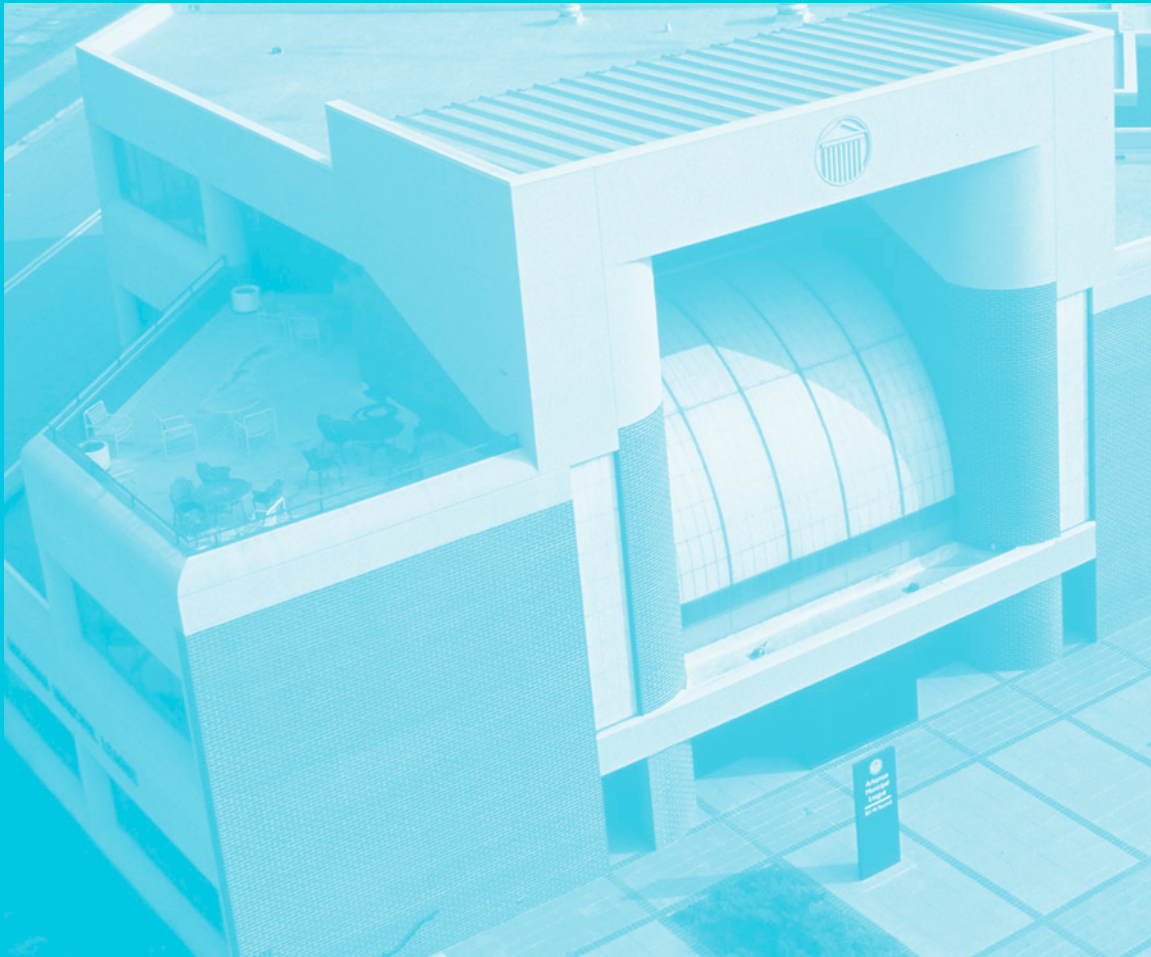




# Municipal Health Benefit Fund

Effective December 1, 1981 (As Amended January 1, 2009)

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



## Mandatory Administrative Appeals Procedure

As a condition precedent to all the benefits, terms and conditions of this contract, an employer member and all its covered members must agree to exhaust all their administrative remedies including, but not limited to, the claims denial procedure before the Board of Trustees before any legal actions is brought in any court.

Fund Administrative Office

P.O. BOX 188, North Little Rock, AR 72115 • 501-374-3484

**MUNICIPAL HEALTH BENEFIT FUND (Health Fund No. 1)**  
**Effective December 1, 1981 (As Amended January 1, 2009)**  
**DECLARATION OF TRUST**

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

This booklet describes benefits available to you under the Municipal Health Benefit Fund. A separate certificate outlines your Accidental Death and Dismemberment (AD&D) benefits that are underwritten by an insurance company. Consult your Employer to determine the amount of your Life and AD&D Benefits and to determine if your group has Disability Income Benefits.

The self-funded Municipal Health Benefit Fund may be amended or discontinued by giving sixty (60) days notice by regular mail to member cities and other public entities at their regular business addresses. **It is the responsibility of the Participating Employer to notify its employees of any amendments or changes of the Municipal Health Benefit Fund.**

Federal law (including HIPAA) imposes upon group health plans the following requirements:

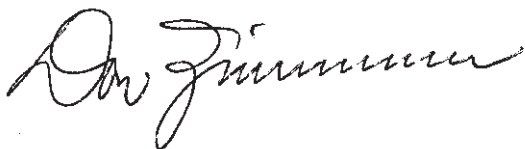
- (1) Limitations on preexisting condition exclusion periods.
- (2) Special enrollment periods for individuals (and dependents) losing other coverage.
- (3) Prohibitions against discriminating against individual members and beneficiaries based on health status.
- (4) Standards relating to benefits for mothers and newborns.
- (5) Parity in the application of certain limits to mental health benefits.
- (6) Standards relating to the Women's Health and Cancer Rights Act of 1998.

**Federal law gives the plan sponsor of a self-funded non-federal government plan the right to exempt the plan in whole or in part from the requirements described above and the Municipal Health Benefit Fund has elected to do so.**

**PATIENT PRIVACY**

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

The specifics of coverages provided by the Plan are contained on the following pages.



Plan Administrator

# Table of Contents

ANNUAL LIFETIME BENEFITS.....	7
BENEFICIARY DESIGNATION.....	3
CALENDAR YEAR DEDUCTIBLES .....	9
CASE MANAGEMENT.....	10
CERTIFICATE OF NOTICE AND ACCEPTION OF PLAN PROVISIONS .....	3
COORDINATION OF BENEFITS .....	28
COVERED MEDICAL CHARGES .....	11
COVERED MEDICAL CHARGES WITH SPECIAL LIMITATIONS .....	13
DECLARATION OF TRUST .....	Inside Front Cover
DEFINITIONS.....	43
DENTAL BENEFITS.....	25
DISABILITY INCOME BENEFITS .....	34
ELIGIBILITY AND EFFECTIVE DATE REQUIREMENTS See General Information	
EXPLANATION OF BENEFITS AND BENEFIT LIMITATIONS .....	8
FEDERAL LAW EXEMPTION .....	Inside Front Cover
GENERAL INFORMATION.....	35
HIPAA PRIVACY NOTICE.....	5
HEALTH CARE EXCLUSIONS .....	15
HOW TO PRINT A TEMPORARY ID CARD.....	6

LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGE .....	34
MANDATORY ADMINISTRATIVE APPEALS PROCEDURE .....	33
MATERNITY BENEFITS AND NEWBORN CHILD CARE .....	14
NOTICE AND PROOF OF CLAIM .....	32
OVERPAYMENTS AND RIGHT OF RECOVERY .....	29
PRECERTIFICATION, PENALTY DEDUCTIBLES AND UTILIZATION REVIEW .....	9
PREFERRED PROVIDER NETWORK .....	8
PRESCRIPTION DRUG COVERAGE .....	20
PRESCRIPTION DRUG COVERAGE WHEN MEDICARE IS PRIMARY .....	24
RETIREE COVERAGE .....	42
RIGHT TO CONTINUATION COVERAGE UNDER COBRA .....	39
SCHEDULE OF BENEFITS .....	7
SPECIAL BENEFITS .....	10
STOP-LOSS PROVISION .....	8
VISION CARE BENEFITS .....	27
WELLNESS PROGRAM .....	10
WHEN YOUR BENEFITS STOP .....	38





# HIPAA PRIVACY NOTICE

The Municipal Health Benefit Fund (MHBF) is subject to the PRIVACY, SECURITY and ELECTRONIC DATA INTERCHANGE components of the Health Insurance Portability and Accountability Act (HIPAA) passed by Congress in 1996. HIPAA requires privacy and security safeguards for Protected Health Information (PHI). PHI is generally defined as “any individually identifiable health information element that is transmitted or maintained in any form that could identify the subject (person) of the information”. PHI can include all forms of information, including paper records, electronic records, or oral communications. PHI data elements include such items as name, address, birth date or age, telephone number, medical record number, biometric identifiers, health plan numbers, occupation, photo, employer, etc.

MHBF has adopted sufficient policies, procedures and safeguards (including employee training and sanctions for failure to comply) in order to comply with HIPAA and safeguard member PHI. Under HIPAA, members have the right to access their own PHI (at a time and place and at a cost as determined reasonable by the MHBF) and to request modifications to such records should they find errors. YOUR PHYSICIAN OR MEDICAL INSTITUTION IS THE BEST, MOST COMPLETE SOURCE OF MEDICAL RECORDS INFORMATION.

MHBF takes a “minimum necessary” approach to the release of member PHI. Releases of PHI to persons other than the members themselves will only be made with the express consent of the member, unless required by law, and such releases will be documented. MHBF is not required to, nor will it provide an accounting for disclosures that are made for the purposes of health care treatment, operations or payments. However, MHBF will provide an accounting of any disclosures required by law.

A complaint process is available to MHBF members who believe that a violation of the PHI privacy or security requirements has occurred. Member may notify the Arkansas Municipal League Privacy Officer at League Headquarters in North Little Rock at (501-374-3484). The Privacy Officer will investigate the complaint and ensure that the MHBF Board and the Plan Administrator are aware of the issue and the resolution of the complaint. If you are dissatisfied with the internal resolution, or if you prefer, you may submit a written complaint to the Office of Civil Rights, which enforces HIPAA.

(A complete listing of the Municipal Health Benefit Fund’s Privacy Policies and Procedures are available at [www.arml.org](http://www.arml.org).)

This form should be returned to your Employer

# HOW TO PRINT A TEMPORARY ID CARD

You may print a temporary ID card from the Catalyst Rx Web site if one is needed until the permanent card is received or if an ID card is lost and a card is needed immediately.

Below are the instructions for printing a Temporary ID card:

1. Please contact Customer Service to obtain the **unique ID number**. Phone number 501-374-3484, Option 6, then Option 2 for Customer Service.
2. Social Security numbers are never used due to Identity Theft. **Only the member's name** is used on the ID card; no spouse or other dependent's name is ever listed. The card will be sent to the address on file with Municipal Health Benefit Fund. Please be sure it is the correct address.
3. The Web site is [www.catalystrx.com](http://www.catalystrx.com)
4. Use the second box to sign on using the new ID# and the date of birth of the member. (Use the /)—example: mm/dd/yyyy—**Enter**
5. On the next screen click on Common Questions.
6. Scroll down to the large box that says Print Temporary ID Card.
7. Type the employee's name as it is listed on the enrollment form and the new ID#. (**Never use a Social Security number or a spouse's name or dependent's name.**)—**Enter**
8. You will get a message that tells you a card will be printed—**click OK**.
9. Print card screen comes up. **Print the Temporary ID Card**.

# MUNICIPAL HEALTH BENEFIT FUND (Health Fund No. 1)

## Schedule of Benefits

### Major Medical

#### Coverage Maximums

Individual Medical Coverage	.....Annual	\$ 300,000
	.....Lifetime	\$2,000,000
Acute Inpatient Rehabilitation	.....30 days per illness or incident	
Sub-Acute Inpatient Rehabilitation	.....15 days per illness or incident	
Chiropractic Services	.....Annual	\$ 1,000
Home Health Care Services	.....Annual	\$ 3,000
Mental and Nervous Disorders	.....30 visits annually	
	.....Lifetime	\$ 10,000
Newborn Child Care:		
Maximum Benefit for first year	.....	\$ 150,000
Maximum Benefit for first year for multiple births	.....	\$ 200,000
Occupational Therapy (Outpatient)	.....Annual	\$ 2,500
Physical Therapy	.....Annual	\$ 2,500
Well-baby/Well-child Care Visit	.....1 visit per year	
	.....Annual	\$ 200

(Please see Covered Medical Charges with Special Limitation of Specific Types of Medical Treatments)

### **Major Medical Deductibles**

- Standard: Individual calendar year medical .....\$200, \$500 or \$1,100.
- Emergency Room Deductible .....\$100 per occurrence for non-admission visits

### **Individual Co-insurance**

The individual pays co-insurance for the first \$20,000 of Arkansas In-Network Provider covered expenses after the calendar year deductible(s) and any penalty deductibles. Once the individual in Arkansas In-Network co-insurance maximum is reached, the

- Plan will pay 100 percent of all covered In-State In-Network services for the remainder of the calendar year.
- The Stop-Loss Provision does not apply for Out-of-State In-Network or Non-PPO providers, and the individual must pay a co-insurance for all covered expenses from Out-of-State In-Network Providers.
- Co-payments for Emergency Room Services are not included with the Stop-Loss provision.

After the calendar year deductible(s), the Plan will pay the following percentages:

In-Network Providers (In-State)	90 percent
In-Network Providers (Out-of-State)	90 percent
Non-PPO Providers (In-State)	50 percent
Non-PPO Providers (Out-of-State)	50 percent

### **Emergency Room Services**

Outpatient emergency room visits at a hospital will require a \$100 co-payment made by the covered member for each visit, in addition to any other Plan deductible or co-payment requirements. Emergency room co-payments do not apply to the Plan deductible or towards the co-insurance maximum. When an emergency room visit results in an inpatient hospital admittance, the \$100.00 emergency room co-payment requirement will be waived.

## Schedule of Benefits continued

### Prescription Drugs

Prescription drug benefits are covered through the Prescription Drug Card Program. See page 20 for additional information.

### Dental Care Coverage Maximums and Deductible

Dental Procedures .....	Annual	\$1,200
Orthodontic.....	Lifetime	\$1,000
Temporomandibular Joint Dysfunction (TMJ).....	Annual	\$1,000
Calendar Year Deductible.....	Annual	\$ 50

### Vision Care Coverage Maximum and Deductible

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

### Life and Accidental Death and Dismemberment Benefits

(Consult your Employer to determine the amount of your Life and AD&D Benefits.)

### Disability Income Benefits

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

## Explanation of Benefits and Benefit Limitations

### Stop-Loss for Major Medical

When In-State In-Network covered charges reach \$20,000 after the calendar year deductible(s) are met, the Plan will pay 100 percent of all covered services above that amount for the remainder of the calendar year, unless excluded or modified by other portions of this benefit booklet. This is called a Stop-Loss Provision. Out-of-State In-Network Provider and Non-PPO provider charges do not count toward the \$20,000 Stop-Loss Maximum and the Plan will not pay 100 percent of Out-of-State In-Network Provider and Non-PPO provider charges. In addition, penalty deductible(s) and the Emergency Room Services co-payments do not count toward the \$20,000 Stop-Loss Maximum. The Plan will not pay 100 percent of the Emergency Room Service charges unless the co-payment is waived due to hospital admission.

### Preferred Provider Network for provision of Major Medical, Vision and Dental Care

In an effort to better control costs and provide quality service, the Plan is participating in a managed care concept. The concept encourages the employees and their dependents to use physicians and hospitals that have agreed to join the Network of Preferred Providers. The Municipal Health Benefit Fund has developed and maintains its own Preferred Provider Network. You may choose to use a PPO provider or a non-PPO provider. The Plan will pay a higher benefit if you choose to use a PPO provider. It will be the member's responsibility to inquire whether a provider is in the PPO Network. Your personal identification card will notify the provider of your membership in the Plan.

Directories listing hospitals and providers for medical, dental and vision services who have agreed to handle billing and collections for the patient, as well as participating pharmacies, are available through your Employer. The Provider Directory is also available on the League's Web site at [www.arml.org](http://www.arml.org).

## Calendar Year Deductibles for Major Medical, Vision care and Dental Care

**Medical**—A Calendar Year Deductible of \$200, \$500 or \$1,100 (please consult your Employer for the amount of the deductible) shall be applied to the amount of covered medical expenses that are incurred each calendar year. Each covered member shall satisfy the \$200, \$500 or \$1,100 calendar year deductible if the covered member incurs and submits covered medical expenses in an amount equal to the deductible.

**Dental**—A \$50 Calendar Year Deductible will be applied to the amount of covered dental expenses that are incurred each calendar year. Each covered member will satisfy the calendar year deductible if the covered member incurs and submits covered dental expenses in an amount equal to the deductible.

**Routine Vision**—A \$50 Calendar Year Deductible will be applied to the amount of covered vision expenses that are incurred each calendar year. Each covered member will satisfy the calendar year deductible if the covered member incurs and submits covered vision expenses in an amount equal to the deductible. (See Precertification, Penalty Deductibles and Utilization Review for Medical Vision information.)

## Precertification, Penalty Deductibles and Utilization Review

**It is the member's responsibility to precertify by calling 1-888-295-3591.** A penalty deductible of \$500 will apply for failure to precertify the following services, per occurrence:

- 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.)
- Outpatient and Ambulatory Surgery Procedures, whether they are performed in a Hospital, Ambulatory Surgery Center or Doctor's office
- Inpatient Hospital Confinements (requiring an overnight stay)
- Durable Medical Equipment (if purchase price or annual rental cost exceeds \$1,000)
- Prosthetic Devices (if purchase price exceeds \$1,000)
- Home Health Care Services (care in a home setting)
- Hospice Care

**Please call 1-888-295-3591 anytime to verify if precertification will be needed if in doubt.**

## Utilization Review Program

The Municipal Health Benefit Fund has adopted a Utilization Review Program. In certain cases, the Review Program requires certification prior to treatment, as well as concurrent review, discharge planning, cost effectiveness and medical case management. Failure to precertify with the Review Program will result in a penalty deductible of \$500 which will be assessed if you fail to precertify your care where the Plan requires pre-certification. You or your doctor may precertify by calling the Review Program at **1-888-295-3591**. The ultimate responsibility to precertify rests with the covered Plan member.

## Inpatient Admission

You must precertify your admission to the hospital. As soon as you know you will be hospitalized, you, or your physician, must precertify your care by calling the Review Program at **1-888-295-3591**. Tell the Review Program that you are covered under the Municipal Health Benefit Fund and provide the Program with your doctor's name and telephone number. If your hospital admission is due to an emergency, you will not be assessed the \$500 penalty deductible, but you or your doctor must call **1-888-295-3591** to provide the necessary review information within 48 hours of admission, or the next business day, if the admission is on a weekend or holiday. In any event, you must call the Program before you are discharged from the hospital. Outpatient observations lasting more than 23 hours may be considered an inpatient admission or reduced to the 23-hour observation limit.

## **Exception for Childbirth**

The Plan does not restrict the duration of hospital stay for the mother or newborn child, up to a stay of 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. Stays in excess of 48 hours or 96 hours must be pre-certified.

## **Outpatient Surgical Procedures**

Pre-certification is also required for outpatient procedures regardless of where they are performed.

## **Hospice and Home Health Care**

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

## **Durable Equipment**

You must precertify certain durable medical equipment purchases and rentals and purchases of prosthetic devices. See the topic Rental or Purchase of Durable Medical Equipment, under Covered Medical Charges.

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

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

## ***Special Benefits:***

### **Case Management**

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

In an effort to reduce recurring visits to a hospital setting, Alternative Case Management may be recommended. Benefits may be extended, based on the recommendation of the Case Manager, if such recommendation would tend to provide for physician-approved treatment outside the hospital setting. Alternative Case Management may be considered if medical expenses are expected to exceed the Plan's defined maximum for a specific benefit. Alternative Case Management will normally include, but will not be limited to, durable medical equipment, home health and hospice, inpatient and outpatient therapy. At the sole option of the Plan Administrator, alternative benefits may be provided by the Plan in lieu of Major Medical Expense benefits. Alternative benefits shall be provided if, in the sole discretion of the Plan Administrator, 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, not to exceed \$5,000 in a calendar year. Eligible Case Management charges will be paid using the Plan's percentage reimbursements.

### **Wellness Program**

After a \$30 co-payment, the Plan will pay 100 percent of the charges up to \$200 annually for adults age 19 years and older for the wellness benefit. Any charges that exceed \$200 will be considered under the normal Major Medical benefits, but can be applied toward the member's deductible and co-insurance. Medical diagnoses will not be covered under the Wellness Program. For more information, please see the Covered Medical Charges section of this booklet.

## Wellness Program continued

Specific preventative vaccines, such as:

- Hepatitis A (HepA)
- Hepatitis B (HepB)
- Human Papillomavirus (HPV)
- Influenza
- Measles, Mumps, Rubella (MMR)
- Meningococcal
- Pneumococcal
- Tetanus, Diphtheria, Pertussis (Dd, Tdap)
- Varicella (Chickenpox)
- Zoster (Shingles)

will be covered under the Wellness Program and be included under the \$200 wellness benefit maximum as stated above. If a vaccine is not included in the above listing, please contact Customer Service to verify if it is a covered vaccine under the Wellness Program.

Other injectable medicines may be covered under the Drug Card Program. Please contact Utilization Review at 888-295-3591 to verify if an injectable medication requires pre-authorization for coverage. The Member will be responsible for the applicable Drug Card Co-payment. For more information, please see the Prescription Drug Card section of this booklet.

## Covered Major Medical Charges

Covered Medical Charges include only the charges and fees described below that (a) are not excluded by other provisions applicable to these benefits, (b) are medically necessary for the care and treatment of illness or injury of a covered member, (c) are recommended by an attending physician, (d) do not exceed the usual, customary and reasonable charges as determined by the Plan in accordance with health care industry standards for the area in which the services and supplies are furnished and (e) are deemed necessary by the Utilization Review Program. A charge is considered to be incurred on the date a covered member receives the services or supplies for which the charge is made.

**Accident-Related Dental Charges**—Dental charges are not covered under 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. Treatment must start within 30 days and be completed within six months. Any injury to teeth while eating is not covered in this provision.

**In-Network Ambulance**—Charges-for emergent medically necessary local transportation of a covered member by professional ambulance service to and from a hospital.

**Out-of-Network Ambulance**—if an out-of-network ground or air ambulance is utilized, the Plan will pay a maximum amount of \$500.00 per incident.

**Anesthesia Charges**—for the administration of anesthesia when not included in Hospital Charges.

**Cataract Surgery**—The first pair of eyeglasses or contact lenses needed as a result of the removal of cataracts. (See Pre-certification, Penalty Deductibles and Utilization Review for Medical Vision information)

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

**Emergency Transportation Charges**—for regularly scheduled commercial transportation by train or plane within the continental United States and Canada to, but not from, a hospital having medical equipment not available locally for spe-

## **Covered Major Medical Charges continued**

cial inpatient treatment. Transportation must be certified by an attending physician, as necessary, due to its emergent nature, not to exceed one trip for any one accident or illness.

**Family Planning**—Benefits are provided for elective vasectomy and elective tubal ligations.

**Hospital Charges**—for room and board and other necessary services and supplies.

In-Hospital Room accommodations covered are: Semi-private Room (two or more beds); Approved Intensive and Cardiac Care Units; Private Room. If you use a private room, you will be responsible for the difference between the hospital's charge for an average semi-private room and its private room charge. If the hospital is an all-private room facility, the Plan will consider 90 percent of the private room charge as the covered charge.

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

**Physicians' Fees**—for medical care and treatment other than the performance of surgical procedures. (For more information, please see Surgeon's Fees.)

**Prosthetic Devices**—When ordered by a physician, coverage is provided for prosthetic devices such as orthopedic braces; custom built shoes or supports, internal fixation (such as hip pinnings), internal prostheses, and replacement of artificial legs, arms and eyes. Also included is the replacement of these devices when required by a change in your physical condition, as well as repairs to prosthetic devices. Precertification is required for purchase of all prosthetic devices that exceed \$1,000. A penalty deductible of \$500 will be assessed if charges exceeding \$1,000 are not precertified.

**Radiological and Laboratory Charges**—for radiological examinations and diagnostic laboratory services.

**Rental or Purchase of Durable Medical Equipment**—The Plan will pay for standard durable medical equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an illness or injury, (d) and is appropriate for use in the home. Additionally, the Plan will replace standard durable medical equipment that is no longer serviceable provided it meets the criteria above. The Plan will not pay for air conditioners, dehumidifiers, humidifiers, air purifiers, waterbeds, car seats, whirlpools, spas, exercise equipment, motorized or other specialty or customized equipment, nor for service and/or maintenance contracts and agreements for durable medical equipment. Durable medical equipment, such as a standard hospital bed, standard wheelchair, etc., must be prescribed by a physician and must be required for temporary therapeutic use. If a member must rent durable medical equipment for an extended period of time, the Plan reserves the right to pay for the rental monthly, not to exceed the purchase price. If an item of durable medical equipment is not available for purchase, the Plan reserves the right to establish a rental or purchase price based on the reasonable and customary charge for such equipment.

Precertification is required when any durable medical equipment is purchased, rented or leased if the purchase price or annual rental cost will exceed \$1,000. A penalty deductible of \$500 will be assessed if charges exceeding \$1,000 are not pre-certified.

**Speech Therapy Charges**—Speech therapy benefits will be provided where speech has already existed and when speech therapy is used to restore speech when the loss is due to a disease or injury. When speech loss is due to disease or injury, the Plan will pay benefits for the following services of a doctor or speech pathologist if the speech therapy program is prescribed by and under the supervision of a doctor: (a) Diagnostic services to determine the extent of the loss or impairment of the patient's ability to speak; and (b) rehabilitative services to restore or improve the patient's ability to speak.

## **Covered Major Medical Charges continued**

**Surgeons' Fees**—for the performance of surgical procedures by a physician. Pre-op and Post-op care is paid for when the surgeon bills under the global surgical CPT (Current Procedural Technology) coding rules.

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

## **Covered Medical Charges with Special Limitations on Specific Types of Medical Treatments**

**Acute Inpatient Rehabilitation**—Payment for this benefit is limited to a maximum of 30 days per illness or incident. 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. A penalty deductible of \$500 will be applied if precertification is not performed.

**Sub-acute Inpatient Rehabilitation**—Payment for this benefit is limited to a maximum of 15 days per illness or incident. 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. A penalty deductible of \$500 will be applied if precertification is not performed.

**Chiropractic Services**—are covered only for an eligible Member 5 years and older. Payment for covered services performed by a Chiropractor, including visits, adjustments and other covered charges, is limited to \$1,000 per calendar year. Please note that Temporomandibular Joint Dysfunction (TMJ) is not a covered benefit under Chiropractic Services. TMJ is addressed under the Dental Benefits provisions of the Plan.

**Childhood Congenital Anomaly**—Medically necessary services and treatments to correct a childhood congenital anomaly will not be covered unless the eligible dependent child has been continuously covered by the Plan since birth. These services or treatments must have prior authorization and meet the medical necessity guidelines of the Plan to be considered.

**Diabetic Education or Training**—The Plan will allow for a one-hour Diabetic Education or Training session per calendar year. However, if there is significant change in the Covered Member's condition or symptoms making it medically necessary to change the Covered Member's diabetic management process, the Plan will allow for an additional one-hour Diabetic Education or Training session. The additional Diabetic or Training session must be prescribed by a Physician.

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

**Home Health Care Services (care performed in a home setting)**—Payment of these benefits is limited to an annual maximum of \$3,000 and is subject to review by Case Management to identify medical criteria and cost effective alternatives. A penalty deductible of \$500 will be applied if precertification is not performed. 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.

**Hospice Care**—The Plan will pay for covered Hospice charges, whether in the home or in an inpatient setting, including equipment and supplies, which are medically necessary for treatment if the member is totally disabled as a result of terminal illness and has a life expectancy of six months or less. A treatment plan is required and must be submitted to Case Management for precertification before benefits can be considered. A penalty deductible of \$500 will be applied if

## **Covered Medical Charges with Special Limitations, etc., continued**

precertification is not performed. Hospice Care charges will be limited to a lifetime maximum of 180 days. (Please see Alternative Case Management for additional information.)

**Maternity Benefits and Newborn Child Care**—Maternity benefits will be effective when the date of conception follows the effective date of the member's coverage. Newborn baby care will be covered provided dependent coverage is in effect at the time of delivery. The Plan will cover routine nursing and pediatric charges for newborn baby care with payment limited to a period of five (5) days or until the mother is discharged from the hospital, whichever is the lesser period.

Payment of services for a newborn child is limited to \$150,000 during the first 12 months of life of the newborn child. Payment for services for multiple births is limited to \$200,000 during the first 12 months of life of the newborn children. Once the child (or children) reaches the age of one year, he or she will be eligible for resumption of benefits as defined in the booklet.

If you have single coverage and wish to provide coverage for an eligible newborn, you must meet the following requirements:

- You must be unmarried
- You must have no other eligible dependents from any previous relationship
- You must add family coverage by the sixth month of pregnancy

**Mental and Nervous Disorders**—Payment for services incurred in connection with treatment of mental illness or functional nervous disorders, is limited to a maximum of 30 physician visits per calendar year for inpatient and outpatient charges. The lifetime maximum is limited to \$10,000. These payments are not eligible for the Stop-Loss Provision.

**Organ Transplant Charges**—Payment for services for an organ transplant including testing prior to transplant and all post-operative treatment is limited to two per lifetime and is subject to the Major Medical Annual Coverage Maximum. Eligible procedures are: heart, lung, liver, kidney, pancreas, cornea and bone marrow. Donor costs are not covered, whether or not the donor is a member of the Municipal Health Benefit Fund.

**Physical Therapy and Occupational Therapy Services (Outpatient Clinical Setting)**—Therapy services will be limited to an annual maximum of \$2,500 for Physical Therapy and \$2,500 for Occupational Therapy. The services of a Licensed or Registered Physical Therapist or Licensed Occupational Therapist (OPT) are covered if the treatment meets all of the following:

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

Benefits will not be provided for professional services where the provider is an immediate member of the family or normally resides in the home. Benefits are not provided for maintenance or aquatic therapy, nor services or supplies not related to the therapy.

**Well-baby/Well-child Care**—After a \$30 co-payment, the Plan will cover one well-baby/well-child care visit per year and pay 100 percent of charges up to \$200 annual maximum for newborns and children to age 18. Charges exceeding the \$200 maximum will become the member's responsibility. (Please note: Childhood immunizations and vaccines are available through your local Health Department at a minimal charge.)

**Wound Care and Hyperbaric Oxygen Treatment**—The total number of one-hour sessions for hyperbaric oxygen ther-

## Covered Medical Charges with Special Limitations, etc., continued

apy and/or the total number of treatments received in an outpatient Wound Care facility will be limited to a maximum of 40 per year provided the treatment is for a condition that is covered under the Plan and is prescribed by and administered under the direct supervision of a licensed physician.

## Health Care Exclusions

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

- It is recommended or prescribed by a physician;
- It is the only available treatment for your condition; or
- Was a covered benefit in previous Plan years;

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;

**Acupuncture**—Any services or charges associated with Acupuncture treatment, regardless of the provider performing the services;

**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 or other device 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.

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

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

**Benefits Outside the United States**—Services and supplies including, but not limited to drugs, office visits, surgical centers and/or treatments and diagnostic procedures received in or out of a hospital setting outside the United States of America are not covered under the Plan. However, charges may be submitted for possible benefit consideration at the sole discretion of the Plan Administrator.

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

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

**Blood**—Blood, blood plasma, blood derivatives and fees to cover blood donations or blood storage.

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

## Health Care Exclusions continued

**Cosmetic**—Cosmetic surgery or services, including reconstruction of the jaw to improve dental alignment or bite, or any complications related to a previous cosmetic surgery or procedure unless incurred as a result of (1) an accidental injury sustained while covered under this Plan or (2) for the reconstruction of the breast due to cancer.

**Counseling Services**—The following outpatient counseling services: marriage, family, career, children, social adjustment, pastoral, financial or any form of group counseling.

**Diagnostic Cardiac Catheterizations**—The Plan does not provide coverage for Cardiac Catheterizations in environments where cardiac interventions cannot be performed.

**Deductible(s), Co-payment(s) or Co-insurance**—Services that are reimbursable under any other Municipal Health Benefit Plan provisions or charges that are applied to the Plan's deductible, coinsurance or co-payment provisions.

**Dental**—Care or treatment of teeth, gums or alveolar process, except as a result of accidental injury as defined under Medical benefits in this Plan. Any injury to teeth while eating is not covered; see Dental Coverage for related coverages.

**Developmental Delay**—Services or treatments for mental or physical behavioral or learning disabilities and/or developmental delays.

**Domestic Partners**—The Plan does not provide coverage for domestic partners of the same sex or opposite sex.

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

**Education or Training**—Testing or training performed for educational purposes, including play therapies and therapies for persons with behavioral or learning disabilities and/or developmental delays. (For more information, please see Developmental Delay.)

**Exercise**—Any routine exercise or Wellness programs unless provided for by the Plan.

**Experimental or Investigative**—Charges for care, treatment, services or supplies that are experimental or investigational in nature.

**Gastric Bypass Surgery**—Gastric Bypass Surgery and complications from Gastric Bypass Surgery.

**Genetic Testing or Services**—Genetic testing or measurements of biochemical markers as a diagnostic or screening technique. The services of geneticists or genetic counselors are not covered under the Plan.

**Growth Deficiencies or Abnormalities**—Testing and treatment for growth deficiencies/abnormalities except when medically necessary due to pituitary gland removal.

**Hearing**—Charges for hearing aids or devices, including, but not limited to surgery to implant hearing aids or devices.

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

**IDET Procedures**—Intra-Discal Electrothermal 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.

## Health Care Exclusions continued

**Immediate Relative**—Services or charges provided by someone who is an immediate relative as defined in the “Definitions” section of this booklet or who ordinarily resides in your home.

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

**Injuries by Third Parties**—Treatment or services for any illness or injury for which a third party is liable or legally responsible.

**Inpatient Cognitive Rehabilitation**—any treatment modality(s) designed specifically for the remediation of disorders of perception, memory and language in brain-injured persons. Supplies or services provided, as, or in the conjunction with, Cognitive Rehabilitation are not covered. Cognitive rehabilitation will be covered under the outpatient provisions of the Plan.

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

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

**Maternity**—Maternity benefits when the date of conception is prior to the effective date of the member’s coverage.

**Minimally Invasive Hip Replacement Surgery**—Charges for minimally invasive hip replacement surgery and complications of minimally invasive hip replacement surgery.

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

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

**Obesity or Weight Reduction**—Any treatments, services or charges for obesity from any cause. This exclusion also applies to prescription drugs for the treatment of obesity and/or treatment for weight reduction.

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

**Penile Implants**—Charges incurred for any services or procedures related to penile implants will not be covered by the Plan;

**Pre-employment Medical Services** – Medical services and immunizations to fulfill requirements to obtain and/or retain a job are not covered under the Plan;

**Preexisting Conditions**—Treatment of conditions, illnesses or injuries existing prior to the effective date of your coverage until your coverage has been in effect for a period of at least six (6) consecutive months will not be covered. In other words, if you have a medical problem at the time your coverage is effective and you seek treatment for that medical problem within the first six months after the effective date of the coverage, the Plan will not be obligated to pay for such treatments. The Plan will consider a condition, injury or disease to have existed, if, during the six (6) consecutive months prior to the effective date of your coverage you have knowledge of a condition, illness or injury that would ordinarily cause a reasonable person to:

- Seek out professional advice, or;
- Receive treatment, or;

## **Health Care Exclusions continued**

- Seek to be diagnosed, or;
- Be given care, or;
- Have medication prescribed for the condition, illness or injury.

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

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

**Self-inflicted**—Services or charges for self-inflicted injuries or illnesses arising out of an intentional action on the part of the member to bring about an injury or illness to themselves.

**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 services or charges associated with tattooing for any reason will not be covered by the Plan.

**TMJ**—Temporomandibular joint dysfunction and related procedures by whatever name called, diagnosis and/or treatment even when deemed medically necessary, unless defined otherwise under the Dental section of this Plan.

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

**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 radial keratotomy (RK), photo refractive keratotomy (PRK), automated lamellar keratoplasty (ALK), lasik or any related kerato-refractive surgery to correct refractive error. See Vision Care coverage section of this Plan for covered services.

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

**Voluntary Exposure to Danger**—Participation in nontraditional sports, activities and adventure sports engaged in for leisure, recreation, competition, entertainment or monetary purposes. Nontraditional sports, activities and adventure sports typically involve a high level of inherent danger such as but not limited to activities involving speed, height, high levels of physical exertion, highly specialized gear, spectacular stunts involving a higher number of inherently uncontrollable variables than traditional activities with pronounced risk-taking allowing and encouraging individual creativity in the innovation of new maneuvers and in the stylish execution of existing techniques requiring control of risk.

**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.

## Health Care Exclusions continued

**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.

\*\*Please note; medical complications occurring as a result of receiving services excluded under the Plan, including but not limited to, surgeries, procedures, or medications, are not covered by the Plan.

# PRESCRIPTION DRUG COVERAGE

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

- Prescription/Medical ID cards should be delivered within 30 days from the date the Plan has received and processed your enrollment paper work.
- Coordination of Benefits Rules do not apply to the Drug Card Program.
- Co-payments do not go toward any deductible(s) or stop-loss provisions.

**Prescription Drug Card Program** - Municipal Health Benefit Fund program members will be provided with an ID Medical/Drug card that can be used in most drug stores in the state and nationwide. Under this program, **a member will pay \$5 for a covered over-the-counter (OTC) product, \$10 for a generic drug, \$30 for a preferred brand, and \$50 for a non-preferred brand.**

Covered OTC Products for a \$5.00 co-pay include:

## Anti Ulcer Medications

- Axid AR
- Pepcid AC OTC
- Prilosec OTC
- Tagamet HB OTC
- Zantac-150 OTC

## Non and Low sedating antihistamines

- Claritin OTC
- Zyrtec OTC
- Zyrtec-D OTC

**Obtaining Benefits for Covered OTC Products**—A written prescription is required for these OTC (over-the-counter) products. At the pharmacy, take the covered prescribed OTC product, your prescription and your ID Medical/Drug card to the pharmacist. The purchase will be processed in the same manner as a prescription drug purchase is processed. You pay the \$5 copay to the pharmacy.

If you are currently taking a brand-name version of prescription-strength Axid, Pepcid, Prilosec, Tagamet or Zantac and your physician intends to continue treatment, ask your pharmacist to handle the switch to the over-the-counter (OTC) product or prescription-strength generic product and instruct you on the proper dosage.

**Brands with a Generic Available**—A brand with a generic available is a product for which a therapeutically equivalent generic alternative is available. Most brand drugs with generics available are considered non-preferred products and will collect the 3rd tier co-payment. The co-payment applies regardless of whether the member or the physician chooses the product.

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

**Diabetic Sense Program**—To assist members living with diabetes, the Plan has implemented the Catalyst Rx Diabetic Sense Program. This program is provided at no additional charge and members can receive their diabetic supplies (not medications) for zero co-pay, along with educational information and quarterly testing reminders.

## Prescription Drug Coverage continued

Diabetic Sense Program provides:

Free blood glucose meters  
(Bayer Healthcare Ascensia or Roche Diagnostics Accu-Chek)

Mail-order delivery of your supplies including:

- Alcohol pads
- Educational materials
- Lancets
- Spring powered devices for lancets
- Syringes
- Test strips

Plus, access to Certified Diabetes Educators, Registered Pharmacists and more.

All Diabetics or newly diagnosed members should enroll by contacting the Diabetic Sense Program at 877-852-3512 or log on to the Catalyst Rx Web site at [www.catalystrx.com](http://www.catalystrx.com).

(Note: Insulin infusion pumps and tubing are not handled through the Diabetic Sense Program.)

**Mail-Order Pharmacy**—In addition to the traditional retail pharmacy network, plan members may obtain their medications through the Catalyst Rx mail order facility, a 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 Catalyst Rx at 888-869-4600 or by visiting [www.catalystrx.com](http://www.catalystrx.com).

**Maintenance Medications**—Up to a 60-day supply of a covered drug that falls within the listed drug categories of medications below may be obtained per prescription at a retail pharmacy or through Catalyst Rx mail order pharmacy. The same co-pay applies for either retail or mail order. This health plan will implement drug therapy management programs that may affect dispensing limitations of specific drugs.

Drugs in the following categories are considered Maintenance under the Plan, either retail or mail order. If your medication falls in these categories, you will be able to get a 60-day supply for one co-pay. You will need a prescription from your doctor with enough refills to allow 60 days.

- Alzheimer Disease medication
- Antipsychotic medication
- Antivirals for HIV
- Asthma and other respiratory medication
- Benign Prostatic Hyperplasia (BPH) medication
- Blood pressure medication (e.g., beta blockers, calcium channel blockers, diuretics, ACE-inhibitors)
- Blood thinners and other circulation drugs
- Cancer medication
- Cholesterol-lowering drugs
- Diabetes medication
- Glaucoma medication
- Hormone replacement medication
- Heart medication
- Organ transplant medication
- Osteoporosis medication
- Parkinson's Disease medication
- Potassium supplements

## Maintenance Medications continued

- Seizure medication
- Thyroid medication

For purposes of this Plan, “maintenance medications” are defined as follows:

- A drug in which the most common use is to treat a chronic disease state when a therapeutic endpoint cannot be determined. Therapy with the drug is not considered curative.
- A drug that has a low probability for dosage or therapy changes due to side effects, serum drug concentration monitoring, or therapeutic responses over a course of prolonged therapy.

While certain drugs may sometimes be used on a chronic basis, the drug will only meet the above definition if it is most commonly used in this way. The most common examples of maintenance medications are medicines used to treat high blood pressure, diabetes, high cholesterol or hypothyroidism.

In addition, the Prescription Drug Card Program employs management tools for all covered members in order to ensure adequate delivery of pharmaceutical services at an affordable price.

**New Drugs Entering the Market**—All new drugs entering the market will automatically be placed in the non-preferred category and will require the 3rd tier co-pay amount (currently \$50). These drugs will remain in the non-preferred category until evaluated by the Pharmacy and Therapeutics Committee of Catalyst Rx. If this committee, made up of practicing physicians and pharmacists, determines that a product should be preferred, it will then be moved to preferred status and will require the 2nd tier co-pay amount. Otherwise, it will remain in the non-preferred category.

## Drug Card Quantity Limitations

(i) Anti-Nauseant Medications—These products (Ansetmet/Emend/Kytril/Zofran) are used for the treatment of nausea and vomiting associated with chemotherapy, radiation therapy and surgery. The prescription drug card program will limit these drugs to a five-day supply per prescription. These allowances should be adequate for most members. The length of treatment, however, will remain consistent with the prescribing physician’s orders.

(ii) Migraine Therapy Program—this program ensures appropriate usage of drugs that treat migraine headaches. Limitations have been placed on the products listed below on both a per-prescription and a per-30-day basis. These allowances should be adequate for most members. This list will be updated as newer drugs in this category enter the market:

- |            |             |
|------------|-------------|
| ❖ Axert®   | ❖ Maxalt®   |
| ❖ Amerge®  | ❖ Migranal® |
| ❖ Frova®   | ❖ Relpax®   |
| ❖ Imitrex® | ❖ Zomig®    |

(iii) Anti-Inflammatory Drugs (COX-2 Inhibitors)—The class of anti-inflammatory drugs known as COX-2 inhibitors are covered under the prescription drug card program. These drugs include Celebrex, however, based on FDA-approved indications and dosing recommendations, quantity limits per prescription will apply to these products.

(iv) Narcotic Analgesics—Quantity limits, consistent with FDA-approved dosing recommendations, are placed on two narcotic analgesic products, Duragesic patches and Oxycontin products.

(v) Antidepressants—Many of the drugs in this class are intended to be dosed once per day. Often, physicians will start patients on lower doses and, over time, increase the dose per day. In order to ensure the most cost-effective strengths are used, certain lower strength doses of these products will have a quantity limit of one per day. If the dose is doubled, the

## Drug Card Quantity Limitations continued

patient will be required to use the higher dose product, taking one per day rather than two of the lower strength product. The following products are impacted by these limits:

- Celexa 20mg.
- Effexor XR 37.5mg and 75mg
- Paxil 10mg and 20mg
- Zoloft 25mg and 50mg

(vi) Specialty Pharmacy—Many very expensive medications (many of which are injectables) used to treat relatively uncommon and/or potentially catastrophic illnesses are covered under the prescription drug benefit. However, due to the extreme cost of many of these products, they will be covered only through a specialty pharmacy provider. If a prescription for one of these products is taken to your local pharmacy, a message will be sent to the pharmacist indicating that product is covered only through a specialty pharmacy. Catalyst Rx customer service personnel will forward the required paperwork to obtain pertinent information and make the referral to the specialty pharmacy. The member will be contacted to arrange for shipment of the medication. The member is also provided instructions on how to obtain subsequent refills, pursuant to the physician's authorization.

(vii) Singulair—This is a drug indicated for the treatment of asthma and seasonal allergic rhinitis (i.e. hay fever). However, less expensive alternatives to treat seasonal allergic rhinitis are often equally effective. Consequently, a contingent edit will be placed in the pharmacy claims process that will require evidence of use of one of the less expensive alternatives or evidence of other treatment for asthma within the past 6 months before the claims will be paid.

(viii) Sedative/Hypnotics—Ambien, Lunesta and Sonata, three drugs in this category, are approved by the Food and Drug Administration (FDA) for the short-term treatment of insomnia. Hypnotics should generally be limited to 7 to 10 days of use, and treatment beyond 2 to 3 weeks is not recommended. As a result, these products will be limited to a maximum quantity of 15 tablets/capsules per 30-day supply, with a maximum quantity of 120 units per year.

## Drug Card Exclusions

The products or drug categories listed below are excluded from coverage under the prescription drug program, but may be reimbursed under major medical portion of the plan:

### Implantable Contraceptives

- Biologicals
- Contraceptive Devices
- Miscellaneous Medical Supplies
- Nutritional/Dietary Drugs.

The products or drug categories listed below are excluded from coverage under the prescription drug program, and will not be reimbursed under major medical portion of the plan:

- |                                         |                                                                |
|-----------------------------------------|----------------------------------------------------------------|
| ❖ Anabolic Steroids                     | ❖ Growth Hormones                                              |
| ❖ Anorexiant                            | ❖ Obsolete Drugs                                               |
| ❖ Appetite Suppressants                 | ❖ Research Drugs                                               |
| ❖ Anti-Obesity Drugs                    | ❖ Smoking Cessation Drugs                                      |
| ❖ Anti-Abuse Drugs                      | ❖ Topical Minoxidil                                            |
| ❖ Cosmetic Agents                       | ❖ Unit Dose Drugs                                              |
| ❖ Erectile Dysfunction Drugs            | ❖ Xyzal (antihistamine)                                        |
| ❖ Experimental or Investigational Drugs | ❖ Over-The-Counter medications<br>(unless otherwise specified) |

## **Drug Card Exclusions continued**

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

A benefit is provided by the Municipal Health Benefit Fund to supplement Medicare Part D prescription drug coverage. **Enrollment for Medicare Part D coverage is required in order to be eligible for this benefit supplement.**

The supplement pays benefits toward out-of-pocket costs for expenses eligible under Medicare Part D that are also eligible under the provisions of Prescription Drug Coverage of the Municipal Health Benefit Fund for Employees and Dependents. Your out-of-pocket cost for these expenses, after the combined benefits, is no more than: \$10.00 for a generic drug; \$30.00 for a preferred brand; \$50.00 for a non-preferred brand.

#### **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 Catalyst Rx as the secondary carrier;
- You pay only the copay of \$10.00 for a generic drug; \$30 for a preferred brand; \$50 for a non-preferred brand.

#### **Important Note:**

If the pharmacy cannot coordinate benefits, ask for a receipt showing what your primary carrier paid and submit any out-of-pocket expense, along with a Direct Reimbursement Form (available at [www.arml.org](http://www.arml.org)) to:

**Catalyst Rx Direct Member Reimbursement**  
**P.O. Box 1069**  
**Rockville, MD 20849-1069**  
**Fax (877)-524-3784**

**Status of these claims can be obtained by calling the Pharmacy Help Desk number on your ID Medical/Drug card at (888)869-4600.**

# Dental Benefits

**Benefits Payable**—These 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 and incurred in a calendar year. 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.

**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, defect or injury to teeth and which (a) are not included by other provisions applicable to these benefits and (b) do not exceed the usual and customary charges within the area 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;
- Replacement of an existing partial, or fully removable denture(s), or fixed bridgework by a new denture, or new bridgework, including crowns and inlays forming the abutments for replacement of teeth, two or more years after the effective date of the covered member's benefits, or the addition of teeth to an existing partial removable denture, or to bridgework to replace extracted natural teeth, but only if evidence satisfactory to the Plan Administrator is presented that:
  - a. The existing denture or bridgework cannot be made serviceable and was installed at least five years prior to its replacement; or
  - b. The existing denture is an immediate temporary denture and replacement by a permanent denture is required and takes place within 12 months from the date of installation of the immediate denture; or
  - c. The replacement or addition of teeth is required to replace one or more additional natural teeth, extracted while covered under these provisions and after the existing denture or bridge work was installed;
- Inlays, gold fillings, crowns (including precision attachments for dentures) and initial installation of fixed bridgework (including inlays and crowns to form abutment) to replace one or more natural teeth extracted while covered under these provisions;
- Orthodontic treatment, including correction of malocclusion. However, the total amount of benefits payable for all such expenses incurred will not exceed the maximum benefit of \$1,000 for orthodontic treatments, even if required as a part of a medical procedure.
- 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 any TMJ services, even if treatment is related to a medical condition, and is covered only under the Dental Benefit.

## 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:
  1. The replacement of a lost or stolen prosthetic device;
  2. Charges made by a provider other than a dentist, or charges for treatment by a provider other than a dentist, except for a prophylaxis, if otherwise covered by these benefits, which may also be performed by a licensed dental hygienist working under the supervision of a dentist;
  3. 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:
  1. To the extent that, in the absence of these benefits, they are covered expenses reimbursable in full or in part under this Plan:
  2. Furnished primarily for cosmetic purposes;
  3. Provided by someone who is an immediate relative as defined in the “Definitions” sections of this booklet or who ordinarily resides in your home.

**Additional Dental Provisions**—The Exclusions provision of the Hospital or Major Medical Expense Benefits will, to the extent not inconsistent, also apply to these benefits.

# Vision Care Benefits

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

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

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

**Medical Eye Care**—Eye disease and other medical treatment of the eye will be covered under the major medical care provision for service provided by an Optometrist or Ophthalmologist. (See Precertification, Penalty Deductibles and Utilization Review for further information)

## Vision Care Limitations:

Vision Care provisions are subject to the Health Benefit Fund General limitations. In addition, expenses due to the following are not Covered Vision Expenses:

- Examination, lenses or frames received in or from an institution owned or operated by the federal government where there is no obligation to pay in the absence of coverage.
- Sun glasses.
- Duplicate or spare lenses or frames.
- Repair to frames.

**Additional Vision Provisions**—The Exclusions provision of the Hospital or Major Medical Expense Benefits will, to the extent not inconsistent, also apply to these benefits.

# Coordination of Benefits

The benefits payable under this Plan for medical, dental or vision expenses will be coordinated with group insurance and health benefit plans providing benefits for such expenses to cover up to 100 percent of Allowable Expenses incurred, after the deductible has been satisfied. Benefits payable under the Plan will also be coordinated with applicable medical payment coverages, including, but not limited to, auto and homeowners coverages. The Municipal Health Benefit Fund will follow the usual rules of coordination of benefits.

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

For covered members who are totally disabled or reach age 65 and are eligible for Medicare and fail to apply for Medicare in a timely fashion, the Municipal Health Benefit Fund will coordinate with Part A, Part B and Part D of Medicare the same as if the covered member had Part A , Part B and Part D of Medicare.

The benefits payable under this Plan for such expenses will be reduced so that the total amount payable under all plans does not exceed the total allowable expenses incurred during each calendar year.

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

## Definitions

As used in this provision:

**Allowable Expenses**—means usual, customary and reasonable charges made for necessary services and supplies, a portion of which is covered by at least one of the plans, other than Medicare, covering the member for whom the claim is made. The services will be treated as an Allowable Expense and a benefit paid. Allowable Expenses do not include charges used to satisfy the deductible or co-payments assessed under a prescription drug card plan.

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

**Plan**—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.

## Overpayments: Right of Recovery

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

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

### Right of Reimbursement

As a condition to receiving benefits from the Plan and by their receipt of said benefits, all participants and insureds grant the Plan the right to recover from any proceeds, including any form of consideration whatsoever, that the participant/insured receives from a third party, via judgment, settlement, or otherwise in connection with the accident, injury or other event that resulted in the Plan’s expenditures, dollar for dollar beginning with the first dollar received by the

## **Right of Reimbursement continued**

member from the third party, regardless of how those proceeds are characterized or labeled (e.g., payment of medical expenses, pain and suffering damages, compensatory damages, punitive damages, or any other type of non-economic or economic damages), in an amount equal to the expenditures made by the Plan in providing benefits to the member.

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

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

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

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

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

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

## **Assignment of Rights**

In addition to providing the Right of Reimbursement described above, and as an additional condition to receiving benefits from the Plan, the member will assign to the Plan any and all rights to pursue an action or claim against any third party in connection with the accident, injury or other event that gave rise to the Plan's expenditures. If the Plan pursues

### **Assignment of Rights continued**

any such action or claim, the member shall cooperate and assist the Plan and shall be prohibited from taking any action that would prejudice the Plan's rights or in any way diminish its prospects for a recovery.

- In addition, the participant must execute a lien in favor of the Plan for the amount to which the Plan is entitled. However, even if the participant or insured does not give the Plan a lien, the participant is liable to the Plan for reimbursement under these provisions.
- To ensure that any amounts received from or on behalf of a third party are kept separate and are not commingled with any other funds.
- To notify the Plan within 10 days after receiving any recovery from or on behalf of a third party.

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

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

# Notice and Proof of Claim

**Filing a Claim**—All claims are to be filed with the Plan Administrator and mailed to Municipal Health Benefit Fund (MHBF), P.O. Box 188, North Little Rock, Arkansas 72115. For any questions, you may call 501-374-3484. All claims, along with supporting information/documentation must be received in the Municipal Health Benefit Fund office or by the Plan Administrator within 180 days of the date the claim was incurred, unless defined otherwise in this section. If an entire group or individual member is terminating coverage, any incurred claim for benefits must be filed within 60 days of the last day of membership in the Plan, or within the 180 days of the date of service, whichever is less.

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

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

No legal action will be brought against the Plan prior to sixty (60) days after proof of claim has been filed with the Plan Administrator. If the time for beginning legal action is less than that permitted by law of the jurisdiction in which the Municipal Health Benefit Fund is domiciled, such limit is extended to the minimum period permitted by such law.

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

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

**Policies and Appeals Procedure**—The five-member Board of Trustees of the Municipal Health Benefit Fund Trust will establish policies and hear appeals.

# Mandatory Administrative Appeals Procedure

If a disputed claim or benefit question cannot be resolved, there is a formal appeals procedure. As a condition precedent to all the benefits, terms and conditions of this contract, an employer member and its employee members must agree to exhaust all their administrative remedies including, but not limited to, the claims denial procedure before the Board of Trustees, before any legal action is brought in any court.

A denial of a claim for benefits will be explained in writing. The explanation will include the 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 you have a question about your claim payment or how the Plan works, we urge you to call and visit with a MHBFB Customer Service Representative. If a claims question cannot be resolved through Customer Service, the following claims appeal procedure will be followed.

**First Written Appeal**—To request a written appeal, address a letter to the attention of the Claims Supervisor, at Municipal Health Benefit Fund, P.O. Box 188, North Little Rock, Arkansas 72115. The request must be submitted within 60 days of your receipt of the claim denial notice. In your request for review and appeal specifically state why you believe the denial was incorrect.

The Claims Supervisor will normally respond to your request with a decision in writing within sixty (60) days referencing the Plan provision upon which the denial was based and an explanation of the Plan's claim appeal procedure. If an extension is needed to investigate the facts, you will be notified of the need.

**Final Appeal**—If the decision rendered by the Claims Supervisor is not satisfactory, you or a duly authorized representative may appeal any denial of a claim for benefits by filing a written request for a review to the Plan Administrator and the Municipal Health Benefit Fund Board of Trustees. The request should be directed to the Plan Administrator at P.O. Box 188, North Little Rock, Arkansas 72115. In connection with such a request, documents pertinent to the administration of the Plan may be reviewed, and issues outlining the basis of the appeal may be submitted. You may have representation throughout this review procedure.

Your request for review must be filed within sixty (60) days after receipt of the written notice of denial from the Claims Supervisor. You need not appear at the quarterly meeting of the Board of Trustees to have your claim reviewed by the Board. 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 possible. The decision after the Board's review shall be in writing and shall include specific reference to the pertinent Plan provisions on which the decision was based.

# Life and Accidental Death and Dismemberment Coverage

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

Employee	Consult your Employer for amount	
Spouse		\$5,000
Child by Age at Death	2 weeks	Nil
	2 weeks but less than 6 months	\$200
	6 months but less than 23 years	\$2,000
	23 years or over	Nil

Coverage for the employee will be reduced by 75 percent when the employee reaches age 70 and coverage for the employee's spouse will be reduced by 50 percent when the spouse reaches age 70. Life benefits cease when coverage terminates, members go on retired status or go on COBRA.

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

## Accidental Death and Dismemberment Benefits

A separate certificate outlines your benefits for Accidental Death and Dismemberment that are underwritten by an insurance company. Consult your Employer for amount of benefit.

## Disability Income Benefits

### (Optional Coverage for Full-Time Employees Only)

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

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

#### Option A (26 Weeks Benefit)

Weekly Benefit	\$105
First Benefit Day for Disability Due to Accident	1st Day
Illness	8th Day
Maximum Number of Weeks Payable	26 Weeks

#### Option B (52 Weeks Benefit)

Weekly Benefit	\$105
First Benefit Day for Disability Due to Accident	183rd Day
Illness	183rd Day
Maximum Number of Weeks Payable	52 Weeks



## Eligible Class continued

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

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

## Effective Date Requirements

- To be covered, you must enroll in the Plan when eligible and agree to make any required premium contributions. If you do not enroll yourself and your dependents before the date you become eligible, you may not enroll until January 1 of the following year.
- If you acquire new dependents during the year, either by marriage, birth, or adoption, you may elect to add all eligible dependents by the first of the month following the date new dependents were acquired.
- A newborn dependent is eligible for coverage on the date of birth **only if the Plan member has family coverage at the time of delivery of the newborn.**
- If you have single coverage and wish to provide coverage for an eligible newborn, you must meet the following requirements:
  - You must be unmarried.
  - You must have no other eligible dependents from any previous relationship.
  - You must add family coverage by the sixth month of pregnancy.
- Dependent coverage may be added the first of the month following the loss of health coverage due to termination of employment of your spouse. If this is the case you must notify the Plan with a letter from your spouse's employer which states the date that employment ended, along with a Certificate of Credible Coverage from the employer's health insurance carrier indicating the date health care coverage ended.
- If you are Court Ordered, due to divorce or to a Child Support/Medical Support Order, to provide coverage for eligible dependent children, dependent coverage may be added to your existing single coverage as of the first day of the month following the date of the Order. A completed Change of Status form and copy of the Order are required.

If you do not add the newly acquired dependent(s) by submitting a completed "change of status" form within 30 days of when they become eligible, you may not enroll them until January 1 of the next year.

Your Municipal Health Fund Benefits will become effective, provided you are actively at work, on the date you become eligible if you have enrolled before that date. If you are not actively at work for the full duration of your normal daily work schedule on the date your coverage would otherwise become effective or be increased and you are then disabled or under a physician's care due to illness or injury, your coverage will not become effective or be increased until the first day of the month following the date you resume full-time active work with the Employer. If a dependent is confined in an institution as a result of illness or injury on the date coverage would otherwise become effective or be increased, coverage will not become effective or be increased until the day following discharge from the institution. This provision will not defer the original effective date of coverage for your newborn child, born while you have other dependents covered under the Municipal Health Benefit Fund. However, coverage for your dependents will not become effective before your own personal coverage becomes effective.

**Special Requirements**—Members moving from one covered group to another without a lapse in coverage do not have to meet the 30-day employment requirement. If this provision applies in your case, contact the Plan Administrator for additional information.

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

## **Effective Date Requirements continued**

**Family Medical Leave Act**—The Plan recognizes and complies with the Family Medical Leave Act of 1993. Your Employer must notify the Plan in writing at its Administrative offices if you have left your employment under provisions of the Family Medical Leave Act.

**COBRA**—The Plan recognizes and complies with all extended coverage benefits for employees and dependents provided for by the Consolidated Omnibus Budget Reconciliation Act of 1987 (COBRA). Benefits do not include Life, AD&D and/or disability income.

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

## When Your Benefits Stop

When an employee's salary ceases, the employee's coverage also ends, albeit on the last day of the month in which the salary ceases. Coverage ends whether you leave your employment, retire, die or go on unpaid leave of absence. If you become a member of an ineligible class, coverage will end on the last day of the month in which you became a member of an ineligible class.

In addition to the above, coverage is also terminable for failure to make premium payment. Coverage for you will stop on the earliest of:

- The last day for which your premium has been paid.
- When the participating employer fails to make the required premium payments.
- When the participating employer cancels coverage under the Municipal Health Benefit Fund.
- The last day of the month you cease to meet the eligibility requirements as defined herein.

Your Dependents Benefits will automatically terminate on the earliest of:

- The date your personal benefits terminate.
- The last day for which your dependent's premium has been paid.
- The last day of the month following your termination from the payroll of the city.
- The date coverage for dependents is terminated under the Municipal Health Benefit Fund.
- For any dependent, the last day of the month he or she ceases to be an eligible dependent.
- The last day of the month you cease to meet the eligibility requirements as defined herein.

Eligibility as a dependent will cease: (a) for any dependent, on the date he or she becomes covered for personal coverage under the Municipal Health Benefit Fund, enters active service with the armed forces of any country or otherwise ceases to be in a covered classification according to the definition of an eligible dependent, (b) for your spouse, the end of the month following the date of divorce or legal separation and (c) for your child, the end of the month following date of the child's marriage or attainment of the applicable maximum age limit, whichever is the earliest date. However, if your child is incapable of sustaining employment by reason of mental retardation or physical handicap following attainment of age 19 and if covered hereunder up to that time, will continue to be eligible as a dependent so long as he or she remains continuously in that condition, provided the member/employee notifies the Plan Administrator and such condition actually exists. If there is a conflict between dates when coverage could end, the earliest date governs. Additionally, the Plan will not pay for services or supplies furnished after the date coverage ends, even if the Municipal Health Benefit Fund pre-certifies or provides benefit information for a treatment plan submitted before the end of coverage.

# RIGHT TO CONTINUATION COVERAGE UNDER COBRA

## Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice 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.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

## What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

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

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

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

## **When Is COBRA Coverage Available?**

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee or the employee becomes entitled to Medicare benefits (under Part A, Part B or both), the employer must notify the Plan Administrator of the qualifying event.

## **You Must Give Notice of Some Qualifying Events**

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child is losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Plan Administrator, Municipal Health Benefit Fund, P.O. Box 55152, Little Rock, Arkansas 72215.

## **How Is COBRA Coverage Provided?**

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

## **Disability Extension of 18-month Period of Continuation Coverage**

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage

## **Second Qualifying Event Extension of 18-month Period of Continuation Coverage**

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both) or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

## **If You Have Questions**

For questions concerning your Plan or your COBRA continuation coverage rights, please contact your Employer, or the Plan Administrator, Municipal Health Benefit Fund, P.O. Box 55152, Little Rock, Arkansas 72215. For additional information about your rights under COBRA or the Health Insurance Portability and Accountability Act (HIPAA), contact the U.S. Department of Health and Human Services at:

**<http://www.cms.hhs.gov/COBRAContinuationofCov/> or <http://www.cms.hhs.gov/HIPPAInfo/> or call the Regional Health and Human Services office at (214) 767-6423.**

### **Keep the Plan Informed of Address Changes:**

In order to protect your family's rights, you should keep the Plan Administrator 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 Plan Administrator.

If you have changed marital status or you or your spouse have changed addresses, please notify the Plan Administrator or his agent at the above address, or call 501-374-3484.

# RETIREE COVERAGE

**Retirees Age 55 or Older**—When any municipal official or municipal employee is:

- age 55 or over,
- who has completed 20 years of service with a Participating Employer,
- who is vested in the Participating Employer’s properly sanctioned retirement system,
- retires from the Arkansas municipality.

The retiree may then continue to participate in the Municipal Health Benefit Fund, receiving the same medical benefits and paying the same premium as active employees, as long as the retiree pays the total premium due to the Municipal Health Benefit Fund.

**Benefits Available**—A member retiring under this status will be eligible for all provisions of the standard benefit plan as described in the Fund Booklet, with the exception of the following coverages: Life, AD&D and Disability Income Benefits.

**Continuation of Health Coverage Under Retiree Status**—Retired members may remain covered provided the former employer remains in the Municipal Health Benefit Fund. The Employer shall be responsible for collecting premiums for such retired employees and remitting them promptly to the Municipal Health Benefit Fund.

# Definitions

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

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

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

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

**Employee Benefit** means the benefit provided for eligible employees.

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

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

**Clean Claim** is a properly completed billing form UB 92, HCFA 1500, or their successor form(s), or one providing equivalent information with complete CPT-4 or ICD-9 coding, which needs no additional information or clarification from Provider or Covered Individual for payment to be made properly, i.e., medical records, detailed billing, invoices or any other such like information.

**Co-Insurance** means the ratio (percentage) of splitting the bill between the Plan and the Covered Member. **Example**—90 percent for the first \$5,000 of eligible charges means the Plan will pay \$4,500 and the Covered Member is responsible for the remaining \$500.

**Co-Payment** means an amount required to be paid by a Covered Member each time a specific Covered Service is accessed. The co-payments are set forth in the Schedule of Benefits.

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

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

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

**Dependent** means your spouse not legally separated, or your unmarried child from birth but less than 19 years of age, excluding anyone who resides outside the United States or Canada, is in the armed forces of any country or has coverage under the Municipal Health Benefit Fund as an employee or as a dependent of another person. Coverage will con-

## Definitions continued

tinue for dependent children reaching age 19 through the last day of the month in which the dependent reaches age 19.

The term **Child** shall include:

- 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, or
- A child may also include a grandchild who is under legal guardianship or custody of the employee and may be enrolled under the Dependent Only coverage if the employee submits documentation of custody and/or guardianship and pays an additional monthly premium as determined by the Plan.

For additional information, see the Full-time Student definition.

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

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

**Employee**—See member/employee.

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

**Entitlement**—Medicare Individuals become entitled to Medicare once they actually apply to begin Social Security income payments or file an application for hospital insurance benefits under Part A of Medicare.

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 Plan Administrator 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 Plan Administrator will be considered final and binding on all parties. After all other provisions of the Plan have been complied with, the following criteria and guidelines will be used by the Plan in determining whether medical devices, medical treatments and pharmaceutical treatments are to be considered experimental or investigative and whether they will or will not be covered by the Plan.

- If FDA approval for use of a drug to treat a specifically diagnosed condition has not been given at the time of treatment, such use shall be known as "off-label" use and will not be covered by Municipal Health Benefit Fund.
- The Plan will not provide coverage for medical services that are subject to ongoing clinical trials or research.
- The Plan will not provide coverage for medical devices unless all of the following criteria are met:
  - a. The FDA has approved the device for marketing.
  - b. The device is being used to treat a condition specifically recognized and authorized by the FDA marketing approval.
  - c. The device has been recognized for its clinical effectiveness in treating the condition according to the nationally accepted medical guidelines utilized by the Plan.

Federal law gives the plan sponsor of a self-funded non-federal government plan the right to exempt the Plan from requirements imposed upon group health plans, and the Municipal Health Benefit Fund has elected to do so. This means that the Cancer Rights Act of 1998 does not apply with regard to benefits for MHBF members.

**Full-Time Student** means a covered dependent age 19 to 23 who is enrolled in an accredited school or college as a stu-

## Definitions continued

dent carrying a minimum load of 12 semester hours or who is otherwise classified as a full-time student as defined by the accredited school or college in attendance and approved by the Plan.

- Covered dependents attaining the age of 19 years must submit proof of full-time student status in the form of a signed letter from the Registrar's Office of the school or college for coverage to continue. Proof of status must be submitted to the Plan by the last day of the month the student turns age 19. If such status is not received, student eligibility will end at midnight on the last day of the month the dependent turns age 19. **(Evidence of pre-registration as a student will only be accepted for students turning age 19 during the summer break.)**
- Covered dependent students ages 19 to 23 must submit to the Plan documentation for proof of full-time student status, in the form of a signed letter from the Registrar's office of the accredited school or college, by September 15 of each year for coverage to continue. Student eligibility ends at midnight on the last day of the month the student turns age 23 or no longer meets the dependent requirements as outlined in the Fund Booklet.
- If such full-time student documentation is not received within 30 days of the required submission date, dependent coverage will be terminated at midnight on the last day of the month the dependent is otherwise eligible for coverage.
- Documentation of full-time student status must be received at the time new dependent students are enrolled in the Plan.

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

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

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

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

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

**Illness** means illness or disease and related medical conditions.

**Immediate Relative** means your spouse, parents, children, brother, sister, grandparents, uncles, aunts, nieces, nephews or legal guardian of the covered member who received the services.

**Injury** means a bodily injury sustained accidentally by external means.

## Definitions continued

**Inpatient** means a member who is a patient using and being charged for the daily room and board facilities of a hospital or a member who remains in observation longer than 23 hours.

**Licensed Certified Social Worker** means a person who has a Master's Degree from an accredited social work program in an accredited institution approved by the state in which they are licensed to practice. This definition shall also extend to licensed certified counselors. To qualify for benefits, the Plan member must have been referred to the social worker by a licensed medical physician.

**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.

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

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

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

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

Any appeal 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.**

**Member/Employee** means an eligible person or their dependent that has submitted an enrollment form and has been accepted as a member of the Municipal Health Benefit Fund, and remains a member in good standing according to the policy provisions of the Plan. In addition to full-time active employees who work at least 30 hours per week for a participating employer, those eligible for membership also includes 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.

**Municipal** means pertaining to a local governmental unit or political subdivision, e.g., incorporated cities and towns of Arkansas and Arkansas counties.

**Occupational Therapist** means a person who helps patients to develop skills in carrying out activities of daily living, vocational skills and fine motor hand skills. They also make and apply orthoses and treat psychologically impaired patients.

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

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

## **Definitions continued**

**Outpatient Clinical Setting** means outpatient hospital facility or physician office.

**PHI** means Personal Health Information.

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

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

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

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

**Precertification** means prior notification to the Utilization Review Program before any of the service types listed on page 9 of the Fund Booklet are received by the covered individual.

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

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

**Satisfactory Evidence of Coverage** means evidence that is approved by the Plan Administrator at his Home Office and is furnished without expense to the Plan Administrator.

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

**Stop-Loss** is a limit on the co-insurance required from the Covered Member.

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

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





## Is Included in Your MHBF Benefits

Log on to [www.eDocAmerica.com](http://www.eDocAmerica.com) from any computer with Internet access and ask our board-certified physicians any question, anytime. Our physicians are “on call” 24/7. We guarantee an answer within 24 hours, but in most cases your personalized answer arrives within three to four hours.

### Registering couldn't be easier ...

1. Enter our site at [www.edocamerica.com](http://www.edocamerica.com)
2. Click on “Register”
3. Select **Arkansas Municipal League** from the drop-down menu and follow the online instructions

### Registered Nurse Advice Line

You can also call the eDocAmerica Registered Nurse Advice Line toll free 24/7/365 for issues requiring a more immediate response. Call toll free 1-866-842-5365. Offered in both English and Spanish.

Need assistance with eDocAmerica? Call toll free 1-866-525-3362, or email us at [info@edocamerica.com](mailto:info@edocamerica.com).

## **PLAN ADMINISTRATION: Enrollment and Premiums**

Municipal Health Benefit Fund Premium

P.O. Box 55152

Little Rock, Arkansas 72215

Phone: (501) 374-3484

Fax: (501) 537-7252

*www.arml.org*

## **CLAIMS ADMINISTRATION: Claims and Benefits**

Municipal Health Benefit Fund

P.O. Box 188

North Little Rock, Arkansas 72115

Phone: (501) 374-3484

Fax: (501) 537-7252

*www.arml.org*

**For Precertification, please call:**

1-888-295-3591

(Precertification does not provide Benefit Information.)