") or under a state child health plan under Title XXI of such Act ("CHIP") and coverage of the Employee or Dependent under such a plan is terminated as a result of loss of eligibility for such coverage or you or your Eligible Dependent becomes eligible for assistance, with respect to coverage under the Plan, under such Medicaid or CHIP plan (including any waiver or demonstration project conducted under or in relation to such a plan). You must request a change of coverage within 60 days after the termination of the coverage or the date of eligibility for such assistance.

In order to change your Coverage due to a Qualifying Event, you must complete a *Change of Status Form* (available from your Employer or the Program) and provide a copy of supporting documentation of the Qualifying Event within 60 days of the date of the Qualifying Event .** If you do not add a newly acquired Eligible Dependent(s) within these guidelines, you may not enroll the Eligible Dependent(s) until the next Open Enrollment Period.

Retiree Coverage

The Program will provide Retiree Coverage to the Members of the Eligible Class-Class 6 consistent with the Participating Employer's established criteria, provided a written copy of the ordinance or policy is furnished to the Program by January 1 of the Program year. If no ordinance or policy is provided, then the Program will provide Retiree Coverage as authorized by state law and as described below.

For municipalities who are Participating Employers, state law ((as set forth in Ark. Code. Ann. § 24-12-132))allows a retired employee or official (excluding police officers) to participate in the health care plan of the Participating Employer if the retiring municipal official or employee:

1. Is receiving a retirement benefit from the Arkansas Local Police and Fire Retirement System, Arkansas Public Employees Retirement System, or a local pension fund;
2. Pays both the Employer and Employee contribution to the Program;
3. Is not covered at any time during retirement by another health care plan; and
4. Notifies the Employer within 30 days of the official date of retirement of their intent to participate in the Program. The retired employee or official may include their Eligible Dependents in the Program provided the dependent premium is paid. (Ark. Code. Ann. § 24-12-132)

Only Members who are retired employees or municipal officials who meet the requirements set forth above will be eligible for Retiree Coverage under the Program.

For eligible police officer retirees employed by a Participating Employer, state law ((as set forth in Ark. Code Ann. §14-1-110):)allows those officers to participate in the health care plan offered by the municipality or county if:

1. The officer is an eligible police officer, which means (as set forth in Ark. Code Ann. §14-1-110):
    a. Law enforcement officer engaged in official duty who is a member of any regular or auxiliary police force of a municipality or county on a full-time or part-time basis, including sheriffs, sheriff deputies, constables and night marshals;

b. Eligible to retire with full retirement benefits under Arkansas Local Police and Fire Retirement System, Arkansas Public Employees Retirement System, a municipal or county retirement system, or a local pension fund;
c. Is at any age with twenty-eight (28) years of credited service; at least fifty-five (55) years of age and has at least twenty (20) years of credited service; at least sixty (60) years of age and has at least five (5) years of credited service; or at least sixty (60) years of age and has at least ten (10) years of actual Arkansas Local Police and Fire Retirement System service credit;

2. The officer is not eligible for Medicare enrollment;
3. Pays the portion of the premium as determined by the municipality or county or the cost of the policy issued to the eligible police officer.
4. Notifies the Employer within sixty (60) days from the date of retirement of their intent to participate in the Program. The eligible police officer may include their Eligible Dependents in the Program as well. (Ark. Code Ann.§14-1-110)

Only Members who are retired eligible police officers who meet the requirements set forth above will be eligible for Retiree Coverage under the Program. Please refer to the ordinance or policy of your Participating Employer, or to the applicable state law, for more information.

Important Information

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

An Employee's Child must be added to the Program during an Open Enrollment Period or a Special Enrollment Period prior to their 26th birthday to be Covered under the Program as an Eligible Dependent. Coverage for an Employee's Child will end on the last day of the month in which the Employee's Child attains age 26.

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

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

Family Medical Leave Act—The Program recognizes and complies with the Family Medical Leave Act of 1993 for

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

When Your Benefits Stop

When your employment ceases or your hours are reduced to part-time, your Coverage under the Program also ends, albeit on the last day of the Month in which your employment ceases or your hours have been reduced. Subject to continuation coverage under COBRA or Retiree Coverage, if

applicable, coverage ends whether you leave your employment, retire, die, undergo a reduction in hours so that you no longer meet the eligibility requirements, or at the end of an Employer approved 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.

Coverage under the Program will end if the Program is terminated effective as of the date the Program terminates.

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

- The last day for which your premium has been paid if the required premium for the next period is not paid when due.
- When the Participating Employer fails to make the required premium payments. Coverage will be suspended if monthly premium payments are thirty (30) days past due and Coverage will be terminated if monthly premium payments are sixty (60) days past due.
- When the Participating Employer cancels participation Coverage under the Program.

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

- The date your personal Coverage terminates for any reason.
- The last day for which your Eligible Dependents' premium has been paid if the required premium for the next period is not paid when due.
- The date Coverage for Eligible Dependents is terminated under the Program.
- The last day of the month in which he or she ceases to be an Eligible Dependent.
- The last day of the month you cease to meet the eligibility requirements as defined herein.

Eligibility as a Dependent will cease:

a. For any Dependent, on the date he or she becomes covered individually under the Program, 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 or upon entering active service with the armed forces of any country; and
c. For your Children, the end of the month following the attainment of age 26.

However, if your Child is incapable of sustaining employment by documented reason of mental disability or physical handicap, primarily dependent on you for support and maintenance and unmarried and upon attainment of age 26 and is Covered hereunder up to that time, your Child may continue to be an Eligible Dependent so long as he or she remains continuously in that condition, provided you notify the Program and submit proof that such condition actually exists prior to the Child attaining age 26. The Program may require, at reasonable intervals during the two years following the Child reaching age 26, subsequent proof of the Child's total disability.

If there is a conflict between dates when Coverage could end, the earliest date governs. Additionally, the Program will not pay for services or supplies furnished after the date Coverage ends, even if the Program pre-certifies or provides Benefit information for a treatment plan submitted before the end of Coverage.

Right to Continuation Coverage under COBRA

The right to COBRA continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation Coverage may be available to you when you would otherwise lose your Coverage under the Program. It can also become available to your Eligible Dependents who are Covered under the Program when they would otherwise lose Coverage under the Program. Subject to any provision in the Code or Treasury Regulations governing COBRA continuation coverage to the contrary, any Member who is eligible for COBRA continuation coverage under this Program shall be allowed to continue to participate in this Program in accordance with COBRA continuation coverage so long as such Member complies with the provisions set out in COBRA and the Plan.

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

What is COBRA Continuation Coverage?

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

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

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

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

- Your spouse dies.
- Your spouse's hours of employment are reduced.
- Your spouse's employment ends for any reason other than their 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 Eligible Dependent Children will become Qualified Beneficiaries if they lose coverage under the Program because any of the following Qualifying Events happens:

- The Employee dies.
- The Employee's hours of employment are reduced.
- The Employee's employment ends for any reason other than their gross misconduct.
- The Employee becomes entitled to Medicare benefits (Part A, Part B, or both).
- The Child stops being eligible an Eligible Dependent for Coverage under the Program.

When is COBRA Coverage Available?

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

Notice Must Be Given of Some Qualifying Events

For the other Qualifying Events (divorce or legal separation of the Employee and Spouse or a Dependent Child losing eligibility for Coverage as a Dependent Child), you must notify the Program within 60 days from the later of the date of the Qualifying Event or the date Coverage would be lost due to the Qualifying Event. You must provide this notice to:

MHBP Eligibility & Enrollment

Municipal Health Benefit Program

P.O. Box 188

North Little Rock, AR 72115

If notice is not provided to the Program at the address above within the 60-day period, COBRA coverage will not be offered. Upon timely notification of a Qualifying Event, the Program will notify the Qualified Beneficiary of the right to elect COBRA coverage.

How can you elect COBRA continuation Coverage?

To elect continuation Coverage, you must complete the Election Form provided by the Program or your Employer and furnish it according to the directions on the Form. Each Qualified Beneficiary under Section 4980B of the Code 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. In addition, a Child born or placed for adoption with the covered Employee during the COBRA continuation period will become a Qualified Beneficiary under COBRA if the covered Employee elects to continue coverage pursuant to COBRA and the Child is enrolled in the Program in accordance with the COBRA election requirements.

If the Program has received all the required notices, the Qualified Beneficiaries have 60 days from the date coverage would end under the Plan as a result of the Qualifying Event or the date of the notice, whichever is later, to elect COBRA continuation coverage. If the Qualified Beneficiary does not submit a completed election form by the due date, he or she will lose the right to elect COBRA. If COBRA continuation coverage is elected and paid for in the proper time frames, coverage will not be interrupted. If COBRA continuation coverage is waived, the waiver may be revoked during the remaining election period. Any claims incurred during the waiver period may not be covered. The Program reserves the right to revoke COBRA continuation coverage for any person who is determined to be ineligible for coverage including the right to rescind coverage, in accordance with the requirements set forth in Treasury Reg. Sec. 54.9815-2712T (as amended and finalized).

What are the COBRA continuation coverage periods?

COBRA Qualified Beneficiaries may elect to continue the coverage they have at the time of the Qualifying Event and will be provided with the same coverage as similarly situated active Employees. COBRA coverage is a temporary continuation of coverage. The COBRA coverage periods described below are maximum coverage periods:

a. *Death, divorce, legal separation, or Child's loss of Eligible Dependent status*. When Program Coverage is lost due to the death of the Employee, the covered Employee's divorce or legal separation, a Child's losing eligibility as an Eligible Dependent Child, COBRA coverage under the Program can last for up to a total of 36 months.

b. *If the covered Employee becomes entitled to Medicare within 18 months before experiencing a Qualifying Event that is a termination of employment or reduction of hours.* When Program Coverage is lost due to the end of employment or reduction of the Employee's hours of employment, and the Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA coverage under the Program for Qualified Beneficiaries (other than the Employee) who lose coverage as a result of the Qualifying Event can last until up to 36 months after the date of Medicare entitlement. This COBRA coverage period is available only if the covered Employee becomes entitled to Medicare within 18 months before the termination or reduction of hours.

c. *Termination of employment or reduction of hours.* When Program Coverage is lost due to the end of employment or reduction of the Employee's hours of employment, COBRA coverage under the Program generally can last for only up to a total of 18 months.

d. *Extension of Maximum Coverage Period*. If the Qualifying Event that resulted in the Qualified Beneficiary's COBRA election was the covered Employee's termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a Qualified Beneficiary is disabled or a second Qualifying Event occurs. The Program must be notified of a disability or a second Qualifying Event in order to extend the period of COBRA coverage. Failure to provide notice of a disability or second Qualifying Event will eliminate the right to extend the period of COBRA coverage.

    1. Disability Extension of COBRA Coverage

       If a Qualified Beneficiary is determined by the Social Security Administration to be disabled and the Program is notified in a timely fashion, all of the Qualified Beneficiaries in the family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for Qualified Beneficiaries who are receiving COBRA coverage because of a Qualifying Event that was the covered Employee's termination of employment or reduction of hours. The disability must have started at some time before the 61st day after the covered Employee's termination of employment or reduction of hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above).

Each Qualified Beneficiary will be entitled to the disability extension if one of them qualifies.

The disability extension is available only if the Program is notified in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

i. the date of the Social Security Administration's disability determination;
ii. the date of the covered Employee's termination of employment or reduction of hours; and
iii. the date on which the Qualified Beneficiary loses (or would lose) coverage under the terms of the Program as a result of the covered Employee's termination of employment or reduction of hours.

This notice must be provided to the Program within 18 months after the covered Employee's termination of employment or reduction of hours in order to be entitled to a disability extension.

2. Second Qualifying Event Extension of COBRA Coverage

An extension of coverage will be available to Spouses and Dependent Children who are receiving COBRA coverage if a second Qualifying Event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following the covered Employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second Qualifying Event occurs is 36 months. Such second Qualifying Events may include the death of a covered Employee, divorce or legal separation from the covered Employee, or a Dependent Child's ceasing to be eligible for coverage as an Eligible Dependent under the Program. These events can be a second Qualifying Event only if they would have caused the Qualified Beneficiary to lose coverage under the Program if the first Qualifying Event had not occurred. (This extension is not available under the Program when a covered Employee becomes entitled to Medicare after his or her termination of employment or reduction of hours unless the entitlement to Medicare would have been itself a Qualifying Event.).

Any extension due to a second Qualifying Event is available only if the Program is notified in writing of the second Qualifying Event within 60 days after the later of:

i. the date of the second Qualifying Event; and
ii. the date on which the Qualified Beneficiary would lose coverage under the terms of the Program as a result of the second Qualifying Event (if it had occurred while the Qualified Beneficiary was still covered under the Program).

How much does COBRA continuation Coverage cost?

If a Qualified Beneficiary elects COBRA coverage, the Qualified Beneficiary will 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 Program (including both Employer and Employee contributions) for Coverage of a similarly situated plan participant or beneficiary who is not receiving continuation Coverage. The amount of COBRA premiums may change from time to time during the period of COBRA coverage. The Qualified Beneficiary will be notified of COBRA premium changes.

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

If a Qualified Beneficiary elects COBRA continuation Coverage the Qualified Beneficiary must make the first payment for the COBRA continuation Coverage not later than 45 days after the date of the COBRA continuation Coverage election. (This is the date the Election Notice is postmarked, if mailed.) If the first payment for continuation Coverage is not made in full within 45 days from the date of the election, all COBRA continuation Coverage rights under the Program will be lost. Qualified Beneficiaries are responsible for making sure that the amount of the first payment is correct. Qualified Beneficiaries may contact the Employer or the Program premium office to confirm the correct amount of the first payment.

Periodic payments for continuation Coverage

After the first payment for COBRA continuation Coverage has been made, periodic payments for each subsequent Coverage period will be required to be made. The periodic payments must be made on a monthly basis. The amount due for each periodic monthly payment for each Qualified Beneficiary will be disclosed in the election notice provided to the Qualified Beneficiary. Under the Program, each of these periodic payments for continuation Coverage is due on the first (1^{st}) day of each calendar month for that Coverage period. Ifa periodic payment is made on or before the first day of the Coverage period to which it applies, COBRA continuation Coverage under the Program will continue for that Coverage period without any break. The Program will send a monthly notice of payments due for these Coverage periods to the Participating Employer along with their regular monthly premium notice. Notwithstanding the foregoing, a Qualified Beneficiary will be responsible for the required periodic monthly payments even if the Qualified Beneficiary does not receive a monthly premium notice from the Participating Employer or the Program.

Grace periods for periodic payments

Although periodic payments are due on the dates shown above, Qualified Beneficiaries will be given a grace period of 30 days after the first day of the Coverage period to make each periodic payment. COBRA 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 a Qualified Beneficiary pays 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, the Coverage under the Program may be suspended as of the first day of the Coverage period and then retroactively reinstated (going back to the first day of the Coverage period) when the periodic payment is received. This means that any claim submitted for benefits while Coverage is suspended may be denied and may have to be resubmitted once the Coverage is reinstated.

If a periodic payment is not made and received before the end of the grace period for that Coverage period, all rights to continuation Coverage under the Program will be lost.

The first payment and all periodic payments for continuation Coverage should be sent to the Participating Employer of the Employee , or you may be sent directly to the Program address.

Termination of COBRA continuation Coverage before the end of the maximum Coverage period

COBRA coverage will automatically terminate before the end of the maximum period if:

a. any required premium payment is not paid in full on time;
b. a Qualified Beneficiary becomes covered, after electing COBRA, under another group health plan;
c. a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA;
d. the Participating Employer ceases to provide any group health plan for its Employees; or
e. during a disability extension period, the disabled Qualified Beneficiary is determined by the Social Security Administration to be no longer disabled (COBRA coverage for all Qualified Beneficiaries, not just the disabled Qualified Beneficiary, will terminate).

Keep the Program informed of address changes

In order to protect you and your family's rights, you should keep the Program informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Program. Additionally, if you have changed marital status or you or your Spouse have changed addresses, please notify the Program in writing at the above address. Please note: If you have questions concerning your Program or your COBRA continuation Coverage rights, contact your Employer, or the Program, Municipal Health Benefit Program, P.O. Box 188, North Little Rock, AR 72115. For additional information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

Section 2: Major Medical Benefits

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

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

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

Allowed Amount

The Allowed Amount is the maximum amount deemed by the Program, in its sole discretion, to be reasonable payment for a Covered Service. The Allowed Amount for Preferred Providers means the amount Preferred Providers have agreed to accept as payment in full for Covered Services. Unless otherwise provided*, for Out-of-Network Providers, the Allowed Amount means charges equivalent

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

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

*Covered Members who have an emergency medical condition and get emergency services from an Out-of-Network Provider or Facility may not be balance billed. Furthermore, Covered Members who receive services from an Out-of-Network Provider providing services at an In-Network Hospital or ambulatory surgical center also may not be balance billed. The most these provider or facilities may bill you is the MHBP In-Network cost-sharing amount (such as copayments and coinsurance). Please see Section 5: How MHBP Pays Benefits, "No Surprise Billing: Out-of-Network Emergency Services & Out-of-Network Providers at In-Network Facilities" for additional information related to certain Out-of-Network services. In addition, the Allowed Amount for these covered services subject to the No Surprises Act will be based on the applicable Out-of-Network Rate set forth in Section 5.

Calendar Year Deductibles for Major Medical Benefits

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

Calendar Year Deductible – Standard Deductible Plan Option	In-Network	Out-of-Network
Individual Option 1*	$500	$500
Individual Option 2*	$1,200	$1,200
Individual Option 3*	$2,000	$2,000
Family	$6,000	$6,000

*Refer to the enrollment information of the Participating Employer for the applicable specific Calendar Year Deductible.

Calendar Year Deductible – Qualified High Deductible Plan Option	In-Network	Out-of-Network
Individual	$2,500	$2,500
Family	$7,500	$7,500

Standard Deductible Plan Option

For Covered Members participating in the Standard Deductible Plan Option, please consult your Participating Employer for your specific Calendar Year Deductible. The Calendar Year Deductible shall be applied to the amount of covered Major Medical *expenses, excluding Prescription Drugs benefits,* that are incurred each calendar year. For these Covered Members, it is important to know that only costs incurred under the Major Medical benefit count towards your Calendar Year Deductible, and that the Office Visit and Prescription Drug copays do NOT count towards your Calendar Year Deductible (but Office Visit copays do count towards your Out-of-Pocket Maximum—see below).

Each Covered Member shall satisfy the applicable $500, $1,200 or $2,000 Individual Calendar Year Deductible, and up to the Family Deductible of $6,000 in case of Family Coverage, before a Covered Member's benefits will begin, except for where an Office Visits or Prescription Drug copay applies. Under Family Coverage, each member must meet their own Individual Calendar Year Deductible until the total amount of the costs paid towards the Individual Calendar Year Deductible collectively meet the overall Family Deductible for the same Calendar Year.

Qualified High Deductible Plan Option

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

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

Each Covered Member must satisfy the $2,500 Individual Calendar Year Deductible, and up to the $7,500 Family Deductible in case of Family Coverage, before a Covered Member's benefits will begin. Under Family Coverage, each member must meet their own Individual Calendar Year Deductible until the total amount of the costs paid towards the Individual Calendar Year Deductible collectively meet the overall Family Deductible for the same Calendar Year.

Individual Coinsurance

Coinsurance is the percentage of costs a Covered Member must pay after he or she has met their Calendar Year Deductible. The following Coinsurance percentages apply to both the Standard Deductible Plan Option and the Qualified High Deductible Plan Option.

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

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

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

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

**However, when a Covered Member receives emergency care Out-of-Network, or when a Covered Member receives care at an In-Network Facility, but the care is provided by an Out-of-Network Provider, the benefits paid by the Program may be different than the Out-of-Network benefits and percentages included above. Please see Section 5: How MHBP Pays Benefits, "No Surprise Billing: Out-of-Network Emergency Services & Out-of-Network Providers at In-Network Facilities" for additional information related to certain out-of-network services. In addition, the Allowed Amount for these covered services subject to the No Surprises Act will be based on the applicable Out-of-Network Rate set forth in Section 5.

Out-of-Pocket Maximum

An Out-of-Pocket Maximum is a cap, or limit, on the amount of money a Covered Member must pay for Covered Services each Calendar Year. The Program offers the following Out-of-Pocket Maximums included below.

Out-of-Pocket Maximum – Standard Plan Option - Medical (Calendar Year)	In-Network	Out-of-Network
Individual Option 1*	$4,500	Unlimited
Individual Option 2*	$5,200	Unlimited
Individual Option 3*	$6,000	Unlimited
Family	$8,000	Unlimited
Out-of-Pocket Maximum – Standard Plan Option – Prescription Drugs (Calendar Year)		

Individual	$2,600	Unlimited
Family	$5,200	Unlimited

*Refer to the enrollment information of the Participating Employer for the applicable specific Calendar Year Out-of-Pocket Maximums.

Out-of-Pocket Maximum – Qualified High Deductible Option (Calendar Year)	In-Network	Out-of-Network
Individual	$5,000	Unlimited
Family	$10,000	Unlimited

Standard Deductible Plan Option

For Covered Members participating in the Standard Deductible Plan Option, please consult your Participating Employer for your specific applicable Calendar Year Out-of-Pocket Maximum. It is also important to know that the Major Medical Out-of-Pocket Maximum is separate from the Program's Prescription Drug Out-of-Pocket Maximum and only applies to Major Medical expenses, excluding Prescription Drug expenses, that are covered by the Program. The Prescription Drug Out-of-Pocket Maximum applies to Prescription Drug expenses that are covered by the Program. Further, Individual and Family Calendar Year Deductibles and office visit copays for Major Medical expenses count towards the Calendar Year Out-of-Pocket Maximum for Major Medical. Prescription Drug copays count towards the Calendar Year Out-of-Pocket Maximum for Prescription Drugs.

Qualified High Deductible Plan Option

For Covered Members participating in a Qualified High Deductible Plan Option, the Calendar Year Out-of-Pocket Maximum combines expenses incurred by a Covered Member for the Major Medical *and* the Program's Prescription Drug benefits This means that the Calendar Year Out-of-Pocket Maximum applies to medical and prescription drug expenses that are covered by the Program. Individual and Family Calendar Year Deductibles and copays count towards the Calendar Year Out-of-Pocket Maximum.

Standard Deductible and Qualified High Deductible Plan

Once the Out-of-Pocket Maximum has been met under the applicable Program option, the Covered Member participates in, the Program will pay 100 percent (100%) of the Allowed Amount of all In-Network Covered Services for the remainder of the Program Year (calendar year), unless excluded or modified by other portions of this Program Booklet.

Generally, any costs incurred towards premiums, penalties and Out-of-Network services do not count toward the Calendar Year Out-of-Pocket Maximum(s).

Note, however, that under both the Standard Deductible Plan Option and Qualified High Deductible Plan Option, the Out-of-Pocket Maximum does not apply to Out-of-Network Provider services. This means that there is not an Out-of-Pocket Maximum for Out-of-Network Providers and the Program will never pay one-hundred percent (100%) of the Allowed Amount for services provided by Out-of-Network Providers. The Covered Member will always be responsible for their portion of coinsurance

for all Covered Services received from Out-of-Network Providers (as well as any amounts beyond the Allowed Amount charged by the Out-of-Network Provider, also referred to as "balance billing")

Copayment

A copayment is a fixed amount of money a Covered Member pays to the provider, facility, pharmacy, etc. when you receive certain services. Copayments are not applicable under a Qualified High Deductible Plan Option except with respect to Prescription Drug benefits once the Calendar Year Deductible for the Qualified High Deductible Plan Option has been met.

Office Visit Copayment

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

Under both options, a Covered Member is responsible for a copayment of $20.00 for outpatient professional services rendered by a physician or other healthcare professionals at an office location (primary or specialist), at an urgent care location, or via telehealth that is not affiliated with Lyric Health ("Office Visit Copayment"). The Office Visit Copayment of $20.00 also applies to each visit for services provided by a mental health medical provider. The Office Visit Copayment will count toward the Out-of-Pocket Maximum.

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

Under the Enhance Copayment Option, the Office Visit Copayment will be applied to the CPT codes as listed above, as well as any other services or procedures rendered during the office visit. Please note that if a provider requires testing (i.e. lab work, diagnostic testing, etc) in conjunction with the office visit, but the testing is submitted on a separate claim or by a different provider, the separate claim is not considered a part of the office visit and will be subject to the Calendar Year Deductible and applicable Coinsurance.

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

See the Prescription Drug Benefit Section for additional information on the Prescription Drug Benefit Copayment.

Emergency Room Copayment

A copayment of $250 will be assessed against outpatient emergency room visits. This $250 copayment is in addition to any other Program deductible, copayment or co-insurance requirements.. When an emergency room visit results in hospital admission, 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.

Preventive Care Benefits

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

Preventive Care Program

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

Preventive Care Benefits includes services that are required to be covered under the ACA as may be amended from time to time as reflected in the list of Preventive Care Services set forth at: https://www.healthcare.gov/coverage/preventive-care-benefits/ which is incorporated herein.

The following list is an example of the types of services often considered as Preventive Care Benefits:, however, refer to the Preventive Care Services list published by the Department of Health & Human Services as referenced and as incorporated herein:

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

Immunizations/Inoculations

- DT (Diphtheria and Tetanus Toxoids)
- DtaP (Diphtheria, Tetanus Toxoids, and Pertussis)
- Td (Tetanus) booster

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

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

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

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

Please visit the following links for additional information:

https://www.healthcare.gov/coverage/preventive-care-benefits/

https://www.healthcare.gov/preventive-care-women/

https://www.healthcare.gov/preventive-care-children/

Major Medical Benefits

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

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

Pre-certification

It is the Covered Member's responsibility to ensure that all proper pre-certifications for services listed below have been obtained. To obtain the requisite pre-certifications, Covered Members, or their providers, must call the Program at 888-295-3591.

. Pre-certification requirements apply even if the Program is a secondary payer. A Covered Member must pre-certify the following services including but not limited to:

- Ambulatory Surgical Procedures (whether they are performed in a hospital, ambulatory surgery center or doctor's office)
- Bariatric Weight Loss Program
- Chemical Dependency Treatment
- Certain Durable Medical Equipment
- Home Health Care Services (care in a home setting)
- Hospice Care
- Inpatient Hospital Confinements (including Inpatient Mental Health and Rehabilitation)
- Organ Transplant Services
- Outpatient Observation lasting more than 23 hours (all outpatient stays lasting more than 24 hours will be reimbursed as Inpatient Confinements, and/or charges will be reduced to 23 hours of observation)
- PET Scans
- Prosthetic Devices (if purchase price exceeds $2,000)
- Anterior or Posterior repair of female pelvic prolapse
- Arteriovenous anastomosis
- Arthrodesis
- Arthroplasty or fusion of any joint or spine
- Arthroscopy of any joint
- Aqua Ablation
- Bladder Sling
- Blepharoplasty (repair of drooping eyelids)
- Brachytherapy of any tumor site
- Breast reconstruction/Implant (for Cancer dx only)
- Bunionectomy
- Capsule endoscopy
- Cardiac catheterization/Arteriogram
- Cardioversion
- Carpal Tunnel release
- Cervical rhizotomy
- Cholecystectomy (Lap Chole)
- COMPLEX Repair of Moh's or Tissue Transfer, (moh's itself does not need a precert)
- Cleft palate
- CTA
- D&C (except for miscarriage)
- Defibrillator Implantation
- ECT Therapy
- EECP (External Cardiac Counter Pulsation)
- Endoscopic sinus surgery
- Enteral Feeds (tube feeds)
- ERCP
- Fasciotomy/Fasciectomy for any reason

•Gamma Knife Radiation Therapy
•Hammertoe correction
•Hysterectomy (abdominal, vaginal or laparoscopic)
•Hysteroscopy
•Incision and Drainage (done in OP facility)
•Laminectomy
•Laminotomy
•Laparoscopy
•Lymphedema Treatment (wound care)
•Manipulation under anesthesia
•Mastectomy
•Mediastinoscopy (exam of chest wall through incision)
•MRA – angiogram
•MRCP
•Nerve Decompression Surgery
•Nissen Procedure or Fundoplasty
•Novasure Ablation
•Observation at hour number 24
•Pilonidal Cyst
•Pacemaker Implantation
•PET Scan
•Photodynamic Light with J Code
•Port placement
•Proton Radiation Therapy
•Prostate Surgery
•Reconstructive surgery for any purpose
•RFA's (radio frequency ablation)
•Rotator Cuff Repair
•Septoplasty or septo-rhinoplasty for repair of deviated septum
•Strabismus
•Thyroidectomy
•Tunneled catheter for dialysis
•Tympanoplasty
•Urethral Suspension
•Ulnar Nerve Release
•Varicose Vein Procedures
•Vascular procedures
•Y90 radioembolization treatment
•Bilevel Positive Airway Devise (Bi-pap)
•Oxygen Concentrator
•Portable/Home Ventilator
•Wearable Defibrillator
•Continuous Glucose Monitor/Insulin Pump
•Bone Growth Stimulator
•Spinal Cord Stimulator
•Intrathecal Pump
•Electric Scooter

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

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

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

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

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

If your in-patient admission is due to an emergency, you or your family or provider will have until 5:00 p.m. the next business day to notify the Utilization Review Program of that admission. Direct admissions from your provider's office are not considered emergencies and must be pre-certified by you or your physician within twenty-four (24) hours.

Outpatient observations lasting more than 23 hours may be considered an inpatient admission and therefore are subject to the precertification requirement. Coverage for outpatient observation in excess of 23 hours may be denied in whole or in part if and/or reduced to the 23 hour observation limit if not pre-certified. .

Exception for Childbirth

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

Prior Authorization for Medications

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

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

Utilization Review Program

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

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

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

Additional Utilization Review Program Information

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

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

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

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

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

Additionally, Medically Necessary standards apply to all covered benefits outlined in the Program. If Utilization Review Program determines that a service is not Medically Necessary before or after a participating Preferred Provider renders it, we prohibit the Preferred 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 Out-of-Network Providers that are not considered Medically Necessary by the Utilization Review Program will be the responsibility of the Covered 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.

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

Case Management

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

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

Major Medical Schedule of Benefits

The following Schedule of Benefits includes a list of medical care and services covered under the Program, as well as any applicable Benefit maximum allowance. This list is not an exhaustive list of Covered Services, but rather a Schedule of Benefits wherein a maximum allowance applies. Please call 1-833-265-6534 if you have any questions about the Program's Covered Services.

Benefit		**Benefit Maximum Allowance**
Individual Medical Coverage	Lifetime	No Maximum Dollar Limit
Acute Inpatient Habilitation/Rehabilitation	Annual	30 Days
Sub-Acute Inpatient Habilitation/Rehabilitation Habilitative Services		15 Days
Bariatric Weight Loss Program*	Lifetime	1 Procedure

Chemical Dependency Treatment	Annual	30 Days
Diabetic Training	Annual	1 Day Session
Emergency Ambulance Services-Ground	Annual	2 Occurrences
Emergency Ambulance Services-Air	Annual	2 Occurrences
Non-Emergency Surgical Procedures Requiring Precertification (Hospital or Ambulatory Surgery Center)	Annual	2 Procedures
Hearing Aids	One per ear one (1) time every three (3) years	
Home Health Services	Annual	20 Visits
Hospice Care	Lifetime	90 Days
Inpatient Hospital Services	Annual	30 Days
Mental/Nervous Disorders Inpatient	Annual	30 Days
Nutritional and Weight Counseling****	Annual	2 Visits
Outpatient Occupational, Physical, Speech, Habilitative Therapy and Chiropractic Services (Combined Benefit)	Annual	40 Visits Combined
Organ Transplant Benefits	Lifetime	2 Transplants***
Custom Molded Foot Orthotics	Annual	2 Pairs
Diabetic Related Footwear/Shoes	Annual	2 Pairs
Prosthetic Bra for Oncology Covered Members	Annual	2 Each
Sleep Study	Annual	2 Visit

**All services must be precertified and must be performed at a designated facility. For more information call 888-295-3591.*

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

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

*****Nutritional counseling rendered pursuant to a mental health diagnosis are not subject to this limitation and are covered as general office visits subject to the office visits copayment.*

Covered Major Medical Charges

Covered Major Medical Charges include only the charges and fees described below that (a) are not excluded by other provisions applicable to these Benefits, (b) are Medically Necessary for the care and treatment of illness or injury of a Covered Member, (c) are recommended by an attending physician, (d) do not exceed the Usual, Customary and Reasonable charges (see "UCR" section for more information) as determined by the Program in accordance with health care industry standards

for the area in which the services and supplies are furnished, and are deemed necessary by the Utilization Review Program (See the "*Utilization Review Program*" section). A charge is considered to be incurred on the date a Covered Member receives the services or supplies which the charge is made.

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

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

Ambulance Services (Ground and Air)—Charges for emergent, Medically Necessary, local transportation of a Covered Member by a professional ambulance company to and from a hospital will be covered subject to any applicable Deductibles and Coinsurance amounts and subject to the per occurrence maximums, being two (2) each for Ground and Air, per Program Year and based upon the following requirements:

- Benefits are provided under the Program for Ground Ambulance Services for local transportation to the nearest hospital in the event medical emergency care is needed, or to the nearest neonatal special care unit for newborn infants for treatment of Injuries, Illnesses, congenital birth defects or complication of premature birth that require that level of care.

- Benefits for Air Ambulance Services are provided under the Program but are limited to transportation to the nearest hospital capable of providing medical emergency care. The Program's coverage of air ambulance is limited to those situations in which:

    - The Covered Member is in a location that cannot be reached by ground ambulance due to weather or road conditions or other circumstances exist that make it impossible for Ground Ambulance Services to be obtained; or

    - Transportation by Ground Ambulance poses a threat to the Covered Member's survival or seriously endangers the Covered Member's health due to the time or distance involved.

NOTE: The Program excludes benefits for any Air Ambulance transport between or among different hospitals unless the first hospital to which a Covered Member is transported is not capable of providing medical emergency care that will stabilize the Covered Member. If the Covered Member's medical condition is capable of being stabilized at any hospital to which the Covered Member has been transported, the Program excludes coverage for any Air Ambulance transfer to another hospital. In addition, the Program excludes coverage of Air Ambulance or Ground Ambulance for transfer of a Covered Member to any private residence or to any facility that will not furnish further medical treatment to the Covered Member.

- Coverage for non-emergent transport is limited to Ground Ambulance services only if the following conditions apply:

    - The Covered Member is confined to a bed or requires monitoring during transportation from a trained medical professional and cannot be safely transported by any other means; and

    - Transportation is needed to a different location in order to access Medically Necessary treatment that cannot be safely and adequately provided at the Covered Member's location.

- The Program does not cover and excludes the following charges related to to both Air and Ground Ambulance Services:

    - Expenses incurred for Ambulance Services covered by a local governmental or municipal body, unless otherwise required by law;

    - Non-emergency Ambulance Services, except as stated above;

    - Non Medically Necessary Ambulance Services;

    - Ambulance Services that originate:
        - Outside the 50 United States and the District of Columbia; or
        - From a country or territory outside of the United States to a location within the 50 United States or the District of Columbia; or
        - From a location within the 50 United States or the District of Columbia to a country or territory outside of the United States; or
        - Ambulance Services provided for comfort or convenience for a Covered Member, their family, caregiver, Provider, or any facility; or
        - That portion of any Ambulance Services ride that is farther from the point of origin than the nearest hospital capable of providing medical emergency care.

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

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

Emergency Room Charges—Charges for Medically Necessary emergency room services.

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

Inpatient Hospital Charges—The Program will pay up to a maximum of 30 days per year for covered room and board and other necessary services and supplies, unless defined elsewhere in this

booklet. In-hospital room accommodations covered are: semi-private room (two or more beds), approved intensive and cardiac care units and private room. If you choose to have a private room, you will be responsible for the difference between the hospital's charge for an average semi-private room and its private room charge. If the hospital is an all-private room facility, the Program will consider 90 percent of the private room charge as the covered charge.

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

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

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

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

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

Precertification is required for the following specific durable medical equipment:

- Bilevel Positive Airway Device (Bi-Pap)
- Oxygen Concentrator
- Portable Ventilator
- Wearable Defibrillator
- Insulin Pump
- Continuous Glucose Monitor

- •Bone Growth Stimulator
- •Spinal Cord Stimulator
- •Intrathecal Pump

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

Special Limitations on Specific Types of Medical Treatments

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

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

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

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

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

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

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

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

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

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

How to Obtain a Precertification

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

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

Chemical Dependency Treatment—These services are limited to 30 in-patient days per plan per year. Services must be rendered at the Program Chemical Dependency Treatment Center to be covered. You must contact Program case management at 888-295-3591 who will direct your care and Precertify services. No benefits will be available for Chemical Dependency services performed at any facility which is not designated by the Program. An order by a court or state agency for psychiatric treatment is not an indication of eligibility under this benefit.

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

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

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

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

Individual Coinsurance and the Individual Calendar Year Deductible will not be applied to the hearing aid benefit under the Standard Deductible Plan Option and the Coinsurance will not be applied to the hearing aid benefit for the Qualified High Deductible Plan. Additionally, these devices will not be covered if they are misused or lost. (See Exclusions Section.) All charges and/or costs

above the $1,400 maximum per ear one (1) time every three (3) years will be the Covered Member's entire responsibility.

Please note: Payment for hearing aids will not be considered before they have been received by the individual Covered Member and MHBP has received a signed delivery receipt.

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

Hospice Care—The Program will pay for covered Hospice charges, whether in the home or in an inpatient setting, including equipment and supplies, which are medically necessary for treatment if the Covered 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 Program's annual inpatient hospital maximum applies to this benefit.

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

Mental and Nervous Disorders—Payment for services incurred in connection with treatment of mental illness or functional nervous disorders is limited to a maximum of 30 inpatient days per calendar year, however, there is no limit for office visits for individual mental health or services.

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

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

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

Outpatient Clinical Setting Physical Therapy, Speech Therapy, Habilitative, Chiropractic, and Occupational Therapy Services—These therapeutic services, when provided in an outpatient clinical

setting, will be combined to allow for an annual maximum of 40 visits unless excluded elsewhere in the policy.

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

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

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

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

Special Benefits

Telemedicine

Lyric Health—The Program offers a telemedicine and telehealth benefit through Lyric Health.

Benefit Exclusions—WHAT IS NOT COVERED

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

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

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

Expenses for the following are not covered by the Program:

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

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

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

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

Alcohol Consumption & Controlled Substances—Health care, services, or the treatment of injuries , brought about in whole or in part, by the Member being intoxicated or under the influence of any controlled substances unless administered on the advice of a physician, 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, except as provided under Chemical Dependency Treatment or as defined elsewhere in this Program Booklet.

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

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

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

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

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

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

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

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

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

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

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

Genetic testing related to the diagnosis of cancer is covered, but only when the Program has determined that the particular genetic test (a) is the only way to diagnose the disease or condition;

(b) has been scientifically proven to improve outcomes when used to direct treatment; or (c) will affect the individual's treatment plan.

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

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

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

Illegal Act—Health care or services for the treatment of injuries occurring in the course of or in the furtherance of the Covered Member's commission of acts contrary to federal, state, or local law which resulted in a conviction of the Covered Member. This exclusion does not apply if the injuries resulted from a medical (including both physical or mental) condition.

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

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

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

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

Maintenance Care—All services, equipment, and supplies which are provided solely to maintain a Covered Member'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 care or services required by court order, or otherwise mandated by a third party, is not covered by the Program.

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

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

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

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

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

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

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

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

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

a. Care of corns or calluses;
b. Care of toenails;

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

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

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

Gender Identity Treatment—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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Coordination of benefits when a Covered Member is enrolled in more than one plan and this Program is not the primary plan.
- Subrogation, reimbursement, and third-party recovery rights of the Program.
- Reductions for certain multiple surgical procedures.
- Reductions for charges that exceed the usual and customary or negotiated fee Allowed Amounts.
- Reductions and/or denials for services which are not medically necessary or generally accepted as inappropriate and/or are considered as over utilization.
- Denial for services for anyone currently residing outside the United States or Canada, except for emergency services.
- Denial for anyone already covered under the Program as an Employee or dependent of another Member (no dual Coverage).
- Reduction and/or denial for anyone who is actively serving in the armed forces of any country.
- Denial for services, treatments, medications, and supplies that are excluded under the Program.
- A Covered Member failing to provide requested documentation such as an accident claim form, multiple Coverage inquiry, certificate of acceptance of plan provisions, 2-page accident and injury questionnaire, etc.
- Services must be performed at an accredited, licensed, certified facility for the treatment received.

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

Notice and Proof of Claim

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

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

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

No legal action can be brought against the Program prior to the Member having exhausted all administrative reviews and appeals, including the External Review Process, as applicable, under the Program in accordance with the Program's claims procedures (Section 7:Appeals). In addition, no legal action may be brought by a Member except within one (1) year after the Program's notification of the final adverse benefit determination. A Provider, whether or not such Provider is acting as an authorized representative of the Member, shall not be permitted to pursue legal action on behalf of a Member and shall not be recognized as having any standing to assert any rights as a beneficiary under this Program.

Payment of Benefits

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

The Program reserves the right to make payment of Benefits, in its sole discretion, directly to the Provider of the services or to the Covered Member. Notwithstanding the foregoing, however, the direct payment from the Program to the Provider does not confer upon the Provider status as the Covered Member or beneficiary under the Program and is not, and shall not be construed to be, an assignment of rights or benefits under the Program to the Provider. Any payment made by the Plan Administrator to a Provider will completely discharge the Plan Administrator's obligations to the extent of such payment and the Plan Administrator.

Prohibition of Assignment—No Benefits under the Program shall in any manner or to any extent be assigned, alienated or transferred by any Member, or be subject to attachment, garnishment or other legal process, except that the Plan Administrator shall adhere to the terms of any judgment, decree, or court order which is determined to be a QMCSO, pursuant to the procedures established by the Plan Administrator. Notwithstanding the foregoing, a Member shall be entitled to appoint an Authorized Representative to act on the Member's behalf with respect to a Benefit claim or appeal, as provided, and subject to the limitations provided, in the Program.

Section 3: Prescription Drug Program

General Coverage

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

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

You also have access to MedImpact's online prescription tool at www.medimpact.com. On this site, you can compare medication costs at local pharmacies, and see savings between brand-name and generic medications.

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

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

If you have any questions regarding your prescription drug plan, please feel free to contact Explain My Benefits at (833) 750-0369.

Prescription Drug Copayments

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

Generic Drugs	Preferred Brand Name Drugs	Non-Preferred Brand Name Drugs
$10.00	$30.00	$50.00

Deductible

Covered Members covered under a Qualified High Deductible Plan Option are subject to an Individual Calendar Year Deductible or a Family Calendar Year Deductible as set forth in the Calendar Year Deductibles for Major Medical Benefits Section. This means that the Calendar Year Deductible applies to the Major Medical benefit, as well as to prescription drugs covered by the

Program and that the Individual or Family Deductible shall be met before the Program will begin paying benefits. All other Covered Members are not subject to a Prescription Drug Benefit Deductible.

Out-of-Pocket Maximum

For Covered Members participating in the Standard Deductible Plan Option, the Calendar Year Out-of-Pocket Maximum for the Prescription Drug Benefit is:

Out-of-Pocket Maximum – Standard Plan Option – Prescription Drugs (Calendar Year)	In-Network	Out-of-Network
Individual	$2,600	Unlimited
Family	$5,200	Unlimited

For these Covered Members, it is important to know that this Out-of-Pocket Maximum is separate from the Major Medical Out-of-Pocket Maximum and only applies to prescription drugs that are covered by the Program. For Covered Members covered by the Qualified High Deductible Plan Option, there is a combined Out-of-Pocket Maximum for both Major Medical benefits and prescription drug benefits covered under the Program as set forth in the Out-of-Pocket Maximum Section of this Program Booklet.

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

Generic Incentive Policy

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

Covered Prescriptions

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

Mail-Order Pharmacy

The Program's standard Copayment structure will apply to each 30-day supply of medication obtained through the mail service pharmacy. A maximum of a 90-day supply of medication may be

obtained through the mail service pharmacy, however a Copayment for each one-month supply will be charged.

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

MRx Select Savings Program (Payer Matrix)

Members in the Program are able to utilize the MRx Select Savings Program which is an employee assistance program designed to provide relief for select high dollar Specialty Drug costs. Magellan Rx Management, in partnership with Payer Matrix, will administer the MRx Select Savings Program to identify alternative funding for select high-cost Specialty Drugs, not otherwise covered by the Program. Magellan Rx Management and Payer Matrix will utilize manufacturer assistance programs to help Members cover the cost of the Specialty Drug, which could be reduced to zero.

The employee assistance program will only be available with respect to those Specialty Drugs included in the Managed Specialty Drug Tier. The Managed Specialty Drug Tier is established for the purpose of making the employee assistance program available with respect to certain Specialty Drugs that are not otherwise covered by the Program. Program Members will be required to meet prior authorization criteria and administrative review under the MRx Select Savings Program to be eligible for any assistance with respect to those drugs included in the Managed Specialty Drug Tier. If you do not enroll in the MRx Select Savings Program you will be responsible for the full cost of your medication. If, you are NOT eligible for a Magellan or Payer Matrix identified alternate funding program, the drug will not be covered by the Program unless Magellan determines that a coverage exception applies. A comparable drug may be available under the Program and you should contact Magellan to determine your options.

A Magellan or Payer Matrix representative will reach out if one of your medications has an available manufacturer assistance program. The Payer Matrix representative is a clinician with Specialty Drug expertise. They coordinate the details with you and your physician if you qualify for assistance. They also work on your behalf to help you receive your Specialty Drug on time, every month, once in the program.

Because the MRx Select Savings Program is only available for drugs that are not covered by the Program, any amount that you pay toward the cost of the drug and any assistance that you receive will not count toward the Program's deductible or out-of-pocket maximums.

To obtain additional information about the MRx Select Savings Program or to connect with a Payer Matrix representative you may call 877-305-6202 or email customerservice@payermatrix.com.

Drug Therapy Management Features

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

Dosing Guidelines/Quantity Limitations

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

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

Step Therapy

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

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

Prior Authorization

The Program has established Coverage policies for certain medications and drug classes which will require Prior Authorization. When these medications are prescribed by your provider, your provider will be required to obtain authorization from the Program in order for the medication to be eligible for coverage (Prior Authorization). Your provider must contact MedImpact by calling 1 (888)-266-7481, faxing (858)-790-7100, or submitting an electronic request through CoverMyMeds or Sure Scripts, to request prior authorization for medications requiring prior approval by the Program.

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

Preventive Services

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

Drugs / Drug Categories	Coverage Parameters
Aspirin to Prevent Cardiovascular Disease	For Members > 45 years of age. Quantity Limit of 100
Iron Supplementation for Children	For children up to 1 year of age
Oral Fluorides for Children	For children > 6 months and < 6 years of age
Folic Acid Supplements	For female Members < 55 years of age. Quantity Limit of 100

Tobacco Cessation	Annual Limit: 2 cycles of treatment (12 weeks/cycle)
Routine Vaccinations for Children & Adults	Please refer to the Preventive Care section of the Program Booklet for detailed coverage policy
All FDA approved contraceptive methods	Coverage limited to The Program's custom list and is subject to change
Breast Cancer Prevention	Tamoxifen, raloxifene
Vitamin D Supplementation	For Members > 65 years of age
Cholesterol Reducers (Statins)	The following low-to-moderate potency agents are covered for Members between 40–75 y/o for primary prevention: ***Atorvastatin*** 10mg, 20mg: ***Lovastatin*** 10mg, 20mg, 40mg: ***Pravastatin*** 10mg, 20mg, 40mg, 80mg: ***Rosuvastatin*** 5mg, 10mg: ***Simvastatin*** 5mg, 10mg, 20mg, 40mg

Diabetes Testing Supplies

To assist Members with diabetes in managing their disease, the Program provides the following supplies for a $0 copayment (available at no charge to Covered Members covered under the Program).

Blood Glucose Meter (1 free meter per year)

•Accu-Chek Guide-Me blood glucose meter

Blood Glucose Test Strips

•Accu-Chek Guide Test Strips

Lancets

Note: This list is subject to change.

You can receive your blood glucose strips and lancets at your local pharmacy. These supplies are available at no charge when purchased within 100 days of your insulin or diabetic medication. The pharmacy must process the prescription for your insulin or diabetic medication before processing the supplies. **Please Note**: The brands of diabetes testing supplies, syringes and pen needles provided by the Program are subject to change. Such changes will be communicated to affected Program participants. If a Covered Member purchases diabetic supplies within 100 days of filling an insulin or diabetic medication, the Covered Member will have a $0 copayment on those related supplies.

Medicare Retirees and/or those Medicare-eligible Covered Members whose primary insurance is Medicare must purchase their diabetic supplies under Medicare Part B. The pharmacy must electronically bill Medicare as primary and then bill MHBP/MedImpact as secondary.

Continuous Blood Glucose Monitoring Devices—To assist Members with diabetes who require intense monitoring of blood glucose levels and who may be at increased risk of blood glucose

fluctuations, the Program provides access to the following continuous glucose monitoring (CGM) devices. It is important to know that access to these devices are subject to prior authorization and will require a copayment. The brands currently provided by the Program are listed below and are subject to change.

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

Tobacco Cessation Program

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

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

Provider & Member Assistance

Providers may call MedImpact for questions regarding medications at 1 (888)-266-7481.

Members having general questions about the Program's prescription drug Coverage should call Explain My Benefits at 1 (833) 750-0369. The hours for Explain My Benefits are 8am-4pm CST. Members may also submit a question through the link in the Member portal found on the www.arml.org/mhbpn webpage.

Member Claims--If the pharmacy cannot process a claim for a Covered Drug or coordinate benefits, submit a Prescription Drug Claim Form (available at www.arml.org/mhbp) to:

Medimpact Healthcare System, Inc.
PO Box 509098
San Diego, CA 92150-9108

Attach copies of prescription receipts showing the following information:

Patient Name

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

Please allow 4-6 weeks for processing.

Status of these claims can be obtained by calling MedImpact.

Section 4: Optional Benefits

Optional Benefits

The Program offers the following list of optional benefits that a Participating Employer may elect to offer its Eligible Classes.

Dental Benefits

Municipal Health has partnered with Delta Dental of Arkansas to offer a dental benefit for Covered Members. See below for a schedule of benefits:

Deductible: Applies to Basic Restorative and Major Restorative Services per benefit period.

	Premiere and PPO In Network	Out-of-Network
Individual	$50.00	$50.00

Annual and Lifetime Maximum Payment: The annual maximum amount applies to Diagnostic and Preventative Services, Basic Restorative Services and Major Restorative Services per benefit period.

	Premiere and PPO In Network	Out-of-Network
Annual Individual	$1,200.00	$1,200.00
Lifetime Orthodontic	$1,000.00	$1,000.00
Lifetime TMJ	$1,000.00	$1,000.00

Benefit period: A benefit period for each eligible participant shall mean a calendar year, the period from January 1st to December 31st of each year.

Dependent Age Limit: To the end of the month year in which the Eligible Child reaches age 26.

Coverages and Maximum Plan Allowances (MPA)

Coverage A – Diagnostic and Preventative Services

Premiere In Network 100% MPA
PPO In Network 100% MPA
Out-of-Network 100% MPA

- Routine periodic and specialty evaluations are Covered Services up to two (2) time(s) in any Calendar Year. This is inclusive of an initial, oral evaluation.
- Prophylaxis (Cleaning) is a Covered Service up to two (2) time(s) per Calendar Year. (*Please see information on Evidence Based Dentistry)

- Sealants are Covered Services for Eligible Dependents prior to age sixteen (16) one (1) time(s) per tooth per lifetime.
- Topical application of fluoride is a Covered Service two (2) time(s) per Calendar Year for Eligible Dependents prior to age nineteen (19).
- Application of silver diamine fluoride Two (2) times in a Calendar Year per tooth.
- One (1) additional fluoride application per Calendar Year is a Covered Service for Eligible Dependents prior to age nineteen (19) who are identified at a moderate or high risk (as defined by the American Dental Association's Dental Procedure Codes) for developing caries.
- A Caries Risk Assessment is a Covered Service once every twelve (12) months for Eligible Dependents to age three (3) to nineteen (19).
- Brush Biopsy is a Covered Service upon consultant review.
- Bitewing are Covered Services as required in any Calendar Year.
- Bitewing x-rays are limited to two (2) films in any single visit for children under the age of ten (10).
- Periapical x-rays are Covered Services as required in any Calendar Year.
- A full mouth series x-ray or panoramic x-ray is a Covered Service one (1) time within any sixty (60) consecutive month period.
- A space maintainer is a Covered Service when used to replace prematurely lost or extracted teeth for Eligible Dependents prior to age fourteen (14).
- A space maintainer is a Covered Service up to one (1) space per lifetime.

Coverage B – Basic Restorative Services

Premiere In Network 80% MPA
PPO In Network 80% MPA
Out-of-Network 50% MPA

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- Palliative treatment is a Covered Service once per visit as long as no other procedures, except for x-rays, exams, or any diagnostic service, are performed on the same date.
- Periodontal Maintenance is a Covered Service up to two (2) per Calendar Year following active periodontal treatment. (*Please see information on Evidence Based Dentistry)
- Restorative benefits (fillings) are Covered Services once per surface, per tooth in a twenty-four (24) month period.
- Composites on molars are not Covered Services. An amalgam allowance will be made for molars with any fee difference being the responsibility of the Participant.
- Stainless Steel Crowns used as a restoration to natural teeth are Covered Services for Eligible Dependent(s) to age sixteen (16) when the teeth cannot be restored with a filling material.
- Simple extractions.
- Surgical periodontics.
- Non-surgical periodontics.
- Oral surgery, except TMJ surgery, is a Covered Service.
- A TMJ x-ray is a Covered Service once in any three (3) year period.
- Surgical and Non-Surgical TMJ is a Covered Service once in a lifetime, by report, upon consultant review.
- Crowns, inlays, onlays, and veneers are Covered Services for the treatment of visible decay and fractures of tooth structure when teeth are so badly damaged they cannot be restored with amalgam or composite restorations.
- Root canal treatment is a Covered Service once in a lifetime, per tooth, by the same Provider or Provider's office that performed the root canal. Benefits for root canal treatment include charges for temporary restorations.

- Replacement of a crown, inlay, onlay, or veneer is a Covered Service only after sixty (60) months of the previous prosthetic.
- Endosteal implants are Covered Services once in a lifetime per tooth.

Coverage C – Major Restorative Services

Premiere In Network 80% MPA
PPO In Network 80% MPA
Out-of-Network 50% MPA

- Prosthodontics, including procedures for construction of fixed bridges, full or partial dentures.
- Replacement of full or partial removable dentures that the Participant received in the previous sixty (60) consecutive months are not Covered Services except where the loss of additional teeth requires the construction of a new appliance.

Orthodontic Services

Premiere In Network 80% MPA
PPO In Network 80% MPA
Out-of-Network 50% MPA

The initial payment for comprehensive treatment will be half (1/2) of the total plan responsibility for treatment subject to Participant's co-pay percentage and lifetime maximum, paid upon receipt of the initial claim. Subsequent payment(s) for the remaining half (1/2) of the plan responsibility will be made on the one (1) year anniversary of the initial banding date. All payments are subject to the Participant's Co-payment percentage and lifetime maximum. If estimated comprehensive treatment time is less than twelve (12) months, the initial payment will be the total fee for treatment, subject to Participant's Co-pay percentage and lifetime maximum. Orthodontia is considered a pre-existing condition if treatment begins prior to the date he/she became eligible under this plan or prior to the end of any waiting periods that may apply.

Questions? Contact Delta Dental's Customer Service Department at (800) 462-5410. Delta Dental's network of participating providers may be found on our website at www.deltadentalar.com

Maximum Payment Amount (MPA) for Covered Dental Charges is the maximum amount deemed to be reasonable payment for Covered Dental Charges

Vision Care Benefits

Vision Care Services

The Program offers a vision benefit through Eyemed. A Schedule of Benefits is below.

	In-Network	Out-of-Network
Exam (With dilation as necessary)	$25 Copay	$40

Frames

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

Contact Lenses

Contact Lens allowance includes materials only.

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

Standard Plastic Lenses

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

Covered Lens Options

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

Additional Vision Care Services

Discounted Exam Services

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

Photochromic (Plastic)	$15
UV Treatment	$15
Standard Plastic Scratch Coating	$15
Standard Polycarbonate—age 19 and over	$40

Monthly Rate:

Individual Coverage:	$4.58
Family Coverage:	$11.70

Vision coverage is only available for Participating Employers who adopt the Vision Coverage for its Eligible Class through the Program.

Once a Participating Employer has enrolled in the vision coverage for its Eligible Classes, the vision benefit will be administered by EyeMed. You can reach EyeMed's customer service support at 844-409-3401.

Dental, Vision, and Hearing Aid Benefit for Medicare-eligible Elected Officials

Active elected officials who are on Medicare are eligible for dental, vision, and hearing aid coverage with Municipal Health upon a premium payment of $50.00. To qualify, the elected official should be enrolled in all parts of Medicare (A, B and D).

Life Coverage

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

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

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

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

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

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

Important:

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

In this instance the term Child shall include:

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

Disability Income Benefits

Optional Coverage for Full-Time Employees Only

Some Participating Employers have an accident and illness income benefit that the Municipal Health Benefit Program administers. Please consult your Participating 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 Participating Employer may offer you, are under the direct care of a physician, are not engaged in any other work for compensation or profit, including self-employment and a physician determines that you are totally disabled. The Program reserves the right to request a determination of disability by a physician selected by the Program. This benefit is not assignable.

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

Option B (52 Week Benefit)	
Weekly Benefit	$105
First Benefit Day for Disability due to Accident	183rd Day
Illness	183rd Day

Maximum Number of Weeks Payable	26 Weeks

Maximum Number of Weeks Payable	52 Weeks

Weekly Benefits are payable from the First Benefit Day of any one continuous period of disability up to the appropriate Maximum Number of Weeks. One-seventh of the Weekly Benefit is payable for each full day of covered disability but no benefit is payable for part of a day. Successive periods of disability, separated by less than two consecutive weeks of continuous full-time work with the Participating 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 Participating Employer for at least one full day.

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

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

Section 5: How MHBP Pays Benefits (PPO)

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

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

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

Allowed Amount

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

The Program calculates and pays Program benefits on the basis of the Allowed Amount, an amount that may vary substantially from the amount a provider chooses to bill. Once the Allowed Amount is determined with respect to any Provider's submitted charges, the Covered Member may be

responsible for a percentage or portion of the Allowed Amount, depending on the terms of the Program with respect to copayments, Coinsurance, and the Calendar Year Deductible.

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

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

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

For an Out- of-Network Provider, unless otherwise provided, the circumstances are substantially different. For example, if services are provided by an Out-of-Network Provider, once the Covered Member has satisfied their Calendar Year Deductible, the Program may pay only 50% of the Allowed Amount, in which case the Covered Member would be responsible for the remaining 50% of the Allowed Amount. In addition, there is no Out-of-Pocket Maximum for Out-of-Network charges which means the Covered Member's Coinsurance is unlimited. Further, the Covered Member may also be held responsible by the Out-of-Network Provider for paying the difference between the Allowed Amount and the Provider's full, billed charges ("balance billing").

Preferred Provider Network

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

	In-Network	Out-of-Network
	80% of the Program's Preferred Provider Allowed Amount	80% of the Program's Out-of-Network Allowed Amount*
	80% of the Program's Preferred Provider Allowed Amount	50% of the Program's Out-of-Network Allowed Amount*

Out-of-Network Covered Services

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

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

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

Specific hospital payments, charges and costs reported by code

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

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

Out-of-Network Providers are not under any obligation to accept the Program's Allowed Amount as payment in full and Covered Members will be responsible for all amounts billed by Out-of-Network Providers in excess of the Allowed Amount (in addition to the Covered Member's cost share of the Allowed Amount).

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

In certain out-of-network scenarios, a Covered Member may be protected from "balance billing" under the No Surprises Act. The scenarios are limited to when a Covered Member receives

emergency care treatment by an out-of-network hospital or ambulatory surgical center, or receives care by an Out-of-Network Provider at an In-Network Facility.

Balance Billing ("Surprise Billing")

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

"Surprise billing" is an unexpected balance bill. This can happen when a Covered Member can't control who is involved in their care—like when there is an emergency or when a Covered Member schedules a visit at an In-Network Facility but is unexpectedly treated by an Out-of-Network Provider.

Covered Members may be protected from balance billing in certain circumstances such as when seeking emergency care Out-of-Network, or when seeking care at an In-Network Facility, but the care is provided by an Out-of-Network Provider as described in more details below.

Emergency services

If a Covered Member has an emergency medical condition and receives emergency services from an Out-of-Network Provider or Facility, the most the provider or facility may bill the Covered Member is the Program's In-Network cost-sharing amount (such as copayments and coinsurance). The Covered Member **cannot** be balance billed for these emergency services. This includes services the Covered Member may get after they are in stable condition, unless the notice and consent procedures set forth in the No Surprises Act are satisfied, resulting in the Covered Member consenting to being treated by the Out-of-Network Provider for these post-stabilization services. The Covered Member cost sharing amount for emergency services provided by an Out-of-Network Provider will be calculated based on the Recognized Amount.

Emergency air ambulances services

Covered emergency air ambulance transportation services will be covered applying the In-Network cost-sharing amount when provided by an Out-of-Network provider. The cost sharing amount for air ambulance provided by an Out-of-Network provider will be calculated based on the lesser of the Qualified Payment Amount as determined under applicable law or the amount billed by the Out-of-Network air ambulance service provider.

Certain services at an In-Network hospital or ambulatory surgical center

When a Covered Member receives ancillary services from an In-Network hospital or ambulatory surgical center, certain providers there may be Out-of-Network. In these cases, the most those providers may bill the Covered Member is the Program's In-Network cost-sharing amount. This

applies to ancillary services which include emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **cannot** balance bill a Covered Member and may **not** ask a Covered Member to give up their protections not to be balance billed. Non-ancillary services by an Out-of-Network Provider will be covered at the Program's In-Network cost-sharing amount, unless the notice and consent procedures set forth in the No Surprises Act are satisfies, resulting in the Covered Member consenting to being treated by the Out-of-Network Provider. The cost sharing amount for the ancillary services, or non-ancillary services (without notice and consent) provided by an Out-of-Network Provider will be calculated based on the Recognized Amount.

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

If covered, the services described herein subject to the No Suprises Act that are processed at the In-Network cost sharing benefit level will not be subject to balance billing by the Out-of-Network Provider.

Recognized Amount

The Recognized Amount used to determine the Covered Member's cost sharing amount for the covered services subject to the No Surprises Act, other than emergency air ambulance services, is determined as follows:

- the applicable All-Payer Model Agreement under Section 1115A of the Social Security Act;
- if there is no applicable All-Payer Model Agreement, an amount determined under state law;
- if there is no applicable All-Payer Model Agreement or state law, the lesser of:
    - the amount billed by the Out-of-Network Provider, or
    - the Qualified Payment Amount (as defined below)

Cost sharing amounts for covered emergency air ambulance services provided by an Out-of-Network Providers will be calculated based on the lesser of the Qualified Payment Amount or the amount billed by the Out-of-Network air ambulance service provider.

Qualified Payment Amount

The Qualified Payment Amount for purposes of determining the cost-sharing amount for covered services subject to the No Surprises Act as described herein, is based on the median of the Program's contracted rates with In-Network Providers in the geographic region in which the services are provided in accordance with the regulations under the No Surprises Act, any subsequent guidance issued thereunder, and any applicable law.

Allowed Amount for Out-of-Network Services under No Surprises Act

Payments made by the Program for covered services described herein that are processed at the In-Network cost sharing benefit level pursuant to the No Surprises Act will equal the amount by which the Out-of-Network Rate exceeds the Covered Member's cost-sharing amounts for such services. For this purpose, the Out-of-Network Rate is (a) an amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act; (b) if there is no applicable All-Payer Model Agreement, an amount determined by a specified state law; (c) if there is no applicable All-Payer Model Agreement or specified state law, the payment amount agreed to by the Program

and Out-of-Network Provider or Facility; or (d) if none of the above conditions apply, the amount determined through the independent dispute resolution (IDR) process.

Continuity of Care

A Covered Member receiving treatment from an In-Network Provider that cease to be an In-Network Provider during an ongoing course of treatment will be permitted to continue treatment with the provider or facility at In-Network Provider rates for a period of up to 90 days if the Covered Person is considered a "continuing care patient" and the provider or facility is no longer considered an In-Network Provider because the contractual relationship between the Program and the provider or facility has terminated.

For this purpose, a Covered Member is considered a "continuing care patient" if the Covered Member was and continues to be under a treatment plan by a provider or facility that was part of the Program's In-Network Providers and such Covered Member:

- Is undergoing a course or treatment for a serious and complex condition that:
    - In the case of an acute illness, is a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
    - In the case of a chronic illness or condition, is a condition that is life-threatening, degenerative, potentially disabling or congenital and requires specialized medical care over a prolonged period of time;
- Is undergoing a course of institutional or inpatient care from the provider or facility;
- Is scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such surgery;
- Is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
- Is or was determined to be "terminally ill" (i.e., has a medical prognosis that the individual's life expectancy is six months or less) and is receiving treatment for such illness from such provider or facility.

Section 6: Coordination of Benefits & Third Party Recovery

Coordination of Benefits (COB)

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

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

Integration of Benefits

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

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

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

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

How Coordination of Benefits (COB) Works

1. This is how COB usually works, if there is no med-pay issue involved: If more than one group covers you, COB guidelines determine which plan pays for the covered services first.
    A. Your Primary Plan is the plan paying first.
    B. Your Secondary Plan is the plan paying second or after the Primary Plan has paid.
2. This is how to determine which is the Primary Plan and Secondary Plan:
    A. The plan covering the Employee is primary unless the employee's automobile med-pay comes into play such as in the event of a single-vehicle accident. The plan covering the Employee as an Eligible Dependent is secondary.
    B. If both the mother's and father's plans cover the child, the plan of the parent whose birthday month is earlier in the year is the primary plan.
    C. Benefits for children of divorced or separated parents are determined in the following order:
        a. Plan of the parent the court has established as financially responsible for the child's health care pays first (we must be informed of this requirement and documentation will be required).
        b. Plan of the custodial parent.
        c. Plan of the custodial parent's new spouse (if remarried).
        d. Plan of the non-custodial parent.
        e. Plan of the non-custodial parent's new spouse (if remarried).

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

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

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

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

The Program will comply with the Medicare Secondary Payer regulations which generally follows the following guidelines:

    A. If you are actively employed by the Participating Employer and your or your spouse becomes eligible for and enrolls in Medicare because of age or disability, the Program will be primary.
    B. If a Covered Member has End-Stage Renal Disease (ESRD), the Program will generally be primary for the first 30 months from the date of Medicare eligibility based on ESRD. At the end of the 30 month period, Medicare will become primary.
    C. Medicare will be primary when you are no longer actively employed, or when you or your spouse have retiree coverage, or if coverage is through COBRA continuation coverage.

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

Third Party Recovery Provisions

Right of Subrogation and Reimbursement

The Covered Member may incur medical, vision or dental charges due to Injuries or Sickness caused by the act or omission of a Third Party or a Third Party may be responsible for payment of such charges. In such circumstances, the Covered Member may have a claim against that Third Party, or insurer, for payment of the medical, vision or dental charges. Accepting benefits under the Program for those incurred medical, vision or dental expenses automatically assigns to the Program any rights the Covered Member may have to Recover payments from any Third Party or insurer. This Subrogation right allows the Program to pursue any claim which the Covered Member has against any Third Party, or insurer, whether or not the Covered Member chooses to pursue that claim. In addition, the Program shall have a Reimbursement right which provides the Program with an equitable lien on any amount Recovered by the Covered Member whether or not designated as payment for medical, dental or vision expenses. This equitable lien shall remain in effect until the Program is repaid in full. In addition, each Covered Member agrees to hold Recoveries in a constructive trust for the benefit of the Program. The equitable lien and constructive trust shall remain in effect until the Program is repaid in full. In the event that the Covered Member dies as a result of his Injuries or Sickness and a wrongful death or survivor claim is asserted against a Third Party, the Program's Subrogation and Reimbursement rights shall still apply, and the entity pursuing such claim shall honor and enforce these Program rights and terms by which benefits are paid on behalf of the Covered Member and all others that benefit from such payment. The Program may withhold all future payments under the Program (whether or not related to the claim in question) if the Covered Member violates the terms of this section.

The Covered Member must:

(1) automatically assign to the Program his or her rights against any Third Party or insurer when this provision applies;
(2) repay to the Program the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer;
(3) if applicable, execute and deliver a signed Subrogation and Reimbursement Agreement;
(4) notify the Program in writing of any proposed settlement and obtain the Program's written consent before signing a release or agreeing to any settlement; and
(5) notify any attorney retained of the Program's Subrogation and Reimbursement rights.

The failure of the Covered Member to execute and deliver a signed Subrogation and Reimbursement Agreement shall have no effect on the Program's ability to enforce its Subrogation and Reimbursement rights pursuant to this section.

In the event a court of competent jurisdiction determines that any part of the foregoing Right of Subrogation and Reimbursement is unenforceable for any reason, it is the intent of the parties that the Program shall retain all rights provided for in those parts that remain enforceable, including without limitation the Program's right to recover the expenditures it has made to provide benefits to the Covered Member, to the extent that any portion of the proceeds paid to the Covered Member by any Third-Party is designated as compensation for medical expenses or for other expenses paid

by the Program to or on behalf of the Covered Member, or which are intended as, or can reasonably be attributed to, compensation for medical expenses or other expenses paid by the Program, though not expressly designated as such, which determination shall be made at the sole discretion of the Program.

Amount Subject to Subrogation. Accepting benefits under the Program for medical, vision or dental charges incurred as a result of Injuries or Sickness caused by the act or omission of a Third Party automatically assigns to the Program any and all rights the Covered Member may have to recover payments from any Responsible Third Party. Further, accepting benefits under the Program for those incurred medical, vision or dental expenses automatically assigns to the Program the Covered Member's Third Party Claims.

Amount Subject to Reimbursement. The Covered Member agrees to recognize the Program's right to Reimbursement. This right provides the Program with a 100%, first dollar priority out of any and all Recoveries and funds paid by a Third Party to a Covered Member relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. The Program reserves the right to be reimbursed for its court costs and attorneys' fees if the Program needs to file suit in order to Recover payment for medical, vision or dental expenses from the Covered Member. Also, the Program's right to Reimbursement shall apply regardless of whether: (i) the Recovery is for, or is described as being for, damages other than the benefits paid hereunder, or (ii) the Recovery received by the Covered Member is less than the claimed damage, and, as a result, the Covered Member is not made whole. In no event will the Program be obligated or required to reduce its lien for any reason or otherwise share in any of the costs or attorneys' fees incurred by a Covered Member or Dependent in connection with obtaining the Third Party recovery. The Program expressly disavows and repudiates the make whole doctrine and the common fund doctrine and the Program's equitable lien shall supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignments of rights which interferes with or compromises in any way the Program's equitable lien and the right to reimbursement.

Cooperation by the Covered Member. When a right of Recovery exists, the Covered Member will execute and deliver all required instruments and papers, including but not limited to a signed Subrogation and Reimbursement Agreement. As a condition to any payment by the Program (including payment of future benefits for other Injury or Sickness), the Covered Member shall be required to cooperate fully with the Program in order to secure the Program's right of Subrogation and Reimbursement. In addition, the Covered Member will do nothing to prejudice the Program's Subrogation and Reimbursement rights. Notwithstanding anything to the contrary, the Program's Subrogation and Reimbursement rights shall not be diminished or reduced as a result of the Covered Member's failure to cooperate with the Program, nor shall the Program's decision to pay any medical or other benefits prior to the execution of a signed Subrogation and Reimbursement Agreement be construed as a waiver of the Program's right to enforce its Subrogation and Reimbursement rights.

Conditions Precedent to Coverage. The Program shall have no obligation whatsoever to pay medical, vision, or dental benefits to a Covered Member if a Covered Member refuses to cooperate with the Program's Subrogation and Reimbursement rights or refuses to execute and deliver such papers as the Program may require in furtherance of its Subrogation and Reimbursement rights. The Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claim for benefits by the Covered Member and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or Sickness) under the Program by the amount due as Reimbursement to the Program. Further, in the event the Covered Member is a minor, the Program shall have no obligation to pay any medical, vision or dental benefits incurred on account of Injury or Sickness caused by a Responsible Third Party until after the Covered Member or his authorized legal representative obtains valid Court

recognition and approval of the Program's 100%, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Defined terms: "Covered Member" means anyone covered under the Program, including minor Dependents or his or her authorized representatives acting on behalf of such Covered Member.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Covered Member (or his or her authorized representative acting on behalf of the Covered Member) by way of judgment, settlement, agreement or otherwise to compensate for all losses caused by or in connection with the Injury or Sickness, whether or not said losses reflect medical, vision or dental charges covered by the Program. "Recover," "Recovered," "Recovery" or "Recoveries" further includes, but is not limited to, recoveries for medical, vision or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Reimbursement" means repayment to the Program for medical, vision or dental benefits that it has paid toward care and treatment of the Injury or Sickness and for the expenses incurred by the Program in collecting such amounts.

"Subrogation" means the Program's right to pursue the Covered Member's claims for medical, vision or dental charges against a Third Party.

"Third Party" means any individual or organization, other than the Program, who is responsible for the payment of the medical, vision or dental charges incurred in connection with the Covered Member's Injury or Sickness. The term "Third Party" shall include the party or parties who caused the Injuries or Sickness as well as the insurer, guarantor or other indemnifier of the party or parties who caused the Injury or Sickness.

Recovery from another Program under which the Covered Member is covered. This right of Reimbursement also applies when a Covered Member recovers under an uninsured or underinsured motorist Program (which will be treated as Third Party coverage when Reimbursement or Subrogation is in order), homeowner's Program, renter's Program, medical malpractice Program or any liability Program.

Excess Insurance. If at the time of the Injuries or Sickness there is available, or potentially available, any coverage (including but not limited to coverage resulting from a judgement at law or settlement), the benefits under this Program shall apply on as an excess over such other sources of coverage, except as otherwise provided under the Program's Coordination of Benefits.

The Program's benefits shall be excess to:

- The responsible party, its insurer, or any other source on behalf of that party;
- Any first party insurance through medical payment coverage, personal injury protection, no- fault coverage, uninsured or underinsured motorist coverage;
- Any policy of insurance from any insurance company or guarantor of a third party;
- Worker's compensation or other liability insurance company; or
- Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds. Benefits paid by the Program, funds recovered by the Covered Member, and funds held in trust over which the Program has an equitable lien exist separately from the property and estate of the Covered Member, such that the death of the Covered Member, or filing of bankruptcy by the Covered Member, will not affect the Program's equitable lien, the funds over which the Program has a lien, or the Program's right to Subrogation and Reimbursement.

Section 7: Claims & Appeals

Claims Reviews and Appeals Procedures

Getting Help with your Claim for Benefits

If you have a question about your claim payment or how the Program works, we urge you to call and visit with a Municipal Health Benefit Program customer service representative at **501-978-6137, Option 2**.

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

Claims and Appeals Procedures Generally

Claims and appeal processes are governed by the Patient Protection and Affordable Care Act (PPACA) as well as the regulations pertinent to the Act. As such, Federal law requires the Program to use reasonable procedures with respect to requests, also known as a claim, for a Program 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 in this Section 7.

The Claims Review Team and the Board of Trustees for the Municipal Health Benefit Program will have full discretion and authority to construe and interpret the terms and all provisions of the Program and to determine whether a claim should be approved and paid or denied as applicable under the Program. This discretionary authority includes but is not limited to the right to remedy possible ambiguities, inconsistencies and/or omissions in the Program and related documents, to make determination in regards to issues relating to eligibility for benefits and payment of Claims and permissible expenses from Program assets; to develop and enforce rules it deems necessary or proper for the efficient administration of the Program; to decide disputes that may arise relative to a Member's rights; and to determine all questions of fact and law arising under the Program. Such decisions are binding on all interested parties.

How to Submit a Claim

Benefits under the Plan shall be paid only if the Claims Review Team and the Board of Trustees decide in its discretion that a Covered Member is entitled to them.

When a Covered Member incurs a claim, generally, the provider will file the claim for payment directly with the Program on behalf of the Covered Member. In the event that the provider does not file the claim for payment, the Covered Member may seek payment for the claim by submitting a

claim form from the Program by contacting the Program's customer representative number at **501-978-6137, Option 2**.

Initial claims for payment for benefits under the Program must be received by the Program within 180 days of the date the charges for the services were incurred and in the case of a prescription drug claim, within 180 days of the date of the prescription. Benefits are based on the Program's provisions at the time the charges were incurred. Claims received after this time will be denied.

The Claims Review Team will determine if enough information has been submitted to enable proper consideration of the claim. If more information is necessary, it may be requested from the Covered Member or the provider.

Provider Appeals:

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

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

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

Member Appeals:

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

The Program requires a Participating Employer and its Covered 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 set forth below.

Internal Claims and Appeal Reviews

1. Definitions

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

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

•Any rescission of Coverage, where such rescission results in a cancellation of coverage that has a retroactive effect, 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 Program after the denial of an initial claim.

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 Program applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine; or
- A physician with knowledge of the claimant's medical condition opines that without the care or treatment that is the subject of the claim the claimant would be subjected to severe pain that cannot be adequately managed; unless
- Any claim that a physician with knowledge of the claimant's medical condition determines is a "claim involving urgent care" shall be treated as a "claim involving urgent care."

D. Claimant—The term "claimant" means any Covered Member who makes a claim for benefits under the Program . 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 Program 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 Program participants, beneficiaries and other specified individuals. See 9(j) for more information on notice to non-English literate persons covered by the Program.

J. Post-service claim—The term "post-service claim" means any claim for a benefit under the Program that is not a pre-service claim. A post-service claim include claims that involve only the payment or reimbursement of the cost of medical care or benefit that has already been provided.

K. Pre-service claim—The term "pre-service claim" means any claim for a benefit under the Program, with respect to which the terms of the Program condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

L. Rescission—The term "rescission" is a cancellation or discontinuance of Coverage that has retroactive effect. For example, a cancellation that treats Coverage as void from the time of the individual's or group's enrollment is a rescission. 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 Program has established reasonable procedures for determining whether an individual has been authorized to act on behalf of a claimant. Also, in the case of a claim involving urgent care, a health care professional, with knowledge of a claimant's medical condition shall be permitted to act as the authorized representative of the claimant.

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

2. Denials

Except as provided below in this section with regards to Urgent Care, Concurrent Care, Pre-service and Post-service claims, if a claim is wholly or partially denied, the Program shall notify

the claimant of the Program's adverse benefit determination within a reasonable period of time, but not later than ninety (90) days after receipt of the claim by the Program, unless the Program determines that special circumstances require an extension of time for processing the claim. If so, written notice of the extension shall be furnished to the claimant prior to the termination of the initial ninety (90) day period. In no event shall such extension exceed a period of ninety (90) days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Program expects to render the benefit determination.

3. Urgent care

   In the case of a claim involving urgent care, the Program shall notify the claimant of the benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the claim by the Program, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Program. In the case of such a failure, the Program shall notify the claimant as soon as possible, but not later than twenty-four (24) hours after receipt of the claim by the Program, of the specific information necessary to complete the claim. The claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. The Program shall notify the claimant of the Program's benefit determination as soon as possible, but in no case later than forty-eight (48) hours after the earlier of:

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

   The approval of an urgent-care claim does not guarantee payment or assure coverage; it means only that the information furnished to the Program at the time indicates that the requested services, supply, prescription drug, equipment or treatment is Medically Necessary and not Experimental or Investigational. An urgent-care claim must still meet all the other coverage terms, conditions and limitations. Coverage for any such urgent-care claim may still be limited or denied if, when after the requested service, supply, or prescription drug, equipment, or treatment is completed and the Program receives a post-service claim, investigation shows that a benefit exclusion or limitation applies, that the claimant ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment, that out-of-network limitations apply, or any other basis specified in the Program applies to limit or exclude the claim.

   After the claimant receives the benefits that were subject to the urgent-care claim, the claimant must submit a post-service claim with the Program.

4. Concurrent care decisions

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

   Any reduction or termination by the Program of such course of treatment (other than by amendment of the Program's benefits or termination of the Program) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. The Program shall notify the claimant of the adverse benefit determination at a time sufficiently in

advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated. If the reduction or termination by the Program of such course of treatment involves an urgent care claim, however, the Program shall notify the claimant of the adverse benefit determination no later than 72 hours from the reduction or termination.

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

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

5. Pre-service claims

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

The approval of a pre-service claim does not guarantee payment or assure coverage; it means only that the information furnished to the Program at the time indicates that the requested services, supply, prescription drug, equipment or treatment is Medically Necessary and not Experimental or Investigational. A pre-service claim must still meet all the other coverage terms, conditions and limitations. Coverage for any such pre-service claim may still be limited or denied if, when after the requested service, supply, or prescription drug, equipment, or treatment is completed and the Program receives a post-service claim, investigation shows that a benefit exclusion or limitation applies, that the claimant ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment, that out-of-network limitations apply, or any other basis specified in the Program applies to limit or exclude the claim.

After the claimant receives the benefits that were subject to the pre-service claim, the claimant must submit a post-service claim with the Program.

6. Post-service claims

In the case of a post-service claim, the Program shall notify the claimant of the Program's adverse benefit determination within a reasonable period of time, but not later than thirty (30) days after receipt of the claim. This period may be extended one time by the Program for up to fifteen (15) days, provided that the Program that such an extension is necessary due to matters beyond the control of the Program and notifies the claimant, prior to the expiration of the initial thirty (30) day period, of the circumstances requiring the extension of time and the date by which the Program expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least forty-five (45) days from receipt of the notice within which to provide the specified information. If the claimant fails to submit the required information, the claim will be denied, subject to appeal.

7. Calculating time periods

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

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

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

   A. Information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of diagnosis and treatment codes and corresponding meanings;

   B. The specific reason(s) for the adverse benefit determination, including any denial code along with its corresponding meaning, and a description of the Program's standard, if any, that was used in denying the claim;

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

   D. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

   E. A description of the Program's internal review procedures and appeal, and the Program's external review process and the time limits applicable to such procedures, as well as a statement of the claimant's right to bring any legal action with respect to an adverse benefit determination after an appeal or final internal adverse benefit determination.

   F. A statement that the claimant may review the claim file and, in addition, a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

G. The Program will also disclose the availability of, and contact information for the Arkansas Insurance Department's Consumer Assistance Program, *i.e.*:

Telephone: **800-852-5494 or 501-371-2640**

Fax: **501-371-2749**

Email: **insurance.consumers@arkansas.gov**

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

I. In the case of an adverse benefit determination by the Program concerning a claim involving urgent care, the information provided by the Program to the claimant may be given to the claimant orally within prescribed time frames given that a written or electronic notification is furnished to the claimant not later than seventy-two (72) hours after the oral notification.

J. if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request.

K. If the adverse benefit determination is based on a Medically Necessary determination or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Program to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

L. A statement that the claimant has the right to submit comments, documents, records, evidence, testimony and other information related to the claim for benefits.

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

9. Appeal of adverse benefit determinations

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

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

The Program will:

A. Provide claimants at least 180 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;

B. Provide claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

C. Provide a claimant, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;

D. Provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;

E. Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Program who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

F. Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

G. Provide for the identification of medical experts whose advice was obtained on behalf of the Program in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

H. Provide that the health care professional engaged for purposes of a consultation shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and

I. Provide, in the case of a claim involving urgent care, for an expedited review process pursuant to which—
   a. A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and
   b. All necessary information, including the Program's benefit determination on review, shall be transmitted between the Program and the claimant by telephone, facsimile, or other available similarly expeditious method.

J. The Program will provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Program (or at the direction of the Program) in connection with the claim as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided under this section to give the claimant a reasonable opportunity to respond prior to that date; and before issuing a final internal adverse benefit determination based on a new or additional rationale, the Program will provide to the claimant, free of charge, the rationale as soon as is possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided under paragraph 10 of this section to give the claimant a reasonable opportunity to respond prior to that date.

10. Timing of notification of benefit determination on review

    A. **Urgent care claims—**In the case of a claim involving urgent care, the Program shall notify the claimant of the Program's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the claimant's request for review of an adverse benefit determination by the Program.

    B. **Pre-service claims—**In the case of a pre-service claim, the Program shall notify the claimant of the Program's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. Because the Program provides for two appeals of an adverse determination, such notification shall be provided, with respect to any one of such two (2) appeals, not later than fifteen (15) days after receipt by the Program of the claimant's request for review of the adverse determination.

    C. **Post-service claims—**In the case of a post-service claim, except as provided for in appeals to the Board of Trustees, the Program shall notify the claimant of the Program's benefit determination on review within a reasonable period of time. Because the Program provides for two appeals of an adverse determination, such notification shall be provided, with respect to any one of such two appeals, not later than thirty (30) days after receipt by the Program of the claimant's request for review of the adverse determination.

11. Calculating time periods

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

12. Furnishing documents

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

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

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

    A. An adverse benefit determination on appeal shall include information sufficient to identify the claim involved (including the date of service, the healthcare provider, the claim amount (if applicable), and a description of the availability, upon request by claimant, to obtain the diagnosis code and the treatment code and the corresponding meaning of these codes);

    B. The specific reason or reasons for the adverse determination which shall include the denial code and its corresponding meaning, a discussion of the decision, as well as the description of the Program's standard, if any, used in the denial;

C. Reference to the specific Program provisions on which the benefit determination is based;

D. 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.

E. A description of the Program's mandatory second level appeal procedures, if any, the Program's external review process and the time limits applicable to such procedures and the claimant's right to obtain information about such procedures, contact information for the state insurance regulatory agency, and a statement of the claimant's right to bring any legal action with respect to a final internal adverse benefit determination;

F. if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination on appeal, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination on appeal and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request;

G. if the adverse benefit determination on appeal is based on Medically Necessary determination or Experimental or Investigational treatment or similar exclusion or limit under the Program, either an explanation of the scientific or clinical judgment for the determination, or a statement that such explanation will be provided free of charge upon request; and

H. A statement that the Program will provide upon request from the claimant the identification of any medical or vocational experts whose advice was obtained in making an adverse benefit determination on appeal (whether or not such advice was relied upon).

14. Failure to establish and follow reasonable claims procedures

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

Independent External Claims Review

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

Your claim is eligible for external review if either:

- The Program or its designee does not strictly adhere to all claim determination and appeal requirements under federal law (other than minor violations); or
- You have exhausted the standard levels of appeal and your appeal relates to:

a. An adverse benefit determination (ABD) by the Program, including a final internal ABD, that involves medical judgment (including, but not limited to those based on the Program's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or, its determination that a treatment is Experimental or Investigational), as determined by the external reviewer; or
b. A rescission, which is a retroactive cancellation or discontinuance of Coverage.

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

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

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

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

Notification of External Review

Rights and Assignment to Independent External Review Organization

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

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

You must provide the following information:

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

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

For example, you may provide:

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

Instructions for Sending Your External Review Request

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

MAXIMUS Federal Services

3750 Monroe Avenue, Suite 705

Pittsford, NY 14534

By Fax: 1-888-866-6190

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

Preliminary Review

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

This includes:

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

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

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

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

The final external review decision notice will contain:

- A description of the reason for the requested external review with sufficient information to identify the claim;
- The date the examiner received the external review assignment;
- References to evidence or documentation considered in decision;

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

Expedited Reviews

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

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

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

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

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

Translated brochures are available upon request, under CLAS standards

Legal Actions Following Appeals

Only after completing and exhausting all mandatory appeal levels, including external reviews, through the Program, does a Covered Member have the right to file a legal action on a final adverse benefit determination. No such action may be filed against the Program later than one (1) year from the date of the final adverse benefit determination on appeal, or external review. In addition, no legal action with respect to an adverse benefit determination under the Program may be brought by a provider, whether or not such provider has been appointed as an authorized representative.

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, they 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, they will be considered inactive, and their benefits will be terminated as defined in the Program.

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

Adv**anced 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 their 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, for a complete definition.

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

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

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

The Allowed Amount does not include charges used to satisfy the Member's Calendar Year Deductibles or copayment assessed under the Program's Major Medical Benefit or the Prescription

Drug Card Program. Charges used to satisfy the Member's applicable Calendar-Year Deductible or copayment will be deducted from the Allowed Amount.

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

Benefit means the benefit provided to Members of the Program.

Employee Benefit means the Benefit provided for eligible Employees.

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

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

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

1. The substance is often taken in larger amounts or over a longer period of time than was intended;
2. There is a persistent desire or unsuccessful efforts to cut down or control substance use;
3. There is a great deal of time spent in activities necessary to obtain the substance, use the substance, or recover from its effects, craving or strong desire to use the substance;
4. There is a problematic pattern of substance use leading to clinically significant impairment or distress as manifested by at least two of the following occurring in a 12-month period:
5. There is a recurrent use resulting in failure to fulfill major role obligations at work, school, home;
6. There is continued substance use despite having persistent or recurrent social or interpersonal problems;
7. Important social, occupational, or recreational activities are given up or reduced because of substance use;
8. There is recurrent substance use in situations in which it is physically hazardous;

   Substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance;
9. Tolerance, as defined by either of the following:
   A. A need for markedly increased amounts of the substance to achieve intoxication or desired effect,
   B. A markedly diminished effect with continued use of the same amount of substance.

10. Withdrawal, as manifested by either of the following:
    A. Characteristic withdrawal syndrome for the substance,
    B. Use of the substance or closely related substance is taken to relieve or avoid withdrawal symptoms.

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

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

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

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

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

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

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

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

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

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

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

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

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

- **An Employee's Spouse**—Not legally separated or divorced from the Employee;

- **An Employee's Child**—A dependent (other than the Employee's spouse) who is under the age of twenty-six (26) years; the term Child(ren) shall include:
    d. An Employee's natural child(ren) from birth until less than 26 years of age.
    e. An Employee's stepchild(ren), foster child(ren), adopted child(ren), or child(ren) under legal guardianship or legal custody, if such child depends primarily on the Employee for support and maintenance and lives with the Employee in a regular parent-child relationship.
    f. Adopted children and stepchildren ages 19 to 26 must have met the above requirements at the time the Child turned 19 to be considered an Eligible Dependent. Copies of supporting documentation will be required for these Dependents

Employee—means a person who is an active, regular employee of the Participating Employer, Actively Working for the Participating Employer in an employee/employer relationship.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Home Office means the Home Office of the Plan Administrator.

Home Setting means medical care provided in the home.

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

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

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

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

Illness means illness or disease and related medical conditions.

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

Injury means a bodily injury sustained accidentally by external means.

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

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

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

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

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

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

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

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

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

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

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 their 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.

No**n-PPO** means an out-of-network provider that does not participate in the Program's preferred provider network.

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

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

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

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

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

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

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

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

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

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

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

Plan (other than the Program) means any group insurance or group prepaid arrangement of Coverage, whether on an insured or uninsured basis, which provides benefits or services for, or by reason of medical, dental, or vision care or treatment, or any Coverage required or provided under,

or by any government program or law, including Medicare. Hospital indemnity benefits (provided on a non-expense incurred basis) of $30 per day or less are not included within the meaning of "Plan." Each policy, contract or other arrangement for providing benefits or services will be considered a separate Plan. If only a part of such policy, contract or other arrangement is subject to a provision similar to this provision, that part will be treated as one Plan and the remainder will be treated as a separate Plan.

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

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

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

Pregnancy means the state of a female after conception until delivery and/or until termination of gestation. **Provider** means a person or business that provides health care services to Covered Members.

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

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

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

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

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

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

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

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

You and Your means an Employee/Member covered by or in an Eligible Class for Employee Benefits.
A glossary of commonly used Health Coverage & Medical Terms is available at www.armuni.org/MHBP or by calling Customer Service at 501-978-6137.

Section 9: HIPAA

Definitions

The following definitions shall be used only for purposes of this Article. Other defined terms in this Article shall have the meanings given to them by the Privacy Regulations, or if there is no definition in the Privacy Regulations, by the Plan.

"Health Care Operations" means any of the activities of the Plan that would be within the definition of "Health Care Operations" in section 164.501 of the Privacy Regulations, but only to the extent the activities were actually undertaken by the Program.

"Individually Identifiable Health Information" means information that is Health Information, including demographic information collected from an individual, and (i) is created or received by the Program to carry out the administration functions it performs for the Program or by the Program; and (ii) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (iii) that identifies the individual, or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Protected Health Information includes information of persons living or deceased subject to the rule in 45 CFR 160.103.

"Privacy Notice" means the notice that is required by the Privacy Regulations to be distributed by the Program to participants regarding the privacy practices of the Program.

"Privacy Regulations" means regulations promulgated by the Department of Health and Human Services at 45 Code of Federal Regulations ("CFR") part 160 and 45 CFR part 164, as amended, to regulate the uses and disclosures of Protected Health Information as required by the Health Insurance Portability and Accountability Act of 1996, as amended.

"Protected Health Information" means Individually Identifiable Health Information: Except as provided in paragraph (ii) of this definition, that is:

(i) Transmitted by Electronic Media; maintained in any medium described in the definition of Electronic Media; or transmitted or maintained in any other form or medium.

(ii) Protected Health Information does not include Individually Identifiable Health Information in: education records covered by the Family Educational Right and Privacy Act, as amended, 20 U.S.C. 1232g; records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and Employment records held by the Program in its role as an employer, including enrollment and disenrollment information created by the Employer when performing enrollment functions. Enrollment and disenrollment information is held by the Program sponsor in the sponsor's capacity as Employer.

(iii) Genetic Information is considered PHI for purposes of the HIPAA Privacy Rule and cannot be used or disclosed for underwriting purposes.

Restrictions on Program Disclosures. The Program will not disclose Protected Health Information to the Employer, except in accordance with the provisions of this Article or as allowed in the Privacy Regulations. Specifically, the Program will:

1. Not disclose Protected Health Information to the Employer, except as permitted by this Article or as required by law;
2. Not disclose, and not permit an Insurer or HMO offering benefits under the Program to disclose, Protected Health Information to the Employer, except as otherwise permitted by this Article or the Privacy Regulations, unless such disclosure is listed as a permitted disclosure in the Privacy Notice;
3. Not disclose Protected Health Information to the Employer for the Employer's use in employment-related actions or decisions; and
4. Not disclose Protected Health Information to the Employer for the Employer's use or disclosure in connection with any other benefit or employee benefit plan of the Employer without the Member's authorization.

Permitted Uses and Disclosure of Summary Health Information .

The Program (or Claims Administrator of the Program) may disclose Summary Health Information to the Employer, provided the Employer requests the Summary Health Information for the purpose of (i) obtaining premium bids for insurance coverage under the Program; or (ii) modifying amending, or terminating the Program. "Summary Health Information" means: information that (i) summarizes the claims history, claims expenses or type of claims experienced by individuals for whom an Employer had provided health benefits under a health plan; and (ii) from which the information described at 42 CFR Section 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR Section 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP Code.

Permitted Program Disclosures .

The Program may disclose Protected Health Information to the Employer for Program administration purposes, but only after the Employer certifies to the Program that the Program amendments required by the Privacy Regulations to allow such disclosures were made. "Program administration purposes" means administration functions performed by the Employer on behalf of the Program, such as quality assurance, claims processing, auditing, and monitoring. Program administration functions do not include functions performed by the Employer in connection with any other benefit or benefit plan of the Employer, and they do not include any employment-related function. Notwithstanding the provisions of this Program to the contrary, in no event shall the Employer be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR Section 164.504(f) or 45 CFR Section 164.502(a)(5)(i).

Employer Disclosures to an Agent.

The Employer will not disclose Protected Health Information received from the Program to its agent, unless such agent has agreed, in writing, to the same restrictions and conditions that apply to the Employer with respect to such Protected Health Information.

Availability of Protected Health Information.

The Employer will make Protected Health Information available only as follows:

1. Access to Protected Health Information. The Employer will make available Protected Health Information in accordance with Section 164.524 of the Privacy Regulations. If the Program maintains an electronic health record of a Member's Protected Health Information, then the Member shall be entitled to request the receipt of such information in an electronic format.
2. Amendment of Protected Health Information. The Employer will make available Protected Health Information for amendment and incorporate any amendment to PHI in accordance with Section 164.526 of the Privacy Regulations.
3. Accountability of Protected Health Information. The Employer make available Protected Health Information to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Regulations.
4. Disclosure to the Department of Health and Human Services. The Employer will make its internal practices, books, and records relating to its uses and disclosures of Protected Health Information received from the Program available to the Secretary of Health and Human Services ("Secretary") or other officer or employee of the Department of Health and Human Services so delegated by the Secretary for purposes of determining compliance by the Program with respect to the Privacy Regulations.
5. Destruction of Protected Health Information. To the extent feasible, the Employer will return or destroy all Protected Health Information received from the Program that the Employer has retained in any form (and will retain no copies of such Protected Health Information) when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Employer will limit further uses and disclosures to those purposes that make the return or destruction of the information not feasible.

Employer Report to the Program.

The Employer will report to the Program any use or disclosure of Protected Health Information of which the Employer becomes aware that is inconsistent with the permitted uses and disclosures allowed in the Privacy Regulations.

Access by Individuals Responsible for Program Administration.

The Employer will give access to the Protected Health Information, if any, from the Program that is used by the Employer in the administration of the Program only to those employees of (or other persons under the control of) the Employer who must have access to the Protected Health Information, as identified by the Program pursuant to the Program's policies and procedures with respect to disclosure and use of the Program's Protected Health Information. The Program will create and maintain a list of the persons or classes of persons who will be allowed access to Protected Health Information pursuant to this Section, which list is incorporated in the Program by this reference. No other employees of the Employer or other persons under the control of the Employer shall have access to Protected Health Information that is held or used by the Employer.

Any person given access to Protected Health Information under this Section must abide by the terms of the Program with respect to disclosure and use of the Program's Protected Health

Information. Failure to follow the terms of the Program with respect to use or disclosure of Protected Health Information will result in actions being taken against the person in accordance with the Program's policies and procedures establishing sanctions for those violating the Program's policies and procedures about Protected Health Information. The Employer will ensure that to the extent its involvement is needed, it will ensure that the adequate separation required by section 164.504(f)(2)(iii) of the Privacy Regulations is established.

Restrictions on Employer's Uses and Disclosures.

The Employer may not use or disclose Protected Health Information it has received from the Program:

1. Other than as permitted by this Article, the Privacy Regulations and other applicable law.
2. For employment-related decisions or actions with respect to the individual identified in the Protected Health Information or members of his family.
3. In connection with any other benefit or employee benefit plan of the Employer without the Member's authorization.

Security Rule.

The Program will comply with the security regulations under HIPAA and shall be construed consistent with that purpose. For purposes of this section, the term "Electronic Protected Health Information" shall have the meaning set forth in Section 160.103 of the Privacy Regulations under HIPAA. The Program Sponsor agrees that if it creates, receives, maintains or transmits Electronic PHI (other than enrollment/disenrollment information and Summary Health Information and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR 164.508, which are not subject to these restrictions) on behalf of the covered entity will:

1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic Protected Health information that it creates, receives, maintains or transmits on behalf of the group health plan.
2. Ensure that adequate separation between the health plan and plan sponsor is supported by reasonable and appropriate security measures and that such firewall is supported by reasonable and appropriate measures.
3. Ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health information agrees to implement reasonable and appropriate security measures to protect the information; and
4. Report to the group health plan any security incident of which the plan sponsor becomes aware.

The Program agrees to disclose to the Employer Protected Health Information necessary for the Employer to comply with the requirements of the Medicare Modernization Act of 2003, including without limitation, 42 CFR § 423.884(b) and its filing requirements, and in turn the Employer agrees to comply with the Privacy Regulations and all other applicable law with regard to such Protected Health Information.

Adequate Separation Between Program and Employer.

The Employer shall allow only those workforce members specifically identified in the Program's privacy policy and procedures to have access to PHI. No other persons shall have access to PHI. These Employees shall only have access to and use PHI to the extent necessary to perform the plan administration functions that the Employer performs for the Program. In the event that any of these specified employees do not comply with the provisions of this Section that Employee shall be subject to disciplinary action by the Employer for non-compliance pursuant to the Employer's Employee discipline and termination procedures.

The Employer will ensure that the provisions of this Section are supported by reasonable and appropriate security measures to the extent that the designees have access to electronic PHI.

Certification.

This Section incorporate the provisions of 45 CFR Section 164.504(f)(2)(ii) and the Employer agrees to the conditions of the disclosures set forth herein.

Member's Right to Request Restrictions on Certain Disclosures.

A Member may request a restriction on the use or disclosure of the Member's Protected Health Information for treatment, payment or health care operations., The Program is generally not required to agree to the Member's request for restrictions, unless the disclosure (i) is to the Program for payment or health care operations and (ii) pertains to a health care item or service for which the health care provider was paid in full out-of-pocket.

Member's Right to be Notified of a Breach.

In the event that the Program or any of its business associates (as defined in Section 160.103 of the Privacy Regulations) discovers a breach of unsecured Protected Health Information, the Program shall notify each Member whose Unsecured Protected Health Information has been accessed, acquired or disclosed as a result of such breach. For purposes of this section a "breach" shall mean the acquisition, access, use, or disclosure of Protected Health Information in a manner not permitted under the Privacy Regulations which compromises the security or privacy of the Protected Health Information. Unsecured Protected Health Information means Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary of Health and Human Services.

EXHIBIT A

HIPAA PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU
MAY BE USED AND DISCLOSED AND
HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

This HIPAA Privacy Notice ("Notice") describes the obligations of the Program regarding the privacy of your Protected Health Information held by the Program pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH"). This Notice describes how your Protected Health Information may be used or disclosed as permitted under HIPAA or as required by law and to inform you of your privacy rights with respect to your Protected Health Information.

If you have any questions about this notice, please contact the Privacy Officer c/o Program Administrative Office, P.O. Box 188, North Little Rock, AR 72115, (501) 978-6137.

PROTECTED HEALTH INFORMATION

The HIPAA Privacy Rule protects only certain medical information known as "protected health information ("PHI")." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received from a health care provider, a health care clearinghouse, a health plan, or the employer on behalf of a group health plan that relates to:

(1) your past, present, or future physical or mental health or condition;
(2) the provision of health care to you; or
(3) the past, present, or future payment for the provision of health care to you.

Genetic information is considered PHI for purposes of these rules and federal law specifically prohibits the use or disclosure of your genetic information for underwriting purposes.

REQUIREMENTS UNDER HIPAA

We are required by law to:

- Make sure your PHI is kept private;
- Provide you with certain rights with respect to your protected health information;
- Give you this Notice of our legal duties and privacy practices with respect to your PHI; and
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:

The following categories describe different ways that we may use and disclose your PHI without your authorization. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- For Treatment. We may use or disclose your PHI to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we may disclose information about your prior prescriptions to a pharmacist to determine if prior prescriptions contraindicate a pending prescription.

- For Payment. We may use or disclose your PHI to determine your eligibility for Program benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Program, or to coordinate Program coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary or to determine whether the Program will cover the treatment. We may also share PHI with a utilization review or pre-certification service provider. Likewise, we may share PHI with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

- To Business Associates. We may contract with individuals or entities known as Business Associates to perform various functions on behalf of the Program or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, transmit, use and/or disclose your PHI, but only after the Business Associates agree in writing with the Program to implement appropriate safeguards regarding your PHI. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with the Program.

- For Health Care Operations. We may use and disclose your PHI for other Program operations. These uses and disclosures are necessary to run the Program. For example, we may use PHI in connection with: conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Program coverage; submitting claims for stop-loss (or excess loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Program administrative activities. However, we will not use your genetic information for underwriting purposes.

- Treatment Alternatives or Health Related Benefits and Services. We may use and disclose your PHI to send you information about treatment alternatives or other health related benefits and services that might be of interest to you.

- As Required By Law. We will disclose PHI about you when required to do so by federal, state or local law. For example, we may disclose PHI when required by national security laws or public health disclosure laws.

- To Avert a Serious Threat to Health or Safety. We may use and disclose your PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose PHI about you in a proceeding regarding the licensure of a

physician.

- To Program Sponsors. For the purpose of administering the Program, disclosure of PHI to certain employees may be necessary. However, those employees will only use or disclose that information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your PHI cannot be used for employment purposes without your specific authorization.

SPECIAL SITUATIONS:

- Disclosure to Health Program Sponsor. PHI may be disclosed for purposes of facilitating claims payments under that plan.

- Military and Veterans. If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.

- Workers' Compensation. PHI may be released for workers' compensation or similar programs but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or illness.

- Public Health Risks. As required by law, PHI may be disclosed for public health actions. These actions generally include the following:
    - to prevent or control disease, injury, or disability;
    - to report births and deaths;
    - to report child abuse or neglect;
    - to report reactions to medications or problems with products;
    - to notify people of recalls of products they may be using;
    - to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
    - to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

- Health Oversight Activities. PHI may be disclosed to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

- Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order. We may also disclose PHI about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain a court or administrative order protecting the information requested.

- Law Enforcement. PHI may be released if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement; about a death that is believed to be the result of criminal conduct; about criminal conduct at the Program, and in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

- Coroners, Medical Examiners and Funeral Directors. PHI may be released to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release PHI about Members of the Program to funeral directors as necessary to carry out their duties.

- National Security and Intelligence Activities. PHI may be released about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

- Protective Services for the President and Others. PHI may be disclosed to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

- Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release PHI about you to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

- Organ and Tissue Donation. If you are an organ donor, we may release your PHI to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

- Research. PHI may be disclosed to researchers when (1) the individual identifiers have been removed; or (2) when an institutional review board or privacy board (i) has reviewed the research proposal, and (ii) establishes protocols to ensure the privacy of the requested information, and approves the research.

- SUD Treatment Information. We will comply with the Final Rule modifying the Confidentiality of Substance Use Disorder (SUD) Patient Records regulations at 42 CFR Part 2 ("Part 2"). If we receive or maintain any substance use disorder treatment records from a Part 2 program as a result of a general consent you provide to the Part 2 program, we may use and disclose these records for treatment, payment, and health care operations purposes as set forth in this Notice and as permitted by the HIPAA Privacy Rule. If we receive or maintain your Part 2 program records through a specific consent you have provided, we will use and disclose these records only as expressly permitted by that specific consent as provided to us. In no event will we use or disclose your Part 2 program records, or provide testimony that describes the information contained in your Part 2 program records, in any civil, criminal, administrative, or legislative proceedings by an Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it has provided you with notice of the court order. We will also comply with the breach notification requirements for Part 2 records consistent with this Notice and the HIPAA Privacy Rule. You have a right to request an accounting of disclosures of disclosures involving Part 2 program records as set forth in this Notice.

REQUIRED DISCLOSURES:

We are required to make the following disclosures of your PHI.

- Governmental Audits. Disclosure of PHI is required to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with HIPAA Privacy Rule.

- Disclosures to Covered Persons. If you make a request to the Program, we are required to disclose the portion of your PHI that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your PHI where the disclosure was for reasons other than for payment, treatment or health care operations, and where the PHI was not disclosed pursuant to your individual authorization.

OTHER DISCLOSURES:

- Personal Representatives. We may disclose your PHI to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide a written authorization and any supporting documents (i.e., power of attorney) specifically authorizing the disclosure of such PHI to such personal representative. Under the HIPAA Privacy Rule, we do not have to disclose information to a personal representative if we have a reasonable belief that (1) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; (2) treating such person as your personal representative could endanger you; or (3) in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

- Spouses and Other Family Members. In most cases, Program communications will be mailed directly to the employee, including mail relating to an employee's spouse or children who may be covered under the Program. The Program communications sent to the employee may include information relating to the receipt or denial of Program benefits by the employee's spouse or children. However, if we receive (and agree to) a Request for Restriction or Confidential Communications, we will send the Program communications as provided in the Request for Restriction or Confidential Communications. For more information regarding a Request for Restriction or Confidential Communications see the section titled "YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU" below.

DISCLOSURES REQUIRING AUTHORIZATION:

We may use or disclose your PHI in the following circumstances only upon receiving a valid authorization from you:

- Psychotherapy Notes. Except as otherwise permitted by law any PHI which includes psychotherapy notes may be used or disclosed only if you provide a valid authorization permitting such use or disclosure.

- Marketing. We may use or disclose your PHI for marketing purposes (including subsidized treatment communications) only if you provide a valid written authorization permitting such use or disclosure. However, a valid authorization is not required if the marketing activities are in the form of (1) face-to-face communications or (2) a promotional gift of nominal value.

- Sales. Your valid authorization is required for any use or disclosure of your PHI which would constitute a sale of PHI within the meaning of 45 CFR 164.501.

Other uses and disclosures of PHI not covered by this notice or as required by law will be made only with your written authorization. If you provide us with authorization to use or disclose PHI, you may revoke that authorization, at any time as long as the revocation is in writing. Upon receiving the written revocation, we will no longer use or disclose such PHI for the reasons covered pursuant to the written authorization. However, we are unable to take back any disclosures already made with your authorization.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU:

You have the following rights regarding your PHI maintained by the Program and any requests may be made to the Program care of Privacy Officer c/o Program Administrative Office, P.O. Box 188, North Little Rock, AR 72115, (501) 978-6137.

- Right to Inspect and Copy. You have the right to inspect and copy PHI that may be used by the Program to make decisions about your group health coverage. Usually, this includes medical and billing records. If the Program maintains an electronic record of your PHI, you have the right to request the receipt of that information in the electronic form and format that you request, if the information can be readily produced in that form and format. If the information cannot be readily produced in that form and format, we will work with you to come to an agreement on the form and format. If we cannot agree on an electronic form and format, we will provide you with a paper copy.

  To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Program.

  If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing or other supplies associated with your request. You may also ask for the PHI to be sent to a third party. Your request must be in writing and signed and clearly identify the third party who will receive the information. Generally, we will respond to your request within 30 days after we receive it; if we need more time, we will notify you within the original 30-day period.

  We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to PHI you may request that the denial be reviewed by submitting a written request to the Program. Another individual chosen by the Program will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

- Right to Amend. If you feel that PHI we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Program.

  To request an amendment, your request must be made in writing and submitted the Program. In addition, you must provide a reason that supports your request.

  We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the request may be denied if it is to amend information that:

  - Was not created by the Program, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the medical information kept by or for the Program;
  - Is not part of the information which you would be permitted to inspect and copy; or
  - Is accurate and complete.

  We will respond to the request for an amendment within 60 days after receiving the request unless we notify you, in writing, that a 30 day extension is necessary to complete the response. If

the request is denied, you have the right to file a statement of disagreement with the Program and any future disclosures of the disputed information will include such statement.

- Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures the Program has made of your PHI. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permitted disclosures about you. However, to the extent that we use or maintain an Electronic Health Record of your PHI, you may request an accounting of disclosures made to carry out treatment, payment or health care operations but only with regard to disclosures made within three years prior to the date on which the accounting is requested.

  To request this list or accounting of disclosures, you must submit your request in writing to the Program. Your request must state the time period you want the accounting to cover, which may not be longer than six (6) years before the date of your request. The request should indicate in what form to provide the list (for example, on paper, electronically). Generally we will respond to your request within 60 days. The first list you request within a twelve (12) month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- Right to Request Restrictions. You have the right to request a restriction or limitation on your PHI that the Program uses or discloses for treatment, payment or health care operations. You also have the right to request a limit on your PHI disclosed to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a treatment you received.

  We are not required to agree to your request. However, we will comply with a request for restriction if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and not for purposes of carrying out treatment) and (2) the PHI pertains to a health care item or service for which the health care provider was paid in by you or another person. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

  To request restrictions, you must make your request in writing to the Program. In your request, you must state (1) what information to limit; (2) whether to limit the use, disclosure or both; and (3) to whom the limits should apply, for example, disclosures to your spouse. You will be provided a written response detailing whether the Program agrees to or rejects the proposed restriction.

- Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

  To request confidential communications, the request must be in writing to the Program. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- Right to be Notified of a Breach. You have a right to be notified in the event that we or any of our

Business Associates discover a breach of your unsecured protected health information.

- Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

  To obtain a paper copy of this notice, please contact the Program.

CHANGES TO THIS NOTICE:

This notice may be changed at any time and may include new provisions regarding your PHI maintained by the Program, as allowed or required by law. If any material change is made to this notice, you will be provided with a copy of the revised notice via intranet posting or by mail to your last known address on file.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with the Program or with the Office of Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Program, contact the Privacy Officer. All complaints must be submitted in writing.

You will not be penalized or in any other way retaliated against for filing a complaint with the Office of Civil Rights or with us.