MUNICIPAL HEALTH BENEFIT FUND SEMINAR
AGENDA
October 28, 2016

8:30 a.m. – 9:00 a.m. Registration

9:00 a.m. – 10:00 a.m. Welcome and Opening Remarks
Don Zimmerman, Executive Director
Arkansas Municipal League

MHBF Plan Changes 2017
Tracey Pew, MHBF Coordinator
Arkansas Municipal League

10:00 a.m. – 10:30 a.m. Prescription Benefits Updates
Alan Gardner, Vice President of Operations
RxResults

10:30 a.m. – 10:45 a.m. BREAK

10:45 a.m. – 11:30 a.m. The Obesity Epidemic and
Obesity Treatment Plans
John Baker, MD, FACS
MHBF MBS-AQUIP Medical Director

11:30 a.m. – 12:00 p.m. ACA Reporting Going Forward
Wes Dozier, My Benefits Channel

12:00 p.m. – 1:00 p.m. LUNCH
<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Speaker(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:00 p.m. – 2:00 p.m.</td>
<td><strong>Patient Participation in Medical Care and How eDoc Can Help</strong></td>
<td>Dr. Charles Smith, MD, Associate Dean of Primary Care Service Line</td>
</tr>
<tr>
<td>1:30 p.m. – 2:00 p.m.</td>
<td><strong>We’re Here to Help! – MHBF Customer Service &amp; Provider Relations Staff</strong></td>
<td>Beth Chappell, Supervisor, Pam Adams, Wilma Huckaby, Kate Cantrell, Michelle Philmon, Krystal Berline, Robyn Hayes</td>
</tr>
<tr>
<td>2:00 p.m. – 2:30 p.m.</td>
<td><strong>Flexible Spending Accounts</strong></td>
<td>Rob Yetter, Regional Vice President of American Fidelity</td>
</tr>
<tr>
<td>2:30 p.m. – 3:00 p.m.</td>
<td><strong>Closing Remarks/Q&amp;A</strong></td>
<td>Don Zimmerman, Executive Director of Arkansas Municipal League</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tracey Pew, MHBF Coordinator of Arkansas Municipal League</td>
</tr>
</tbody>
</table>
MHBF 2017

PLAN CHANGES & IMPORTANT REMINDERS
REQUIRED NOTICES
Required Notices to Employees

- HIPAA Privacy Notice
- Health Insurance Marketplace Coverage Options Notice
- Summary of Benefits and Coverage

Copies of these notices have been included in your meeting packet, along with an Acknowledgment of Receipt form.

You must maintain a record demonstrating that these notices were provided to your employees. Retain these records for seven (7) years.
The 2017 Fund Booklet has been restructured to make it more user-friendly.

You will now find “Definitions” in the last section of the book.

The term “elective” surgery has been changed to “non-emergency” surgery to alleviate confusion.

You will find that many topics/subsections have been relocated. For example, “Tobacco Cessation” is now found in both the Preventative Benefit Section and the Prescription Drug Section.

Benefit descriptions and clarifications have been made throughout the Fund Booklet.

All changes were made with the end user in mind.
FORMS: Certificate of Notice and Acceptance of Plan Provisions

- **Lifetime Certificate of Notice & Acceptance**
  - If you have a signed 2015 Certificate of Notice and Acceptance on file, you will not have to sign another; **unless**:
    - You move from one employer group to another; or
    - Leave your job for an extended period of time and then go to work for another participating employer group; or
    - Are a new employee of a participating employer group; or
    - Are an employee of a new participating employer group.

A spouse’s signature is no longer required on the form.
If you or any family member covered as your dependent by MHBF have any other medical, dental or vision insurance coverage, please complete a Multiple Coverage Inquiry.

If you or any covered dependent have already completed this form and coverage changes, please complete a new form with corrected information.

If you or any covered dependent drops additional medical, dental or vision coverage, please advise MHBF by completing a new Multiple Coverage Inquiry.

Failure to complete this form may result in claims being delayed or denied.
FORMS: Enrollment/Change/Termination Form

- Use this form for:
  - Enrollment in the Plan
  - Coverage Declination
  - Add/Drop Dependent
  - Cancel Coverage
  - Address Change
  - Name Change
  - Coverage Change – Individual to Family or Family to Individual
  - Status Change – (i.e., marriage, divorce)
  - Employee Termination
2017 BENEFIT CHANGES
If you have **Family Coverage**, an eligible newborn can be added to your coverage on the newborn’s date of birth. The newborn must be added within sixty (60) days of their date of birth, regardless if SSN is received.

In 2016, a member had ninety (90) days to add a newborn to the existing Family Coverage.

The guidelines for Individual Coverage remains the same. If you have single/individual coverage, family coverage may be added on the first day of the month after a qualifying event. (i.e., marriage, birth, adoption, etc.) It is important to note that the coverage does not go back to a newborn’s date of birth.
Benefit Changes for 2017

- Prescription strength and over-the-counter (OTC) gastric acid reducers/ulcer medications such as Nexium and Prilosec will no longer be covered.
- Prescription strength and over-the-counter (OTC) antihistamines, such as Flunisolide or Claritin will no longer be covered.
  - Both of these drug types are readily available over-the-counter without a prescription.

Alan Gardner with RxResults will address Prescription Benefit changes in more detail later this morning.
BECOMMING A WISE HEALTHCARE CONSUMER
Common Mistakes that Increase Out-of-Pocket Costs

- Failure to pre-certify. When in doubt, call 888-295-3591.
- Using the Emergency Room for non-emergency events.
- Failing to check in-network status of a provider.
- Failing to add dependent to coverage in a timely manner.
- Failing to find out if a service, test or procedure is covered prior to the event.  (i.e., genetic testing, PET scans, unproven medical procedure).
- Failure to carry minimum medical coverage on automobile insurance.
- Failure to turn in Accident Claim Form or other required documentation.

Be a wise healthcare consumer. Encourage members in your group to read the Fund Booklet and know their coverages and exclusions. Members can always contact Customer Service at 501-978-6137, Option 4 with questions!
Helpful Contact Information

- Enrollment and Premiums: 501-978-6137, Option 5
- Claims and Benefits: 501-978-6137, Option 4
- Provider Information: 501-978-6137, Option 7
- Precertification: 888-295-3591
- Tracey Cline-Pew: 501-978-6111
- www.arml.org
Prescription Benefits Updates and Costly Pharmacy Trends

October 28, 2016

www.rxresults.com
2017 MHBF Plan Changes
MHBF 2017 Plan Changes

- New drugs to market
  - Same drugs but different formulations
  - Some having no evidence of better performance
  - Minor strength differences
- New high cost generics
- Products moving to over-the-counter status
- Letters to impacted members
Noteworthy Specific Changes

- Long-acting / extended release ADHD Drugs
  - Coverage limited to cost of immediate release versions (reference priced)
  - Exception for children under 19

- Non-sedating antihistamines excluded
  - Very few are still available in prescription strength
  - Widely available over-the-counter (OTC)
  - Examples: Claritin®, loratidine, Allegra®/fexofenadine, Clarinex®, etc.
  - Both prescription and OTC strengths excluded
Noteworthy Specific Changes

- Gastric acid reducers (proton pump inhibitors) excluded
  - Widely available over-the-counter
  - Examples: Nexium®, Prilosec®, Dexilant®, omeprazole, etc.
  - Both prescription and OTC strengths excluded

- Certain antifungals
  - Strong TV marketing for new topicals
  - Oral versions just as effective
  - Examples: Jublia®, Cresemba®, Kerydin®
Noteworthy Specific Changes

• Long-acting opioid pain medicines excluded
  • CDC recommendation and call to action for physicians

• Topical non-narcotic analgesics & anesthetics excluded
  • Patches, gels, sprays, lotions, ointments, etc.
Costly Pharmacy Trends
Combination Drugs

- Combining older generic drugs to make new patentable brand drugs

Examples:
- **Duexis®** - $1,841 per 30-day supply
  
  Combination of ibuprofen (Advil) and famotidine (Pepcid)
  
  Single ingredients per 30 days
  
  - Ibuprofen: <$10
  - Famotidine: <$5
Combination Drugs

More examples:

- **Vimovo®** - $2,054 per 30-day supply
  Combination of naproxen (Naprosyn®) and esomeprazole (Nexium®)
  Single ingredients per 30 days
  - Naproxen: <$5
  - Nexium 24HR®: <$18

- **Treximet®** - $716 per 30-day supply (9 tablets)
  Combination of naproxen (Naprosyn®) and sumatriptan (Imitrex®)
  Single ingredients
  - Naproxen: <$5
  - Sumatriptan: <$14
Packaging (Kits, Paks, etc.)

• Packaging drugs with other products or other drugs

• Examples:

  • **Tretin-X®** - $227 per 30-day supply
    Tretinoin cream, cleanser and moisturizer
    Tretinoin cream: $10
    Cleanser and moisturizer available without prescription

  • **PrevPac®** - $960 per 14-day supply
    Lansoprazole, amoxicillin and clarithromycin
    Lansoprazole: $38 (or alternative, omeprazole $7)
    Amoxicillin: $6
    Clarithromycin: $72
Delivery Methods

- Using older generic drugs to make new brand drugs with different delivery methods

Examples:

- DermacinRx® Lexitraltm PharmaPak - $4,668 for 30-day supply
  Diclofenac and capsaicin applied as drops
  - Diclofenac tablet: $18
  - Capsaicin cream: $6

- Intermezzo® - $282 per 30-day supply
  Zolpidem (Ambien®) as a sublingual tablet
  - Zolpidem tablet: <$3
Delivery Methods

More examples – tablets vs. capsules:

- **Generic venlafaxine ER (Effexor XR®)**
  - Tablets: $92 for 30-day supply
  - Capsules: $10

- **Generic tizanidine (Zanaflex®)**
  - Capsules: $142
  - Tablets: $13
Questions?
ACA Reporting Going Forward
About Us

• We specialize in schools, governments, and hospitals
• Located in Franklin, Tennessee (Nashville)
• Began as benefits & HR firm in 1989
• Started developing proprietary cloud software in 2004
• Added ACA “Audit Ready” apps 2013
• Provide complete ACA management and auditing services
ACA Compliance Suite

- Secure Communications
- Variable Hour Employee Tracking
- ACA Electronic Notices
- IRS 1094-C & 1095-C Reporting
- IRS Form 1094-C Toolkit
- ACA Knowledge Base
Today’s Agenda

• Phase Out of ACA Transitional Relief
• New Penalties/Reporting Deadlines
• 1095-C Coding Changes
• Status of ACA Enforcement
• New ACA Complete Care Model
Disclosure

MyBenefitsChannel is not a law or accounting firm. No suggestion, recommendation, or opinion of the company or its employees shall constitute legal or tax advice. You are advised to consult with your own attorney or accountant for a determination of your specific legal rights, responsibilities and liabilities, including the interpretation and/or applicability of any statute or regulation, as may relate to your activities.
Phase Out of ACA Transitional Relief
Phased Out Relief Items

1. **Extended Reporting Deadlines** – no longer available.

2. **Good Faith Effort for Informational Returns** – no longer available.

3. **4980H Transitional Relief** – available only for 2015 plan year months (i.e. no longer available in 2016 for calendar year plans)

4. **Non-Calendar Year Transitional Relief** – no longer available.

5. **Six Consecutive Month Period for Determining ALE Status** – no longer available.


7. **Dependent Coverage Transitional Relief** – no longer available.

8. **MEC for Pay Periods in January 2015** – no longer available.
New Reporting Deadlines/Penalties
Reporting Deadlines

- **January 31, 2017** – Deadline to Distribute Form 1095-C to Recipients

- **February 28, 2017** – Deadline to File Paper Forms 1094-C and 1095-C with IRS.

- **March 31, 2017** – Deadline to Electronically File Forms 1094-C and 1095-C with the IRS.
  - Must utilize electronically filing if required to file 250 or more informational returns.
Increased Reporting Penalties

- **$260** – penalty for failure to timely file a correct informational return with the IRS.

- **$260** – penalty for failure to timely distributed a correct statement to a recipient.

- These penalties can double in circumstances where a failure is due to intentional disregard of the reporting requirement.
1095-C Coding Changes
• **1I** – Qualifying Offer Transition Relief 2015. Employee (and spouse or dependents) received no offer of coverage; received an offer that is not a qualifying offer; or received a qualifying offer for less than 12 months.

• **2I** – Non-calendar year transition relief applies to this employee.
New Codes

- **1J** – Minimum essential coverage providing minimum value offered to employee and at least minimum essential coverage conditionally offered to spouse; minimum essential coverage not offered to dependent(s).

- **1K** – Minimum essential coverage providing minimum value offered to employee; at least minimum essential coverage offered to dependents; and at least minimum essential coverage conditionally offered to spouse.

- **Conditional Offer of Spousal Coverage** – A conditional offer is an offer of coverage that is subject to one or more reasonable, objective conditions (for example, an offer to cover an employee’s spouse only if the spouse is not eligible for coverage under Medicare or a group health plan sponsored by another employer).
• An offer of COBRA coverage to a continuing employee should be coded, for the remaining months of the reporting year following the COBRA offer, using the appropriate Series 1 offer of coverage code which reflects the specific individuals eligible to enroll in the COBRA coverage.

• Generally, an offer of COBRA coverage is required to be made only to individuals who were enrolled in coverage immediately before the loss of eligibility due to the COBRA qualifying event.
• For the months remaining during the reporting year following a full-time employee’s termination, code 1H (no offer of coverage) and code 2A (not an employee) should be listed on lines 14 and 16 of the 1095-C, respectively.

• This simplifies an employer’s reporting by placing all terminated full-time employees in the same bucket, whether or not they receive a continuing offer of coverage (COBRA, retiree, or otherwise) or no continuing offer of coverage.
Offers of Coverage to Non-Employees/Non-Full-Time Employees

- Code 1G is generally utilized in line 14 when completing a Form 1095-C for a non-employee or non-full-time employee enrolled in an employer’s self-insured health plan.

- In 2015, it was not clear what the appropriate line 14 code should be when an offer of coverage to a non-full-time employee ceased mid-year.

- The Finalized 2016 Instructions for Forms 1094-C and 1095-C clarify that Code 1G applies for the entire year or not at all.
Affordability Safe Harbor Restrictions

• The Finalized 2016 Instructions for Forms 1094-C and 1095-C indicate that the affordability safe harbor codes (2F, 2G, and 2H) may only be utilized when the employer offers coverage to at least 95% of its full-time employee population for the month (as indicated in column (a) of the 1094-C, Part III).
2016 IRS Reporting Take-a-Ways

• Transitional relief is gone – the full employer mandate penalties now apply

• Reporting accuracy matters – good faith effort is no longer good enough

• Time is of the essence – no more delays in reporting deadlines

• 1095-C codes/guidance have changed – make sure you understand which changes affect your organization

• Cost of IRS reporting penalties is increasing
Status of ACA Enforcement
Federal Enforcement of ACA

- Department of Labor
- Department of Health and Human Services
- Department of the Treasury
Health Plan Audits

U.S. Department of Labor

Employee Benefits Security Administration
J.F. Kennedy Federal Building, Room 670
Boston, MA 02203
Phone: (617) 560-9900
Telefax: (617) 565-8989

December 2012

REDACTED

Re: REDACTED

BIPA/PA: REDACTED

Dear REDACTED,

The Department of Labor has responsibility for the administration and enforcement of Title I of the Employee Retirement Income Security Act of 1974 (ERISA). Title I establishes standards governing the operation of employee benefit plans such as the REDACTED Welfare Benefits Plan ("the Plan").

The Plan is scheduled for investigation by this office. Investigative authority is vested in the Secretary of Labor by Section 504 of ERISA, 29 U.S.C. 1134, which states in part:

The Secretary of Labor shall have the power, in order to determine whether any person has violated or is about to violate any provision of this title or any regulation or order thereunder...to make an investigation, and in connection therewith to require the submission of reports, books, and records, and the filing of data in support of any information required to be filed with the Secretary under this title...

Additionally, the Plan will be examined for the purpose of determining whether it is complying with the laws contained in Part 7 of ERISA, including the Health Insurance Portability and Accountability Act of 1996, the Newborns' and Mothers' Health Protection Act, the Women's Health and Cancer Rights Act (WHCRA), the Mental Health Parity and Addiction Equity Act, the Genetic Information Nondiscrimination Act, and the Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act (together, the Affordable Care Act). These laws amended Part 7 of ERISA and provide requirements for group health plans.

We have found in the past that submission of relevant documents to our office prior to the inception of an on-site field investigation can lessen the time subsequently spent with, and the administrative burden placed on, plan and corporate officials and may eliminate the need for an on-site visit entirely. To that end, we ask that you submit to this office, within ten business days of your receipt of this letter, the documentation listed on the enclosed Attachment A.

From the library of
The Kiplinger Tax Letter
Dear Benefits Manager:

The person listed below submitted an application for health coverage through the Health Insurance Marketplace in Tennessee and indicated that he or she is an employee of [Redacted] at the address shown above.

This person reported that he or she:

- didn’t have an offer of health care coverage from
- did have an offer of health care coverage, but it wasn’t affordable or didn’t provide minimum value; or
- was in a waiting period and unable to enroll in health care coverage.

The employee has been determined eligible for advance payments of the premium tax credit (APTC) or cost-sharing reductions (CSRs) for at least one month during 2016 to help pay for Marketplace coverage and has enrolled in coverage through the Marketplace.

<table>
<thead>
<tr>
<th>Employee Name</th>
<th>Birthday</th>
<th>Last 4 digits of Social Security Number</th>
<th>Marketplace Application ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Redacted]</td>
<td>March 04</td>
<td>7514</td>
<td>[Redacted]</td>
</tr>
</tbody>
</table>

Why am I getting this notice?

This notice informs you that your employee was found eligible for APTC or CSRs and that, if various conditions are met, you may have to pay an employer shared responsibility payment to the Internal Revenue Service (IRS) in the future. It also notifies you of your opportunity to appeal this eligibility determination.

Certain employers (those with at least 50 full-time employees or full-time equivalent employees, called
• No major ACA enforcement activity thus far.

• At this point, IRS should have all the information needed to begin the assessment of penalties under the ACA employer mandate and IRS reporting for 2015.

• Likely the next shoe to drop from an ACA enforcement perspective.
ALE Responsibilities

New W-2 Reporting Requirements
Mandatory Annual SBCs
Material Modification Notices
Health Insurance Marketplace Notices
Ongoing ACA Average Hours Worked Tracking
Annual IRS 1094 & 1095 Reports
1411 Certification Appeals
Cadillac Tax Tracking (2020)
IRS & DOL ACA Audits
Employee & Admin Education

Copyright © 2016 MyBenefitsChannel All rights reserved.
Got Risk Tolerance?

- Consider a maximum one year penalty for 400 FTs
  - 4980H (a) penalties (95% Rule) = $740,000
  - IRS forms incorrect/untimely = $200,000
  - Willful failure to provide SBCs timely = $400,000
  - Total potential fine = $1,340,000
The Problem

"Data Source"

Payroll
Enrollment
Ben Admin
HRIS
Time & Attendance
Carriers
Brokers
TPAs
DOL
IRS
Marketplace

"Requirement"

Required Notices
Employment Status Tracking
IRS Reporting
1411 Certification Appeals
ACA Audits
Coming Soon “Cadillac Tax”
Employee/Admin Education

Copyright © 2016 MyBenefitsChannel All rights reserved.
ACA Solutions

• SaaS:
  – MBC provides software, support, and consulting.
  – ALE does the work.
  – Additional consulting service package available.

• ACA Complete Care:
  – Employer provides the data and/or access to data.
  – MBC does all the work, consulting & audit management.
  – MBC team sends you reports to keep you up to date.
What is ACA Complete Care?:

- Think FSA/HRA/HSA - TPA service models.
- Priced on a per employee per month basis.
- Designed for ALEs who “Do Not” want to do the work, and want to reduce compliance liability.
- MBC manages 1411 appeals and IRS / DOL / HHS audits.
- Most employers add the cost to their health plans.
- It is expected most ALE’s will outsource ACA compliance.
Make smart choices. Simplify your processes. Reduce your workloads.

CONTACT US TODAY!
info@mybenefitschannel.com | 800.435.5023
Participatory Medicine

How can eDoc Help?
What is Participatory Medicine?

- Participatory Medicine is a model of cooperative health care that seeks to achieve active involvement by patients, professionals, caregivers, and others across the continuum of care on all issues related to an individual's health. Participatory medicine is an ethical approach to care that also holds promise to improve outcomes, reduce medical errors, increase patient satisfaction and improve the cost of care.

--SPM home page.

Dr. Charles W. Smith, Jr.
The Society of Participatory Medicine offers a blog site where you can keep up with, and contribute to others who are passionate about, and involved in, this movement.

Dr. Charles W. Smith, Jr.
The Society also publishes an **online Journal**, peer reviewed, where articles about participatory medicine are published by professionals as well as by patients.

Dr. Charles W. Smith, Jr.
Traditional vs. “Industrial Age” Health Care Model

Focusing on the Central Importance of Self Care

Dr. Charles W. Smith, Jr.
Dr. Charles W. Smith, Jr.

Information Age Healthcare


doctom@doctom.com, www.fergusonreport.com

Dr. Charles W. Smith, Jr.
So Who is Really Responsible?

Doctor?

OR

Patient?

Dr. Charles W. Smith, Jr.
How to Become a Participatory Patient

- Understand your “diagnoses”
- Know your medications, dosages
- Choose doctor who uses EMR and has patient portal
- Craft an agenda for office visits
- Visit doctor for annual wellness checks
- Commit to a healthier lifestyle

Dr. Charles W. Smith, Jr.
Healthier Lifestyle

- Weight
- Diet
- Alcohol
- Smoking
- Exercise
- Stress

Dr. Charles W. Smith, Jr.
How Can eDoc Help?

- Log on and ask questions.
- Get a second opinion from eDoc.
- Use fitness, nutrition, pharmacy, psych in addition to docs.
- Read Health Tips
Customer Service & Provider Relations

WE ARE HERE TO HELP!
Customer Service

We can assist our members with questions like:

‘Are MRI’s covered under my plan?’
‘Can you help me understand my explanation of benefits’
‘Does my surgery require precertification?’
‘What are my dental benefits?’
Who else can assist with questions?

- Questions regarding enrollment options, premiums, or coordination of benefits, contact Eligibility and Enrollment at (501) 978-6137, option 5

- Questions regarding Prescription Benefits, call Optum at 1-855-253-0846

- For questions regarding Precertification or to precertify a service, call 888-295-3591 or (501) 978-6137, option 3
Important Phone Numbers

Municipal Health Benefit Fund Main Number
(501) 978-6137

Option 3 – Precertification
Option 4 – Customer Service
Option 5 – Eligibility
Option 7 – Provider Relations
The Municipal Health Benefit Fund Booklet

Online at arml.org
  Click on the MHBF tab at the top
  Scroll down to MHBF Information Center
  Click on Municipal Health Benefit Fund Booklet 2016

Human Resources
  Go to your HR department and request a copy

Call MHBF Customer Service
  Call our customer service line and request a copy of the current Fund Booklet – we will mail a copy to the address on file
A department of the Municipal Health Benefit Fund that maintains a private network of providers for a higher level of benefits for its members.
How to find In-Network providers

Website:
Go to arml.org
Click on the MHBF tab
Click on Preferred Provider Directory

Provider Relations:
Contact the MHBF Provider Relations department

Customer Service:
Contact the MHBF Customer Service line
Questions
## Municipal Health Benefit Fund: MHBF

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period:** 01/01/2017 – 12/31/2017

**Coverage for:** Individual + Family | **Plan Type:** PPO

---

**Important Questions** | **Answers** | **Why this Matters:**
--- | --- | ---
What is the overall deductible? | $500, 1,200 or $2,000 individual/$6,000 family | You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services? | No | You don’t have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses? | Yes. For in-state in-network medical providers, $4,000 per individual, $8,000 per family. For pharmacy providers, $2,600 per individual, $5,200 per family. | The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit? | Premiums, co-payments, penalty deductibles, balance billed charges, out of state and out of network care and health care this plan does not cover. | Even though you pay these expenses, they don’t count toward the out-of-pocket limit.
Does this plan use a network of providers? | Yes. For a list of preferred providers, see [www.arml.org](http://www.arml.org) or call 1-501-978-6137. | If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist? | No | You can see the specialist you choose without permission from this plan.
Are there services this plan doesn’t cover? | Yes | Some of the services this plan doesn’t cover are listed on page 5. See your policy or plan document for additional information about excluded services.

---

**Questions:** Call 1-501-978-6137 or visit us at [www.arml.org](http://www.arml.org). If you aren’t clear about any of the bolded terms used in this form, see the Glossary.

You can view the Glossary at [www.arml.org](http://www.arml.org) or call 501-978-6137 to request a copy.
Copayments are fixed dollar amounts (for example, $20) you pay for covered health care, usually when you receive the service.

Coinsurance is your share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200. This may change if you haven’t met your deductible.

The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)

This plan may encourage you to use MHBF PPO In-Network Providers by charging you lower deductibles, copayments, and coinsurance amounts.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use an In-network Provider</th>
<th>Your Cost If You Use an Out-of-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$20 copayment and then 20% coinsurance</td>
<td>$20 copayment and then 50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$20 copayment and then 20% coinsurance</td>
<td>$20 copayment and then 50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Coverage is limited to 2 PET scans per year</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT scans, Pet Scans, MRIs)</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>$10/prescription</td>
<td>Not covered</td>
<td>Coverage is limited to a 30 day supply per prescription</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>$30/prescription</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>$50/prescription</td>
<td>Not covered</td>
<td></td>
</tr>
</tbody>
</table>

Questions: Call 1-501-978-6137 or visit us at www.arml.org. If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.arml.org or call 501-978-6137 to request a copy.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use an In-network Provider</th>
<th>Your Cost If You Use an Out-of-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>More information about prescription drug coverage is available at <a href="http://www.arml.org">www.arml.org</a>. If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at <a href="http://www.arml.org">www.arml.org</a>.</td>
<td>Reference-Priced drugs</td>
<td>Total cost of the dispensed drug less the total cost of the reference drug per prescription</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty drugs up to $1,000; Specialty drugs up to $1,000.01 or higher.</td>
<td>$50/prescription</td>
<td>$100/prescription</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center).</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Coverage is limited to a 30 day supply per prescription and you must pre-certify by calling 866-285-2935.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>$250 copayment per visit and then 20% coinsurance</td>
<td>$250 copayment per visit and then 20% coinsurance</td>
<td>$250 copayment is waived if admitted to inpatient hospital.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>Coverage is limited to 2 ground and 2 air transports annually.</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$20 copayment and then 20% coinsurance</td>
<td>$20 copayment and then 20% coinsurance</td>
<td>---None---</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Coverage is limited to 30 days annually. You must pre-certify by calling 888-295-3591. There is a $1,500 deductible for failure to pre-certify.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td></td>
</tr>
</tbody>
</table>

Questions: Call 1-501-978-6137 or visit us at www.arml.org. If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.arml.org or call 501-978-6137 to request a copy.
# Municipal Health Benefit Fund: MHBF

## Summary of Benefits and Coverage: What this Plan Covers & What it Costs

**Coverage Period:** 01/01/2017 – 12/31/2017

**Coverage for:** Individual + Family  |  **Plan Type:** PPO

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use an In-network Provider</th>
<th>Your Cost If You Use an Out-of-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you have mental health, behavioral health, or substance abuse needs</strong></td>
<td>Mental/Behavioral health - outpatient services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Coverage is limited to 24 visits annually</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health - inpatient services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Coverage is limited to 10 days annually. You must pre-certify by calling 888-295-3591. There is a $1,500 deductible for failure to precertify.</td>
</tr>
<tr>
<td></td>
<td>Substance abuse disorder - inpatient services</td>
<td>20% coinsurance</td>
<td>Not covered</td>
<td>Coverage is limited to 1 treatment plan, whether inpatient or outpatient per lifetime at MHBF Designated Chemical Dependency Center(s). You must pre-certify by calling 888-295-3591.</td>
</tr>
<tr>
<td></td>
<td>Substance abuse disorder - outpatient services</td>
<td>20% coinsurance</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Prenatal and postnatal care</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>———— None ————</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>You must pre-certify an extended inpatient stay by calling 888-295-3591. There is a $1,500 deductible for failure to pre-certify.</td>
</tr>
<tr>
<td></td>
<td>Home health care</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Coverage is limited to 20 visits annually. You must pre-certify by calling 888-295-3591. There is a $1,500 deductible for failure to pre-certify.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Coverage is limited to 30 days for acute care and 15 days for sub-acute care, annually. You must pre-certify by calling 888-295-3591. There is a $1,500 deductible for failure to pre-certify.</td>
</tr>
</tbody>
</table>

---

Questions: Call 1-501-978-6137 or visit us at [www.arml.org](http://www.arml.org). If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at [www.arml.org](http://www.arml.org) or call 501-978-6137 to request a copy.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use an In-network Provider</th>
<th>Your Cost If You Use an Out-of-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Habilitation Services</td>
<td></td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>These services will be combined to allow a maximum of 40 visits annually with physical therapy, speech therapy, occupational therapy, and chiropractic svs.</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td></td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Coverage is limited to 15 days annually. You must pre-certify by calling 888-295-3591. There is a $1,500 deductible for failure to pre-certify.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td></td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Coverage is limited to 90 days per lifetime. You must pre-certify by calling 888-295-3591. There is a $1,500 deductible for failure to pre-certify.</td>
</tr>
<tr>
<td>Hospice service</td>
<td></td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Eye exam</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn’t a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental Care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty Nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Questions: Call 1-501-978-6137 or visit us at www.arml.org. If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.arml.org or call 501-978-6137 to request a copy.
Other Covered Services (This isn’t a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery is only covered under the MBS-AQUIP Program
- Smoking Cessation Program
- Hearing aids

Your Rights to Continue Coverage:
If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 501-978-6137. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact Municipal Health Benefit Fund at www.arml.org or 501-978-6137 or you may contact the Consumer Assistance Program of the Arkansas Insurance Department at insurance.consumers@arkansas.gov, 855-332-2227 or 501-371-2645.

Does this Coverage Provide Minimum Essential Coverage?
The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 501-978-6137

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

Questions: Call 1-501-978-6137 or visit us at www.arml.org. If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.arml.org or call 501-978-6137 to request a copy.
About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

Having a baby
(normal delivery)

- Amount owed to providers: $7,540
- Plan pays $5,610
- Patient pays $1,930

Sample care costs:

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital charges (mother)</td>
<td>$2,700</td>
</tr>
<tr>
<td>Routine obstetric care</td>
<td>$2,100</td>
</tr>
<tr>
<td>Hospital charges (baby)</td>
<td>$900</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>$900</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$500</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$200</td>
</tr>
<tr>
<td>Radiology</td>
<td>$200</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$7,540</td>
</tr>
</tbody>
</table>

Patient pays:

- Deductibles                   | $500   |
- Copays                        | $30    |
- Coinsurance                   | $1,400 |
- Limits or exclusions          | $0     |
| **Total**                      | $1,930 |

*This coverage example assumes self-only coverage (sometimes referred to as the individual coverage tier).

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- Amount owed to providers: $5,400
- Plan pays $4,510
- Patient pays $890

Sample care costs:

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions</td>
<td>$2,900</td>
</tr>
<tr>
<td>Medical Equipment and Supplies</td>
<td>$1,300</td>
</tr>
<tr>
<td>Office Visits and Procedures</td>
<td>$700</td>
</tr>
<tr>
<td>Education</td>
<td>$300</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$100</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$5,400</td>
</tr>
</tbody>
</table>

Patient pays:

- Deductibles                   | $500   |
- Copays                        | $50    |
- Coinsurance                   | $340   |
- Limits or exclusions          | $0     |
| **Total**                      | $890   |

*This coverage example assumes self-only coverage (sometimes referred to as the individual coverage tier).

Questions: Call 1-501-978-6137 or visit us at www.arm.org. If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.arm.org or call 501-978-6137 to request a copy.
Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?
- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?
For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?
- **Yes.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Can I use Coverage Examples to compare plans?
- **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?
- **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

**Questions:** Call 1-501-978-6137 or visit us at [www.arml.org](http://www.arml.org). If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at [www.arml.org](http://www.arml.org) or call 501-978-6137 to request a copy.
Your Information.
Your Rights.
Our Responsibilities.

By law, the Municipal Health Benefit Fund (Fund) is required to protect the privacy of your protected health information. This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

Your Rights
You have the right to:

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

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

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

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

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

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

Get a copy of health and claims records

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

Ask us to correct health and claims records

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

Request confidential communications

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

Ask us to limit what we use or share

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

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

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

Get a copy of this privacy notice

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

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

File a complaint if you feel your rights are violated

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

Your Choices

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

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

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

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

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

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

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

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

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

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

Pay for your health services

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

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

Administer your plan

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

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

**How else can we use or share your health information?**

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

Help with public health and safety issues

- We can share health information about you for certain situations such as:
  - Preventing disease
  - Helping with product recalls
  - Reporting adverse reactions to medications
  - Reporting suspected abuse, neglect, or domestic violence
  - Preventing or reducing a serious threat to anyone’s health or safety

**Do research**

- We can use or share your information for health research.

**Comply with the law**

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director

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

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

We can use or share health information about you:

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

Respond to lawsuits and legal actions

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

Our Responsibilities

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

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticewpp.html.

Changes to the Terms of this Notice

This privacy notice is based upon "Model Notices of Privacy Practices" provided by the United States Department of Health and Human Services on their website as of September 10, 2015. HHS may change the regulatory law governing Privacy Practices or may change their model notice. If so, the MHBF will comply with the law and will change the terms of this notice. The changes will apply to all information we have about you. We will provide you with a copy of the new notice and the notice will be available on our website.

Other Instructions for Notice

- September 15, 2016
- Privacy Official: Katie Bodenhamer, 501-374-3484, ext. 126, kbodenhamer@arml.org.
New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

What is the Health Insurance Marketplace?

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

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact: Municipal Health Benefit Fund, P. O. Box 188, North Little Rock, Arkansas 72115, 501-978-6137, or see www.arml.org/benefit_programs.html#1

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

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

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

<table>
<thead>
<tr>
<th>3. Employer name</th>
<th>4. Employee identification number (EIN)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Employer address</td>
<td>6. Employer phone number</td>
</tr>
<tr>
<td>9. ZIP code</td>
<td></td>
</tr>
</tbody>
</table>

10. Who can we contact about employee health coverage at this job?

11. Phone number (if different from above) | 12. Email address

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

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

- With respect to dependents:
  - We do offer coverage. Eligible dependents are:

  - We do not offer coverage,

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

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

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

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?
   Yes (Continue)
   13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? (mm/dd/yyyy) (Continue)
   No (STOP and return this form to employee)

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

15. For the lowest-cost plan that meets the minimum value standard,* offered only to the employee (don't include family plans): Is the employer paying all the cost? If not, what is the employer cost? $.
   a. How much would the employee have to pay in premiums for this plan? $.

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

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

Date of change (01/01/201-)

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).
Effective January 1, 2017, Municipal Health Benefit Fund will expand its integration of an evidence-based prescription drug program with the prescription drug benefit. Changes to the prescription plan are based on recommendations and assistance from RxResults, LLC.

- **Reference Pricing** – The plan uses this initiative when there are one or more similarly effective and lower cost drugs in a drug category. When these occur, the benefit plan will only pay the amount it would pay for the lower-cost drugs and patients will pay the difference in cost between the higher-cost drug and the lower-cost alternatives in the form of a higher co-payment. **NOTE:** the amount paid in excess of the lower-cost alternative will no longer count towards the annual maximum out-of-pocket. Many times, patients have an opportunity to reduce their co-payment expenses by switching to an alternative drug product.

- **Prior Authorization** – The plan uses this initiative when it is recommended that qualified personnel review a patient’s medical situation or medication history prior to benefit coverage of a particular drug.

- **Step Therapy** – The plan uses this initiative to require that a patient first try one or more drug products before the plan will provide benefit coverage for another drug.

- **Exclusions** – The plan uses this initiative when there are other lower-cost drug products that are considered equally effective. Refer to the additional Exclusions document for a list of excluded drugs.

For questions, please call RxResults Member Services toll free at 1-844-853-9400 between 7 a.m. and 7 p.m.

### Reference Pricing

<table>
<thead>
<tr>
<th>If you are taking any of these drugs with high patient co-payments:</th>
<th>Ask your physician if you can switch to these drug alternatives with lower patient co-payments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADHD/CNS Stimulants</td>
<td>Immediate release amphetamine-dextroamphetamine, dextroamphetamine, methylphenidate, dexamfetamine or clonidine (for Kapvay) Children age 19 and under are exempt.</td>
</tr>
<tr>
<td>Antibiotics (alternatives in right column correlate to same line in left column)</td>
<td>Immediate release doxycycline, (except 75 mg and 150 mg capsules)</td>
</tr>
<tr>
<td>Acticlave, Adoxa, Doryx, doxycycline hyclate DR, doxycycline capsules 75mg &amp; 150 mg, Monodox, Oracea, Oraxyl, Periostat, Targadox</td>
<td>Immediate release minocycline, amoxicillin</td>
</tr>
<tr>
<td>Minocin, minocycline ER, Moxatag, Solodyn</td>
<td></td>
</tr>
<tr>
<td>Anticonvulsants – Gabapentin</td>
<td></td>
</tr>
<tr>
<td>Gralise, Horizant, Lyrica, Neurontin, Neurontin Sol, Spritam gabapentin or levetiracetam sol (for Spritam)</td>
<td></td>
</tr>
<tr>
<td>Antidepressants</td>
<td></td>
</tr>
<tr>
<td>Cymbalta, Desvenlafaxine ER, desvenlafaxine, duloxetine, Effexor XR, Fetzima, Irenka, Khedezla EF, Pristiq, venlafaxine Tablet ER (37.5mg, 75mg, 150mg and 225mg)</td>
<td>bupropion, citalopram, escitalopram, fluoxetine, paroxetine, sertraline, immediate release venlafaxine or venlafaxine ER (capsule only)</td>
</tr>
<tr>
<td>Anhyptertensives (High Blood Pressure Drugs)</td>
<td></td>
</tr>
<tr>
<td>Generic ARB Agents: losartan/HCTZ, irbesartan, eprosartan</td>
<td></td>
</tr>
</tbody>
</table>

All brand drug products listed are registered trademarks of their respective manufacturers. Updated 10/21/2016
### Reference Pricing

**If you are taking any of these drugs with high patient co-payments:**

<table>
<thead>
<tr>
<th>Cholesterol Reducers – Fibric Acid Derivatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antara, brand Fenofibric Acid, <strong>fenofibrate</strong> (50, 120, 130, 135, 145 &amp; 150 mg only), fenofibrac cap, Fenoglide, Fibricor, Lipofen, Lotifibra, Lopid, Tricor, Triglide, Trilipix</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cholesterol Reducers – Statins</th>
</tr>
</thead>
</table>
| Advicor, Altoprev, amlodipine/ctorvastatin combination, Caduet, Crestor (except 40mg strength), **fluvasatin tab 80 mg**, Lescol, Lescol XL, Lipitor, Livalo, Mevacor, Pravachol, rosvastatin (except 40mg strength), Simcor, Vytorin, Zocor | **Preferred generics**: lovastatin, pravastatin, simvastatin.  
**Other generic alternatives**: atorvastatin, fluvastatin. |

<table>
<thead>
<tr>
<th>Migraine Agents – Triptans</th>
</tr>
</thead>
<tbody>
<tr>
<td>almatriptan, Amerge, Axert, Frova, frovatriptan, Imitrex (brand only), Imitrex Spray, Maxalt, Onzetra, Relpax, sumatriptan spray, SumaChip, Sumavel, Treximet, zolmitriptan, Zecuity Pads, Zembrace Inj, Zomig, Zomig spray</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Muscle Relaxants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amrix, Carisaprodol, Flexmid, Lcrzone, metaxalone, Norflex, orphenadrine inJ, Parafox, Robexin, Skelaxin, Soma, Tabradol, tizanidine capsules, Zanaflex</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Osteoporosis Agents – Bisphosphonates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actonel, brand ALendronate, Atelvia, Boniva, Boniva, Fosamix, Fosamax-D, Ibandronate, risedronate</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Overactive Bladder – Urinary Antispasmodics</th>
</tr>
</thead>
<tbody>
<tr>
<td>darifenacin, Detrol/LA, Ditropan XL, Enablex, Gelniq, Myrbetriq, oxybutynin ER, Oxytrol, tolterodine/ER, Tovlaz, trospium Cl, trospium Cl ER, Vesicare</td>
</tr>
</tbody>
</table>

### Pain Medication / Analgesics (alternatives in right column correlate to same line in left column)

<table>
<thead>
<tr>
<th>Analgesics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaprox, Arthotec, Celebrex, celecoxib, Daypro, diclofenac/misoprostol, indomethacin cap ER/ISR, Ketoprofen ER, mefenamic acid cap, Mobic, Naprelan, Naproxen naproxen 550mg tablet, Naproxen CR, oxaprozin, Ponstel, Tovibex, Voltaren-XR, Vividex, Zipsor, Zorvolex</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Immediate release tramadol</th>
</tr>
</thead>
<tbody>
<tr>
<td>ConZip, Ryzolt, tramadol HCL ER, Ultracet, Ultram (brand only), Ul tram ER Duragesic Dis, Lazanda Spray, Subsys Spray</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sleep Aids – Sedatives/Hypnotics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambien (brand only), Ambien CR, Belsomra, Edluar, eszopiclone, Intermeloo, Lunesta, Roxerem, Silenor, Sonata (brand only), zolpidem ER, Zolpiprist</td>
</tr>
</tbody>
</table>

---

*All brand drug products listed are registered trademarks of their respective manufacturers. Updated 10/21/2016*
## PRIOR AUTHORIZATION

<table>
<thead>
<tr>
<th>Drugs requiring prior-authorization</th>
<th>Exceptions / Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Antibiotics - Oxazolidinones</strong></td>
<td>Bactrim, clindamycin, doxycycline</td>
</tr>
<tr>
<td>linezolid, Vancocin, vancomycin, Zyvox</td>
<td></td>
</tr>
<tr>
<td><strong>Antidiabetics – Amylin Analogues, DPP-4 Inhibitors and GLP Receptor Agonists</strong></td>
<td>Coverage is grandfathered if same drug filled in the last 100 days.</td>
</tr>
<tr>
<td>Byetta, Janumet, Janumet XR, anuvia, Jentadueto, Jentadueto XR, Kazano, Kombiglyze / XR, Resina, Onglyza, Oseni, Symlin pen, Tanzeum, Tradjenta, Trulicity, Victoza</td>
<td></td>
</tr>
<tr>
<td><strong>ADHD / CNS Stimulants</strong></td>
<td>Coverage is grandfathered if same drug filled in the last 100 days.</td>
</tr>
<tr>
<td>armodafinil, modafinil, Nuvigil, Provigil</td>
<td></td>
</tr>
<tr>
<td><strong>Anti-Fungals</strong></td>
<td></td>
</tr>
<tr>
<td>Vfend, voriconazole</td>
<td>fluconazole, itraconazole</td>
</tr>
<tr>
<td><strong>Cholesterol/Lipid Reducers – Statins &amp; Ezetimibe</strong></td>
<td>No grandfathering for Crestor 40mg or rosuvastatin 40 mg. Coverage for Zetia is grandfathered if Zetia has been filled in the last 100 days.</td>
</tr>
<tr>
<td>Crestor (40mg strength only), rosuvastatin (40mg strength only), Zetia</td>
<td></td>
</tr>
<tr>
<td><strong>Dermatologica – Topical Anesthetics</strong></td>
<td>Other generic topical anesthetics preferred</td>
</tr>
<tr>
<td>Lidoderm Dis 5%, lidocaine pad 5%</td>
<td></td>
</tr>
<tr>
<td><strong>Gout Agents</strong></td>
<td>Generic allopurinol preferred</td>
</tr>
<tr>
<td>Uloric</td>
<td></td>
</tr>
<tr>
<td><strong>Miscellaneous</strong></td>
<td></td>
</tr>
<tr>
<td>Compound prescriptions greater than $200</td>
<td></td>
</tr>
<tr>
<td>Nasal Steroids</td>
<td>budesonide, Pumicort</td>
</tr>
<tr>
<td>Pain Medication/Analgesics</td>
<td>Actiq lozenges, Fentanyl lozenges, Fentora</td>
</tr>
</tbody>
</table>

## STEP THERAPY

<table>
<thead>
<tr>
<th>Drugs with step therapy requirements</th>
<th>Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Antibiotics – Diflicid and Vancomycin</strong></td>
<td>Must try metronidazole or metronidazole SR before coverage</td>
</tr>
<tr>
<td>Diflicid, linezolid, vancomycin, Vancocin, Zyvox</td>
<td></td>
</tr>
<tr>
<td><strong>Antiasthmetics – Beta Agonists, including Combination Products</strong></td>
<td>Coverage allowed if patient has been compliant with an inhaled corticosteroid. Patients 40 years or older are exempt from step therapy.</td>
</tr>
<tr>
<td>Advair, Arcapta, Brovana, Dulera, Foradil, Perforomist Neb, Serevent, Symbicort</td>
<td></td>
</tr>
</tbody>
</table>

## EXCLUSIONS

See the Exclusions List for a list of drugs excluded from coverage.

---

All brand drug products listed are registered trademarks of their respective manufacturers. Updated 10/21/2016
## MHBF Quantity Limits January 2017

<table>
<thead>
<tr>
<th>Drug</th>
<th>Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Erectile Dysfunction (Limit to men only)</strong></td>
<td></td>
</tr>
<tr>
<td>Caverject</td>
<td>5 mg, 10 mg, 20 mg, 40 mg vials: 6 units/30 days</td>
</tr>
<tr>
<td>Cialis</td>
<td>10 mg &amp; 20 mg: 6 tabs/30 days, 2.5 mg &amp; 5 mg PA only</td>
</tr>
<tr>
<td>Edex</td>
<td>5 mg, 10 mg, 20 mg, 40 mg vials: 6 units/30 days</td>
</tr>
<tr>
<td>Levitra</td>
<td>2.5 mg, 5 mg, 10 mg, 20 mg: 6 tabs/30 days</td>
</tr>
<tr>
<td>Miare</td>
<td>125 mg, 250 mg, 500 mg, 1000 mg pellets: 6 units/30 days</td>
</tr>
<tr>
<td>Viagra</td>
<td>25 mg, 50 mg, 100 mg: 6 tabs/30 days</td>
</tr>
<tr>
<td><strong>Influenza</strong></td>
<td></td>
</tr>
<tr>
<td>Tamiflu</td>
<td>20 mg: 20 caps/180 days</td>
</tr>
<tr>
<td></td>
<td>45 mg &amp; 75 mg: 10 caps/180 days Solution: 75 mL/180 days</td>
</tr>
<tr>
<td><strong>Micronaine</strong></td>
<td></td>
</tr>
<tr>
<td>Ammerge</td>
<td>1 mg &amp; 2.5 mg: 9 tabs/30 days</td>
</tr>
<tr>
<td>Avera</td>
<td>6.25 mg: 6 tabs/30 days</td>
</tr>
<tr>
<td></td>
<td>12.5 mg: 12 tabs/30 days</td>
</tr>
<tr>
<td>Prova</td>
<td>2.5 mg: 9 tabs/30 days</td>
</tr>
<tr>
<td>Imitrex (sumatriptan)</td>
<td>25 mg, 50 mg, 100 mg: #9tabs/30 days Nasal Spray: 12 devices/30 days Injection: 4 injections/30 days</td>
</tr>
<tr>
<td>Maxalt &amp; Maxalt-MLT</td>
<td>5 mg &amp; 10 mg: 12 tabs/30 days</td>
</tr>
<tr>
<td>Relpax</td>
<td>20 mg &amp; 40 mg: 12 tabs/30 days</td>
</tr>
<tr>
<td>Treximet</td>
<td>9 tabs/30 days</td>
</tr>
<tr>
<td>Zomig</td>
<td>2.5 mg &amp; 5 mg and ZMT tabs: 12 tabs/30 days Nasal Spray: 12 devices/30 days</td>
</tr>
<tr>
<td><strong>Nausea &amp; Vomiting</strong> (7 cancer chemo treatment days)</td>
<td></td>
</tr>
<tr>
<td>Anzentan</td>
<td>50 mg: 14 tabs/30 days 100 mg: 7/30 days</td>
</tr>
<tr>
<td>Cesmet</td>
<td>1 mg: 42 caps/30 days</td>
</tr>
<tr>
<td>Emepron</td>
<td>40 mg: 1 cap/capsy</td>
</tr>
<tr>
<td></td>
<td>80 mg: 4 caps/month</td>
</tr>
<tr>
<td></td>
<td>Trifold Pack (80 mg &amp; 125 mg): 6/month</td>
</tr>
<tr>
<td>Kytril (granisetron)</td>
<td>1 mg: 14 tabs/mo.</td>
</tr>
<tr>
<td>Kytril (granisol) Solution: 70 mL/mo.</td>
<td>Solution: 70 mL/mo.</td>
</tr>
<tr>
<td>Sancuso</td>
<td>2 patches/mo.</td>
</tr>
<tr>
<td><strong>Antipsychotic Agents</strong></td>
<td></td>
</tr>
<tr>
<td>Abilify</td>
<td>2 mg, 5 mg, 10 mg, 15 mg, 20 mg, 30mg and disc tab 10 mg: 30/30 days; Disc tab 15 mg: 60/30 days</td>
</tr>
<tr>
<td>Abilify 1mg/lisin soln</td>
<td>900 ml/30 days</td>
</tr>
<tr>
<td>Faniap</td>
<td>1 mg, 2 mg, 4 mg, 6 mg, 8 mg, 10 mg, 12 mg tablet: 60/30 days (2 tablets per day)</td>
</tr>
<tr>
<td>Goedon</td>
<td>20 mg, 40 mg, 60 mg, 80 mg: 60/30 days (2 per day)</td>
</tr>
<tr>
<td>Inviga</td>
<td>1.5 mg, 3 mg, 9 mg: 30/30 days, 6 mg 60/30 days</td>
</tr>
<tr>
<td>olanzapine</td>
<td>2.5 mg, 5 mg, 7.5 mg, 10 mg, 15 mg, 20 mg: 30/30 days</td>
</tr>
<tr>
<td>Zyproxa Zydus</td>
<td>5 mg, 10 mg, 15 mg, 20 mg: 30/30 days</td>
</tr>
<tr>
<td>risperidone</td>
<td>0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg: 60/30 days (2 per day)</td>
</tr>
<tr>
<td>risperidone 1MG/ML SOLN</td>
<td>240ml/30 days; 8ml/day</td>
</tr>
<tr>
<td>risperidine mTAB</td>
<td>0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg: 60/30 days (2 per day)</td>
</tr>
<tr>
<td>SAPHRIS SUB</td>
<td>3 mg, 10 mg: 60/30 days</td>
</tr>
<tr>
<td>Seroquel</td>
<td>25 mg, 50 mg, 100 mg, 200 mg, 300 mg, 400 mg: 60/30 days (2 per day)</td>
</tr>
<tr>
<td>Seroquel XR</td>
<td>50 mg, 150 mg: 30/30 days, 200 mg: 90/30 days, 300 mg, 400 mg: 60/30 days</td>
</tr>
<tr>
<td>Symbax</td>
<td>25MG-3MG CAP, 25MG-6MG CAP, 25MG-12MG CAP, 50MG-6MG CAP, 50MG-12MG CAP: 30/30 days (1 per day)</td>
</tr>
</tbody>
</table>

Updated: 0.24.2016
Municipal Health Benefit Plan
Prescription Drug Program – Prior Authorization List - Effective January 1, 2017

The Municipal Health Benefit Fund prescription drug program utilizes the services of RxResults’ Evidence-Based Prescription Drug Program to establish coverage criteria for each of the drugs/drug categories listed below. Coverage of these drugs will require prior authorization.

Your physician may call RxResults at 844-853-9400, Monday – Friday 7:00 AM – 7:00 PM, to request prior authorization. Covered Specialty Drugs are filled through Allcare Specialty Pharmacy.

Anti-asthmatic Agents
• Arcapta
• Advair
• Brovana
• Dulera
• Foradil
• Perforomist
• Serevent
• Symbicort

Antibiotics
• linezolid
• Vancocin
• vancomycin
• Zyvox

Antidiabetic Agents
• Byetta
• Janumet / XR
• Januvia
• Jentadueto/XR
• Kazano
• Kombiglyze / XR
• Nesina
• Onglyza
• Oseni
• Symlin pen
• Tanzeum
• Tradjenta
• Trulicity
• Victoza

Antifungals
• Vfend
• voriconazole

Cholesterol Reducers
• Crestor 40 mg
• rosuvastatin 40 mg
• Zetia

CNS Stimulants (Narcolepsy)
• armodafinil
• modafinil
• Nuvigil
• Provigil

Dermatologicals
• Lidoderm Dis 5%
• Lidocaine pad 5%

Gout Agents
• Uloric

Miscellaneous Products
• Compounded prescriptions over $200

Nasal Steroids
• budesonide
• Pulmicort

Pain Medication/Analgesics
• Actiq lozenges
• Fentanyl lozenges
• Fentora

Specialty/Bio-Tech Drugs
• Filled through Allcare Specialty Pharmacy

NOTE: This may not be an all-inclusive list and is subject to change without notice. Updated: 10/21/2016