2019 Municipal Health Benefit Program and Municipal League Workers’ Compensation Program Seminar

Wednesday, November 13, 2019
### Municipal Health Benefit Program (MHBP) and Municipal League Workers’ Compensation Program (MLWCP)

**What Members Need to Know Seminar**

**Wednesday, November 13, 2019**  
**Wyndham Hotel – Silver City Rooms 6-7**  
**2 Riverfront Place, North Little Rock, AR**

#### Session 1: Municipal Health Benefit Program (MHBP)

<table>
<thead>
<tr>
<th>Time</th>
<th>Session Title</th>
<th>Presenter/Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00 a.m. – 9:05 a.m.</td>
<td>Welcome and Opening Remarks</td>
<td>Mayor Harold Perrin, League President City of Jonesboro</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Whitnee V. Bullerwell, Deputy Director Arkansas Municipal League</td>
</tr>
<tr>
<td>9:05 a.m. – 9:30 a.m.</td>
<td>Overview of MHBP and MLWCP</td>
<td>Mark R. Hayes, Executive Director Arkansas Municipal League</td>
</tr>
<tr>
<td>9:30 a.m. – 9:35 a.m.</td>
<td>Introduction of MHBP Staff</td>
<td>Katie Bodenhamer, MHBP General Manager and Legal Counsel Arkansas Municipal League</td>
</tr>
<tr>
<td>9:35 a.m. – 10:15 a.m.</td>
<td>MHBP Plan Changes for 2020 and Benefits Overview</td>
<td>Katie Bodenhamer, MHBP General Manager and Legal Counsel Arkansas Municipal League</td>
</tr>
<tr>
<td>10:15 a.m. – 10:30 a.m.</td>
<td>Break</td>
<td></td>
</tr>
<tr>
<td>10:30 a.m. – 11:30 a.m.</td>
<td>eDocAmerica Demonstration</td>
<td>Matt Henry, Vice President of Sales and Marketing, eDocAmerica</td>
</tr>
<tr>
<td></td>
<td>Pharmacy Benefits</td>
<td>Dwight Davis, Director of Evidence-Based Prescription Drug Program (EBRx)</td>
</tr>
<tr>
<td></td>
<td>American Fidelity Assurance</td>
<td>Charles Angel, Public Sector Director American Fidelity Assurance</td>
</tr>
<tr>
<td></td>
<td>Eyemed</td>
<td>Blair Paterson, National Account Manager</td>
</tr>
<tr>
<td>Time</td>
<td>Event</td>
<td>Presenter</td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------------------------------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>11:30</td>
<td>Eyemed</td>
<td></td>
</tr>
<tr>
<td>-</td>
<td>Frequently Asked Questions (FAQs)</td>
<td>MHBP Staff</td>
</tr>
<tr>
<td>11:45</td>
<td>Annunciation of Door Prize Winners</td>
<td>MHBP Staff</td>
</tr>
<tr>
<td>12:00</td>
<td>Lunch/Networking</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Municipal Health Benefit Program (MHBP) and</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Municipal League Workers’ Compensation Program (MLWCP)</td>
<td></td>
</tr>
<tr>
<td>12:45</td>
<td>Introduction of MLWCP Staff</td>
<td>Katy Busby, MLWCP</td>
</tr>
<tr>
<td>12:50</td>
<td>Return to Work Initiative</td>
<td>Katy Busby, MLWCP</td>
</tr>
<tr>
<td>1:45</td>
<td>Workers’ Compensation 101</td>
<td>Katy Busby, MLWCP</td>
</tr>
<tr>
<td>1:45</td>
<td>Return to Work Initiative</td>
<td>Katy Busby, MLWCP</td>
</tr>
<tr>
<td>1:45</td>
<td>Workers’ Compensation 101</td>
<td>Katy Busby, MLWCP</td>
</tr>
<tr>
<td>2:45</td>
<td>Return to Work Initiative</td>
<td>Katy Busby, MLWCP</td>
</tr>
<tr>
<td>3:00</td>
<td>Frequently Asked Questions (FAQs)</td>
<td>MLWCP Staff</td>
</tr>
<tr>
<td>3:15</td>
<td>Annunciation of Door Prize Winners</td>
<td>MLWCP Staff</td>
</tr>
<tr>
<td>3:30</td>
<td>Closing Remarks</td>
<td>Mark R. Hayes, Executive Director Arkansas Municipal League</td>
</tr>
</tbody>
</table>
AN OVERVIEW

Municipal Health Benefit Program
MHBP: What is the Health Program?

- Self-funded health plan: NOT TRADITIONAL INSURANCE
- Risk-sharing pool made up of cities and other public entities
- Governed by a Board of Trustees
- Responsible for providing medical, dental, and vision benefits to our Groups’ employees and officials
How is MHBP administered?

- Mostly in-house administration
- Enrollment & Eligibility
- Claims Adjudication and Clinical Review
- Provider Relations: build own network, contract directly with providers
- Customer Service
Health Benefit Plan

- Policy Document included in MHBP Booklet
- Online at arml.org/mhbp
- City/Group HR Director
- Contact MHBP
Enrollment & Eligibility

ENROLLING IN MHBP
Enrollment/Change/Termination

- Enrollment in the Plan
- Coverage Declination
- Add/Drop Dependent
- Cancel Coverage
- Address/Name Change
- Coverage Change (Individual/Family)
- Status Change (Marriage/Divorce)
- Employee Termination
If any employee or their dependent has coverage in addition to MHBP for medical, dental or vision, the employee must provide that information on the Multiple Coverage Inquiry form.

If the additional coverage is cancelled, this form must be completed to notify MHBP of the change.

Failure to provide this information can result in claims being delayed or denied.
Certificate of Notice

- Acknowledges that an employee has accepted the health benefit plan
- Reviewed, signed and returned to the HR Department upon employment
When is Coverage Effective?

For new employees, you will become eligible for benefits the 1st day of the calendar month following 60 days of employment.

E.g. Hired on January 6th, coverage is effective April 1st (60 days from January 6th is March 6th).
Change No. 1
Enrollment & Eligibility

- May now add any “ward” to family coverage if you can show proof of legal guardianship or legal custody (previously, other than a child, a stepchild, or adopted child, you could only add a grandchild under legal guardianship or custody to “dependent only” coverage)
Codified the **Supporting Documentation** required for certain Qualifying Events:

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

- Adding an Eligible Dependent through Birth or Adoption—copy of the birth certificate, certificate or record of live birth, Adoption decree, or social security card

- Adding an Eligible Dependent through Court-Order—copy of the court order obligating Employee to cover an Eligible Dependent
Benefits

MHBP COVERAGE
Major Medical Benefits

- Individual Medical Coverage - Lifetime Coverage, No Maximum Dollar Limit
- In-Patient Hospitalization - 30 Days Per Year
- Bariatric Weight Loss Program
- Chemical Dependency Treatment – 1 Treatment Plan Per Lifetime
- Non-Emergency Surgeries – 2 Per Year
- Hearing Aids – 1 Per Ear, Every 3 Years (limited to $1,400 for each hearing aid)
- Home Health Services - 20 Visits Per Year
- Nutritional and Weight Counseling – 2 Visits Per Year
- Outpatient Occupational, Physical, Speech, Habilitative and Chiropractic Services – 40 Visits Per Year (Note: This is a combined benefit)
- Sleep Study – 1 Night Per Year
- Mental/Nervous Disorders
  - Inpatient Stay - 10 Days Per Year
  - Individual Therapy Sessions - 24 Visits Per Year
An office visit is a problem-focused appointment with a medical provider designed to discuss new or existing health problems or symptoms.

- Cold, flu, chronic disease management, new patient assessment, etc.
- $20.00 co-payment, and then the Fund picks up the costs at 100%
- Co-payment does not apply to deductible
Preventative Care Program

MHBP offers annual routine wellness benefit

Reimbursed at 100% of the Allowable Amount

No deductible, copayment or insurance
Preventative Services

- Mammogram — one (1) per calendar year, including 3D mammograms
- PAP Screening — one (1) per calendar year
- PSA (Prostate Specific Antigen test) — one (1) per calendar year
- TB
- Chest X-Ray (front and lateral)
- Well Baby Care/Well Child Care Visits
New Preventative Service

Colon-Rectal Examinations — Coverage for medically-recognized screening examination for the detection of colorectal cancer for

- Members forty-five (45) years of age or older every 10 years
- Members who are less than forty-five (<45) years of age and that have a family or personal history of colorectal cancer every 3 years

Screenings include annual fecal occult blood tests and a colonoscopy and/or flexible sigmoidoscopy (examination of the large intestine), including COLOGARD (excludes coverage for virtual colonoscopies)
Pharmacy Benefit

- Generic Drugs -- $10.00 co-payment
- Preferred Brand Name Drugs -- $30.00 co-payment
- Non-Preferred Brand Name Drugs -- $50.00 co-payment
- Specialty Drugs:
  - Drug Cost < $1,000/30 days -- $100.00 co-payment
  - Drug Cost > $1,000/30 days -- $200.00 co-payment
<table>
<thead>
<tr>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partnered with Eyemed</td>
</tr>
<tr>
<td>$30 co-pay</td>
</tr>
<tr>
<td>$100 frame/contact lens allowance,</td>
</tr>
<tr>
<td>percentage off balance over $100</td>
</tr>
<tr>
<td>Wal-Mart Vision centers</td>
</tr>
<tr>
<td>Expanding network</td>
</tr>
</tbody>
</table>
How MHBP Pays Benefits

**Deductible**
- Amount you must pay before benefits begin. The deductible starts over each January, and does not apply to preventative care services.

**Co-Payment**
- $20 Co-payment for Office Visits (does not apply to preventative and specialty programs)
- $250 Co-payment for Emergency Room. Waived if admitted.

**Coinsurance**
- 20% Coinsurance In-Network; 50% Usual & Customary Out-of-Network

**Out-of-Pocket Maximum**
- Out-of-Pocket calendar year maximum is $4,000 for in-network providers (excluding out-of-state providers); no maximum for out-of-network providers**
- Co-payments, deductibles, balance-billing and penalty charges are not included in the out-of-pocket maximum
Preferred Provider Network

MHBP builds and maintains its own provider network

Contract directly with providers and health organizations

In-network benefits are higher; 80/20 split, pay negotiated rate

Always expanding the network; utilize one-time agreements
Out of Network Benefit

- 50% of usual and customary for non-emergency services
- 80% of usual and customary for emergency services
- Fair Market Pricing
 Appeals

» If you disagree with a determination regarding your benefits, you have the option to appeal.
» First level appeal will be reviewed by the Claims Review Team.
» Second level appeal will be reviewed by the Board of Trustees.
» Certain claims may be appealed externally after Board adjudication.
Customer Service

HERE TO HELP YOU
What can we do to help our members?

- Offer Case Management
- Verify if pre-certification is required
- Address and resolve any balance billing issues
- Clarify our benefits
- Verify our preferred provider network
Common Mistakes That Cost Money

- Failure to pre-certify a procedure.
- Using the emergency room for non-emergency events
- Going out of network—know before you go, check the status of your provider
- Failing to add a dependent to coverage in a timely manner
- Paying a provider bill before receiving your EOB
Money Saving Tips

- Call MHBP Customer Service to verify coverage of any procedure BEFORE it's provided.
- Carry the minimum medical coverage (Personal Injury Protection) on your automobile insurance.
- Turn in Accident Claim Forms and all other required documentation requested by MHBP.
- To ensure coverage when traveling, purchase “Travel Insurance” when visiting somewhere out of the country.
### Municipal Health Benefit Program

- **Option 1**: Pre-certification
- **Option 3**: In-network Providers
- **Option 6**: Customer Service
- **Option 7**: Premium Information

Municipal Health Benefit Program
(501)978-6137
Certificate of Notice and Acceptance of Plan Provisions
Public Health Service Act Exemptions
Continuation of Coverage (COBRA)
Beneficiary Designation
Effective December 1, 1981 (as Amended Each Plan Year)

You must sign this form on your behalf and your dependents.
You must return this signed form to your employer.
If you do not sign and return this form to your employer the Program will not provide you or your dependents with coverage.
When you sign the form you are agreeing that you have received a copy of the Privacy Notice and the Summary of Benefits and Coverage (SBC). These are two separate documents.
By signing the form you also acknowledge that you may obtain a copy of the Municipal Health Benefit Program Booklet at www.arml.org/mhbp and that you agree to accept the terms and conditions of the Municipal Health Benefit Program.
The Program’s Plan is subject to Federal law, including, the Patient Protection and Affordable Care Act and the Consolidated Omnibus Budget Reconciliation Act of 1987 (COBRA). COBRA provides for the extension of coverage under the Plan should certain special life events take place. (See the Declaration of Trust on page 1 of the Program Booklet for more information).
Federal law also allows the Program to exempt the Program from some requirements imposed by Federal law. The Program has done so. (See page 1.)

You further acknowledge that although the Plan may have provided benefits for an illness or condition in past years, the Plan does not necessarily provide benefits for those illnesses or conditions in subsequent Plan years.
By signing below you authorize any hospital, physician or health care provider and/or payer to furnish any information requested by the Municipal Health Benefit Program that may be necessary to determine benefits payable.
Your authorization for the release of records to determine benefits payable also provides for the release of records of your eligible covered dependents. Your authorization shall remain in effect until changed or updated by you or the Plan. An electronic or photo-static copy of this authorization shall be considered effective and valid as the original for purposes of medical authorization only.
You may revoke your medical authorization on your behalf or that of your eligible covered dependent by providing a written revocation to the Program.
If you or your eligible dependent(s) changes their coverage status by dropping coverage or changing coverage to a different group then a new certificate must be signed. All new employees are required to execute this Certificate of Notice and Acceptance of Plan Provisions.

Member/Employee: ___________________________ Signature of Member (Includes Retiree or COBRA Member) ___________________________ Social Security Number

Member/Employee: ___________________________ Print Your Full Member Name ___________________________ Date of Birth

Home Telephone Number: ___________________________ Date Signed: ___________________________

Please list a Beneficiary and their relationship to you for your Life Benefits

Beneficiary: ___________________________ Print Name Clearly ___________________________ S=Spouse C=Child SC=Step Child AC=Adopted Child

Beneficiary’s Date of Birth ___________________________

This portion is to be completed by Employer Representative and mailed to:
Municipal Health Benefit Program, P.O. Box 188, North Little Rock, AR 72115

City/Entity of: ___________________________

Group Representative: ___________________________

This form should be returned to your Employer.
The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-501-978-6137 or visit www.arml.org/services/mhbp/. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-501-978-6137 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$500, $1,200, or $2,000/individual; or $6,000/family</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Preventive care services are covered before you meet your deductible.</td>
<td></td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don't have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>For network providers $4,000 individual / $8,000 family; for out-of-network providers there is no limit. For pharmacy providers $2,600 individual / $5,200 family</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Copayments, deductibles, premiums, balance-billing charges, penalties for failure to precertify, out-of-state and out-of-network care and health care this plan doesn't cover.</td>
<td>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.arml.org/services/mhbp">www.arml.org/services/mhbp</a> or call 1-501-978-6137 for a list of network providers.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a healthcare provider's office or clinic</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>$20 \text{ copayment/visit and } 20% \text{ coinsurance}</td>
<td>$20 \text{ copayment/visit and } 50% \text{ coinsurance}</td>
<td>You may have to pay for services that aren’t preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Your deductible does not apply to copayments.</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>$20 \text{ copayment/visit and } 20% \text{ coinsurance}</td>
<td>$20 \text{ copayment/visit and } 50% \text{ coinsurance}</td>
<td></td>
</tr>
<tr>
<td>Other practitioner office visit</td>
<td>$20 \text{ coinsurance}</td>
<td>50% \text{ coinsurance}</td>
<td></td>
</tr>
<tr>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>50% \text{ coinsurance}</td>
<td></td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% \text{ coinsurance}</td>
<td>50% \text{ coinsurance}</td>
<td>You may have to pay more for out-of-network diagnostic tests, even if they were ordered by in-network providers. Coverage limited to 2 PET scans/year.</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% \text{ coinsurance}</td>
<td>50% \text{ coinsurance}</td>
<td></td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>More information about prescription drug coverage is available at <a href="http://www.arml.org/services/mhbp/">www.arml.org/services/mhbp/</a> and in section 3 of your policy booklet.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic drugs</td>
<td>$10 \text{ copay/prescription}</td>
<td>Not covered</td>
<td>Coverage limited to a 30-day supply per prescription. Your deductible does not apply to copayments for any prescription drugs of any type.</td>
</tr>
<tr>
<td>Preferred brand drugs</td>
<td>$30 \text{ copay/prescription}</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Non-preferred brand drugs</td>
<td>$50 \text{ copay/prescription}</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Reference-Priced drugs</td>
<td>Total cost of the dispensed drug less the total cost of the reference drug per prescription</td>
<td>Not covered</td>
<td>Coverage is limited to a 30-day supply per prescription. This difference in total costs is considered a penalty, and will not count towards your deductible. Coverage is limited to a 30-day supply per prescription and you must pre-certify by calling 844-853-9400.</td>
</tr>
<tr>
<td>Specialty drugs up to $1,000</td>
<td>$100 \text{ copay/prescription}</td>
<td>Not covered</td>
<td>Coverage is limited to a 30-day supply per prescription and you must pre-certify by calling 844-853-9400.</td>
</tr>
<tr>
<td>Specialty drugs over $1,000</td>
<td>$200 \text{ copay/prescription}</td>
<td>Not covered</td>
<td>Coverage is limited to a 30-day supply per prescription and you must pre-certify by calling 844-853-9400.</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% \text{ coinsurance}</td>
<td>50% \text{ coinsurance}</td>
<td>Coverage for non-emergency surgery is limited to 2 surgeries annually. You must pre-certify by calling 888-295-3591. There is a $1,500 penalty deductible for failure to pre-certify.</td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>20% \text{ coinsurance}</td>
<td>50% \text{ coinsurance}</td>
<td></td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td></td>
<td></td>
<td>$250 \text{ copayment} is waived if admitted to inpatient hospital. Your deductible does not apply to copayments.</td>
</tr>
<tr>
<td>Emergency room care</td>
<td>$250 \text{ copay/visit and } 20% \text{ coinsurance}</td>
<td>$250 \text{ copay/visit and } 20% \text{ coinsurance}</td>
<td></td>
</tr>
</tbody>
</table>

Questions: Call 501-978-6137 or visit www.arml.org/services/mhbp/. For help understanding any of the underlined terms used in this document, please see the Glossary located at https://www.healthcare.gov/sbc-glossary/ or call 501-978-6137 to request a free copy.
<table>
<thead>
<tr>
<th>If you need immediate medical attention</th>
<th>Emergency medical transportation</th>
<th>20% coinsurance</th>
<th>20% coinsurance</th>
<th>Coverage is limited to 2 ground and 2 air transports annually.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Urgent care</td>
<td>$20 copay/visit and 20% coinsurance</td>
<td>$20 copay/visit and 20% coinsurance</td>
<td>Your deductible does not apply to copayments.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Coverage is limited to 30 days annually. You must pre-certify by calling 888-295-3591. There is a $1,500 penalty deductible for failure to pre-certify.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Coverage is limited to 24 visits annually.</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient mental/behavioral health services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Coverage is limited to 10 days annually. You must pre-certify by calling 888-295-3591. There is a $1,500 penalty deductible for failure to pre-certify.</td>
</tr>
<tr>
<td></td>
<td>Inpatient mental/behavioral health services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Coverage is limited to 1 treatment plan, whether inpatient or outpatient, per lifetime at MHBP Designated Chemical Dependency Centers. You must pre-certify by calling 888-295-3591. Consult section 2 of your policy booklet for more information.</td>
</tr>
<tr>
<td></td>
<td>Substance abuse disorder services -- inpatient/outpatient</td>
<td>20% coinsurance</td>
<td>Not covered</td>
<td>Coverage is limited to 1 treatment plan, whether inpatient or outpatient, per lifetime at MHBP Designated Chemical Dependency Centers. You must pre-certify by calling 888-295-3591. Consult section 2 of your policy booklet for more information.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>$20 copay on first visit and 20% coinsurance</td>
<td>$20 copay on first visit and 50% coinsurance</td>
<td>Postnatal care extends up to 90 days post-delivery. You must pre-certify an extended inpatient stay by calling 888-295-3591. There is a $1,500 penalty deductible for failure to pre-certify. Your deductible does not apply to copayments.</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Coverage is limited to 20 visits annually. You must pre-certify by calling 888-295-3591. There is a $1,500 penalty deductible for failure to pre-certify.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Coverage is limited to 30 days for acute care and 15 days for sub-acute care annually. You must pre-certify by calling 888-295-3591. There is a $1,500 penalty deductible for failure to pre-certify.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Coverage is limited to 30 days for acute care and 15 days for sub-acute care annually. You must pre-certify by calling 888-295-3591. There is a $1,500 penalty deductible for failure to pre-certify.</td>
</tr>
</tbody>
</table>

Questions: Call 501-978-6137 or visit www.armi.org/services/mhbp/. For help understanding any of the underlined terms used in this document, please see the Glossary located at https://www.healthcare.gov/sbc-glossary/ or call 501-978-6137 to request a free copy.
<table>
<thead>
<tr>
<th>If you need help recovering or have other special health needs</th>
<th>Habilitation services</th>
<th>20% coinsurance</th>
<th>50% coinsurance</th>
<th>These services will be combined to allow a maximum of 40 visits annually with physical therapy, speech therapy, occupational therapy, and chiropractic services.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Coverage is limited to 15 days annually. You must pre-certify by calling 888-295-3591. There is a $1,500 penalty deductible for failure to pre-certify.</td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Pre-certification required for DME that's purchase price exceeds $2,000. Coverage is limited to 90 days per lifetime. You must pre-certify by calling 888-295-3591. There is a $1,500 penalty deductible for failure to pre-certify.</td>
<td></td>
</tr>
<tr>
<td>Hospice services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If your child needs dental or eye care</th>
<th>Children's eye exam</th>
<th>Not covered</th>
<th>Not covered</th>
<th>Not covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children's glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Children's dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

**Excluded Services & Other Covered Services:**

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.):**

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (adult)
- Routine foot care

**Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.):**

- Bariatric surgery is only covered under the MBS-AQIP Program. Please consult section 2 of your policy booklet for further information.
- Chiropractic care as a component of the 40-visit combined annual limit for all habilitation services.
- Hearing aids
- Weight loss program coverage is limited to two weight loss program visits annually, or only as otherwise covered under the MBS-AQIP Program. Please consult section 2 of your policy booklet for further information.
Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the Municipal Health Benefit Program at 501-978-6137, visit www.arml.org/services/mhbp/ or consult section 7 of your policy booklet.

Does this plan provide Minimum Essential Coverage? Yes.
If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes.
If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

To see examples of how this plan might cover costs for a sample medical situation, see the next section.
About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>The plan's overall deductible</td>
<td>$500*</td>
</tr>
<tr>
<td>Specialist copayment</td>
<td>$20</td>
</tr>
<tr>
<td>Hospital (facility) coinsurance</td>
<td>20%</td>
</tr>
<tr>
<td>Prescription copayment (generic)</td>
<td>$10/Rx</td>
</tr>
</tbody>
</table>

This EXAMPLE event includes services like:
- Specialist office visits (prenatal care)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (ultrasounds and blood work)
- Specialist visit (anesthesia)

**Total Example Cost**: $12,800

**In this example, Peg would pay:**

- **Deductibles**: $500*
- **Copayments**: $60**
- **Coinsurance**: $2,500

  **What isn't covered**

  - Limits or exclusions: $60

  **The total Peg would pay is**: $3,120

*Your deductible may be more than $500. These numbers are informative examples only and should not be considered cost estimators.

**Copayments include copayments for office visits as well as prescriptions, along with any other services listed in the table beginning on page 2 of this document that require copayments. These example scenarios may require the payment of multiple copayments (for example, for multiple visits or prescriptions) over time. The plan would be responsible for the other costs of these EXAMPLE covered services.

### Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>The plan's overall deductible</td>
<td>$500*</td>
</tr>
<tr>
<td>Specialist copayment</td>
<td>$20</td>
</tr>
<tr>
<td>Prescription copayment (generic)</td>
<td>$10/Rx</td>
</tr>
<tr>
<td>Prescription copayment (brand)</td>
<td>$30/Rx</td>
</tr>
</tbody>
</table>

This EXAMPLE event includes services like:
- Primary care physician office visits (including disease education)
- Diagnostic tests (blood work)
- Prescription drugs
- Durable medical equipment (glucose meter)

**Total Example Cost**: $7,400

**In this example, Joe would pay:**

- **Deductibles**: $500*
- **Copayments**: $800**
- **Coinsurance**: $600

  **What isn't covered**

  - Limits or exclusions: $60

  **The total Joe would pay is**: $1,960

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>The plan's overall deductible</td>
<td>$500*</td>
</tr>
<tr>
<td>Emergency room care copayment</td>
<td>$250</td>
</tr>
<tr>
<td>Hospital (facility) coinsurance</td>
<td>20%</td>
</tr>
<tr>
<td>Other coinsurance</td>
<td>20%</td>
</tr>
</tbody>
</table>

This EXAMPLE event includes services like:
- Emergency room care (including medical supplies)
- Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

**Total Example Cost**: $1,900

**In this example, Mia would pay:**

- **Deductibles**: $500*
- **Copayments**: $250**
- **Coinsurance**: $200

  **What isn't covered**

  - Limits or exclusions: $0

  **Limits or exclusions**: $0

  **The total Mia would pay is**: $950
New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn’t meet certain standards. The savings on your premium that you’re eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer’s health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the “minimum value” standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or contact: Municipal Health Benefit Fund, P. O. Box 188, North Little Rock, Arkansas 72115, 501-978-6137, or see www.arml.org/mhbf.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. The Municipal Health Benefit Fund plan exceeds the minimum value standard.
PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

Here is some basic information about health coverage offered by this employer:

• As your employer, we offer a health plan to:
  □ All employees.
  □ Some employees. Eligible employees are:

• With respect to dependents:
  □ We do offer coverage. Eligible dependents are:
  □ We do not offer coverage.

This coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.
The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**
   
   **Yes** (Continue)
   
   13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? __________ (mm/dd/yyyy) (Continue)

   **No** (STOP and return this form to employee)

14. This employer offers a health plan that meets the minimum value standard.
   (Go to question 15)

15. For the lowest cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
   a. How much would the employee have to pay in premiums for this plan? $
   b. How often? __Weekly __Every 2 weeks __Twice a month __Monthly __Quarterly __Yearly

   If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don’t know, STOP and return form to employee.

16. What change will the employer make for the new plan year?
   ______ Employer won't offer health coverage
   ______ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
   a. How much will the employee have to pay in premiums for that plan? $
   b. How often? __Weekly __Every 2 weeks __Twice a month __Monthly __Quarterly __Yearly

   Date of change (01/01/2018)

---

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)
By law, the Municipal Health Benefit Program (Program) is required to protect the privacy of your protected health information. 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.

Your Rights
You have the right to:

• Get a copy of your health and claims records
• Correct your health and claims records
• Request confidential communication
• Ask us to limit the information we share
• Get a list of those with whom we’ve shared your information
• Get a copy of this privacy notice
• Choose someone to act for you
• File a complaint if you believe your privacy rights have been violated

Your Choices
You have some choices in the way that we use and share information as we:

• Answer coverage questions from your family and friends
• Provide disaster relief
• Market our services and sell your information

Our Uses and Disclosures
We may use and share your information as we:

• Help manage the health care treatment you receive
• Run our organization
• Pay for your health services
• Administer your health plan
• Help with public health and safety issues
• Do research
• Comply with the law
• Respond to organ and tissue donation requests and work with a medical examiner or funeral director
• Address workers’ compensation, law enforcement, and other government requests
• Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

• You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
• We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
• We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
• We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

• You can ask us not to use or share certain health information for treatment, payment, or our operations.
• We are not required to agree to your request, and we may say “no” if it would affect your care.

Get a list of those with whom we’ve shared information

• You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
• We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation
- Contact you for fundraising efforts.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information for marketing purposes and never sell your information.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.
Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

*Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.** This does not apply to long term care plans.

*Example: We use health information about you to develop better services for you.*

Pay for your health services

We can use and disclose your health information as we pay for your health services.

*Example: We share information about you with your other insurance providers to coordinate payment.*

Administer your plan

We will not disclose your health information to your health plan sponsor for plan administration without your written authorization to do so.

*Example: The Plan Sponsor contracts with us to provide a health plan and we provide your Plan Sponsor with statistical data to explain the amount charged for coverage. We will not disclose your protected health information to the Plan Sponsor without your written authorization to do so.*

**How else can we use or share your health information?**
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone’s health or safety
Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers’ compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers’ compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).
Changes to the Terms of this Notice

This privacy notice is based upon “Model Notices of Privacy Practices” provided by the United States Department of Health and Human Services on their website as of September 19, 2017. HHS may change the regulatory law governing Privacy Practices or may change their model notice. If so, the MHBP will comply with the law and will change the terms of this notice. The changes will apply to all information we have about you. We will provide you with a copy of the new notice and the notice will be available on our web site.

Other Instructions for Notice

- September 19, 2017
- Privacy Official: Katie Bodenhamer, 501-374-3484, ext. 126, kbodenhamer@arml.org.
From simple health questions to a needed prescription, we are here to meet all of your telemedicine needs.

FREE Online and Telephone Access to Medical Professionals

No Co-pay Telemedicine

☎ 1-877-308-3362

In the State of Arkansas, it is currently law that the first consultation with a licensed telemedicine physician must be a live video consultation. This will require the patient to be logged into the eDocAmerica telemedicine portal where the video consultation will take place.

Once a patient has been through the first initial video consultation, the patient can choose to have future telemedicine consultations by phone or by video. If you are out of state, your first consultation can be by telephone.

- Call the toll-free number to schedule your confidential telephone or video consultation.
- Use it when you travel, available in all 50 states.
- If the physician writes a prescription, it will be called into your pharmacy of choice.
- Treat common ailments like colds, flu, allergies, pink eye, UTIs, sinus infections, headaches, sore throats, nausea, etc.

FREE Online Medical Team

🔗 eDocAmerica.com

Emailing a specialist is perfect for all your non-urgent, everyday life questions and needs. Ask anything, anytime and get a personal response on average within three hours.

- Go to www.eDocAmerica.com
- Click the "Sign In" button (top right corner)
- Either sign in or register your account
- In the center of the screen you will see the "Message A Specialist" option - click the "Start A Conversation Now"
- Choose the specialist and send in your question

Specialists available include primary care, psychologists, pharmacists, dentists, dietitians, trainers, pediatricians, dermatologists, women’s health, and more...

Services are unlimited and for the entire family. All interactions are completely private and confidential.
Municipal Health Benefit Program
Prescription Drug Program
Update for January 1, 2020

Dwight Davis, Pharm.D.
Director, Evidence-Based Prescription Drug Program (EBRx)
UAMS College of Pharmacy

November 13, 2019
Municipal Health Benefit Program
Prescription Drug Program Trend Analysis
2014 - YTD 2019*

* YTD 2019 = through October 2019
Snapshot of a few key cost-driving variables

• Generic drugs now account for 90% of MHBP’s total prescription
• Despite strong generic drug usage, the cost of Specialty drugs continue to increase
• Specialty drugs are used for such conditions as:
  • Rheumatoid Arthritis, Crohns Disease, Plaque Psoriasis
  • Multiple Sclerosis
  • Oncology / Cancer
  • Other conditions: Hereditary Angioedema, Pulmonary Hypertension, etc.
• Specialty Drugs account for 0.6% of MHBP’s total Rx claims and 40% of MHBP’s total spend (based on YTD through October 2019)
• The average cost of a specialty drug for MHBP is ~ $4,800/month. The average member co-payment for these drugs is $200/month.
Update for the MHBP Prescription Drug Program - 1/1/2020

• Closed Drug Formulary implemented in early 2018
• Ongoing Formulary management / clean-up
• No pharmacy-related changes for 1/1/2020
• Clinical Management Tools
  • Plan Exclusion
  • Coverage Policies / Prior Authorization
  • Dispensing/Quantity Limits
  • Step Therapy
  • Reference-Based Pricing
MHBP Drug Co-payment Structure

<table>
<thead>
<tr>
<th></th>
<th>Generic Drugs</th>
<th>Preferred Brand Name Drugs</th>
<th>Non-Preferred Brand Name Drugs</th>
<th>Reference-Based Priced Drugs</th>
<th>Specialty Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$10.00</td>
<td>$30.00</td>
<td>$50.00</td>
<td>Variable by Category</td>
<td>Drug Cost &lt; $1,000/30 days</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Drug Cost &gt; $1,000/30 days</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$100.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$200.00</td>
</tr>
</tbody>
</table>
Clinical Management Tools

• **Plan Exclusions** – all new drugs to market are excluded until reviewed and added to coverage. If there is no clinical reason to add the drug, it will remain excluded unless new information surfaces to support adding it to coverage. Examples are:
  • All new drugs to market (including cancer drugs and other specialty drugs)
  • Existing drugs (some anti-diabetic drugs, triglyceride agents, drugs where OTC equivalents are available (e.g. acid reflux agents, nasal steroids, etc.)

• **Coverage Policies** – written and enforced by EBRx. Pharmacists and physicians, through the EBRx prior authorization call center, assist prescribers with questions.
Clinical Management Tools (cont.)

• **Quantity Limits** - can be placed on specific drugs that may limit (1) # of units/Rx, (2) # of units per timeframe, or (3) # of units/day.

• **Step Therapy** – requires that certain conditions / medications be present before a particular drug can be used.

• **Reference-Based Pricing** – limits amount Plan will pay for a specific drug. Out of pocket costs for drugs associated with Reference-Based Pricing do not apply to the member’s out-of-pocket maximum limit.
Reference-Based Pricing Example

Plan Cost/Tablet

Member Pays

Plan Pays

Drug A

$0.75

Drug B

$0.30

Drug C

$2.50

Drug D

$3.25

Drug E

$4.40

Drug F

$4.10
Purpose of Management Approach

To protect the Program from the financial exposure related to expensive low-value drugs and/or unproven drugs.

In an effort to provide the most cost-effective drug therapy to Program participants, drugs are evaluated based on their safety and effectiveness as demonstrated in the peer-reviewed published literature. An evidence-based approach is used to help steer the Program’s drug coverage policy. Therefore, drugs not meeting certain standards are recommended for exclusion by the Program.

All policies related to this approach are reviewed and approved by the MHBP Board.
Information Regarding Prescription Drug Benefit

**On-line:**
Current version of Drug Formulary / Preferred Drug List – including Quantity Limits, Step Therapy, and Reference-Based Pricing are found on the MHBP website:

[www.arml.org](http://www.arml.org)/Services/Benefit Programs/Municipal Health Benefit Program

**Phone:**
Members may contact OptumRx at (855) 253-0843
Members have access to an OptumRx phone app for co-pay information
Physicians may contact EBRx (UAMS) at (833) 339-8401
The OptumRx app makes the online pharmacy experience as simple as possible. You can easily:

- Search drug prices at multiple pharmacies
- Locate a network pharmacy
- Manage medication reminders
- Access your ID card if your plan allows

Download the OptumRx app now from the Apple® App Store or Google Play™.
The OptumRx app: the most convenient way to manage your prescriptions.

Current
The OptumRx app gives you quick access to your plan’s most current drug coverage information.

Personalized
Access a complete profile of your prescriptions when you view My Medicine Cabinet. You can see all your recent and past prescriptions.

Save time and money
Compare prescription drug options and identify potential cost savings.
Bringing Clarity to Reimbursement Accounts
Understanding FSAs, HSAs, HRAs, and DCAs
Before We Get Into It…
Let’s talk about your employees’ healthcare finances

Potential Healthcare Concerns & Confusion:
• Out-of-pocket costs
• Personal/family annual healthcare spend
• Fear of large expense
• Long-term savings needs (i.e. into retirement)
Understanding Out-of-Pocket Costs

Every health plan has out-of-pocket responsibilities, the degree of coverage varies by plan option.

Costs Covered By Your Health Plan
- Preventative & well-visits
- Co-insurance (plan share)
- Post-deductible expenses

Costs YOU Must Pay Out-of-Pocket
- Deductibles
- Prescriptions
- Co-payments
- Dental & vision expenses
- Co-insurance (your share)

Reimbursement accounts help you minimize cost and maximize value for out-of-pocket spending.
How Reimbursement Accounts Work

An opportunity for employees and employers to save on taxes!

Contribute
Tax-free dollars, up to the IRS limit

Save
Employee’s spendable income stretches further based on individual’s tax bracket.

Spend
On qualified healthcare and dependent care expenses

Grow
Save and invest unused funds for future healthcare expenses

All Account Types: FSA, HSA, and HRA

HSA Only
Account Options

Understanding the options and what makes the most sense for you
**Health Savings Account (HSA)**
- Employee & Employer May Contribute
- Employee Owns the Account and can only access up to the amount contributed

**Flexible Spending Account (FSA)**
- Employee & Employer May Contribute
- "Use or Lose applies"

**Health Reimbursement Arrangement (HRA)**
- 100% Employer Funded
- May have out-of-pocket requirements
Benefits of Offering Reimbursement Accounts
Employer Savings

- **Employer Savings**
  - FICA tax savings
  - Pre-tax employee FSA contributions lower your payroll & FICA tax responsibilities.

- **Other Potential Tax Savings:**
  - Federal Unemployment Taxes (FUTA)
  - State Unemployment Taxes (SUTA)
  - Workers compensation taxes

---

Sample Employer Savings

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total # of FSA participants</td>
<td>200</td>
</tr>
<tr>
<td>Avg. annual employee election</td>
<td>$1,500</td>
</tr>
<tr>
<td>Estimated annual employer tax savings</td>
<td>$22,950</td>
</tr>
</tbody>
</table>

*For illustrative purposes only. Based on 7.65% FICA. Individual tax situations may vary. Please consult a tax advisor.*
Employee Savings

Lower taxable income:
- FSA contributions are made pre-tax - before federal, social security, and most state taxes, meaning:
- Employees can reduce their taxable income and maximize their take-home pay

Savings on qualified healthcare expenses:
- Reimbursement contributions allow employees to save when spending pre-tax dollars they otherwise wouldn’t have.

Sample Employee Savings*

<table>
<thead>
<tr>
<th>Federal Tax Rate</th>
<th>Annual FSA Contribution</th>
<th>Estimated Annual Employee Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>15%</td>
<td>$1,500</td>
<td>$475</td>
</tr>
<tr>
<td>15%</td>
<td>$2,600</td>
<td>$813</td>
</tr>
<tr>
<td>25%</td>
<td>$1,500</td>
<td>$625</td>
</tr>
<tr>
<td>25%</td>
<td>$2,600</td>
<td>$1,067</td>
</tr>
<tr>
<td>33%</td>
<td>$1,500</td>
<td>$745</td>
</tr>
<tr>
<td>33%</td>
<td>$2,600</td>
<td>$1,270</td>
</tr>
</tbody>
</table>

*For illustrative purposes only. Based on 7.65% FICA and 9% State Income Tax. Individual tax situations may vary. Please consult a tax advisor.
A Dig into FSAs
Flexible Spending Accounts
Tax-free savings for medical, dental, and vision

What is it?

An FSA is a tax-advantaged reimbursement account that allows you to save for eligible healthcare costs for this plan year.

<table>
<thead>
<tr>
<th>Max Election</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$2,650</td>
</tr>
</tbody>
</table>
What You Need to Know About FSAs

- FSA contributions lower employees’ taxable income, making each dollar stretch further, depending on the tax bracket of the employee.
- Full election amount is available first day of the plan year.
- Election changes require a qualifying event.
How Do FSAs Work

1. Employee determines annual election amount at open enrollment

2. Evenly deducted from each pay check on a pre-tax basis (if employer permits under their plan) and placed in employee’s account

3. Full amount available on day 1 of plan year to use on qualified out-of-pocket expenses
Using FSA Funds: Qualified Expenses

Qualified expenses include:

✓ Co-pays, coinsurance, deductibles
✓ Dental and orthodontia
✓ Eye exams, contact lenses, eyeglasses
✓ Prescriptions
✓ Over-the-counter medical supplies
✓ Lasik
Employee Benefit Debit Card Spending

• **Gives employees easy access to FSA funds:**
  - Works just like a standard debit card, but funds are spent from the employee’s FSA
  - Real time, on-demand access to funds

• **Use to purchase qualified healthcare products/services at:**
  - Physician & doctor offices
  - Hospitals
  - Pharmacies
  - Optometrists / vision care locations
  - Dental offices
  - And, even qualifying retail stores!
Example: Short-Term Savings Potential with an FSA

Let’s look at how your employees can save money today – even if they are only contributing a small amount!

<table>
<thead>
<tr>
<th></th>
<th>Not Enrolled in a FSA</th>
<th>Enrolled in a FSA</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before-Tax Annual Income:</td>
<td>$38,000</td>
<td>$38,000</td>
<td></td>
</tr>
<tr>
<td>FSA Contribution</td>
<td>$0</td>
<td>-$500</td>
<td>FSA funded by elected contribution</td>
</tr>
<tr>
<td>Taxable Annual Income:</td>
<td>$38,000</td>
<td>$37,500</td>
<td></td>
</tr>
<tr>
<td>Taxes (27.56%)</td>
<td>-$10,127</td>
<td>-$9,994</td>
<td>Pay less in Federal, state &amp; FICA taxes</td>
</tr>
<tr>
<td>Out-of-Pocket Medical Expenses</td>
<td>-$500</td>
<td>$0</td>
<td>Out-of-pocket medical expenses paid by your FSA</td>
</tr>
<tr>
<td>Take-Home Annual Income</td>
<td>$27,373</td>
<td>$27,506</td>
<td>Take-home income increases by $133</td>
</tr>
</tbody>
</table>

*Illustration is just an example, incomes, contributions, and tax rates will vary by individual. Percentage of savings is based on individual’s tax bracket.*
Options Instead of “Use or Lose”

• **Runoff Period** - A period after the plan year ends when employees can submit claims incurred during the previous plan year that have not yet submitted.

• **Carryover Provision** - Employees may carry over up to $500 of unused contributions from one plan year to the next, which may be used to reimburse eligible medical expenses incurred anytime during the next plan year.

• **Grace Period** - An additional 2 ½ months following the end of the plan year in which employees may incur FSA expenses and still receive reimbursements.

Runoff (only), Runoff + Carryover, Runoff + Grace Period
Questions?
Welcome to EyeMed!
What we’ll cover...

Who is EyeMed?
What does the plan cover?
Where can we go?
Member communications and tools
We’re part of the Luxottica Group portfolio of companies and brands

79,000 employees
150 countries
7,200 retail stores
93mm frames manufactured
1 passion
9 million helped worldwide
We’re America’s fastest growing vision benefits company

We’ve grown 31% in the last 3 years alone

From 36 million to more than 47 million members

With over 14,000 clients spread across a variety of industries
# Your vision benefits

<table>
<thead>
<tr>
<th>Service</th>
<th>In-network member cost</th>
<th>OON reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exam services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comprehensive exam</td>
<td>$30 copay</td>
<td>Up to $40</td>
</tr>
<tr>
<td>Retinal Imagine</td>
<td>Up to $39</td>
<td>N/A</td>
</tr>
<tr>
<td>Standard Contact Lens fit</td>
<td>$40</td>
<td>N/A</td>
</tr>
<tr>
<td>and follow up</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premium Contact lens fit</td>
<td>$10% off retail</td>
<td>N/A</td>
</tr>
<tr>
<td>and follow up</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Frame allowance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Once every 12 months</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$100 allowance, plus 20% off the remaining balance</td>
<td>Up to $50</td>
</tr>
<tr>
<td><strong>Standard lenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single vision</td>
<td>Once every 12 months</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$30 copay</td>
<td></td>
</tr>
<tr>
<td>Bifocal</td>
<td>$30 copay</td>
<td></td>
</tr>
<tr>
<td>Trifocal</td>
<td>$30 copay</td>
<td></td>
</tr>
<tr>
<td>Standard Progressive Lenses</td>
<td>$85 copay</td>
<td></td>
</tr>
<tr>
<td>Premium Progressive Lenses</td>
<td>$115-$205 copay based in tier</td>
<td></td>
</tr>
<tr>
<td><strong>Lens options</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tint</td>
<td>$15</td>
<td>N/A</td>
</tr>
<tr>
<td>UV</td>
<td>$15</td>
<td>N/A</td>
</tr>
<tr>
<td>Scratch</td>
<td>$15</td>
<td>N/A</td>
</tr>
<tr>
<td>Polycarbonate</td>
<td>$40</td>
<td>N/A</td>
</tr>
<tr>
<td>Standard anti-reflective</td>
<td>$45</td>
<td>Up to $5</td>
</tr>
<tr>
<td>Other add-ons</td>
<td>20% off retail</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Contact lenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conventional</td>
<td>Once every 12 months</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$100 allowance, plus 15% off balance</td>
<td>Up to $80</td>
</tr>
<tr>
<td>Disposable</td>
<td>$100 allowance</td>
<td>Up to $80</td>
</tr>
<tr>
<td>Medically necessary</td>
<td>$0 copay, paid-in-full</td>
<td>Up to $210</td>
</tr>
</tbody>
</table>
The comprehensive eye exam

Our providers conduct comprehensive eye examinations to diagnose or detect existing conditions of the eye and vision system. Our standards follow those established by the American Academy of Ophthalmology in the “Preferred Practice Patterns” & the American Optometric Association in Clinical Practice Guidelines.

The exam includes:

▪ Dilation (if needed)
▪ Case history
▪ Patient observation
▪ Clinical diagnostic testing, including binocular function
▪ Refractive status
▪ Color vision testing
▪ Stereopsis testing
▪ Assessment, diagnosis and treatment plan

When should a member visit their medical doctor?
For any eye disease or serious condition that may be found during their eye exam.
# Understanding the lens benefit

## Standard lenses
- **Single vision**
  - Prescribed for those who need correction for one field of vision (either far away OR up-close)
- **Multifocal**
  - Lenses that contain correction for two or more fields of vision
  - Include bifocal and trifocal lenses

## Progressive lenses
- Offer a full range of vision correction
- Free of the distinct line often seen on bifocal and trifocal lenses
- Seamless progression of corrective strength:
  - Look up for help seeing distances
  - Look straight ahead for immediate objects
  - Look down to see close-up items
- All options fall within two types:
  - Standard
  - Premium

## Other lens options
- Fixed pricing and discounts on additional lens options
- Members can opt for standard lenses or lenses with multiple add-ons
- Coverage for things like polycarbonate, anti/reflective, tint, UV, etc.
## More on progressive lenses

<table>
<thead>
<tr>
<th>Tier</th>
<th>Features</th>
<th>Customization</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard</td>
<td>▪ General purpose</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td></td>
<td>▪ Traditionally processed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premium Tier I</td>
<td>▪ Softer design</td>
<td></td>
<td>$$</td>
</tr>
<tr>
<td></td>
<td>▪ More reading comfort</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ Traditionally processed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premium Tier II</td>
<td>▪ Increased adaptation</td>
<td></td>
<td>$$</td>
</tr>
<tr>
<td></td>
<td>▪ Traditionally processed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premium Tier III</td>
<td>▪ Improved adaptation</td>
<td></td>
<td>$$$</td>
</tr>
<tr>
<td></td>
<td>▪ Increased clarity at any distance</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ Digitally processed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premium Tier IV</td>
<td>▪ Sharpest level of vision based on design and personal measurements</td>
<td></td>
<td>$$$$</td>
</tr>
<tr>
<td></td>
<td>▪ Digitally processed</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
More details on how your benefits work

Your frequency is based on: 12 months

So, if a member receives an exam today, they will be able to have another exam in 12 months.

Contacts are in lieu of lenses only

That means members are entitled to a full pair of glasses (frame & lenses) OR contacts and frames (members would then receive a 20% discount on their lenses)
Extra discounts for members

- 40% additional pair discount – the best, most flexible in the industry
- 15% off LASIK
- 20% off any remaining frame balance
- 15% off any balance over the conventional contact lens allowance
- 20% off any non-covered item

*In-network only. May not be available on all plans. Confirm if your plan provides this option.
Your network: **INSIGHT + WalMart**

**Nationwide:**
99,900 providers
25,800 locations

**And online:**
GLASSES.com
contactsdirect

- Fully integrated with your benefits
- Huge selection of frames, lenses and contacts
- Free shipping
- Award-winning 3D try-on technology at Glasses.com
Locating a provider

Use the Enhanced Provider Search tool at eyemed.com

Download and use the EyeMed Members App (available for iPhone and Android)

Check the listing of the closest providers on the Welcome Packet

Call the Customer Care Center
All enrolled employees receive ID cards

- Each subscriber will receive 2 punch-out cards upon initial enrollment (cards are not re-issued annually)

- They’re part of the Welcome Packet, which also includes:
  - A summary of benefits
  - Personalized list of providers, located close to their home
  - Details on how to use the benefit
  - How to get benefit support

- Dependents will not receive ID cards, but can always use those issued in the subscriber’s name

- Although ID cards aren’t needed to use the benefit, replacement cards can be downloaded from eyemed.com

- ID cards can also always be viewed on the EyeMed Members App
Member features at eyemed.com

- View benefits and eligibility status*
- Download ID cards and EOBs
- Locate a provider
- Schedule your eye exam (available at many provider locations)
- Download OON claim form
- Check claim status
- View vision wellness information
- Review LASIK information

*NOTE: due to HIPAA regulations, members will not be able to view dependents over the age of 18
EyeMed Members App

- Ability to view ID card
- Benefit details
- Provider locations with directions

- Exam and contact refill reminders
- Ability to load and save prescription
- View additional special offers

Download it today:
Available for Apple devices on the App Store and through Google Play for Android
Ongoing member support with our Customer Care Center

844-409-3402

They can self-serve with our IVR:

- Provider Locator
- Plan Benefits
- ID Cards
- Claim Form
- Claim Status
- Laser Surgery information

Live reps available:

Monday – Saturday:
6:30 – 10 p.m. CST

Sunday:
10 – 7 p.m. CST

Simply state "Agent" or “Customer Service” in order to be directly routed to a live representative
The claims process

In-network

1. Member locates a provider and schedules appointment
2. When they arrive, they identify themselves as an EyeMed member
3. They pay any applicable co-pays at the time of service
4. That’s it – no paperwork. Network providers always file the claim
5. Members can view their EOB through eyemed.com

Out-of-network

1. Member downloads our OON claim form from eyemed.com
2. They receive and pay for services at their choice of provider
3. They’ll complete the OON claim form and submit with an itemized receipt
4. That’s it – we’ll mail them a reimbursement check and their EOB
We’re here for you, too
Member communications

- Open enrollment material support and event representation
- Detailed benefit information
- ID cards
- Customized provider listing
- Wellness resources
- Email blasts
- Webinars
- Vision Plan Descriptions

If there’s anything else you need, no problem - just reach out to your Account Manager.
EyeSiteOnWellness.com

For members:
- Articles and information centering around overall health and wellness
- Interactive content with fun and engaging exercises
- Downloadable content, such as infographics and PDF articles

For you:
- A tool to help increase employee enrollment
- Brand new employee toolkit
- Educational lunch & learn presentation
- Wellness calendar that enables you to customize frequency of communications
Finally, let’s just talk
Any questions?

Learn more at eyemed.com
Workers’ Compensation 101

Presented by:  Katy Busby, General Manager MLWCP
Reporting Timeframes

Dept of Labor - 8 Hours

Date of Injury (DOI) → Date of Knowledge (DOK) → Report to MLWCP

Compensability Determination: Accept – Extend - Deny

First Payment of Disability Due

24 Hours → 24 Hours → 14 Days
Reporting Claims

**Date of Knowledge is CRITICAL**
This is the date the employer knows of a work related injury/incident

**First Report of Injury or Illness needs to be completed accurately**

**Injured employees MUST complete a Form N. This requires a signature on the front and either initials or signature on the reverse side as well.**

**Claim must be reported to AML via the Portal**

**Contact from AML**
All new claims require that AML staff reach out to the member to verify information we have received and to confirm work status and details of the injury.

You can report any concerns, personnel issues, upcoming retirement or other change in status as well as ask any questions during this call.
Reporting Claims – cont’d

Company Nurse

• Rolling out in phases starting first quarter 2020
• Injured employee will contact Company Nurse and report the injury
• RN specializing in Occupational Medicine will triage injury and direct care
• First Report will be completed by Company Nurse as well as Form N which will be mailed to injured employee for signature
• Immediate notification will be sent to all parties and claim will be reported by Company Nurse
Compensability Investigation

All compensable injuries must arise out of employment and occur during the course of employment

- Must be engaged in work for the employer at the time of injury

Investigative Tools

- Recorded statements from injured worker, supervisor, witnesses, or anyone having knowledge of the injury
- Personnel records
- Past medical history and records

Claim Denial vs. Nature and Extent

- Is there something that makes us believe the injury did not occur?
- Are there secondary gain issues?
- Malingering?
Temporary Disability

Temporary wage replacement based upon earnings capacity

66 2/3 of Average Weekly Wage (subject to minimum and maximum rates)

2019 maximum rate is $695/week

Minimum rate is $20/week

Wage Statements are REQUIRED

Time period required is the 52 weeks prior to the injury

Temporary Partial Disability
Medical Treatment

Medical treatment required to cure and relieve effects of injury

Allowed a one time change of treating physician
- Must request change from Commission

Work status must come from approved treating physician

Utilization Review
- Addresses the medical necessity of medical treatment

Pharmacy Benefit Management (PBM)
- Keeps prescriptions in line with formulary
- Best pricing

Independent Medical Evaluation
- Disputes
- Second Opinions
Maximum Medical Improvement (MMI)

Term used when condition is back to pre-injury status (base line), or well stabilized and unlikely to change substantially

Temporary Disability stops here

Physician will provide level of permanent impairment

Physician will provide permanent work restrictions (if any)

Physician will indicate future medical needs, if necessary
Permanent Disability

Based upon the AMA Guides to the Evaluation of Permanent Impairment – 4th Edition

Impairment rating based upon level of injury and body part injured

Paid based upon earnings

- TTD rate multiplied by .75 = PPD rate

Wage Loss is in addition to Impairment Rating

- Cannot exceed 100%

Permanent and Total Disability is absolute loss of earning capacity

- Paid at TTD rate for life
Permanent Work Restrictions

- Provided by physician at time of MMI
- Not always necessary
- Functional Capacity Evaluation (FCE) often required to determine permanent restrictions based upon physical ability
- If permanent restrictions provided, must initiate interactive process
- If unable to accommodate permanent restrictions, Wage Loss benefit may be ordered
Future Medical Treatment necessary and provided post MMI

Future medical treatment has a statute of limitations

Statute is 1 year from last treatment date or 2 years from date of injury (whichever is greater)
Settlement

- Joint Petition
  - Can resolve parts or all issues on the claim
  - Requires approval from ALJ at Commission
  - Must be joint agreement
  - Attorney Fees always at least partially paid by AML
Fraud occurs when someone knowingly lies to obtain some benefit or advantage to which they, or someone else, are not otherwise entitled.

The “Lie”

- Must prove the employee lied
- Must show the lie was important and that it mattered in the evaluation of the claim
- Lie must have been spoken or written in the process of seeking benefits

Burden of Proof

Guilt beyond a reasonable doubt

Four Elements of Fraud (MILK)

- **M**: The lie must be Material (Must make a difference)
- **I**: The lie must be made for the Intent of obtaining a benefit that is not due
- **L**: There is a false representation – the LIE
- **K**: The lie must be Knowingly made

Fraud
To separate fraud from abuse, it is necessary to find a specific, provable lie. An outright lie, misrepresentation, or behavior that implies a lie, must be found for a claim to be considered potentially fraudulent.

Abuse is any practice that uses the workers’ compensation system in a way this is contrary to either the intended purpose of the system or law.

Examples of Abuse:
- Filing a claim that may not be compensable
- Over utilization of benefits and services
- Work/play beyond restrictions
- Missing doctor appointments
- Magnification of complaints or disability that fall short of an outright lie
Questions?
RETURN TO WORK

PRESENTED BY: KATY BUSBY, GENERAL MANAGER MLWCP
TEMPORARY WORK RESTRICTIONS AKA MODIFIED DUTY

What is it?

• When an employee is temporarily unable to work their usual and customary work
• Should focus on what they are able to do
• Some form of physical restriction due to their work injury
RETURN TO WORK PROGRAM

Why Bring Them Back?

• Keeps injured employees engaged and receiving their full wages

• Multiple studies show that an active return to work program reduces overall claims cost by over 40% long term

• Recovery period is reduced and risk of re-injury is minimized

• Members receive productive and valuable work
BRIDGE ASSIGNMENTS

What are they?

• Bridge Assignments are *temporary* transitional work assignments that are composed of meaningful tasks.

• Bridge Assignments are meant to bridge the gap between the onset of the injury and temporary disability and the injured worker’s return to their usual and customary work.

• Tasks are identified in advance, ready to immediately submit to the treating physician for approval, if necessary.

• Injured workers are moved through the Bridge Assignments that are increasingly more physically demanding to promote on-the-job work hardening.
QUESTIONS?
Arkansas Municipal League Loss Control Program

A program to reduce risks and contain costs for your Arkansas Municipal League-sponsored Workers’ Compensation Trust and the Municipal Vehicle and Property Programs.

P.O. Box 38 North Little Rock, AR 72115
501-374-3484
www.arml.org

May 2019
The Arkansas Municipal League developed its Loss Control and Emergency Preparedness Programs to help member cities and towns lower their losses from employee accidents and to help members plan for natural and human-caused disasters. Preventing accidents is less costly than paying for them in lost employee work hours, medical claims, property damage, and higher premiums for coverage. The AML Loss Control Program can assist members in developing safety-related cost-avoidance practices. Loss control services that are available to participating program members include:

♦ Providing on-site workplace, vehicle, property, and equipment inspections.
♦ Recommending guidelines for accident prevention to employees, vehicles, and loss of property.
♦ Conducting on-site PowerPoint seminars and training for employee safety in these categories:

1. **Personal Protective Equipment (PPE)**—Why PPE should be used, types of PPE available, correct selection, proper use and care of equipment.

2. **Trench Safety**—Hazards of trenching and the importance of soil type and classification; the necessity of pre-inspection of the job site; what comprises a competent person; the responsibilities of a competent person; the criteria to determine safety measures; explanations of shoring, shielding, and sloping and guidelines for cave-in emergencies.

3. **Confined Space**—Defining a confined space and why some confined spaces require an entry permit and others may not; the hazards and safety equipment needed; working in a restricted area and the emergency procedures for evacuation.

4. **Blood-borne Pathogens**—Training employees to be aware of the hazards of coming in contact with blood and other body fluids, managing contaminated waste and employee rights to medical evaluation.

5. **Hazard-Communications (Hazcom)**—Class instruction and discussion includes chemicals in the workplace, detecting the presence or release of hazardous chemicals, the health hazards of chemicals and their physical effects, selecting and wearing personal protective equipment while working with hazardous chemicals, and understanding the importance of Safety Data Sheets (SDS) and the requirements of the supplier for SDS information.

6. **Back Safety**—How the back supports the body, the components of the back, the forces of the environment that place constraints on the back, avoiding back injuries, using safe lifting techniques, and why back belts may not be the best safety equipment.

7. **Lockout/tagout (LOTO)**—What it is, when LOTO should be used, LOTO procedures, equipment requiring LOTO, LOTO devices, and employer and employee responsibilities.

8. **Safety Awareness**—Know your environment, learn where hazards lie, job hazard analysis, using the three A’s of safety (attitude, attention, and action) to keep yourself and fellow employees safe.
9. **Safety Programs**—How to develop a citywide safety program that meets the requirements of the Workers’ Compensation Commission. The class studies establishing safe work policies and procedures, a safety committee, an accident investigation committee, determining the need for safety training and developing a return to work program and disciplinary action.

10. **Workplace Emergency and Disaster Plan**—Successful disaster recovery requires assessing how a possible natural or human-made disaster could affect municipal operations; preparing and implementing a comprehensive recovery plan to minimize the effects of a disaster. The Municipal League Loss Control Program has the materials and experience to assist municipalities in preparing for emergencies.

**Cities and towns requesting the services of the Loss Control Program may contact the Arkansas Municipal League at 501-537-3796.**
ARKANSAS MUNICIPAL LEAGUE

Firefighters Supplemental Income Protection and Death Benefit Program

For more information contact:
501-978-6127
www.arml.org
September 2019
Without a special program of the Arkansas Municipal League, volunteer firefighters who are injured in the scope of their duties as a firefighter receive only $20 a week for a compensable injury. Paid firefighters may also lose income due to their work-related injury.

The Arkansas Municipal League offers a valuable program to protect the earnings of volunteer firefighters while they are executing their firefighting duties as well as benefits to assist both part-time and full-time firefighters for lost earnings.

**Coverage for firefighters includes:**

- A weekly benefit to compensate the injured firefighter for earnings lost due to a compensable injury and not otherwise provided for by Arkansas Workers’ Compensation law.
- The program shall pay a sum so that, when combined with temporary total disability benefits provided by Arkansas law, the firefighter shall receive a total weekly indemnity payment up to the statutory maximum benefit for temporary total disability benefit allowed by Arkansas Workers’ Compensation Law.
- The sum paid by the program is based upon the volunteer or part-time firefighter’s loss of earnings due to the inability to receive earnings from work done in addition to work as a firefighter. In the case of a full-time firefighter, the program shall pay a sum so that, when combined with payable workers’ compensation benefits for temporary total disability benefits, the firefighter shall receive a total weekly indemnity payment equal to the statutory maximum temporary total disability benefit allowed by Arkansas Workers’ Compensation Law.
- The program benefit shall be payable for 52 weeks or such periods that the firefighter is eligible to receive worker’s compensation benefits for temporary total disability whichever is shorter.
- $10,000 death benefit payable to eligible dependent if death occurs as a result of a compensable workers’ compensation claim. The death benefit is in addition to funeral expenses covered under Arkansas Workers’ Compensation Law.

**Qualifications**

Cities and towns must cover their firefighters under the Municipal League Workers’ Compensation Program to be eligible for this program. Only municipal departments are eligible. The fire station, fire trucks, and equipment must be municipally owned and operated.

**Costs**

The cost of this coverage is only $20 a firefighter a year. All firefighters in the department may be covered. The minimum premium for each city or town is $240. All new firefighters must be enrolled upon becoming a firefighter. Coverage will cease for each covered firefighter when he or she leaves the fire department.

To enroll or re-enroll, please send to the League a list of all firefighters and whether they are a volunteer, part-paid, or full-time firefighter and a check to cover all personnel at $20 each; the minimum is $240 for each department. Coverage is effective upon receipt of payment. The list of names of firefighters may be emailed to mlwct@arml.org. New firefighters may be added monthly. The $20 fee is a calendar year payment and is not prorated for partial year coverage.
Health and Safety Tool Kit

May 2019

Presented in conjunction with the Arkansas Workers’ Compensation Commission Health & Safety Division
# Table of Contents

The ABC’s & K of Fire Extinguishers ........................................... 5  
  Class A fires ........................................................................... 5  
  Class B fires ........................................................................... 5  
  Class C fires ........................................................................... 5  
  Class K fires ........................................................................... 5  
  Some other important points to remember: ................................ 5  

Accident Investigations ............................................................... 6  
  Don’t Wait Until an Accident Happens! ................................... 6  
  Accident Investigation ............................................................. 6  

Bloodborne Pathogens ............................................................... 7  
  Goal ......................................................................................... 7  
  Objective ................................................................................. 7  
  Background ............................................................................. 7  
  Definitions ............................................................................. 7  
  Exposure Control Plan ............................................................ 7  
  Exposure Determination ......................................................... 8  
  Schedule & Implementation ................................................... 8  
  Labeling Requirements .......................................................... 11  
  References .............................................................................. 12  

Chemical Safety ........................................................................... 13  

Eye and Face Protection .............................................................. 14  
  Selecting the Proper Eye and Face PPE for the Workplace ....... 14  
  Criteria for Eye and Face PPE .................................................. 14  
  Training on Use of Eye and Face PPE ...................................... 15  
  Maintenance and Care of Eye and Face PPE ......................... 15  
  Handling Emergencies ............................................................ 15  

Fire Safety .................................................................................. 16  
  What Causes Fires? ................................................................. 16  
  Fire Prevention ........................................................................ 16  
  FIRE! What to Do if a Fire Occurs .......................................... 17  

Hearing Conservation ................................................................. 18  

Keeping Your Cool When It’s Hot! ............................................. 19  

Personal Protective Equipment .................................................... 20  

Respiratory Protection ............................................................... 21  
  Respiratory Protection Program ............................................. 21  

Safe Lifting and Handling Techniques ........................................ 22  
  Safe Lifting Techniques .......................................................... 22  
  References .............................................................................. 23  

Slips, Trips, and Falls ................................................................. 24  

Meeting Attendance Form ......................................................... 25  

Job Safety Analysis .................................................................... 26
The ABC’s & K of Fire Extinguishers

Just as there is a right tool for every job, there is a right extinguisher for every fire. The class of an extinguisher, identified on its nameplate, corresponds to the class or classes of fire the extinguisher controls. On most construction jobs, we are concerned with Class A, B, and C fires. Consequently, the best extinguisher to have on a job is a multi-purpose Class ABC extinguisher, which contains a dry, powdered chemical under pressure. In food service you will find cooking oils used in high temperature frying, and there should be a Class K (for kitchen) extinguisher. The following describes the classes of fire and the kind of extinguisher that can be used on each. NFPA added Class K to the Portable Extinguisher Standard 10 in 1998.

Class A fires
Wood, paper, trash, and other materials with glowing embers when they burn.

Extinguisher to use: For Class A fires, use a Class A or Class ABC extinguisher. Always remember that a Class A extinguisher contains water and should be used only on a Class A fire. Used on gasoline, it can spread the fire. Used on electrical fires, it can cause you to be electrocuted.

Class B fires
These are fires involving flammable liquids and gases, such as gasoline, solvents, paint thinners, grease, LPG, and acetylene.

Extinguisher to use: Use Class B or Class ABC extinguishers.

Class C fires
These are fires in energized electrical equipment.

Extinguisher to use: Use a Class BC or Class ABC extinguisher.

Class K fires
These are kitchen fires. These fires would generally involve vegetable oils, animal oils, or fats in cooking appliances. Class K extinguishers should be used in commercial kitchens, including those found in restaurants, cafeterias, and caterers.

Extinguisher to use: Use a Class K.

Using Fire Extinguishers

Just as important as knowing what type of fire extinguisher to use is knowing how to properly use the extinguisher. The acronym P.A.S.S. can help you remember.

P: Pull the pin
A: Aim the nozzle at the base of the fire
S: Squeeze the trigger
S: Sweep with nozzle until the fire is extinguished

In addition, stand about eight feet from the fire and have a clear path to the exit.

Some other important points to remember:

- Know where extinguishers are located and how to use them. Follow the directions printed on the label.
- Keep the area around the fire extinguisher clear for easy access.
- Don’t hide the extinguisher by hanging coats, rope, or other materials on it.
- Take care of the extinguishers just as you do your tools.
- Never remove tags from extinguishers. They indicate the last time the extinguisher was serviced and inspected.
- Report defective or suspect extinguishers to your supervisor so that they can be replaced or repaired.
- When inspecting extinguishers, look for cracked hoses, plugged nozzles, and corrosion. Also look for damage that may have been done by equipment running into the extinguishers.
- Don’t use extinguishers for purposes other than fighting fires.
- Nobody wants a fire. But if one starts, know what extinguishers to use and how to use them.
Accident Investigations

Don’t Wait Until an Accident Happens!

Too often hazardous conditions come to our attention only after someone is hurt or seriously injured. If you see an unsafe act or unsafe condition, don’t ignore it and gamble on you or a friend not getting hurt.

If you notice someone working in an unsafe manner, let that person know. You could be preventing a serious injury. Wouldn’t you expect someone to have the same consideration for you? Or, if you see an unsafe condition, correct it. If you can’t, report it to your supervisor.

After an accident happens, there usually is a lot of talk and excitement. Then it is written up, becomes a statistic, and is too soon forgotten.

Accident Investigation

Fortunately, some good can come out of every accident. Investigations can produce information we can use to prevent a similar mishap from occurring in the future. Some persons, however, mistakenly believe that accident investigation is used to put the blame on someone. And so they refuse to cooperate.

If you see an accident...

Make a mental note of everything that occurred and the condition that existed before the accident. Ask yourself the following questions:

1. Where was I when the accident happened?
2. What was I doing?
3. What equipment was involved?
4. Where was the injured person and what work was being done?
5. What was the sequence of events?

Imprint these things on your memory. Remember that others were in a different position and may not have seen things as you did.

Cooperate in the investigation

When the investigator asks questions about the accident, give the facts as you saw them. If you omit or change information to protect someone, how can we accurately determine the causes and help prevent the same thing from happening again? Next time you may be the victim.
Bloodborne Pathogens

Goal
This program is designed to ensure the health and safety of workers with occupational exposure to bloodborne pathogens.

Objective
This information will assist employers in developing an Exposure Control Plan specific to their facility.

Background
In the mid 1980's, workers from the healthcare field petitioned OSHA for a standard to protect those at risk of contracting Hepatitis B Virus (HBV), Human Immunodeficiency Virus (HIV), and other bloodborne pathogens. OSHA responded to this concern by developing the Bloodborne Pathogens Standard, 29 CFR 1910.1030.

When the standard came into effect on June 4, 1992, the public thought of it as solely regulating the healthcare industry. However, the standard also applies to any employer whose employee's duty is to work with blood, body fluids, or other potentially infectious materials. This includes first aid responders, medical researchers, teachers, school nurses, and others who may be required to offer assistance to an injured person.

The standard is based on universal precautions. Universal precautions were developed in 1987 when the Centers for Disease Control published guidelines with instructions to treat all people as if they are infected with a bloodborne pathogen. These precautions are intended to protect workers at risk of exposure.

Definitions
The standard lists definitions for terminology associated with bloodborne pathogens. Some of the more critical definitions are:

Other Potentially Infectious Material: any human body fluids (semen, vaginal secretions, cerebrospinal, synovial pleural, pericardial, peritoneal, amniotic fluids, saliva; any body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids; any unfixed tissue or organ from a human [living or dead]; HIV-containing cell or tissue cultures, organ cultures, and HIV- or HBV-containing culture medium or other solutions; and blood, organs, or other tissues from experimental animals infected with HIV or HBV).

Contaminated: the presence or the reasonably anticipated presence of blood or other potentially infectious materials on an item or surface.

Parenteral: piercing mucous membranes or the skin barrier through such events as needle sticks, human bites, cuts and abrasions.

Occupational Exposure: reasonably anticipated skin, eye, mucous membrane or parenteral contact with blood or other potentially infectious materials that may result from the performance of an employee's duties.

Engineering Controls: controls (e.g., containers for disposing sharp objects, self-sheathing needles) that isolate or remove the bloodborne pathogens hazard from the workplace.

Work Practice Controls: controls that reduce the likelihood of exposure by altering the manner in which a task is performed (e.g., prohibiting recapping of needles using a two-handed technique).

Exposure Control Plan
The standard requires employers to develop a written Exposure Control Plan. This plan is divided into three sections:

1. Exposure determination,
2. Schedule for methods of implementing sections of the standard, and
3. Procedures for evaluating an exposure incident as described under the section “Evaluation Of An Exposure.”

The plan must be reviewed and updated at least annually or whenever new personnel, tasks, or procedures affect occupational exposure. It must be available to all employees upon request.
Exposure Determination

The exposure determination is made by reviewing job classifications within the work environment without regard to the use of personal protective equipment. The job classifications are then listed into two types.

**Type I:** Includes job classifications in which all employees have occupational exposure, such as operating room scrub nurses.

**Type II:** Includes those classifications in which some employees have occupational exposure. Specific tasks and procedures causing occupational exposure must be listed for Type II employees. For instance, some workers might be assigned the task of handling contaminated laundry in a hospital laundry room while other laundry personnel would not. Once employees with occupational exposure have been identified, the hazards must be communicated to these employees.

Schedule & Implementation

This portion addresses the schedule and method for implementing sections of the bloodborne pathogens rule. These sections cover compliance; hepatitis B vaccination and post-exposure evaluations and follow-up; hazard communication (labels and information training); and required recordkeeping.

**Methods of compliance:** Compliance to the bloodborne pathogens standard involves three facets: engineering and work practice controls, personal protective equipment, and housekeeping.

Engineering and work practice controls are the primary methods used to eliminate or minimize occupational transmission of HBV and HIV. Personal protective equipment and clothing are also necessary when occupational exposure to bloodborne pathogens remains even after instituting these controls.

**Engineering controls:** Reduce employee exposure by either removing or isolating the hazard, or isolating the worker from exposure. Self-sheathing needles, puncture-resistant disposal containers for contaminated sharp instruments, hand washing facilities, resuscitation bags, and ventilation devices are examples of engineering controls. Engineering controls must be examined and maintained or replaced on a scheduled basis to ensure effectiveness.

**Work practice controls:** Alter the manner in which a task is performed. In work areas where a reasonable likelihood of occupational exposure exists, work practice controls required include:

- Restricting eating, drinking, smoking, applying cosmetics or lip balm, and handling contact lenses;
- Prohibiting mouth pipetting (apparatus whereby fluid is drawn by suction and retained by closing the upper end);
- Preventing the storage of food and/or drink in refrigerators or other locations where blood or other potentially infectious materials are kept;
- Requiring the use of hand washing facilities; routinely checking equipment and decontaminating it prior to servicing and shipping.

Other work practice requirements include:

- Washing hands when gloves are removed and as soon as possible after skin contact with blood or other potentially infectious materials occurs.
- Recapping, removing, or bending needles is prohibited unless the employer can demonstrate that no alternative is feasible or that such action is required by a specific medical procedure.
- When recapping, bending or removing contaminated needles is required by a medical procedure, this must be done by mechanical means, such as the use of forceps, or a one-handed technique.
- Shearing or breaking contaminated needles is not permitted.

**Personal protective equipment:** helps reduce occupational exposure to infectious materials. Such equipment includes: gloves, gowns, laboratory coats, face shields or masks, eye protection, etc. Personal protective equipment must also be used if occupational exposure remains after instituting engineering and work practice controls, or if those controls are not feasible.

Personal protective equipment is considered appropriate only if it prevents direct contact of blood or other potentially infectious materials with clothes, skin, eyes, mouth, or other mucous membranes. This equipment should protect the worker under normal conditions of use and for the duration of time which the protective equipment is used.

Under the standard, employers must provide, make accessible, and require the use of personal protective equipment at no cost to the employee. Personal protective equipment also must be provided in appropriate sizes. Hypoallergenic gloves
or other similar alternatives must be made available to employees who have an allergic sensitivity to gloves. Employers also
must ensure that protective equipment is properly used, cleaned, laundered, repaired, or replaced as needed.

The employer must also ensure that employees observe the following precautions for safe handling and using personal
protective equipment:

- Remove protective equipment before leaving the work area and after a garment becomes contaminated.
- Place used protective equipment in appropriately designated areas or containers when being stored, washed, decon-
taminated, or discarded.
- Wear appropriate gloves when it can be reasonably anticipated that the employee may have contact with blood or
other potentially infectious materials, when performing vascular access procedures, and when handling or touching
contaminated items or surfaces. Replace gloves if torn, punctured, contaminated, or their ability to function as a
barrier is compromised. Never wash or decontaminate disposable gloves for reuse.
- Utility gloves may be decontaminated for reuse if their integrity is not compromised. Discard utility gloves when
they show signs of cracking, peeling, tearing, puncturing, or deteriorating.
- Wear appropriate face and eye protection such as a mask with glasses with solid side shields or a chin-length face
shield when splashes, sprays, spatters, or droplets of blood or other potentially infectious materials pose a hazard to
the eye, nose, or mouth.
- Wear appropriate protective body covering such as gowns, aprons, caps, and boots when occupational exposure is
anticipated. The type and characteristics will depend upon the task and degree of exposure anticipated.

Under the standard, clean and sanitary housekeeping must be kept for each place of employment. The employer must
develop and implement a cleaning schedule that includes appropriate methods of decontamination and tasks or procedures
to be performed. This written schedule must be based on the location within the facility, the type of surfaces to be cleaned,
the type of contamination present, the tasks or procedures to be performed, and their location within the facility.

The employer must also ensure the following housekeeping procedures are followed:

- Clean and decontaminate all equipment and environmental and work surfaces that have been contaminated with
blood or other potentially infectious materials.
- Decontaminate work surfaces with an appropriate disinfectant after completion of procedures; immediately when
overtly contaminated; after any spill of blood or other potentially infectious materials; and at the end of the work
shift when surfaces have become contaminated since the last cleaning.
- Remove and replace protective coverings such as plastic wrap and aluminum foil when contaminated.
- Inspect and decontaminate on a regular basis reusable receptacles such as bins, pails, and cans that have a likelihood
for becoming contaminated. When contamination is visible, clean and decontaminate receptacles immediately or as
soon as feasible.
- Always use mechanical means such as tongs, forceps, or a brush and a dust pan to pick up contaminated broken
glassware; never pick up with hands even if gloves are worn.
- Store or process reusable sharp objects in a way that ensures safe handling.
- Place other regulated waste (liquid, liquid-blood, items contaminated with blood or other potentially infectious
materials, contaminated sharps, etc.) in closable and labeled or color-coded containers. When storing, handling,
transporting or shipping, place other regulated waste in containers that are constructed to prevent leakage.
- Discard contaminated sharp objects, place them in containers that are closable, puncture resistant, appropriately
labeled or color-coded, and leakproof on sides and bottom.
- Ensure that containers for sharp objects (sharps) are easily accessible to personnel and located as close as is feasible
to the immediate area where sharps are used or can be reasonably anticipated to be found. Sharps containers must
also be kept upright throughout use, replaced routinely, closed when moved, and not allowed to overfill.
- Never manually open, empty, or clean reusable containers where sharp objects are stored.
- Discard all regulated waste according to federal, state, and local regulations.
- Bag contaminated laundry at its location after use. Never sort or rinse contaminated laundry in areas of its use. Laundry should be handled as little as possible using appropriate personal protective equipment. Wet contaminated laundry must be placed in leakproof, labeled or color-coded containers before transporting.

**Hepatitis B vaccination:** Employers are required to make the Hepatitis B vaccine and vaccination series available to all employees who have occupational exposure, as well as post-exposure evaluation and follow-up to all employees who experience an exposure incident. The vaccine and vaccination must be made available at no cost to the employee, provided at a reasonable time and place, and performed by or under the supervision of a licensed physician or another licensed health care provider.

Employees who decline the vaccination must sign a declination form. Employees reserve the right to request and obtain the vaccination at a later date and at no cost if the employee continues to be exposed.

The vaccine and vaccination series must be offered within 10 working days of initial assignment to employees who have occupational exposure to blood or other potentially infectious materials unless:

1. The employee has already received the complete Hepatitis B vaccination series,
2. Antibody test reveals that the employee is immune, or
3. Medical reasons prevent taking the vaccinations.

**Evaluation of an exposure:** Once a report of an exposure has been documented, the standard requires the post-exposure medical evaluation and follow-up be made available immediately for employees who have had an exposure incident. At a minimum, the evaluation and follow-up must include the following elements:

- Document the routes and circumstances of exposure.
- Identify and obtain consent for testing of the source individual to determine HIV and HBV infectivity and document the source's blood test results.
- Provide the exposed employee with the source individual's test results and information about applicable disclosure laws and regulations concerning the source identity and infectious status. Collect and test exposed employee's blood as soon as feasible for HBV and HIV serological status after obtaining consent.
- If the employee does not give consent for HIV serological testing during the collection of blood for baseline testing, preserve the baseline blood sample for at least 90 days.
- Provide HBV and HIV serological testing, counseling, and safe and effective post-exposure prophylaxis following the current recommendations of the U.S. Public Health Service.
- If consent is not obtained, the employer must show that legally required consent could not be obtained. If the source individual is known to be infected with either HIV or HBV, testing need not be repeated to determine the known infectivity.

The health care provider responsible for the employee's Hepatitis B vaccination and post-exposure evaluation and follow-up must be given a copy of the 29 CFR 1910.1030 standard. The provider must also receive a description of the employee's job duties, results of the incident investigation including the source individual's blood test results if available, and all relevant employee medical records.

When the evaluation is completed, the employee must receive a copy of the health care provider's written opinion within 15 days. The written opinion must state if the HBV vaccination is indicated and if the vaccination has been received. The written opinion for post-exposure evaluation must document that the employee has been informed of the results of the medical evaluation and of any medical conditions resulting from the exposure incident that may require further evaluation or treatment. All medical records must be kept in accordance with 29 CFR 1910.20.

**Hazard communication:** Communicating hazards of occupational exposure to bloodborne pathogens is accomplished through labels, information, and training.

The colors and symbols are a large part of the universal precautions system. Warning labels for bloodborne pathogens are required to be fluorescent orange or orange-red with the word “BIOHAZARD” and the biohazard symbol in a contrasting color.

These labels must be attached (by means to prevent loss or unintentional removal) to containers of regulated waste, refrigerators and freezers containing blood or other potentially infectious materials, and other containers used to store, transport, or ship blood or other potentially infectious materials.
The labels are not required when red bags or red containers are used; when containers of blood, blood components, or blood products are labeled as to their contents and have been released for transfusion or other clinical use and when individual containers of blood or other potentially infectious materials are placed in a labeled container during storage, transport shipment or disposal. The following table provides guidelines on the labeling requirements of the standard:

### Labeling Requirements

<table>
<thead>
<tr>
<th>ITEM</th>
<th>BIOHAZARD LABEL</th>
<th>RED CONTAINER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulated waste container (contaminated sharps containers)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Reusable contaminated sharps containers (surgical instruments soaking in a tray)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Refrigerator/freezer holding blood or other potentially infectious materials</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Containers used for storage, transport or shipping of blood</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Blood/blood products for clinical use</td>
<td>No labels required</td>
<td></td>
</tr>
<tr>
<td>*Individual specimen containers of blood or other potentially infectious materials remaining in facility</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>**Contaminated equipment needing service (dialysis equipment, suction apparatus)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Specimens and regulated waste shipped from the primary facility to another for service or disposal</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>***Contaminated laundry</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Contaminated laundry sent to another facility that does not use Universal Precautions</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

*No label is needed if Universal Precautions are used and specific use of container or item is known to all employees or
**Include a label specifying where the contamination exists.
***Alternative labeling or color coding is sufficient if it permits all employees to recognize the containers as requiring compliance with Universal Precautions.

**Information and training** must be provided at no charge to occupationally exposed employees at the time of initial assignment and on a yearly basis thereafter. Additional training is needed when existing tasks are modified or new tasks involving occupational exposure to bloodborne pathogens affect the employee's exposure. Training must be conducted by a person knowledgeable about the subject matter. The information provided must be appropriate in content and vocabulary to educational level, literacy and language of the audience. Training must contain the following:

- Information on obtaining a copy of the standard and an explanation of its contents;
- Information on the epidemiology, symptoms, and transmission of bloodborne diseases;
- Information on recognizing tasks that might result in occupational exposure;
- Explanation of the Exposure Control Plan and the means by which an employee can obtain a copy;
- Explanation of the use and limitations of work practice and engineering controls, and personal protective equipment;
- Information on the types, selection, proper use, location, removal, handling, decontamination, and disposal of personal protective equipment;
- Information on Hepatitis B vaccination such as safety benefits, efficacy, methods of administration, and availability;
- Information on who to contact and what to do in an emergency to include reporting an exposure incident;
- Information on the post-exposure evaluation and medical follow-up;
• Information on warning labels, signs, and color-coding; and
• Question-and-answer session on any aspect of training.

Recordkeeping requirements: Medical and training records must be maintained under the standard. Medical records must be kept according to 29 CFR 1910.20 and include specific bloodborne pathogens requirements. These records must be kept confidential and maintained for at least the duration of employment plus 30 years. The medical records must contain:

• Employee’s name and social security number;
• HBV status including dates and any records related to employee’s ability to receive vaccinations;
• Results of examinations, medical testing, and post-exposure evaluation and follow-up procedures;
• Health care provider’s written opinion; and
• A copy of the information provided to the healthcare provider.

Medical records must be kept according to 29 CFR 1910.20 and include specific bloodborne pathogens requirements. These records must be kept confidential and maintained for at least the duration of employment plus 30 years. The medical records must contain:

• Employee’s name and social security number;
• HBV status including dates and any records related to employee’s ability to receive vaccinations;
• Results of examinations, medical testing, and post-exposure evaluation and follow-up procedures;
• Health care provider’s written opinion; and
• A copy of the information provided to the healthcare provider.

Training records must be maintained for three years and include training dates, content/summary of training, names and qualifications of trainers, and names and job titles of training attendees. These records must be available to employees or their representatives upon request.

Employers must also comply with the Arkansas Workers’ Compensation Law regarding work-related injuries or illnesses. Once an employer becomes aware that an employee has become infected through occupational exposure, the employer is required to complete the Arkansas Workers’ Compensation First Report of Injury or Illness (Form 1A-1).

References

Videos pertinent to this subject may be obtained from the Arkansas Department of Labor/Arkansas Workers’ Compensation Commission’s Health and Safety Resource Center at (501) 682-9090.
**Chemical Safety**

Different kinds of chemicals can be found in every worksite. Some workplaces may limit the chemicals to those found in cleaning agents, while other workplaces deal with hazardous chemicals that can be life-threatening if mishandled. It is important to identify what chemicals are used in your worksite.

Chemical manufacturers have to determine the physical and health hazards of each product they make. Then they have to let users know about those hazards by using container labels and by supplying Material Safety Data Sheets (MSDS). This information will let you know what steps to take when handling hazardous chemicals.

Hazardous chemicals can be handled safely if you learn what the hazards are for each chemical you work with, which chemicals should not be mixed together because they are incompatible, and what protective measures you should take (personal protective equipment, work practices, etc.) when working with chemicals.

Chemicals are considered “hazardous” if they can cause any degree of harm to people or the environment. Chemicals are considered hazardous if they are:

- **Corrosive**: may cause irritation or burns to the skin or eyes on contact.
- **Reactive**: may react violently, even explode, under certain conditions.
- **Flammable**: will catch fire easily.
- **Radioactive B**: emits radiation in the form of particles or electromagnetic waves.
- **Toxic**: may cause illness or in some cases death.

Chemicals that can cause health problems may either cause effects immediately (like a chemical burn) or over a long time (like smoking cigarettes). There are four ways chemicals can enter your body to cause harm:

- Skin or eye contact
- Inhalation or breathing
- Swallowing or eating (may happen if food, beverages or smoking materials are used where chemicals are present)
- Injected (may happen if you cut or stick yourself with a contaminated tool)

One of the best ways to protect yourself from chemicals is to know the hazards of the chemicals you use and take proper precautions. Two sources of information are the MSDS and the label. You may also have operating procedures that tell you of special precautions such as personal protective equipment, ventilation or special operating procedures that you must use. In addition to knowing the hazards and the precautions to take, the following are some basic rules for working around hazardous chemicals:

- Remove objects or chemicals that could burn or react dangerously with nearby materials.
- Remove food, cigarettes, and street clothing from the work area so they don't get contaminated.
- Know where emergency showers and eyewashes are located.
- Make sure the correct type of fire safety equipment is nearby and ready for use.
- Check for adequate ventilation.
- Know what to do in an emergency.
- Have someone who knows where you are and what you are doing at all times.
- Assemble the protective clothing and equipment you'll need for the job.
- Get checked out by your supervisor.
- If you have an upset or spill, clean it up quickly.
- Wear proper personal protective equipment (PPE) during the clean-up and disposal of all contaminated materials properly.
- If you are overexposed to a chemical, inform your supervisor and get medical attention. If you have a skin exposure, wash the area with water for at least 15 minutes.
- If you have a breathing exposure, get into fresh air.

**Remember:** Hazardous chemicals don't have to be dangerous if you handle them with respect.
Eye and Face Protection

Are you in danger of becoming a statistic?

Thousands of people are blinded each year from work-related eye injuries that could have been prevented with the proper selection and use of personal protective equipment (PPE) for eye and face protection. Eye injuries alone cost more than $3 million per year in lost production time, medical expenses and worker compensation.

OSHA requires employers to ensure the safety of all employees in the work environment. Eye and face protection must be provided whenever necessary to protect against chemical, environmental, and radiological hazards or mechanical irritants. Ensuring worker safety includes conducting a workplace hazard assessment and providing adequate training for all workers who require eye and face protection.

Selecting the Proper Eye and Face PPE for the Workplace

A hazard assessment should be conducted, and certified, to determine the risk of exposure to eye and face hazards, including those hazards that may be encountered in an emergency situation. The following chart is an example of a Hazard Assessment.

<table>
<thead>
<tr>
<th>Hazard Type</th>
<th>Examples of Hazard</th>
<th>Common Related Tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impact</td>
<td>Flying objects such as large chips, fragments, particles, sand, and dirt</td>
<td>Chipping, grinding, machining, metal work, woodworking, chiseling, riveting, sanding</td>
</tr>
<tr>
<td>Heat</td>
<td>Any process emitting extreme heat</td>
<td>Furnace operations, pouring, dipping, welding</td>
</tr>
<tr>
<td>Chemicals</td>
<td>Splash, fumes, vapors, and irritating mists</td>
<td>Acid and chemical handling, decorative plating, and working with blood</td>
</tr>
<tr>
<td>Dust</td>
<td>Harmful dusts</td>
<td>Woodworking, buffing, and general dusty conditions</td>
</tr>
<tr>
<td>Optical Radiation</td>
<td>Radiant energy, glare, and intense light</td>
<td>Welding, torch-cutting, brazing, and laser work</td>
</tr>
</tbody>
</table>

Criteria for Eye and Face PPE

PPE must comply with ANSI Z87.1-1989 standard. The PPE should:

- Provide adequate protection against the hazards for which they are designed;
- Fit snugly and not interfere with movements of the worker;
- Be capable of being disinfected; and
- Be distinctly marked to facilitate identification of the manufacturer.
Training on Use of Eye and Face PPE

Eye and face protection is PPE such as spectacles, goggles, face shields, or welding shields that are designed to protect the user against a variety of hazards. Each worker must be trained to know at least the following:

- When PPE is necessary;
- Limitations of the PPE;
- What PPE is necessary;
- How to properly don, doff, adjust and wear PPE; and
- Proper care, maintenance, useful life, and disposal of the PPE.

Training should be conducted by a knowledgeable designated person and presented in a manner that all employees can understand. Employees must demonstrate an understanding of the training and the ability to use the PPE properly.

Maintenance and Care of Eye and Face PPE

PPE must be used, maintained, and stored in a sanitary and reliable condition.

Handling Emergencies

Emergency eyewash stations should be placed in all hazardous areas and the path to them should be kept free and unobstructed.

First-aid instruction should be posted close to potential danger spots.

When employees are trained to work safely and follow the requirements of eye and face protection, they should be able to anticipate and avoid injury from job-related eye and face hazards.
Fire Safety

Every year in our state, people are hurt by fires in the workplace. All too often some of these people die. The best way to keep this from happening is to practice active fire prevention. Know what to do—and what not to do—in case of a fire.

What Causes Fires?

Fire happens when the right combination of fuel, oxygen, and heat are brought together and combustion is created. Oxygen is normally present in the air. Sources of fuel and heat include:

<table>
<thead>
<tr>
<th>Fuel</th>
<th>Heat</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paper</td>
<td>Friction</td>
</tr>
<tr>
<td>Wood</td>
<td>Electricity</td>
</tr>
<tr>
<td>Gasoline &amp; other flammable material</td>
<td>Sparks and open flames</td>
</tr>
</tbody>
</table>

The best way to prevent fires is to make sure that all three of these things—fuel, heat, and oxygen—do not come together.

Fire Prevention

There are lots of things each of us can do every day to make sure that fires don't happen in our workplace:

Housekeeping

- Dispose of waste promptly and properly.
- Keep work areas free of dust, lint, wood chips and other combustible trash.
- Keep combustible materials away from lights, machinery, and electrical sources.

Handling Flammable Substances

- Know what is flammable; check MSDSs and labels.
- Store flammables in approved containers.
- Never store combustible materials with oxidizers.
- Clean up spills promptly and properly.
- Dispose of clean-up materials (rags, sand, etc.) promptly and properly.
- Ground containers when transferring flammable materials so you don't generate static electricity.
- Use only approved tools and equipment when working around flammable materials.
- Don't use flammables around open flames.
- Use flammables in well-ventilated areas.
- Don't cut on or heat a container that held flammable material until you know it is safe.

Electrical Equipment

- Electrical equipment failures or misuse of electrical equipment is the number one cause of industrial fires.
- Make electrical inspections routine practice.
- Replace cords and wires that are frayed or have worn insulation.
- Don't overload circuits, motors, fuses, or outlets.
- Make sure you have good ground connections.
Equipment

• Make sure debris and grease are kept clear of machinery.
• Lubricate bearings and gears so they don't get hot.

Personal

• Smoke only in designated areas.
• Make sure smoking material and matches are put out and placed in proper containers.
• Use space heaters only in approved areas; make sure cords and safety shut-offs are working properly.

It’s a good idea to look around your workplace every day to see if any fire hazards are there. Sometimes, because we see the same thing day after day, we forget that it could cause a problem.

FIRE! What to Do if a Fire Occurs

We hope a fire never happens here. But in case a fire should start, it is important that you know immediately what you should do. Know how to report a fire and how to get out of the building. If you don't know what to do in case of a fire, ask your supervisor now. It's too late when the fire starts.

A mistake people often make that can have tragic results is thinking that the fire is small enough to handle alone. The first thing you should always do when you see a fire is to make the proper notification. Even a small fire can get out of hand in a hurry. In some cases, it may be necessary to leave the building if a fire occurs. It is important to know where you are expected to go in the event that happens. Everyone needs to be accounted for.

If you have fire extinguishers, you should make sure you have the right extinguisher for the type of fire:

• **Class A**: Ordinary combustibles such as paper, cloth, trash, and wood.
• **Class B**: Gases and flammable liquids such as grease, oil, paint, or solvents.
• **Class C**: Electrical equipment. Never use water on fires involving electrical equipment.
• **Class D**: Combustible metals.
• **Classes ABD and BC**: Use on combination fires.

Just as important as using the right type of fire extinguisher is knowing how to use it properly:

1. **P**: Pull the pin
2. **A**: Aim the nozzle at the base of the fire
3. **S**: Squeeze the trigger
4. **S**: Sweep with nozzle until the fire is extinguished

or

1. Pull the pin
2. Stand about 8 feet from the fire.
3. Aim at the base of the fire.
4. Squeeze the trigger. Be careful not to blow burnables and create a larger fire.
5. If the fire seems too big, get out and leave it to the firefighters.
In every worksite there is some level of noise. Whether it be the monotonous hum of the mainframe or the incessant clatter of heavy industrial machinery, repeated exposure to noise levels above 85 dBA may lead to noise-induced hearing loss. Noise, or undesired sound, is one of the most widespread occupational health problems.

Hearing loss can occur as a result of exposure to noise, both loud and soft, and can affect hearing temporarily or can result in permanent hearing damage. Hearing loss that is temporary, which results from short-term exposures to noise, will diminish after a period of rest. However, permanent hearing loss can result due to long-term exposure to noise, with normal hearing to be impaired indefinitely.

In order to prevent hearing loss, hearing protectors must be made available to all workers exposed to noise levels over the permissible limit. Hearing protectors must adequately reduce the severity of the noise level for each employee’s work environment. The protectors should be comfortable to wear and offer a sufficient decrease in noise levels to prevent hearing loss. Thus, employees shall be given the opportunity to select their hearing protectors from a variety of suitable hearing protectors provided by the employer. The employer shall also provide training in the use and care of all hearing protectors provided to employees.

The first step in controlling noise levels is to identify the sources of noise in our worksite. Each of us can think of at least one source of noise that will affect our hearing. Once the sources have been identified, we can determine what interventions can be utilized to reduce the risk of noise-induced hearing loss. There are a number of hearing protectors to choose from. Each of the protectors are beneficial in reducing the level of noise, and are designed to meet the needs of all degrees of noise. Therefore, we must take the initiative to determine which protector best suits the needs of this worksite.

According to OSHA regulations, engineering controls must first be attempted to decrease the noise levels. If the engineering controls cannot be utilized in the work environment, other precautions will have to be made. There are many times when both engineering controls and hearing protection must be implemented to ensure the proper protection against noise-induced hearing loss.

The employer must also reevaluate the suitability of the employee’s present protector whenever there is a change in working conditions that may cause the hearing protector being used to be inadequate. The noise measurement records of audiometric tests must be maintained for the duration of employment of the affected employee. These last two requirements are necessary for effective recordkeeping of hearing conservation programs in any worksite.

Because our hearing is so important, we must recognize the hazards in our worksite that will affect our listening skills. Creating awareness among all of the employees will decrease the likelihood of any type of hearing loss. Intervention strategies can then be implemented to reduce noise levels and to reduce hearing loss to our employees.
Keeping Your Cool When It’s Hot!

Summer in Arkansas means high temperatures and high humidity. We can’t do anything about the weather, but we can work and play smarter when it’s hot to avoid getting sick.

First, let’s review the types of heat-related illnesses:

**Sunburn:** Not only are sunburns painful at the time, but exposure to too much sun could lead to skin cancer.

**Heat Rash:** Sometimes called prickly heat, the best way to avoid this is to bathe regularly and keep your skin clean and dry.

**Heat Cramps:** Painful cramps, often in the legs, arms or stomach, heat cramps can happen when you are sweating heavily but are not getting enough of the minerals your body needs to replace the minerals lost in sweat. The symptoms of heat cramps may not show up until after work. Avoid heat cramps by drinking plenty of fluids and eating a balanced diet.

**Heat Exhaustion:** Symptoms include heavy sweating, thirst, clammy and pale skin, fatigue, weakness, and loss of coordination. A person with heat exhaustion may also be anxious, faint, confused, have a headache, nausea or vomiting, and loss of appetite. Heat exhaustion can be serious. Move the person to a cool area and encourage them to drink water to prevent dehydration. They may also need medical attention. Someone with heat exhaustion should not operate machinery, drive, or do anything strenuous until they have recovered.

**Heat Stroke:** Heat stroke is the most serious heat-related illness. The body has lost its ability to cool itself. Death can quickly result if not treated promptly. Usually the most striking symptom of heat stroke is the absence of sweating. The skin is red, dry, and hot. The pulse is rapid. The person may complain of headaches, dizziness, or nausea and may appear confused or delirious. Fainting, seizures, or collapse may occur. A person in heat stroke needs immediate medical attention at an emergency room or hospital. While help is on the way, move the person to the coolest spot nearby and try to cool their body. They can be immersed in water, but don't place them in ice water. Don't give them anything to drink since they may lose consciousness.

We can’t do much about the weather in Arkansas except wait for fall, but there are some things you can do to help reduce the likelihood that you will have a heat-related illness:

1. Gradually get used to working in the heat. It takes about two weeks for your body to adapt to hot conditions. If you are away for as little as a week (on vacation, for example) your body losses this ability; you will have to get used to the heat again.
2. Dress for the heat. Light colored, loose clothing (that won’t get caught in machinery) is better than going bare skinned.
3. If you will be outside wear a hat; use sunscreen to prevent sunburn.
4. Drink plenty of fluids throughout the day. Make sure you have ample cool, clean water on the job. Your body needs water before you feel thirsty. Water, fruit juice, or sports drinks are best. Sodas, coffee, and tea all contain caffeine and should not be your main source of fluids.
5. Limit your intake of alcohol. Alcohol causes dehydration and can be a big contributor to the more serious heat-related illnesses.
6. Eat well-balanced meals. You need to make sure your body’s stores of vitamins and minerals don’t get depleted. Fresh fruits and vegetables contain needed nutrients plus water.
7. Get plenty of rest. We all have lots of things going on during the summer, but when we don’t get enough rest that puts additional stress on our bodies.
8. Take frequent breaks in the shade or a cooler area. These breaks help reduce the heat load on your body.
9. Plan your work to take advantage of cooler morning hours. Move work to shaded areas when possible.
10. Keep an eye on new hands who aren’t used to the heat and co-workers who have health conditions that may make them more susceptible to heat-related illnesses. If someone looks like they are having heat exhaustion or a heat stroke take action fast to get them to a cool area and get medical attention.

Take care of yourself and your co-workers this summer and you’ll have it “Made in the Shade!”
Personal Protective Equipment

Personal protective equipment, or PPE, is defined as “all clothing and other work accessories designed to create a barrier against workplace hazards.” PPE should not be used as a substitute for engineering, work practice, and/or administrative controls. Personal protective equipment should be used in conjunction with these controls to provide for employee safety and health in the workplace. This equipment must be properly fitted and maintained in a clean and serviceable manner.

Personal protective equipment must not be altered or not worn, even though an employee may find it uncomfortable. Because PPE is so important, it should be as comfortable as possible. Offering different types of PPE can also encourage employees to use the proper PPE. It is management’s responsibility to determine the types of PPE to be used on the job at a particular worksite, but it is everyone’s responsibility to see that it used properly.

Some necessary PPE includes the following:

- **Ear plugs and muffs** will help protect against hearing loss. The type selected and worn must be appropriate to protect against the hazards of the job.
- **Gloves** can protect the hands from extreme temperatures, chemicals, sharp objects, and other workplace hazards. The type of glove must be appropriate for the hazard. For example, glove materials offer different amounts of protection against different chemicals. This information is available from the glove manufacturer.
- **Respirators** can protect you from hazardous fumes, vapors, dusts, and particulates. A respirator should fit snugly around the face. As with gloves, the respirator should be appropriate to protect against the hazards of the job.
- **Safety glasses and goggles** can protect the eyes from flying debris, chemicals and other hazards.
- **Hard hats** can protect from low-hanging, falling and flying objects.
- **Coveralls** are usually used to prevent contamination of personal clothing and to prevent transfer of materials to your vehicle and home. Some coveralls are made of materials that will protect against other hazards, such as chemicals and temperature extremes.
- **Safety boots and shoes** protect the feet and toes against being struck by sharp or falling objects. Some jobs may require metatarsal guards in addition to the steel-toed protection. Safety boots and shoes may also provide protection against slipping hazards on wet or slippery surfaces.

While PPE does not eliminate hazards, it can protect employees against those hazards. Employees must be trained in the use, limitations, care, and maintenance of all PPE to be used on the job. Only then can it provide the protection for which it is designed to do.
Respiratory Protection

Sometimes the air we breathe may not be free of harmful substances that can cause cancer, lung impairment, other diseases, or even death. Wearing the proper respirator, properly, can protect workers from insufficient oxygen environments, harmful dusts, fogs, smokes, mists, gases, vapors, and sprays.

Respiratory Protection Program

A written respiratory program is required:

- When respirator use is required by the employer and/or
- When half-mask respirators are worn voluntarily by employees (partial program).

Elements of a Written Respirator Program

- A medical evaluation must be done to make sure employee can safely wear respirator.
- Worker must be fit-tested to determine type and size needed.
- Worker must be trained how to test, use, clean, and store respirator.
- Voluntary respirator usage:
  - Medical evaluation, training as to use, cleaning, storage, copy of App D
  - If dust masks only, only need to provide copy of App D

Types of Respirators

- Air purifying respirators filter the air being breathed to remove contaminants.
- Supplied air respirators provide clean air from another source.
Safe Lifting and Handling Techniques

To prevent back injuries, it’s important to adopt safe lifting techniques and avoid known hazards.

Safe Lifting Techniques

There are eight steps to performing a lift in a safe manner:

1. Size up the load.
2. Plan the job.
3. Establish a base support.
4. Bend your knees.
5. Get a good grip.
6. Keep the load close.
7. Lift with your legs.
8. Pivot; don’t twist.

Size Up the Load

Always assess the object before lifting it. Make sure the load is stable and balanced. Carefully and slowly put force against the object to determine its weight. If it is too heavy, get help!

Plan the Job

Plan a route that is free of tripping and slipping hazards. Ensure that the planned route allows for easy travel. Know where the object will be unloaded and plan for rest stop if necessary. Think through the lift -lift the load in your mind. Face the object you are about to lift and, if possible, face the direction you want to go. Do not twist your body.

Establish Base of Support

Make sure you have a firm footing. Keep your feet at least shoulder width apart. A staggered stance, with one foot slightly behind the other, often helps provide a firm base of support.

Bend Your Knees

Bend at your knees, not at your waist. Bend or squat down as far as necessary using your legs and not your back. Tuck your chin in toward your chest. This will help keep your back straight. In this position, your knees are bent and your back is straight form your hips to your shoulders, as if you were in a sitting position.

Get a Good Grip

Place your hands at opposite sides of the object. Grip the load firmly, using your whole hand, not just your fingers. Pull your elbows in close to your body.

Keep the Load Close

Keep the load close to your body. The closer it is to your spine, the less force it exerts on your back. Maintain the natural curve of your lower back. Keep your back upright. Whether you are lifting or putting down a load, do not add the weight of your body to the load. Ten pounds at arms length is like lifting 100 pounds.

Lift with Your Legs

Lift with your legs to allow your body’s powerful leg muscles to do the work. Flex your knees and hips, not your back. Avoid bending at the waist!

Pivot; Don’t Twist

Don’t twist your body when moving objects that have already been lifted. Pivot your feet and turn your entire body in the direction of movement.
Back Safety Tips

- If an object is too big to lift, and weight is not a factor, push the object instead of pulling it. Lean into the object and let your body weight and thigh muscles do the work. Pushing out is less strain on the back.

- Keep loads out of the danger zone by keeping the load between shoulder and knuckle height. Working in the danger zone increase the chance of injury.

- Plan rest stops along your route. Muscle fatigue increase the risk of injury.

- Lower the load slowly, by bending your knees and hips. After releasing the load straighten up using your legs. Remember, you can injure yourself putting a load down as well as picking it up.

- Choose the safest and quickest route to your destination. Avoid stairs and other areas that provide poor footing if at all possible. If you must use stairways, get help and use equipment designed for moving up and down stairways when possible.

- Don’t reach over a surface to pick up an object. If you can’t get closer to the object, slide it toward you.

- Tighten the abdominal muscles (stomach) to give added support to the spine. This will help you offset the force of the load.

- Don’t obstruct your view by stacking objects too high. This is of the quickest routes to an injury.

- Keep the worksite clean in order to avoid slipping or tripping hazards. Good housekeeping eliminates a lot of unnecessary injuries.

- Don’t twist. Twisting is one of the most damaging movements for the back. When bending is added, the two multiply the risk of a back injury substantially.

- Move the load in a smooth motion. Don’t use jerky movement. Jerky movements not only increase the chance of strain or sprain, but also may throw you off balance.

- Walk using short steps with your feet far enough apart to maintain a good balance.

- Break large loads into smaller loads whenever possible.

- Use assistive devices such as dollies, winches, pulleys or forklifts when at all possible. These devices will help reduce the possibility of back injuries.

and

**THINK before you lift !!!!**

References

Videos pertinent to this subject may be obtained from the Arkansas Department of Labor/Arkansas Workers' Compensation Commission’s Health and Safety Resource Center at (501) 682-9090.
Slips, Trips, and Falls

The primary cause of injuries in the workplace is falls. Slips and trips are the major contributors to falls. Approximately 20 percent of fall injuries result in death. At the same time, the hazards of slips, trips, and falls are some of the easiest hazards to reduce or eliminate.

Let's look at some of the more common causes of slips, trips, and falls.

- Slippery floors created by water, oil, grease, food, or ice.
- Aisles, passageways, or stairs that are partially blocked by boxes, tools, scrap material.
- Climbing on unstable materials.
- Unguarded floor edges, openings or holes, or scaffolds.
- Using boxes, chairs, tables, etc. for climbing instead of ladders.
- Not using ladders properly or safely or using defective ladders.
- Carrying loads that block vision.
- Poor lighting on stairs or other walkways.
- Improper clothing, including pant cuffs too long, or improper footwear.

Now, let’s look at how to avoid those hazards.

- Clean up spills, scrap material, or other items that may cause slips, trips, or falls.
- Use only ladders and scaffolds that are safe and use them properly.
- Guard open-sided floors, floor openings, or floor holes.
- Make sure walkways and rooms have adequate lighting.
- Wear proper clothing, including clothes that fit, non-slip footwear, etc.

Slips, trips and falls occur every day. Their occurrence, and the extent of the injuries they cause can be eliminated by using safe equipment and by practicing safe work procedures. Don’t be a statistic—watch your step and practice safety.
# Meeting Attendance Form

<table>
<thead>
<tr>
<th>Date</th>
<th>Company Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Project Name</th>
<th>Meeting Location</th>
<th>Person Conducting Meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Items Discussed:

- [ ]
- [ ]
- [ ]
- [ ]
- [ ]

## Problem Areas or Concerns:

- [ ]
- [ ]
- [ ]
- [ ]
- [ ]

## Attendees:

- [ ]
- [ ]
- [ ]
- [ ]
- [ ]

## Comments:

- [ ]
- [ ]
- [ ]
- [ ]
- [ ]
# Job Safety Analysis

<table>
<thead>
<tr>
<th>Job Title (and number if applicable)</th>
<th>Page of JSA No.</th>
<th>Date:</th>
<th>New: ☐</th>
<th>Revised: ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title of Person Who Does Job:</td>
<td>Supervisor:</td>
<td>Analysis By:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Company/Organization:</td>
<td>Plant/Location:</td>
<td>Dept.</td>
<td>Reviewed By:</td>
<td></td>
</tr>
<tr>
<td>Required and/or Recommended Personal Protective Equipment:</td>
<td></td>
<td></td>
<td>Approved By:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sequence of Basic Job Steps</th>
<th>Potential Hazards</th>
<th>Recommended Action or Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Welcome to the Arkansas Municipal League Communities Platform

Our new AML Communities ListServ is more secure and offers a wealth of features designed to make idea sharing easier than ever. Upon login at http://AMLCommunity.arml.org, you may subscribe to the following communities:

- Mayor/City Manager
- Council Member/City Director
- Public Safety
- City Attorney
- Clerk/Recorder/Treasurer
- Technology

Existing subscribers will automatically migrate to their respective groups in the AML Communities ListServ—just follow these steps to set a new password:

- Visit http://AMLCommunity.arml.org
- Click the “sign in” button
- Click the “Can’t access your account?” link
- Follow the directions on the screen!
How Do You Stay Up with the Latest Information?

Join the "AML Communities!"

To join the "AML Community" that interest you, please follow these simple instructions.

**Step 1:** Decide which discussion group you want to join. Choices are:

- [ ] Mayor/City Manager
- [ ] Councilmember/City Directors
- [ ] Clerk/Recorder/Treasurer
- [ ] City Attorney
- [ ] Public Safety
- [ ] Technology

**Step 2:** Subscribe one of two ways.

1. Visit [www.arml.org](http://www.arml.org) – eCommunications (found at the bottom of our homepage)
   
   See: Subscribe to available league eCommunications.
   
   Select the group you are interested in and hit "subscribe."

   OR...

2. Provide the following information on this form:
   
   **Member City:**
   
   **Name and Title:**
   
   **Email:**
   
   **Daytime Phone #:**

**Send completed form to:**

- Email: jbarnett@arml.org; or
- Fax: 501-978-6568; or
- Mail: Arkansas Municipal League
  
  Attention: Whitnee Bullerwell/Jane Barnett

  P.O. Box 38

  North Little Rock, AR 72115

*Important Notice:* Any message(s) sent or responded to a listserv will be distributed to every member of the listserv and cannot be retracted once they are approved by the Listserv Moderator. The Arkansas Municipal League reserves the right to block any message deemed inappropriate and remove offenders from the listserv.
The Municipal Health Benefit Program ("Program") is a self-funded trust of municipalities. The Program is not governed by the Rules and Regulations of the Insurance Department of the State of Arkansas but is regulated by its Board of Trustees and follows the rules of the Affordable Care Act.

**Mandatory Administrative Appeals Procedure**

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

Program Administrative Office
P.O. BOX 188, North Little Rock, AR 72115
501-978-6137
What is eDocAmerica?
- Direct email access to eDocAmerica medical professionals
- Personal responses from, physicians psychologists, pharmacists, dietitians, and more...
- Weekly Health Tips written by physicians and delivered right to your email
- Healthy Lifestyle Assessment to help you monitor your current health status
- All services are FREE, unlimited, confidential, and cover the entire immediate family

24hr Registered Nurse Advice Line
- Toll free access to a registered nurse 24hrs a day, 7 days a week
- A registered nurse will advise the caller as to the proper disposition for their situation
- English and Spanish speaking nurses

To access the eDocAmerica Registered Nurse Advice Line, call toll free:
1-866-842-5365

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

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

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

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

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

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

1. Standards relating to benefits for mothers and newborns.
2. Standards relating to the Mental Health Parity and Addiction Equity Act.
3. Certain requirements to provide benefits for breast reconstruction after a mastectomy.
5. The exemption from these Federal requirements will be in effect for the 2020 plan year that begins on January 1, 2020 and ends on December 31, 2020.
6. This election may be renewed for subsequent plan years.

**Patient Privacy**

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

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

Mark R. Hayes
Plan Administrator
# Table of Contents

- Declaration of Trust ............................................. 1

## Section 1: General Eligibility Information ............................................. 5
- General Eligibility Information ........................................ 5
  - Eligibility Requirements .......................................... 5
  - Open Enrollment .................................................. 6
  - Retiree Coverage .................................................. 7
  - When Your Benefits Stop ......................................... 8
  - Right to Continuation Coverage under COBRA .................. 8
    - What is COBRA Continuation Coverage? ......................... 9
    - When is COBRA Coverage Available? .......................... 9
    - Notice Must Be Given of Some Qualifying Events ............... 9

## Section 2: Major Medical Benefits ..................................................... 11
- Calendar Year Deductibles for Major Medical Benefits ............ 11
- Individual Coinsurance .............................................. 11
- Stop Loss/Out-of-Pocket Maximum for Major Medical ............. 12
- Physician Benefits/Physician Visit Copayment .................... 12
- Emergency Room Copayment ....................................... 12
- Preventative Care Benefits ......................................... 12
- Pre-certification .................................................... 13
- Penalty Deductibles & Inpatient Admission ......................... 13
- Exception for Childbirth .......................................... 14
- Prior Authorization ................................................ 14
- Utilization Review Program ....................................... 14
- Additional Utilization Review Program Information ................ 15
- Case Management .................................................. 15
- Covered Major Medical Charges .................................... 17
- Preventative Care Program ......................................... 18
  - Special Limitations on Specific Types of Medical Treatments .. 19
- Special Benefits ................................................... 23
- Benefit Exclusions—WHAT IS NOT COVERED ....................... 23

## Section 3: Drug Benefits ................................................................. 28
- Prescription Drug Coverage or Prescription Drug Card Program .... 28
  - General Coverage ................................................ 28
  - Drug Therapy Management Programs .............................. 30
  - Prior Authorization ............................................... 31
  - Prescription Coverage for Members and Their Dependents who have Medicare .................... 32
  - Steps to Receive Medicare Part D Benefits ....................... 32
Section 4: Optional Benefits .............................. 33
  Optional Benefits ........................................... 33
    Dental Benefits .......................................... 33
      Dental Care Coverage Maximums and Deductible .................. 33
      Individual Coinsurance .................................. 33
      Dental Exclusions ...................................... 34
  Vision Care Benefits ........................................ 35
    Vision Care Services ..................................... 35
    Frames ...................................................... 35
    Contact Lenses .......................................... 35
    Standard Plastic Lenses ................................ 35
    Covered Lens Options .................................... 35
    Contact Lens Fit and Follow Up ............................ 35
    Member Cost .............................................. 35
    In-Network ................................................. 35
    Out-of-Network Member Reimbursement up to: .................... 35
    Discounted Lens Options ................................ 36
    Monthly Rate: ............................................ 36
  Life Coverage ................................................ 36
  Disability Income Benefits ................................... 37

Section 5: MHBP Preferred Provider Network (PPO) ............ 38

Section 6: Coordination of Benefits ............................ 40
  Coordination of Benefits (COB) .............................. 40
    Integration of Benefits .................................... 40
    How Coordination of Benefits (COB) Works .................... 40
    Notice and Proof of Claim ................................ 41
    Overpayments: Right of Recovery .......................... 42
    Right of Reimbursement ................................... 43
    Assignment of Rights ..................................... 44

Section 7: Appeals ............................................. 45
  Claims Reviews and Appeals Procedure ........................ 45
    Member Appeals: ......................................... 45
    Internal Claims and Appeal Reviews ........................ 46
    Independent External Claims Review .......................... 52
      Notification of External Review ........................... 52
      Rights and Assignment to Independent External Review Organization .......................... 52
      Instructions for Sending Your External Review Request ........... 53
      Preliminary Review ..................................... 53
      Expedited Reviews ..................................... 54

Section 8: Definitions ......................................... 55
  Definitions .................................................. 55

Section 9: Forms ................................................ 62
  Participation Agreement in the Municipal Health Benefit Program ........................................... 62
  Authorization to Disclose Health Information .................... 67
  Revocation of Authorization to Release Health Information ............................................. 69
  Change of Address Form .................................... 71
  American Fidelity .......................................... inside back cover
Section 1: General Eligibility Information

General Eligibility Information

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

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

Eligible Classes include the following:

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

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

Special Provisions related to individual Eligible Classes:

Class 3—To qualify for Coverage under the Program, volunteer firefighters must actively participate in more than:

- 50 percent of fire calls;
- 50 percent of training sessions;
- Verification of participation must be certified in writing under penalty of perjury by the Fire Chief and Mayor, City Manager or Chief Executive Officer;
- Certification must be submitted to the Program each year on or before December 31.

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

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

Eligibility Requirements

To be covered under the Program, you must enroll in the Program as of your Eligibility Date and agree to make any required premium contributions. If you do not enroll yourself and your Eligible Dependents before your Eligibility Date, you may not enroll or change your Coverage election until the next Open Enrollment Period unless you have a Qualifying Event described in this Booklet.
An Eligible Dependent is a dependent of an employee who is eligible for Benefits under the Program and includes the following:

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

**Open Enrollment**

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

**Special Enrollment Periods/Qualifying Event**

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

Qualifying Events:

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

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

**60 Days to Add an Eligible Dependent through Birth or Adoption if you have Existing Family Coverage**

If you have Family Coverage, you may apply for or request a change of Coverage within 60 days from the date of birth or adoption of a child. The Eligible Dependent must be added within 60 days of their date of birth or adoption regardless if a Social Security Number has been received. If the Eligible Dependent is not added to your existing family Coverage within 60 days of their date of birth, adoption, or placement, the newborn may not be eligible for Coverage until the next Open Enrollment Period.
If you do not have existing Family Coverage on the date the child is born or adopted, you have 30 days from the date of birth or adoption of a child to change your Coverage to Family Coverage and add the Eligible Dependent.

Supporting documentation required for certain Qualifying Events:

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

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

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

**Retiree Coverage**

Arkansas law requires municipalities to establish by ordinance, or otherwise, criteria for eligibility as a retiree. The Program will provide Retiree Coverage consistent with locally 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 if the retiring municipal official or employee:

- Is age 55 or older and has completed 20 years of service with a Participating Employer.
- Is receiving a retirement benefit from the Arkansas Local Police and Fire Retirement System, Arkansas Public Employees Retirement System, or a local pension fund.
- Pays both the Employer and Employee contribution to the Program.
- Is not covered at any time during retirement by another health care plan.
- Notifies the Employer within 30 days of the official date of retirement of their intent to participate in the Program. The retired employee or official may include his or her Eligible Dependents in the Program provided the dependent premium is paid.

**Important Information**

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

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

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

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

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

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

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

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

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

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

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

Eligibility as a Dependent will cease:

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

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

Right to Continuation Coverage under COBRA

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

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

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

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

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

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

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

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

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

When is COBRA Coverage Available?

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

Notice Must Be Given of Some Qualifying Events

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

MHBP Eligibility & Enrollment
Municipal Health Benefit Program
P.O. Box 188
North Little Rock, AR 72115
How can you elect COBRA continuation Coverage?

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

How much does COBRA continuation Coverage cost?

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

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

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

Periodic payments for continuation Coverage

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

Grace periods for periodic payments

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

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

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

Keep the Program informed of address changes

In order to protect you and your family’s rights, you should keep the Program informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Program. Additionally, if you have changed marital status or you or your spouse have changed addresses, please notify the Program in writing at the above address. Please note: If you have questions concerning your Program or your COBRA continuation Coverage rights, contact your Employer, or the Program, Municipal Health Benefit Program, P.O. Box 188, North Little Rock, AR 72115. For additional information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, visit the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.
Section 2: Major Medical Benefits

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

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 the Program’s Usual, Customary, and Reasonable Charges, or other methods as determined by the Program (including the use of health care cost management services, a wraparound network or Fair Market Pricing). Covered Members can expect to pay more than the applicable copayment and coinsurance amounts after the Program has paid its portion. Out-of-Network providers may bill Covered Members up to the billed charge after the Program has paid its portion.

Calendar Year Deductibles for Major Medical Benefits

<table>
<thead>
<tr>
<th>Standard Individual Calendar Year Deductible Major Medical</th>
<th>$500, $1,200 or $2,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Maximum Deductible-Major Medical</td>
<td>$6,000</td>
</tr>
</tbody>
</table>

Please consult your Employer for your Calendar Year Deductible. The Calendar Year Deductible shall be applied to the amount of covered medical expenses that are incurred each calendar year. Each Covered Member shall satisfy the $500, $1,200 or $2,000 Individual Calendar Year Deductible, or up to a Family Maximum Deductible of $6,000, 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 deductible expenses paid by all family members meets the overall Family Maximum Deductible.

Individual Coinsurance

Coinsurance is the percentage of costs a Covered Member must pay after he or she has met their Calendar Year Deductible. For services provided by a Preferred Provider, the Covered Member’s Coinsurance responsibility is 20% of the Allowable Amount; for emergency services provided by an Out-of-Network provider, the Covered Member’s coinsurance responsibility is 20% of the Allowable Amount**; and for non-emergency services provided by an Out-of-Network provider, the Covered Member’s coinsurance responsibility is 50% of the Allowable Amount**.

**Covered Members can expect to pay more than the applicable copayment and Coinsurance amounts after the Program has paid its portion 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 Allowable Amount.

| After the Calendar Year Deductible(s) are met, the Program will pay the following percentages for Covered Services: |
|-------------------------------------------------|-------------------------------------------------|
| **Emergency Room Services**                     | **Out-of-Network**                              |
| (In-State or Out-of-State)                       | 80% of the Program’s Preferred Provider Allowable Amount | 80% of the Program’s UCR or Other Allowable Amount |
| **All other Services**                           | 80% of the Program’s Preferred Provider Allowable Amount | 50% of the Program’s UCR or Other Allowable Amount |
| (In-State or Out-of-State)                       |                                                 |                                                |
For Covered Services provided by Out-of-Network providers or facilities, the Program will either 1) determine benefits according to Usual, Customary and Reasonable (UCR) charges, or 2) utilize health care cost management services to determine reasonable reimbursement rates specific to the geographic area and service provided.

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

Once the Calendar Year Deductible(s) have been met, and when In-State, Preferred Provider covered charges reach $20,000 for the Covered Member, or $40,000 for the Covered Member and his or her family, the Program will pay 100 percent (100%) of all Covered Services above that amount for the remainder of the calendar year, unless excluded or modified by other portions of this Program Booklet. This is called the Stop-Loss provision, or Out-of-Pocket Maximum.

The Stop Loss provision, or Out-of-Pocket maximum, does not apply to out-of-state Preferred Providers**, or Out-of-Network provider services, meaning that the Covered Member or Eligible Dependent will be responsible for his or her portion of coinsurance for all Covered Services received from Out-of-State, Preferred Providers, or Out-of-Network providers (some exceptions may apply depending on the location of the provider, please contact your Employer for more information).

In addition, penalty deductible(s), emergency room services copayments, and prescription drug copayments do not count toward the Out-of-Pocket Maximum(s). The Program will not pay 100 percent (100%) of the emergency room service charges even though a provider retains the patient for observation. The copayment may be waived for an inpatient hospital room admission however. For Stop Loss provisions related to Prescription Drug Benefits, see “Important Program Changes related to the Affordable Care Act (Healthcare Reform)” in Section 3, page 29.

**The Stop Loss provision, or Out-of-Pocket Maximum, applies to certain Out-of-State, In-Network providers located in Texas, Tennessee, and Missouri. For a complete listing of providers, please contact the Program.

**Physician Benefits/Physician Visit Copayment**

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

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

The Physician Visit Copayment will not count toward your Calendar Year Deductible. Any services or procedures rendered other than those billed under the CPT Codes listed above will be reimbursed as outlined in the Program Booklet.

**Emergency Room Copayment**

Outpatient emergency room visits will require a $250 copayment (access fee) for each visit. This $250 copayment is in addition to any other Program deductible or copayment requirement. Emergency room copayments do not apply to the Calendar Year Deductible or towards the Stop Loss provision, or Out-of-Pocket Maximum. When an emergency room visit results in inpatient hospital admittance (excluding observation stays), the $250 emergency room copayment will be waived. However, this does not apply when you are admitted to a different hospital than where you received emergency services. The Program will reimburse emergency room services (whether rendered at a Preferred Provider facility or an Out-of-Network facility) pursuant to deductible requirements and benefit percentages (80%) for emergent and immediate care and up to the Program's Allowable Amount for such services.

**Preventative Care Benefits**

The Program will pay 100 percent (100%) of the Allowable Amount for Preventative Care provided by a Preferred Provider (as described further below under “Preventative Care Program”), and any Benefits provided under Preventative Care will not be subject to Coinsurance, Deductible, or Copayment.
Major Medical Benefits

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

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

Pre-certification

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

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

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

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

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

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

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

Penalty Deductibles & Inpatient Admission

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

If your admission is due to an emergency, you or your family or physician will have until 5:00 p.m. the next business day to notify the Utilization Review Program of that admission. Direct admissions from your physician's office are not considered emergencies and must be pre-certified by you or your physician within twenty-four (24) hours. Failure to do so will result in the assessment of a $1,500 penalty deductible.
Outpatient observations lasting more than 23 hours may be considered as an inpatient admission and/or reduced to the 23-hour observation limit. No benefits will be paid for any charges related to non-certified days or services. Any observations lasting more than 23 hours must be pre-certified. **Failure to do so will result in the assessment of a $1,500 penalty deductible.**

### Exception for Childbirth

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

### Prior Authorization

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

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

### Utilization Review Program

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

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

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

If the Utilization Review Program disagrees with the number of days recommended by the doctor, or the use of durable medical equipment, you and your doctor will be advised. The Program will not pay for treatment which is not approved by the Utilization Review Program. If you disagree with any payment decision, you may appeal. See Section 7: Appeals, page 45. The decision to accept treatment is between you and your provider.

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

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

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

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

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

Appeals made by a provider as to medical necessity will be referred to a Medical Reviewer designated by the Plan Administrator. **The decision of the Plan Administrator’s Medical Reviewer shall be final and binding to all parties.** Appeals made by covered members or their legal representative shall be done in accordance with the internal/external review process set out in Section 7, page 45.

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, page 38, for more information. The Case Manager will work with the Covered Member and provider to seek out a cost-effective approach to the illness or injury as described in the Utilization Review Program portion of this booklet.

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

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

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

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Benefit Maximum Allowance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Medical Coverage</td>
<td>Lifetime</td>
</tr>
<tr>
<td>Acute Inpatient Habilitation/Rehabilitation</td>
<td>Annual</td>
</tr>
<tr>
<td>Sub-Acute Inpatient Habilitation/Rehabilitation</td>
<td>15 Days</td>
</tr>
<tr>
<td>Habilitative Services</td>
<td>15 Days</td>
</tr>
<tr>
<td>Bariatric Weight Loss Program*</td>
<td></td>
</tr>
<tr>
<td>Chemical Dependency Treatment</td>
<td>Lifetime 1 Treatment Plan **</td>
</tr>
<tr>
<td>Diabetic Training</td>
<td>Annual 1 Day Session</td>
</tr>
<tr>
<td>Emergency Ambulance Services (ground or air)</td>
<td>Annual 2 Runs/Trips</td>
</tr>
<tr>
<td>Non-Emergency Surgical Procedures</td>
<td>Annual 2 Procedures</td>
</tr>
<tr>
<td>Requiring Precertification (Hospital or Ambulatory Surgery Center)</td>
<td></td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>One per ear one (1) time every three (3) years</td>
</tr>
<tr>
<td>Home Health Services</td>
<td>Annual 20 Visits</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>Lifetime 90 Days</td>
</tr>
<tr>
<td>Inpatient Hospital Services</td>
<td>Annual 30 Days</td>
</tr>
<tr>
<td>Mental/Nervous Disorders</td>
<td>Annual 10 Days</td>
</tr>
<tr>
<td>Inpatient</td>
<td>Annual 24 Visits</td>
</tr>
<tr>
<td>Individual Therapy Sessions</td>
<td>Annual 2 Each</td>
</tr>
<tr>
<td>PET Scans</td>
<td>Annual 2 Visits</td>
</tr>
<tr>
<td>Nutritional and Weight Counseling</td>
<td>Annual 40 Visits Combined</td>
</tr>
<tr>
<td>Outpatient Occupational, Physical, Speech, Habilitative Therapy and Chiropractic Services (Combined Benefit)</td>
<td></td>
</tr>
<tr>
<td>Organ Transplant Benefits</td>
<td>Lifetime 2 Transplants***</td>
</tr>
<tr>
<td>Custom Molded Foot Orthotics</td>
<td>Annual 2 Pairs</td>
</tr>
<tr>
<td>Diabetic Related Footwear/Shoes</td>
<td>Annual 2 Pairs</td>
</tr>
<tr>
<td>Prosthetic Bra for Oncology Covered Members</td>
<td>Annual 2 Each</td>
</tr>
<tr>
<td>Wound Care and Hyperbaric Oxygen Treatment</td>
<td>Annual 20 Visits</td>
</tr>
<tr>
<td>Sleep Study</td>
<td>Annual 1 Visit****</td>
</tr>
</tbody>
</table>

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

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

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

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

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

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

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

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

Cataract Surgery—Charges for cataract surgery, including the first pair of standard eyeglasses or standard contact lenses when needed as a result of and purchased within ninety (90) days of such surgery. Glasses and lenses will be reimbursed at the Program’s Allowable 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. For more information, please see Usual, Customary and Reasonable Charges (UCR).

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

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

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

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

Preventative Care Program

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

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

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

Immunizations/Inoculations

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

Please note: Allergy injections and expenses related to birth of a child are not considered part of this benefit. Other injectable medicines may be covered under the Prescription Drug Card Program. Please see the Prescription Drug Card section of this Program Booklet (Section 3, page 28). Pharmacy copays will be assessed if the above are administered at your local pharmacy, except for Influenza.

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

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

Special Limitations on Specific Types of Medical Treatments

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

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

Allowable Amount—The maximum amount deemed by the Program, in its sole discretion, to be reasonable payment for a Covered Service. The Allowable 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 Allowable Amount means Usual, Customary, and Reasonable (UCR) charges, or charges as established by the Program’s utilization of health care cost management services, less any deductions 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 Allowable Amount as payment in full, and may bill Covered Members up to the billed charge after the Program has paid its portion. Allowable Amounts do not include charges used to satisfy the deductibles, copayments or coinsurance assessed under the Program’s Major Medical Benefit, or the Prescription Drug Card Program. (For more information, see Coordination of Benefits.)
**Average Wholesale Pricing** (AWP)—The charge determined by the Program for products provided to the Covered Members, employing the most current Average Wholesale Price (AWP) or another industry-accepted benchmark as set forth by Medispan, First Databank, or other industry-accepted database. The Program retains the right to review all claims for such products provided to its Covered Members. The Program retains the right to reimburse providers at eighty-five (85%) percent of AWP for claims billed. The National Drug Code (NDC) is a unique product identifier used in the United States for drugs intended for human use. (For more information see Usual, Customary and Reasonable Charges (UCR).

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

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

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

Eligible morbid obesity expenses incurred will be covered subject to Medical Case Management approval and Program limitations. Under this provision, Eligible morbid obesity expenses include the pre-obesity evaluation, medical and surgical treatment for post obesity follow-up care including but not limited to treatment of any complications. The morbid obesity treatment must be performed at a Program-designated Morbid Obesity Treatment Center and is an eligible benefit for covered individuals 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 Morbid Obesity Center**—If the morbid obesity treatment is performed at a Non-Designated Morbid Obesity Treatment Center or if Medical Case Management is refused, the pre-obesity, obesity and post-obesity care will not be covered.

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

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

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

**How to Obtain a Pre-Determination**

1. Call your Program Case Manager at 888-295-3591 and notify them that you are interested in the MBS-AQIP program.  
2. Once pre-determination is completed the member will then contact the MBS-AQIP physician’s office for program registration. This must be done at www.obesity-surgery.net. You must fill out the new patient application online.  
3. After the application is completed and you have been approved for the program, you will then complete six months of physician supervised weight management.  
4. Monthly updates are required to be sent to the Program Case Manager by your physician or dietician.
How to Obtain Pre-Authorization for Bariatric Surgery

1. Call your Program Case Manager and notify them that you have completed the six months of physician supervised weight management and are ready to proceed with surgery.

2. Your case manager will contact the MBS-AQIP physician's office and proceed with prior-authorization.

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

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

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

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

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

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

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

Individual coinsurance and the individual annual deductible will not be applied to the hearing aid benefit; however, any out-of-pocket costs associated with these devices will not be credited toward the individual annual deductible. Additionally, these devices will not be covered if they are misused or lost. (See Exclusions, page 24.) All charges and/or costs above the $1,400 maximum per ear one (1) time every three (3) years will be the member’s responsibility.

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

Home Health Care Services (care performed in a home setting)—Payment of these benefits is limited to an annual maximum of 20 visits per year and is subject to review by Case Management to identify medical criteria and cost effective alternatives. Coverage for this benefit will be limited to charges for Home Health Care visits made by a Registered Nurse, a Licensed Practical Nurse, a Physical Therapist, an Occupational Therapist, or a Speech Therapist and in accordance with a home health care plan established by a doctor and/or recommended by Case Management. You must be homebound to qualify for Home Health Care Services. (See Section 8: Definitions, page 55.)

Hospice Care—The Program will pay for covered Hospice charges, whether in the home or in an inpatient setting, including equipment and supplies, which are medically necessary for treatment if the member is totally disabled as a result of terminal illness and has a life expectancy of six months or less. A treatment plan is required and must be submitted to Case Management for precertification before benefits can be considered. Hospice Care charges will be limited to a lifetime maximum of 90 days. (Please see Alternative Case Management, page 15, for additional information.)
Maternity Benefits and Newborn Child Care—If you have family Coverage, an eligible newborn can be added to your Coverage on the newborn’s date of birth. The newborn must be added within 60 days of their date of birth regardless if Social Security Number is received or not. The Program’s annual inpatient hospital maximum applies to this benefit.

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

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

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

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

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

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

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

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

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

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

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

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

Telemedicine

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

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

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

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

Benefit Exclusions—WHAT IS NOT COVERED

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

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

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

Expenses for the following are not covered by the Program:

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

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

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

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

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

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

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

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

Benign Gynecomastia (abnormal breast enlargement in males)—Services and procedures to treat this condition will not be covered by the Program.
Blood—Blood, blood plasma, blood derivatives as these can be donated or replaced by the member or family. Additionally, fees to cover blood donations or blood storage are not covered.

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

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

Counseling Services—Outpatient counseling services (marriage, family, career, children, social adjustment, pastoral, financial, or any form of group counseling) will not be covered by the Program, unless defined elsewhere in this booklet.

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

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

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

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

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

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

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

Free Flu Clinics/Health Fairs—Charges for services that are free or that a covered member is not required to pay, or would not otherwise be made if Coverage did not exist are not covered under the 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 not covered under the Program with the exception of cancer diagnoses.

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

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

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

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

Immediate Relative—Services or charges provided by someone who is an immediate relative as defined in the Definitions section or who ordinarily resides in your home. (See Section 8: Definitions, page 55.)

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

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

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

Maintenance Care—All services, equipment, and supplies which are provided solely to maintain a covered individual’s condition and from which no functional improvement can be expected or is not life sustaining treatment for a medical condition.
Mandated or Court Ordered Care—Coverage for medical, psychological, or psychiatric care required by court order, or otherwise mandated by a third party, is not covered by the Program.

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

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

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

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

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

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

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

Routine Foot Care—The Program does not cover any services or supplies in connection with:
  a. Care of corns or calluses;
  b. Care of toenails;
  c. Care of flat feet;
  d. Supportive devices of the foot such as arch supports and/or pelvic or spinal stabilizers;
  e. Orthotics for sports use.

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

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

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

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

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

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

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

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

If benefits are paid or provided by the Program whenever this exclusion applies, the Program reserves all rights to recover the reasonable value of such benefits, as provided in the Program Booklet under the Right of Reimbursement terms on page 43.

**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:

- 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);
- Under study in clinical trials other than those clinical trials meeting criteria established by federal law;
- Exceeds (in scope, duration or intensity) that level of care which is needed; or
- 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; mudwing; 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 Preventative Benefits portion of the Program.

**PLEASE NOTE:** that medical complications occurring as a result of receiving services excluded under the Program, including but not limited to, surgeries, procedures, or medications, are not covered by the Program. For other policy provisions, explanation of services and limitations, please see Section 8: Definitions, page 55.

**Circumstances That May Result in the Reduction or Loss of Benefits:**
- Coordination of benefits when a covered person is enrolled in more than one plan and this Program is not the primary plan.
- Subrogation, reimbursement, and third-party recovery rights of the Program.
- Reductions when private hospital rooms are used.
- Reductions for certain multiple surgical procedures.
- Reductions for charges that exceed the usual and customary negotiated fee Allowable Amounts.
- Reductions and/or denials for services which are not medically necessary or generally accepted as inappropriate and/or are considered as overutilization.
- Denial for services for anyone currently residing outside the United States or Canada, except for emergency services.
- Denial for anyone already covered under the 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 person failing to provide requested documentation such as an accident claim form, multiple Coverage inquiry, certificate of acceptance of plan provisions, 2-page accident and injury questionnaire, etc.
- Services must be performed at an accredited, licensed, certified facility for the treatment received.
- For covered Members who decline to purchase the minimum medical and hospital benefits under their automobile insurance Coverage, pursuant to Ark. Code Ann. § 23-89-202(1), the Program will coordinate as if the covered member had purchased this Coverage.
Section 3: Drug Benefits

Prescription Drug Coverage or Prescription Drug Card Program

General Coverage

Prescription Drug Charges—The Program will provide Coverage for drugs and medicines obtainable only on a physician’s written prescription, except as defined under Drug Card Quantity Limitations.

Prescription/Medical ID cards should be delivered within 30 days from the date the Program has received and processed your enrollment paperwork.

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

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

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

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

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

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

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

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

Brands with a Generic Available—The Program enforces a Mandatory Generic Policy for brand-name drugs that are available generically. In the event a brand-name drug is chosen for which a generic 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—Injectable and non-injectable drugs requiring a prescription, except as specifically excluded, are considered covered.

Blood Glucose Monitoring—Blood glucose meters allow members with diabetes to become an active participant in the management of their diabetes by allowing them to detect and treat changes in their blood sugar. In an effort to help members effectively self-manage their diabetes, the Program allows members with diabetes to receive one free blood glucose meter per year at no charge.
The following Accu-Chek and OneTouch blood glucose meters are currently available:

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

**Free Diabetic Supplies**—You can receive your blood glucose strips and lancets at your local pharmacy. These supplies are available for a $0 co-payment when purchased within 100 days of your insulin or diabetic medication. The pharmacy must process the prescription for your insulin or diabetic medication before processing the supplies.

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

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

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

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

Stop-loss or out-of-pocket maximums for the Prescription Drug Benefit is:

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

Also note that expenses related to prescription drugs involved in the Program’s reference pricing program are deemed excluded from Coverage and do not apply to the out-of-pocket maximum.

Important information regarding specific prescription drug Coverage is available on the Program’s website, www.arml.org.

**Preventive Services**—The Program provides Coverage for the following “preventive” medications/drug categories as required by the Affordable Care Act (ACA). These products will be available at $0 copayment unless otherwise specified when accompanied by a prescription from your physician. Reasonable medical management processes will be in place to ensure appropriate frequency, method, treatment, or setting for an item or service.

<table>
<thead>
<tr>
<th>Drugs / Drug Categories</th>
<th>Coverage Parameters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin to Prevent Cardiovascular Disease</td>
<td>For members ≥ 45 years of age. Quantity Limit of 100</td>
</tr>
<tr>
<td>Iron Supplementation for Children</td>
<td>For children up to 1 year of age</td>
</tr>
<tr>
<td>Oral Fluorides for Children</td>
<td>For children ≥ 6 months and ≤ 6 years of age</td>
</tr>
<tr>
<td>Folic Acid Supplements</td>
<td>For female members ≥ 55 years of age. Quantity Limit of 100</td>
</tr>
<tr>
<td>Tobacco Cessation</td>
<td>For members &gt; 18 years of age. Annual Limit: 2 cycles of treatment (12 weeks/cycle)</td>
</tr>
<tr>
<td>Routine Vaccinations for Children &amp; Adults</td>
<td>See Preventative Benefits, page 18.</td>
</tr>
<tr>
<td>All FDA approved contraceptive methods</td>
<td>Coverage limited to the Program’s custom list and is subject to change</td>
</tr>
<tr>
<td>Breast Cancer Prevention</td>
<td>Tamoxifen, raloxifene</td>
</tr>
<tr>
<td>Vitamin D Supplementation</td>
<td>For members ≥ 65 years of age</td>
</tr>
<tr>
<td>Cholesterol Reducers (Statins)</td>
<td>Generic low-to-moderate dose statins at 100% for members 40-75 who have one of the following cardiovascular disease risk factors: diabetes, hypertension, dyslipidemia and/or smoking.</td>
</tr>
</tbody>
</table>
Medicare Retirees and Medicare Eligible Members (MEDICARE PART B & PART D)

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

Mail-Order Pharmacy—In addition to the traditional retail pharmacy network, Program members may obtain their medications through MedVantx mail order pharmacy. The mail order co-payment structure is the same as that for retail. Information and instructions on how to use the mail order pharmacy may be obtained by calling MedVantx at 866-744-0621 or by visiting www.MedVantxRx.com. The Program's standard co-payment structure will apply to each 30-day supply of medication obtained through the mail service pharmacy. A maximum of a 90-day supply of medication may be obtained through the mail service pharmacy, however a copayment for each one-month supply will be charged.

Specialty Pharmacy—Very expensive medications (many of which are injectables) are covered under the prescription drug card benefit. However, due to the extreme cost of these products, they will be covered through a specialty pharmacy provider, Allcare Specialty Pharmacy. The Evidence-Based Prescription Drug program (EBRx) at UAMS will need to be contacted for Prior Authorization by calling (833) 339-8401. If approved, the authorization will be referred to Allcare Specialty Pharmacy. The member or physician will then be contacted to arrange for shipment of the medication.

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

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

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

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

Drug Therapy Management Programs

In an effort to ensure that prescription Coverage remains affordable for the 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 timeframe. The list of drugs managed by quantity limits is available at www.arml.org.

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

Step/Contingent Therapy

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

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

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

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

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

Prior Authorization

The Program has established Coverage policies for certain medications and drug classes which will require Prior Authorization. When these medications are prescribed by your provider, your provider will be required to obtain authorization from the Program in order for the medication to be eligible for benefits (Prior Authorization). Consideration for Coverage will be given for those medications listed on the Program’s Pharmacy Drug List Requiring Prior Authorization, located at www.arml.org. 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.

Provider Assistance

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

Member Assistance

Members having general questions about the Program’s prescription drug Coverage should call the OptumRx call center at 855-253-0846 available 24/7.

Drug Card Exclusions

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

New Drugs Entering the Market

All new drugs entering the market will automatically be excluded from Coverage. These drugs will remain excluded until evaluated by the EBRx Pharmacy and Therapeutics Committee. If this committee, made up of practicing physicians and pharmacists, determines that a product should be covered, it will then be moved to the appropriate preferred or non-preferred copay tier on the formulary. Otherwise, it will remain excluded from Coverage.
Prescription Coverage for Members and Their Dependents who have Medicare as Their Primary Coverage

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

The supplement pays benefits toward out-of-pocket costs for expenses eligible under Medicare Part D that are also eligible under the provisions of Prescription Drug Coverage of the Program for Employees and Dependents. Your out-of-pocket cost for these expenses, after the combined benefits, is no more than the Program copays.

Steps to Receive Medicare Part D Benefits

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

Important Note:

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

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

Attach copies of prescription receipts showing the following information:

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

Please allow 4-6 weeks for processing.

Status of these claims can be obtained by calling the OptumRx Call Center at 855-253-0846.
Section 4: Optional Benefits

Optional Benefits

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

Dental Benefits

Benefits Payable—Dental Benefits are payable if a covered member incurs dental expenses and has satisfied the Dental Calendar Year Deductible of $50 for the year in which the expenses are incurred. Benefits are payable in an amount equal to the appropriate Covered Percentage of such expenses as set out in the Schedule of Benefits. However, the total amount payable for all Covered Dental Charges incurred by a covered member during a calendar year will not exceed the Annual Maximum of $1,200 unless defined otherwise in the Schedule of Benefits.

Dental Care Coverage Maximums and Deductible

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Deductible/Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Calendar Year Deductible (covers all services below)</td>
<td>Annual $50</td>
</tr>
<tr>
<td>Dental Procedures</td>
<td>Annual $1,200</td>
</tr>
<tr>
<td>Orthodontic</td>
<td>Lifetime $1,000</td>
</tr>
<tr>
<td>Temporomandibular Joint Dysfunction (TMJ)</td>
<td>Annual $1,000</td>
</tr>
</tbody>
</table>

Individual Coinsurance

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

- PPO Providers In-State or Out-of-State—80% of the Program’s Allowable Amount for PPO Services
- Non-PPO Providers In-State or Out-of-State—50% of the Program’s Allowable Amount for Non-PPO Services

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

- Oral examinations, including prophylaxis, but not more than two examinations in any calendar year.
- Topical application of sodium or stannous fluoride and the application of sealants.
- Dental X-rays.
- Fillings, extractions, space maintainers, and oral surgery.
- Anesthetics administered in connection with covered dental services.
- Injection of antibiotic drugs by the attending dentist.
- Treatment of periodontal and other diseases of the gums and tissues of the mouth.
- Endodontic treatment, including root canal therapy.
- Repair or re-cementing of crowns, inlays, bridgework or relining or repair of dentures.
- Initial installation (including adjustments for the six-month period following installation) of partial or full removable dentures to replace one or more natural teeth extracted while covered under these provisions.
• New Dentures or Bridgework:
  Two years after the effective date of the covered member’s benefits, the Program will cover a new denture, or new
  bridgework, including crowns and inlays forming the abutments for the replacement of teeth that replaces an exist-
  ing partial, fully removable denture(s) or fixed bridgework; or the Program will cover the addition of teeth to an
  existing partial removable denture or bridgework to replace extracted natural teeth, but only if evidence satisfactory
  to the Program is presented that:
    a. The existing denture or bridgework cannot be made serviceable and was installed at least five years prior to its
       replacement; or
    b. The existing denture is an immediate temporary denture and replacement by a permanent denture is required
       and takes place within 12 months from the date of installation of the immediate denture; or
    c. The replacement or addition of teeth is required to replace one or more additional natural teeth, extracted
       while covered under these provisions and after the existing denture or bridge work was installed.
• Inlays, gold fillings, crowns (including precision attachments for dentures), and initial installation of fixed bridge-
  work (including inlays and crowns to form abutment) to replace one or more natural teeth extracted while covered
  under these provisions.
• Orthodontic treatment, including correction of malocclusion—However, the total amount of benefits payable for
  all such expenses incurred will not exceed the maximum benefit of $1,000 even if required as a part of a medical
  procedure. Orthodontic benefits are not payable under the TMJ provisions of the Program.
• Temporomandibular Joint Dysfunctions (TMJ)—Payment for services for the treatment of TMJ is limited to $1,000
  per calendar year. The calendar year limit will include services for facial or joint pain related to temporomandibular
  joint dysfunction. This limit applies to TMJ services, even if treatment is related to a medical condition, and is cov-
  ered only under the Dental Benefit. TMJ benefits are not payable under the Orthodontic provisions of the Program.

Dental Exclusions
No benefits are payable for charges a covered member is not required to pay or which would not be made if benefits did not
exist, or for expenses incurred:
• On account of or in connection with:
  a. The replacement of a lost or stolen prosthetic device.
  b. Charges made by a provider other than a dentist, or charges for treatment by a provider other than a dentist,
     except for a prophylaxis, which may also be performed by a licensed dental hygienist working under the
     supervision of a dentist.
  c. Incurred due to a medical condition.
  d. Services performed in a hospital or out-patient surgery setting.
  e. Prosthetic devices (including bridges, crowns and appliances) and the fitting thereof which were ordered for
     an individual prior to his becoming covered under these provisions.
• For care, treatment, services, and supplies that are:
  a. Furnished primarily for cosmetic purposes.
  b. Provided by someone who is an immediate relative as defined in Section 8: Definitions, page 55, or who
     ordinarily resides in your home.

Please Note: The Program does not pay for preparatory work done for the eventual placement of crowns, fixed
bridgework, and dentures until services for the placement have been received and completed.
<table>
<thead>
<tr>
<th>Vision Care Services</th>
<th>Member Cost In-Network</th>
<th>Out-of-Network Member Reimbursement up to:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exam (With dilation as necessary)</strong></td>
<td>$30 Copay</td>
<td>$40</td>
</tr>
<tr>
<td><strong>Frames</strong></td>
<td>$0 Copay; $100 allowance</td>
<td>20% off balance over $100</td>
</tr>
<tr>
<td><strong>Contact Lenses</strong></td>
<td>$0 Copay; $100 allowance</td>
<td>$80</td>
</tr>
<tr>
<td><strong>Standard Plastic Lenses</strong></td>
<td>$0 Copay; $100 allowance</td>
<td>$80</td>
</tr>
<tr>
<td>Conventional</td>
<td>15% off balance over $100</td>
<td></td>
</tr>
<tr>
<td>Disposable</td>
<td>$0 Copay; $100 allowance</td>
<td>$80</td>
</tr>
<tr>
<td>Medically Necessary</td>
<td>$0 Copay, Paid-In-Full</td>
<td>$210</td>
</tr>
<tr>
<td><strong>Covered Lens Options</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard Anti-Reflective</td>
<td>$45 Copay</td>
<td>$5</td>
</tr>
<tr>
<td>Premium Anti-Reflective Tier 1</td>
<td>$57 Copay</td>
<td>$5</td>
</tr>
<tr>
<td>Premium Anti-Reflective Tier 2</td>
<td>$68 Copay</td>
<td>$5</td>
</tr>
<tr>
<td>Premium Anti-Reflective Tier 3</td>
<td>$85 Copay</td>
<td>$5</td>
</tr>
<tr>
<td>Standard Polycarbonate under age 19</td>
<td>$0 Copay</td>
<td>$5</td>
</tr>
<tr>
<td><strong>Additional Vision Care Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discounted Exam Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retinal Imaging Benefit</td>
<td>Up to $39</td>
<td></td>
</tr>
<tr>
<td><strong>Contact Lens Fit and Follow Up</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Contact lens fit and two follow-up visits are available once a comprehensive eye exam has been completed.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard Contact Lens Fit &amp; Follow-Up</td>
<td>$40</td>
<td></td>
</tr>
<tr>
<td>Premium Contact Lens Fit &amp; Follow-Up</td>
<td>10% off retail price</td>
<td></td>
</tr>
</tbody>
</table>
**Discounted Lens Options**

<table>
<thead>
<tr>
<th>Option</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Photochromic (Plastic)</td>
<td>$75</td>
</tr>
<tr>
<td>Tint (Solid &amp; Gradient)</td>
<td>$15</td>
</tr>
<tr>
<td>UV Treatment</td>
<td>$15</td>
</tr>
<tr>
<td>Standard Plastic Scratch Coating</td>
<td>$15</td>
</tr>
<tr>
<td>Standard Polycarbonate—age 19 and over</td>
<td>$40</td>
</tr>
</tbody>
</table>

**Monthly Rate:**

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

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

**Life Coverage**

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

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

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

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

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

**Accidental Death and Dismemberment Benefits**—A separate certificate outlines your benefits for Accidental Death and Dismemberment that are underwritten by an insurance company. Consult your Employer for amount of benefit.

**Important:**

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

In this instance the term Child shall include:

a. An employee’s natural child from birth less than 19 years of age.

b. An employee’s adopted child or stepchild under legal guardianship, if such child depends primarily on the employee for support and maintenance and lives with the employee in a regular parent-child relationship.

c. An employee’s grandchild who is under legal guardianship or legal custody of the employee.
Disability Income Benefits
Optional Coverage for Full-Time Employees Only

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

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

<table>
<thead>
<tr>
<th></th>
<th>Option A (26 Week Benefit)</th>
<th></th>
<th>Option B (52 Week Benefit)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekly Benefit</td>
<td>$105</td>
<td>Weekly Benefit</td>
<td>$105</td>
</tr>
<tr>
<td>First Benefit Day for Disability due to Accident</td>
<td>1st Day</td>
<td>First Benefit Day for Disability due to Accident</td>
<td>183rd Day</td>
</tr>
<tr>
<td>Illness</td>
<td>8th Day</td>
<td>Illness</td>
<td>183rd Day</td>
</tr>
<tr>
<td>Maximum Number of Weeks Payable</td>
<td>26 Weeks</td>
<td>Maximum Number of Weeks Payable</td>
<td>52 Weeks</td>
</tr>
</tbody>
</table>

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

Filing a Claim—For a covered member to file a disability claim, he or she should contact their Employer to obtain a Request for Disability Income Form. The requested forms must be submitted and received by the Program within 180 days of the first date of disability. The Disability Income Form is also available online at www.arml.org/services/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: MHBP Preferred Provider Network (PPO)

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

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 the Program’s Usual, Customary, and Reasonable Charges, or other methods as determined by the Program (including the use of health care cost management services, a wraparound network or Fair Market Pricing). Covered Members can expect to pay more than the applicable copayment and coinsurance amounts after the Program has paid its portion. Out-of-Network providers may bill Covered Members up to the billed charge after the Program has paid its portion.

| After the Calendar Year Deductible(s) are met, the Program will pay the following percentages for Covered Services under the Major Medical, and/or Optional Dental Benefit: |
|---------------------------------|---------------------------------|---------------------------------|
| Emergency Room Services (In-State or Out-of-State) | Preferred Provider Network | Out-of-Network |
| 80% of the Program’s Preferred Provider Allowable Amount | 80% of the Program’s UCR Allowable Amount** |
| All other Services (In-State or Out-of-State) | Preferred Provider Allowable Amount | 50% of the Program’s UCR Allowable Amount** |

For optional Vision Benefits, the Program pays according to the terms and conditions listed on page 35.

**For Covered Services provided by Out-of-Network providers or facilities, the Program will either 1) determine benefits according to Usual, Customary and Reasonable (UCR) charges, or 2) utilize health care cost management services to determine reasonable reimbursement rates specific to the geographic area and service provided.

Health care cost management services may include the use of a wrap-around network for out-of-state, Out-of-Network providers.
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

Covered Members can expect to pay more than the applicable copayment and coinsurance amounts after the Program has paid its portion. 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 may bill Covered Members up to the billed charge after the Program has paid its portion.
Section 6: Coordination of Benefits

Coordination of Benefits (COB)

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

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

Integration of Benefits

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

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

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

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

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

How Coordination of Benefits (COB) Works

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

2. This is how to determine which is the Primary Plan and Secondary Plan:
   A. The plan covering the Employee is primary unless the employee's automobile med-pay comes into play such as in the event of a single-vehicle accident. The plan covering the Employee as an Eligible Dependent is secondary.
B. If both the mother’s and father’s plans cover the child, the plan of the parent whose birthday month is earlier in the year is the primary plan.

C. Benefits for children of divorced or separated parents are determined in the following order:
   a. Plan of the parent the court has established as financially responsible for the child’s health care pays first (we must be informed of this requirement and documentation will be required).
   b. Plan of the custodial parent.
   c. Plan of the custodial parent’s new spouse (if remarried).
   d. Plan of the non-custodial parent.
   e. Plan of the non-custodial parent’s new spouse (if remarried).

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

If you or your Eligible Dependent has Coverage under a Primary Plan other than the Program, but you do not follow the plan benefit requirements of the Primary Plan, the Program’s reimbursement for your claims will be reduced by 80 percent. In other words, the maximum the Program will pay is 20 percent of the Allowable 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:
   A. If your Employer has less than 20 employees, Medicare is primary for covered members eligible for Medicare due to age.
   B. If your Employer has less than 100 employees, Medicare is primary for covered members eligible for Medicare due to disability.
   C. If your Employer has more than 100 employees, the Program is primary over Medicare for covered members eligible for Medicare due to age or disability.
   D. A Member eligible for Medicare based solely on end stage renal disease is entitled to receive benefits of this Program as primary for a 30-month waiting period.

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

Notice and Proof of Claim

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

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

Failure to file a claim as required above, will cause the claim to be denied unless the Member can present written proof that it was not reasonably possible to give notice or proof within the required time period.
No legal action will be brought against the Program prior to 90 days after proof of claim has been filed with the Program Administrator. If the time for beginning legal action is less than that permitted by law of the jurisdiction in which the Program is domiciled, such limit is extended to the minimum period permitted by such law.

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

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

**Overpayments: Right of Recovery**

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

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

- As a condition to receiving benefits from the Program, each participant, former participant or other person having an interest in or eligibility under the Program (“member”) shall provide the Program with a Right of Reimbursement and an Assignment of Rights, as described below. These rights enable the Program to recover the amount it has expended to provide the benefits to the member from any proceeds the member receives from a third person in connection with the accident or injury.

- The Program will refuse to provide the participant or other covered members of the participant’s family any benefits under the Program if the participant refuses to execute an agreement agreeing to reimburse the Program, fails to reimburse the Program, or fails to cooperate in helping the Program collect reimbursement from the participant or a third party.

Right of Reimbursement

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

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

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

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

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

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

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

**Assignment of Rights**

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

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

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

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

Furthermore, notwithstanding the above provisions, the Program reserves the right to seek reimbursement for any and all overpayments which it may make by offsetting future payments to or on behalf of the participant or other covered members of the participant’s family, until it has been fully reimbursed for the expenditures it has made.
Section 7: Appeals

Claims Reviews and Appeals Procedure

Getting Help with your Claim for Benefits

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

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

Claims and Appeals Procedures Generally

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

Provider Appeals:

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

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

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

Member Appeals:

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

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

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

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

Within 60 days the receipt of your request, a Claims Review Team Representative will respond to you in writing with a determination regarding your appeal. If your claim is denied the response will reference the Program provision upon which the denial was based and will provide you with an explanation of additional appeals you may make. If the Program needs time to investigate the facts, you will be notified.
Final Internal Written Appeal—If the decision rendered by the Claims Review Team is not satisfactory, you or a duly authorized representative may appeal from that denial to the Board of Trustees for the Municipal Health Benefit Program within 60 days of having received a denial notice from the Claims Review Team. To do so, write to the Plan Administrator, P.O. Box 188, North Little Rock, AR 72115. In your request for a review of the denial specifically state why you believe the denial was incorrect. In connection with your request, you may submit documents supporting your claim. Your appeal will be reviewed by the Board at the quarterly meeting of the Board of Trustees along with documents pertinent to the administration of the Program. You may attend the Board meeting and present your case to the Board and may have representation throughout this review procedure though you need not make an appearance at the Board meeting.

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

Internal Claims and Appeal Reviews

1. Definitions

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

A. Adverse benefit determination—The term “adverse benefit determination” means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for:

- A benefit;
- A benefit based on a determination of whether a participant or beneficiary is eligible to participate in the Program;
- A benefit resulting from the application of any utilization review; as well as
- Failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; or
- Any rescission of Coverage, regardless of whether there is an adverse effect on any particular benefit at that time.

B. Appeal (or internal appeal)—The term “appeal or internal appeal” means a review by the Program.

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 a person covered by the Program who makes a claim under this section. References to a claimant include a claimant’s authorized legal representative.

E. External review—The term “external review” means a review of an adverse benefit determination (including a final internal adverse benefit determination) conducted pursuant to the federal external review process.

F. Final external review decision—The term final external review decision means a determination by the independent review organization at the conclusion of an external review.

G. Final internal adverse benefit determination—The term “final internal adverse benefit determination” means an adverse benefit determination that has been upheld by the 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 a group health plan that is not a pre-service claim.

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

L. **Rescission**—The term “rescission” is a cancellation or discontinuance of Coverage that has retroactive effect. For example, a cancellation that treats Coverage as void from the time of the individual's or group's enrollment is a rescission. As another example, a cancellation that voids benefits paid up to a year before the cancellation is also a rescission for this purpose. A cancellation or discontinuance of Coverage is not a rescission if:

- The cancellation or discontinuance of Coverage has only a prospective effect; or
- The cancellation or discontinuance of Coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of Coverage.

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

In the case of a claim involving urgent care, the Program shall notify the claimant of the benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the claim by the Program, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Program. In the case of such a failure, the Program shall notify the claimant as soon as possible, but not later than twenty-four (24) hours after receipt of the claim by the Program, of the specific information necessary to complete the claim. The claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours after the earlier of:

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

4. **Concurrent care decisions**

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

Any reduction or termination by the Program of such course of treatment (other than by amendment of the Program’s plan or termination of the plan) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. The Program shall notify the claimant of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

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

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

5. **Other claims**

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

6. **Pre-service claims**

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

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

7. **Post-service claims**

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

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

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

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

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

B. Any denial code along with its corresponding meaning, and a description of the Program's standard, if any, that was used in denying the claim;

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

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

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

F. If requested, the Program will provide to participants and beneficiaries, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse benefit determination or final internal adverse benefit determination. The Program will not consider a request for diagnosis and treatment information, in itself, to be a request for an internal or external appeal.

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

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

I. 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

J. 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.

K. In the case of an adverse benefit determination by the Program concerning a claim involving urgent care, the information provided by the Program to the claimant may be given to the claimant orally within prescribed time frames given that a written or electronic notification is furnished to the claimant not later than seventy-two (72) hours after the oral notification.
The Program will provide relevant notices in a culturally and linguistically appropriate manner to those Program participants who reside at an address in a county where 10 percent or more of the population residing in the participant’s county, as determined by Federal law, and who are literate only in the same non-English language. The Program will also provide applicable non-English oral language services, such as a telephone customer-assistance hotline that includes answering questions in any applicable non-English language as well as assistance in filing claims and appeals (including external review).

10. Appeal of adverse benefit determinations

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

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

The Program will:

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

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

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

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

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

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

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

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

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

J. The Program will provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Program (or at the direction of the Program) in connection with the claim as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided under paragraph 11 of this section to give the claimant a reasonable opportunity to respond prior to that date; and before issuing a final internal adverse benefit determination based on a new or additional rationale, the Program will provide to the claimant, free of charge, the rationale as soon as is possible and
sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided under paragraph 11 of this section to give the claimant a reasonable opportunity to respond prior to that date.

11. Timing of notification of benefit determination on review

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

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

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

12. Calculating time periods

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

13. Furnishing documents

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

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

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

A. The specific reason or reasons for the adverse determination;
B. Reference to the specific Program provisions on which the benefit determination is based;
C. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant’s claim for benefits.

For additional information on the manner and content of notification of benefit determination, see paragraph 9 on page 49.

15. Failure to establish and follow reasonable claims procedures

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

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

Your claim is eligible for external review if either:

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

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

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

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

Notification of External Review

Rights and Assignment to Independent External Review Organization

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

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

You must provide the following information:

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

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

For example, you may provide:
• Documents to support the claim, such as physicians’ letters, reports, bills, medical records, and explanation of benefits (EOB) forms;
• Letters sent to the Program about the denied claim; and
• Letters received from the Program.

Instructions for Sending Your External Review Request

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

By Mail:

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

By Fax:
1-888-866-6190

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

Preliminary Review

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

This includes:

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

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

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

Expedited Reviews

- An expedited timeline is followed in cases where you have filed a request for an expedited internal appeal and meets the conditions for an expedited review. (See above.)
- The examiner will contact the Program once the examiner receives a request for expedited review and request all documents and information required under a standard review.
- The examiner will review all information received from the Program and may request additional information that it deems necessary to the external review.
- The examiner will notify you and the Program as expeditiously as possible if the examiner determines that you are not eligible for external review.
- The examiner will review all of the information timely received and then consider the claim without being bound by any decision reached during the plan or issuer’s internal claims and appeals process.
- The examiner will forward all documents submitted by you to the Program. Upon receipt of the information the Program may reconsider its ABD or final internal ABD. This reconsideration must not delay review. The external review may be terminated if the Program decides to reverse its decision and provide Coverage or payment after reconsideration. The Program must immediately provide notice to you and the examiner after making the decision to reverse. This notice may be oral but must be followed up with written notice within 48 hours. The examiner must terminate the external review upon receipt of initial notice from the Program.
- The reviewer shall make a final determination on the external review and communicate it to you and the Program within 72 hours from the time of receipt of the request or sooner depending on medical circumstances of the case.
- If you are notified orally, the reviewer will follow-up with written notice within 48 hours after delivery of the oral notice.
- The examiner’s final external review decision and records maintenance must comply with the same requirements as for final external review decisions in standard external review.
- Upon receipt of a final external review decision reversing the ABD or final internal ABD, the Program must immediately provide Coverage or payment for the claim.

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

- Available 24 hours a day, 7 days a week
- You may leave messages and receive instructions on submitting expedited external review requests
- TTY for hearing impaired
- Interpreter through the AT&T language line
- Translated brochures are available upon request, under CLAS standards
Section 8: Definitions

Definitions

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

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

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

**Adverse Benefit Determination (ABD)** means a denial, reduction or termination (in whole or in part) of payment for a benefit. See Section 7: Appeals, page 45, for a complete definition.

**Allowable Amount** is the maximum amount deemed by the Program, in its sole discretion, to be reasonable payment for a Covered Service. The Allowable 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 Allowable Amount means Usual, Customary and Reasonable (UCR) charges, or charges as established by the Program’s utilization of health care cost management services, less any deductions 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 Allowable Amount as payment in full and may bill Covered Members up to the billed charge after the Program has paid its portion. Allowable Amounts do not include charges used to satisfy the deductibles, copayments or coinsurance assessed under the Program’s Major Medical Benefit, or the Prescription Drug Card Program. (For more information, see Coordination of Benefits.)

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

**Benefit** means the benefit provided to Members of the Program.

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

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

**Certificate of Creditable Coverage** means a written certificate issued by the Program, or another health insurance issuer, that shows your prior health Coverage (creditable Coverage). A certificate will be issued automatically and free of charge when you lose Coverage under the Program, when you are entitled to elect COBRA continuation Coverage or when you lose COBRA continuation Coverage. A certificate will also be provided free of charge upon request while you have health Coverage or within 24 months after your Coverage ends.
**Chemical Dependency Treatment** is treatment for the use of alcohol, cannabis, hallucinogens, inhalants, opioids, sedative-hypnotic, or anxiolytics, stimulants, and tobacco where there is a problematic pattern of substance use leading to clinically significant impairment or distress as manifested by at least two of the following occurring in a 12-month period where:

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

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

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

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

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

**Copayment** means an amount required to be paid by a Covered Person each time a specific covered service is accessed. The copayments are set forth in the Schedule of Benefits. See Section 2: Benefits, page 16.

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

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

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

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

**Dentist** means any physician as otherwise defined in this booklet practicing within the scope of their respective profession who performs a dental procedure covered by the Program.
Dependent means any individual who qualifies as a dependent under Code Section 152 (as modified by Code Section 105(b). “Dependent” shall include an Employee's natural child, stepchild, foster child, adopted child, or a child placed with the Employee for adoption until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person.

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

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

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

Employee—See Member/Employee.

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

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

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

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

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

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

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

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

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

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

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


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

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

**Home Setting** means medical care provided in the home.

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

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

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

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

**Illness** means illness or disease and related medical conditions.

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

**Injury** means a bodily injury sustained accidentally by external means.

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

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

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

**Long-Term Care (LTC)** means the provision of medical, social, and personal care services on a recurring or continuing basis to persons with chronic physical or mental disorders. The care may be provided in environments ranging from institutions to private homes. Long-Term Care services usually include symptomatic treatment, maintenance, and rehabilitation for patients of all age groups.
**Maintenance Therapy** means a therapeutic regimen intended to preserve the patient's functionality so that the patient continues in good health practices without supervision, incorporating them into a general lifestyle.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Participation Agreement in the Municipal Health Benefit Program

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

WITNESSETH

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

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

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

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

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

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

   _____ Dental Coverage

   _____ Vision Coverage

   _____ Life Insurance

   _____ Disability Income Benefits
   - Option A
   - Option B

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

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

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

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

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

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

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

CITY: ________________________________
By: _________________________________
Its: _________________________________

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

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

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

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

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

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

Volunteer Firefighters (Class 3)—to qualify for Coverage under the Program, volunteer firefighters must actively participate in more than:

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

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

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

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

Active elected officials (Class 1) who are on Medicare are eligible for dental, vision, drug card and hearing aid Coverage. However, enrollment in all parts of Medicare, Parts A, B and D, is required for active elected officials (Class 1) choosing to continue Coverage under the dental, vision, drug card and hearing aid Coverage benefits. However, seventy-five percent (75%) of each participating class (2, 3, 4 or 5) must participate for Coverage to continue.
This form is **OPTIONAL**. By completing this form, a covered individual may allow someone other than themselves or their providers access to their Private Health Information (PHI). **PLEASE PRINT**

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

Group/Employer Name: _______________________________________________________________

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

_____________________________________________________/ ________________________________
Print Name       Relationship to Member

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

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

Signature: ___________________________ Date: ___________________________

Witnessed by: ___________________________ Date: ___________________________

_________ ___________________________  ___________________________
Print Name
MUNICIPAL HEALTH BENEFIT PROGRAM
Revocation of Authorization to Release Health Information
P.O. Box 188, North Little Rock, AR 72115
Fax: 501-537-7252

Name of Policy Holder: _____________________________ ID#/SSN: _____________________________
Address: ____________________________________________________________________________
Group/Employer Name: __________________________________________________________________

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

_____________________________________________________/____________________________________
Print Name       Relationship to Member

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

Signature: _____________________________ Date: __________________

Witnessed by: _____________________________ Date: __________________

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

PLEASE PRINT

Name of City/Entity: ___________________________ Group Number: ________________________
Name of Policy Holder: ___________________________ ID#/SSN: ____________________________

PREVIOUS INFORMATION

Mailing Address: ________________________________________________________________
City: __________________ State: _____ ZIP: _______ Phone Number: ______________

CURRENT INFORMATION

Mailing Address: ________________________________________________________________
City: __________________ State: _____ ZIP: _______ Phone Number: ______________

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

Signature: ___________________________________________ Date: _____________________

Please send this form to MHBP at the address or fax number listed above.
To learn more about what American Fidelity can do for your organization, contact:

Charles Angel  
Public Sector Director  
800-450-3506, ext. 3132  
charles.angel@americanfidelity.com
PLAN ADMINISTRATION: Enrollment and Premiums
Municipal Health Benefit Program Premium
P.O. Box 880
Conway, AR 72033
Phone: 501-978-6137 Fax: 501-537-7252
www.arml.org/MHBP

CLAIMS ADMINISTRATION: Claims and Benefits
Municipal Health Benefit Program
P.O. Box 188
North Little Rock, AR 72115
Phone: 501-978-6137 Fax: 501-537-7252
www.arml.org/MHBP

For Precertification, please call:
1-888-295-3591
(Precertification does not provide Benefit Information.)