MUNICIPAL HEALTH BENEFIT FUND SEMINAR
AGENDA
November 2, 2018

8:30 a.m. – 9:00 a.m.    Registration

9:00 a.m.    Welcome
Mayor Joe Smith, North Little Rock
2018-2019 League President

Opening Remarks
Mark Hayes, Executive Director
AML

9:15 a.m. – 10:15 a.m.    MHBF Plan Changes for 2019
and Benefits Overview
Katie Bodenhamer, MHBF General
Manager & Legal Counsel
AML

10:15 a.m. – 10:30 a.m.    BREAK

10:30 a.m. – 11:00 a.m.    Prescription Benefit Update
Dwight Davis, Director
EBRx

11:00 a.m. – 12:00 p.m.    MHBF Benefits Q & A Panel Discussion
--Katie Bodenhamer, MHBF General Manager & Legal Counsel
--Jill Sloan, MHBF Clinical Supervisor
--Purity Ingram, MHBF Enrollment & Eligibility Supervisor
--Cynthia Parker, MHBF Claims Supervisor
--Beth Chappell, MHBF Provider Relations & Customer Service Supervisor

12:00 p.m. – 12:45 p.m.    LUNCH

12:45 p.m. – 1:15 p.m.    OptumRx Portal Information
Sarah Bujak, Account Executive
OptumRx

1:15 p.m. – 2:00 p.m.    MHBF’s New Vision Benefit
Offered Through EyeMed
Robin Wynne, Sr. Regional Sales
Manager, EyeMed

2:00 p.m. – 2:15 p.m.    BREAK

2:15 p.m. – 2:45 p.m.    Flexible Spending Accounts,
Section 125 Plans and Supplemental
Benefits
Charles Angel, Western Regional
Director of Public Sector Markets
American Fidelity

2:45 p.m. – 3:00 p.m.    Closing Remarks/Door Prizes
Municipal Health Benefit Fund

WHAT YOU NEED TO KNOW
Health Benefit Plan

• Included in the MHBF Fund Booklet
• Online at arml.org/mhbf
• Your city’s Human Resources
• Call MHBF Customer Service
Enrollment Forms
Certificate of Notice and Acceptance of Plan Provisions

This form is to acknowledge that you have read the Fund Booklet and that you agree to its terms and conditions.

This form should be reviewed, signed and returned to your HR department.
Enrollment/Change/Termination Form

- Enrollment in the Plan
- Coverage Declination
- Add/Drop Dependent
- Cancel Coverage
- Address/Name Change
- Coverage Change (Individual/Family)
- Status Change (Marriage/Divorce)
- Employee Termination
Multiple Coverage Inquiry

If any employee or their dependent has coverage in addition to MHBF for medical, dental or vision, the employee must provide that information on the Multiple Coverage Inquiry form.

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

Failure to provide this information can result in claims being delayed or denied.
Benefits Review
Major Medical Benefits

• Individual Medical Coverage—Lifetime Coverage, No Maximum Dollar Limit
• In-Patient Hospitalization—30 Days Per Year
• Bariatric Weight Loss Program (Contact Jennifer Elliott 501-978-6137 x 131)
• Chemical Dependency Treatment – 1 Treatment Plan Per Lifetime
• Non-Emergency Surgeries—2 Per Year
• Hearing Aids – 1 Per Ear, Every 3 Years (limited to $1,400 for each hearing aid)
• Home Health Services—20 Visits Per Year
• Nutritional and Weight Counseling – 2 Visits Per Year
• Outpatient Occupational, Physical, Speech, Habilitative and Chiropractic Services – 40 Visits Per Year  (Note: This is a combined benefit)
• Sleep Study – 1 Night Per Year
• Mental/Nervous Disorders
  • Inpatient Stay—10 Days Per Year
  • Individual Therapy Sessions—24 Visits Per Year

**Refer to Fund Book for a more complete list of benefits.
Preventative/Wellness Services Covered at 100%

• Annual Mammogram (NOT 3 or 4-D, Ultrasound)
• Annual Pap Screening
• Annual Colonoscopy or Cologuard
• Annual Wellness Physical (unless a condition of employment)
• Immunizations (DT, DtaP, Influenza, Pnuemococcal, etc)
• Annual Well-Baby/Child Visits
• Annual Chest X-Ray (Front and Lateral)
• Tobacco Cessation Program

To be covered as wellness, must not have a medical diagnosis.

**Refer to Fund Book for a more complete list and for age requirements on some services.
Pharmacy Benefits

• Generic Drugs--$10.00 co-payment
• Preferred Brand Name Drugs--$30.00 co-payment
• Non-Preferred Brand Name Drugs -- $50.00 co-payment
• Specialty Drugs:
  • Drug Cost < $1,000/30 days--$100.00 co-payment
  • Drug Cost > $1,000/30 days--$200.00 co-payment
HOW WE PAY BENEFITS

Deductible

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

Co-Payment

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

Coinsurance

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

Out-of-Pocket Maximum

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

An office visit is a problem-focused appointment with a medical provider designed to discuss new or existing health problems or symptoms.

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

## In-Network Procedure

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billed Charges</td>
<td>$3,000</td>
</tr>
<tr>
<td>MHBF Discount</td>
<td>-$1,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$2,000</strong></td>
</tr>
<tr>
<td>Allowed Amount</td>
<td>$2,000</td>
</tr>
<tr>
<td>Deductible</td>
<td>-$500</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$1,500</strong></td>
</tr>
<tr>
<td>Benefit Allowable</td>
<td>$1,500</td>
</tr>
<tr>
<td>Co-Insurance</td>
<td>x 20%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$300</strong></td>
</tr>
<tr>
<td>MHBF Responsibility</td>
<td>$1,200</td>
</tr>
<tr>
<td>Patient Responsibility</td>
<td>$800 ($300 Co-insurance + $500 Deductible)</td>
</tr>
</tbody>
</table>
In-Network Procedure (Met Deductible)

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billed Charges</td>
<td>$3,000</td>
</tr>
<tr>
<td>MHBF Discount</td>
<td>-$1,000</td>
</tr>
<tr>
<td></td>
<td>$2,000</td>
</tr>
<tr>
<td>Allowed Amount</td>
<td>$2,000</td>
</tr>
<tr>
<td>Deductible</td>
<td>-$0</td>
</tr>
<tr>
<td></td>
<td>$2,000</td>
</tr>
<tr>
<td>Benefit Allowable</td>
<td>$2,000</td>
</tr>
<tr>
<td>Co-Insurance</td>
<td>x 20%</td>
</tr>
<tr>
<td></td>
<td>$400</td>
</tr>
<tr>
<td>MHBF Responsibility</td>
<td>$1600</td>
</tr>
<tr>
<td>Patient Responsibility</td>
<td>$400 (Co-insurance Only)</td>
</tr>
</tbody>
</table>
# Out-of-Network Procedure

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billed Charges</td>
<td>$3,000</td>
</tr>
<tr>
<td>MHBF Discount</td>
<td>-$0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$3,000</strong></td>
</tr>
<tr>
<td>Allowed Amount</td>
<td>$3,000</td>
</tr>
<tr>
<td>Deductible</td>
<td>-$500</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$2,500</strong></td>
</tr>
<tr>
<td>Benefit Allowable</td>
<td>$2,500</td>
</tr>
<tr>
<td>Co-Insurance</td>
<td>x 50%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$1,250</strong></td>
</tr>
<tr>
<td>MHBF Responsibility</td>
<td>$1,250</td>
</tr>
<tr>
<td>Patient Responsibility</td>
<td>$1,750</td>
</tr>
</tbody>
</table>

($1,250 Co-insurance + $500 Deductible)
**EOB - Explanation of Benefit**

![Image of the EOB form]

**Benefit Description**

<table>
<thead>
<tr>
<th>Service Dates</th>
<th>Submitted</th>
<th>Amount</th>
<th>Deductible</th>
<th>Penalty</th>
<th>Balance</th>
<th>Percent</th>
<th>Benefit</th>
<th>Insured</th>
<th>Check</th>
</tr>
</thead>
<tbody>
<tr>
<td>From To</td>
<td>From</td>
<td>To</td>
<td>From</td>
<td>To</td>
<td>From</td>
<td>To</td>
<td>From</td>
<td>To</td>
<td>From</td>
</tr>
<tr>
<td>2/06/18</td>
<td>3/05/18</td>
<td>11,129.54</td>
<td>0.29</td>
<td>5,599.71</td>
<td>4,530.84</td>
<td>0.65</td>
<td>Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Benefit Balance**

- **Deductible:** 4,139.54
- **Balance:** 66.25
- **Result:** 6,599.71
- **Paid by Patient:** 5,599.71
- **Paid by Provider:** 0.00
- **Remaining 2018 Medical Deductible:** 0.00
- **Dental Deductible:** 50.00
- **Vision Deductible:** 50.00

**Group Code Descriptions**

- **CO:** Contractual Obligation
- **OA:** Other Adjustment
- **PH:** Patient Responsibility

**Member/Patient is Responsible for all Deductibles, Co-Payments, Co-insurance and Other Medi-Cal Ineligible Amounts. This is not a Bill - Do Not Make Payment to HEBF.**

Expect to receive an invoice from your OCCUR/Provider who performed these services.

For important information regarding your appeal rights, please refer to the current HEBF booklet.

To access helpful information 24 hours a day, please visit the HEBF website at: www.ahrq.gov - Click on the HEBF Tab.
Provider Relations
Preferred Provider Network

- In-Network Benefits are higher
- Access to thousands of providers
- Access to our wrap-around network for out-of-state providers
Help Locating an In-Network Provider

• Visit www.arml.org/MHBF to find our Preferred Provider Directory

• Contact Provider Relations Department

• Contact Customer Service
Provider Referrals

If you want to use a provider that is not in the MHBF Preferred Provider Network, it’s simple to refer them:

• Go to arml.org
• Click on the MHBF tab
• Click on the Preferred Provider Directory
• Click on Provider Request Form

When you are finished completing the form, click submit and an email is sent directly to our office.
Customer Service
What can we do to help our members?

- Provide copies of EOB’s
- Verify if precertification is required for a service
- Balance billing issues
- Give clarification of benefits
- Verify in-network provider network
Common Mistakes That Increase Out-of-Pocket Costs

• Failure to precertify. When in doubt, call 888-295-3591.

• Using the emergency room for non-emergency events.

• Failing to check in-network status of a provider. (80% vs. 50% and stop-loss vs. no stop-loss)

• Failing to add a dependent to coverage in a timely manner.

• Paying a health provider’s bill prior to receiving an EOB. When in doubt, call us.
More Money Saving Tips

• Call and find out if a service, test or procedure is covered prior to it being performed.

• Keep wellness visits strictly wellness.

• Make sure to carry the minimum medical coverage on automobile insurance.

• Turn in Accident Claim Forms or other required documentation.

• Read the Fund Booklet or review the SBC and know your benefits.
More . . .

• To ensure coverage, buy travel insurance for travel out of the country.

• Turn in Multiple Coverage Inquiry Form every time additional coverage is added or terminated.

• Know and understand what qualifying events are (and are not) for the addition of family members to coverage.

• Don’t forget that eDoc America, along with their 24-hour Registered Nurse Advice Line and Telemedicine is a part of your benefit package.
Contact Information
Municipal Health Benefit Fund
(501) 978-6137
Option 1 – Precertification
Option 3 – Help finding In-Network providers
Option 6 – Customer Service
Option 7 – Premium Accounting
Optum Rx
855-253-0846

Allcare Specialty Pharmacy
855-780-5500

EBRx
(For Rx prior authorizations)
833-339-8401
Municipal Health Benefit Fund
Prescription Drug Program
Update for January 1, 2019

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

November 2, 2018
Municipal Health Benefit Fund
Prescription Drug Program Trend Analysis
2013 - YTD 2018*

* YTD 2018 = through September 2018
Snapshot of a few key cost-driving variables

- Generic drugs now account for 90% of MHBF’s total prescription
- Despite strong generic drug usage, the cost of Specialty drugs continue to increase
- Specialty drugs are used for such conditions as:
  - Rheumatoid Arthritis, Crohns Disease, Plaque Psoriasis
  - Multiple Sclerosis
  - Oncology / Cancer
  - Other conditions: Hereditary Angioedema, Pulmonary Hypertension, etc.
- Specialty Drugs account for 0.4% of MHBF’s total Rx claims and 38% of MHBF’s total spend (based on the most recent quarter of 2018)
- The average cost of a specialty drug for MHBF is ~ $6,000/month. The average member co-payment for these drugs is $200/month.
Update for the MHBF Prescription Drug Program - 1/1/2019

• Closed Drug Formulary implemented in early 2018
• Ongoing Formulary management / clean-up
• No pharmacy-related changes for 1/1/2019
• Clinical Management Tools
  • Plan Exclusion
  • Coverage Policies / Prior Authorization
  • Dispensing/Quantity Limits
  • Step Therapy
  • Reference-Based Pricing
## MHBF Drug Co-payment Structure

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>Drug</th>
<th>Plan Cost/Tablet</th>
<th>Member Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug A</td>
<td>$0.75</td>
<td>$0.75</td>
</tr>
<tr>
<td>Drug B</td>
<td>$0.30</td>
<td>$0.30</td>
</tr>
<tr>
<td>Drug C</td>
<td>$2.50</td>
<td>$2.50</td>
</tr>
<tr>
<td>Drug D</td>
<td>$3.25</td>
<td>$3.25</td>
</tr>
<tr>
<td>Drug E</td>
<td>$4.40</td>
<td>$4.40</td>
</tr>
<tr>
<td>Drug F</td>
<td>$4.10</td>
<td>$4.10</td>
</tr>
</tbody>
</table>
To protect the Fund from the financial exposure related to expensive low-value drugs and/or unproven drugs.

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

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

On-line:
Current version of Drug Formulary / Preferred Drug List – including Quantity Limits, Step Therapy, and Reference-Based Pricing are found on the MHBF website:
www.arml.org/Services/Benefit Programs/Municipal Health Benefit Fund

Phone:
Members may contact OptumRx at (855) 253-0843
Members have access to an OptumRx phone app for co-pay information
Physicians may contact EBRx (UAMS) at (833) 339-8401
OptumRx
Digital Tools

Sarah Bujak, Account Executive
11/2/18
Mobile App
Streamlined home page navigation

Key items right at your fingertips makes managing your account easy.

Quickly:
• Find drug information and prices,
• Set medication reminders
• Locate the closest pharmacy
• Review your claims and more
Enhanced, easy-to-find visible tools
Tools

Allows consumers to easily compare pharmacy pricing on their mobile phone from anywhere.
Refill Reminders and app notifications
Push notifications

Never forget to take your medication

Set up push notifications
Pre-open enrollment registration

Pre-eligibility landing page allowing consumers to pre-register and create their login 90 days prior to their coverage activation date
Consumer Portal
Key Features

Convenient, user-friendly tools help simplify and improve the consumer experience

**Today’s Portal features:**

- Price medications and search for lower cost alternatives
- Review pharmacy benefits, prescription drug list coverage, and claim history
- Locate in-network pharmacies
- Medication reminder enrollment
- Manage household and caregiver access
- Digital delivery of prescription Lit-packs
Hello Arkansas Municipal League

Nice to see you
What we’ll discuss

1. Benefit Enhancements
2. Network Access
3. Benefits Made Easy
4. Q & A
Benefit Enhancements: More Savings, More Value
## EyeMed Plan

<table>
<thead>
<tr>
<th>Benefits</th>
<th>EyeMed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>12/12/12</td>
</tr>
<tr>
<td>Exam</td>
<td>$30</td>
</tr>
<tr>
<td>Copays</td>
<td>$30</td>
</tr>
<tr>
<td>Single Vision:</td>
<td>$30</td>
</tr>
<tr>
<td>Bifocal:</td>
<td>$30</td>
</tr>
<tr>
<td>Trifocal:</td>
<td>$30</td>
</tr>
<tr>
<td>Standard Progressive:</td>
<td>$85</td>
</tr>
<tr>
<td>Standard A/R:</td>
<td>$45</td>
</tr>
<tr>
<td>Allowances</td>
<td>$100</td>
</tr>
<tr>
<td>Frame:</td>
<td>$100</td>
</tr>
<tr>
<td>Contacts:</td>
<td>$100</td>
</tr>
<tr>
<td>Lens options</td>
<td>$15</td>
</tr>
<tr>
<td>Tint:</td>
<td>$15</td>
</tr>
<tr>
<td>UV Treatment:</td>
<td>$15</td>
</tr>
<tr>
<td>Poly for Kids:</td>
<td>$0</td>
</tr>
</tbody>
</table>
## Member Out of Pocket Comparison: Savings vs Retail
### Top 3 Most Common Transactions

<table>
<thead>
<tr>
<th>Transaction</th>
<th>AML Plan</th>
<th>EyeMed Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single Vision Transaction</td>
<td>35%</td>
<td>64%</td>
</tr>
<tr>
<td>Progressive Lens Transaction</td>
<td>23%</td>
<td>51%</td>
</tr>
<tr>
<td>Contact Lens Transaction</td>
<td>50%</td>
<td>65%</td>
</tr>
</tbody>
</table>
## Member savings with benefits – EyeMed

*Top 3 transactions based on book of business*

<table>
<thead>
<tr>
<th>Single Vision (42% of transactions)</th>
<th>Exam</th>
<th>Frame</th>
<th>Single Vision Lens</th>
<th>Polycarbonate (Adults)</th>
<th>Total Member Out of Pocket</th>
<th>% Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail</td>
<td>$104</td>
<td>$167</td>
<td>$90</td>
<td>$62</td>
<td>$423</td>
<td></td>
</tr>
<tr>
<td>AML Vision Plan</td>
<td>$60.80</td>
<td>$60.20</td>
<td>$90</td>
<td>$62</td>
<td>$273</td>
<td>35%</td>
</tr>
<tr>
<td>EyeMed Plan</td>
<td>$30</td>
<td>$53.60</td>
<td>$30</td>
<td>$40</td>
<td>$153.60</td>
<td>64%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Progressive Lens (28% of transactions)</th>
<th>Exam</th>
<th>Material Co-pay</th>
<th>Frame</th>
<th>Varlux Comfort Premium Progressive Lens</th>
<th>Crizal Alize Premium Anti-Reflective</th>
<th>Backside UV</th>
<th>Total Member Out of Pocket</th>
<th>% Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail</td>
<td>$104</td>
<td>n/a</td>
<td>$167</td>
<td>$250</td>
<td>$113</td>
<td>$20</td>
<td>$654</td>
<td></td>
</tr>
<tr>
<td>AML Vision Plan</td>
<td>$60.80</td>
<td>n/a</td>
<td>$60.20</td>
<td>$250</td>
<td>$113</td>
<td>$20</td>
<td>$504</td>
<td>23%</td>
</tr>
<tr>
<td>EyeMed Plan</td>
<td>$30</td>
<td>$30</td>
<td>$53.60</td>
<td>$125</td>
<td>$68</td>
<td>$15</td>
<td>$321.60</td>
<td>51%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contact Lens (30% of transactions)</th>
<th>Exam</th>
<th>Standard CL Fit/Follow-Up</th>
<th>Purchase Acuvue Oasys @ $34 / box (1/2 year supply)</th>
<th>Total Member Out of Pocket</th>
<th>% Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail</td>
<td>$104</td>
<td>$61</td>
<td>$136</td>
<td>$301</td>
<td></td>
</tr>
<tr>
<td>AML Vision Plan</td>
<td>$60.80</td>
<td>$30.50</td>
<td>$59.70</td>
<td>$151</td>
<td>50%</td>
</tr>
<tr>
<td>EyeMed Plan</td>
<td>$30</td>
<td>$40</td>
<td>$36</td>
<td>$100</td>
<td>65%</td>
</tr>
</tbody>
</table>
And there’s more…

Additional Value-Add’s with EyeMed

Learn more at eyemed.com
The future is bright with Sun Perks

A fun sunglass benefit for your employees

- Sun Perks certificate for all enrolled members to use on their purchase of non-prescription sunglasses at Sunglass Hut
- 40 luxury brands to choose from including Ray-Ban®, Coach®, and Prada®
- Why? Because 99% of UVA and UVB rays can be blocked with quality sunglasses*

$50 OFF Sunglass Hut purchase of $200 or more or $20 off any purchase
Additional discounts for added member savings

✅ 40% off additional pair discount—the best, most flexible in the industry

✅ 40% off hearing exams and discounted, set pricing on hearing aids

✅ 20% off any remaining frame balance

✅ 20% off any non-covered item

✅ 15% off LASIK

✅ 15% off any balance over the conventional contact lens allowance

97% of clients agree that our benefits result in low out-of-pocket costs for members*

Discounts are in-network only. May not be available on all plans. Confirm if your provider offers this option. *EyeMed Client Satisfaction Survey conducted by Walker, 2017.

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More value with our Special Offers page online

<table>
<thead>
<tr>
<th>LensCrafters</th>
<th>Complimentary blue IQ coating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearle Vision</td>
<td>Extra $25 off complete pair of glasses or Rx sunglasses</td>
</tr>
<tr>
<td>Glasses.com</td>
<td>$50 off any non-prescription pair of sunglasses</td>
</tr>
<tr>
<td>Target Optical</td>
<td>Extra $100 in instant savings on contact lenses at TargetOptical.com</td>
</tr>
</tbody>
</table>

Always available on our Member Web or the EyeMed Members App

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A global solution for global employees

Our International Travel Solution provides:

- Worldwide provider directory with mapping functionality
- Vision guides detailing the ins and outs of receiving vision care abroad
- 24/7 member support to answer questions in real-time
- Temporary glasses delivered next day—in case of broken or lost eyewear*
- Translation services to support optical transactions in a foreign language
- OON benefits for vision care received abroad
- Easy claim filing—just upload photo of receipt

99% of clients think we make it easy for members to use their benefits**

*Next day delivery in most locations
**EyeMed Client Satisfaction Survey conducted by Walker, 2017

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Network Access for every demographic
Eye care and eyewear when and where employees want it

Why 98% of employees use in-network providers*

The right mix of in-network providers:

- 70% Independent
- 30% Retail
- Online In-Network Applications
  - Glasses.com
  - Contactsdirect.com

Huge eyewear selection:

- Locations close to you
- Providers with evening/weekend hours
- Access to advanced technology
- LensCrafters & Pearle Vision
- Wal-Mart and Sam’s Club

Optical In-network

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More choice and more provider options

**Nationwide locations**

- EyeMed Insight: 29,000
- VSP Choice: 22,000

**Arkansas locations**

- EyeMed Insight: 275
- VSP Choice: 258

*All network data is based on competitive network figures from NetMinder, October 2017

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Online in-network eyewear providers

Glasses.com:
- Huge selection of frames and lenses, including the world’s leading brands
- Photo-realistic and geometrically accurate 3D virtual “try-on” technology
- In-network benefits apply directly in the shopping cart
- Orders typically fulfilled and shipped the following day for free

ContactsDirect.com:
- Wide selection of top-selling brands including Acuvue® and Air Optix®
- User-friendly experience allows members to view their eligibility and available allowance (with application directly in their shopping cart)
- Orders ship as soon as prescription is verified – typically the same day
- Every order ships free
Above all else, we make benefits easy
Making benefits easy to use

Helpful communications
• Open enrollment support
• Welcome Kit with ID card
• Self-serve educational materials
• Wellness mailings and reminders

Online tools
• Enhanced Provider Search
• Mobile app
• Special offers
• Text alerts

Award-winning customer service
• Extended hours, including evenings and weekends
• “Certified Center of Excellence”

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We’ve gone mobile with our benefits

Mobile app for members
- Benefit details
- Provider locations/directions
- ID card
- Ability to set exam and contact lens refill reminders
- Ability to load a prescription

Text alerts
For members who opt-in, we’ll share:
- Wellness information
- Special offers
- Personalized benefits reminders
- Quick tips and guides
Award-winning service day and night

Here for members whenever they need us

- “Certified Center of Excellence” rating for high customer support by Benchmark Portal, 9 years in a row
- Available 102 hours per week:
  on. to Sat.: 7:30–11 p.m. EST & Sun.: 11–8 p.m. EST
  Support 362 days a year
- Need-based routing so calls are answered by the right vision benefits expert every time
- One of America’s highest-rated call centers

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To sum it up...
## Why it’s smart to choose EyeMed

<table>
<thead>
<tr>
<th>The vision care network that members want</th>
<th>EYEMED</th>
<th>CURRENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>The right mix of independents, retail and online</td>
<td>✔️</td>
<td>✔️</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vision benefits that redefine expectations</th>
<th>EYEMED</th>
<th>CURRENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>True vision plan providing better savings across the board</td>
<td>✔️</td>
<td>✔️</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>An experience that makes vision benefits easy</th>
<th>EYEMED</th>
<th>CURRENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tools that make it easy for members</td>
<td>✔️</td>
<td>✔️</td>
</tr>
</tbody>
</table>
Q & A
Flexible Spending Accounts

- Help with common medical expenses not covered by your insurance or with dependent day care expenses
- Elect a portion of your salary to be deducted, on a pre-tax basis, from each paycheck to use for reimbursement of qualified expenses
Healthcare Flexible Spending Accounts (also known as a Healthcare FSA or HCFSA)

How it works

• Used to reimburse eligible medical expenses
• Expenses may be incurred by you, your spouse, or eligible dependents
• Eligible employees may participate, even if you do not have major medical coverage through your employer
Examples of Eligible and Ineligible Expenses

**Examples of Eligible Expenses:**
- Copayments and deductibles for medical visits
- Eye exams and eyeglasses
- Lasik
- Orthodontia expenses\(^1\) and other dental expenses
- Prescription drugs and certain eligible over-the-counter medicines (with a prescription)
- Transportation expenses relative to medical care including mileage at IRC allowable rate

**Examples of Ineligible Expenses:**
- Cosmetic procedures
- Chapstick
- Toothbrushes
- Expenses reimbursed under any other health plan or from any other source
- Insurance premiums
- Vitamins (for general health)

Visit www.americanfidelity.com for more details!

\(^1\)Future service dates require proof of payment
Estimate Your Expenses

Estimate the medical expenses you anticipate to pay out of your own pocket (not covered by health coverage) during the year.

Visit americanfidelity.com/customer-support/FSA-worksheet for the online worksheet.
Healthcare FSA Reminders

Use or Lose

• Carefully choose your election amount each year

• Under Treasury regulations, if you don’t use your full election amount during the required timeframe, any remaining funds are forfeited

• Check with your employer to see if your plan offers a
  • Runoff Period
  • Carryover Provision
  • Grace Period
Carryover Provision

- You are able to carry over up to $500 of unused contributions from one plan year to the next, which may be used to reimburse eligible medical expenses incurred anytime during the next plan year.
Benefits Debit Card

• The Benefits Debit Card allows you to pay for eligible medical expenses with your card instead of paying out of pocket.

• Save Your Receipts!
  • The Internal Revenue Code (IRC) requires proof of the eligible expenses using itemized receipts or other documentation showing the date of service, person for whom service was provided and description of the expense. Depending on the type of expense, documentation may come in the form of third party itemized statements or Explanation of Benefits.
Use Your Benefits Debit Card Online

• Buy eligible items with your card online at FSAstore.com
Dependent Care Accounts
Benefits of an Online Enrollment
Ease and Flexibility for Employers
Confirmation of Benefits

November 02, 2017

Employee Name: Aaron R. Tester
Location: Admin Office

Last Enrollment Date: 11/1/2017
Last Enrollment Method: Enroller Assisted

Your Benefits

This statement confirms your new benefit elections, covered dependents and beneficiaries based on your benefits eligibility date (or effective date for a qualified status change). If you did not enroll for benefits during your initial eligibility period as a new hire (or transfer into a benefit-eligible position), your enrollment method will be listed as "Default" above. This means you will only receive default benefit coverage. You must wait until the next annual open enrollment period to elect any other benefits (unless you have a qualified status change as defined by IRS guidelines). If you feel the information on this statement is incorrect, please contact the Human Resources Department.

<table>
<thead>
<tr>
<th>Benefit Plan</th>
<th>Current Coverage</th>
<th>Pre-tax</th>
<th>After-tax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>Blue Cross PPO, Family</td>
<td>$300.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Health Savings Account</td>
<td>N/A</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Dental</td>
<td>Delta Dental Plan, Family</td>
<td>$24.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Vision</td>
<td>VSP Vision, Family</td>
<td>$25.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Group Life</td>
<td>N/A</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Flexible Spending Account</td>
<td>N/A</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Disability</td>
<td>N/A</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Term Life</td>
<td>N/A</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Whole Life</td>
<td>N/A</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Accident</td>
<td>N/A</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Cancer</td>
<td>N/A</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Texas Life</td>
<td>N/A</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td><strong>Total Employee Cost Per Pay Period</strong></td>
<td></td>
<td><strong>$349.00</strong></td>
<td><strong>$0.00</strong></td>
</tr>
</tbody>
</table>

Please review for accuracy.
Benefits of an Online Enrollment

✓ Choice
✓ Convenience
✓ Education
Variety of Educational Tools

Two-thirds of workers are confident in their ability to make informed benefits choices.

Yet, nearly as many would welcome benefits advice from a third-party advisor or an online program.

Plan Comparisons

Vision

Here is a summary of your current Vision election.

If you wish to make a change, click the Unlock button.

Product Name: VSP Vision
Coverage Level: Employee + Children

<table>
<thead>
<tr>
<th>First Name</th>
<th>MI</th>
<th>Last Name</th>
<th>Date of Birth (MMDDYY)</th>
<th>Sex</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aaron</td>
<td>R</td>
<td>Tester</td>
<td>4/8/1975</td>
<td>M</td>
<td>Employee</td>
</tr>
<tr>
<td>Jimmy</td>
<td></td>
<td>Tester</td>
<td>10/5/2005</td>
<td>M</td>
<td>Child</td>
</tr>
<tr>
<td>Kendra</td>
<td></td>
<td>Tester</td>
<td>10/6/2006</td>
<td>F</td>
<td>Child</td>
</tr>
<tr>
<td>Kent</td>
<td></td>
<td>Tester</td>
<td>10/28/2010</td>
<td>M</td>
<td>Child</td>
</tr>
</tbody>
</table>

Vision is now locked. If you wish to make changes, press the Unlock button.

**My Benefits**

- Medical: $79.00
- Health Savings Account: $0.00
- Dental: $0.00
- Vision: $18.00
- Group Life: $0.00
- Flexible Spending Account: $0.00
- Disability: $0.00
- Term Life: $0.00
- Whole Life: $0.00
- Accident: $0.00
- Cancer: $0.00
- Texas Life: $0.00

Employer Cost: $209.00
Pre-tax cost: $97.00
Post-tax cost: $0.00

Total Cost Per Pay Period: $97.00

Pricing for example purposes only
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/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/).
- We will not retaliate against you for filing a complaint.

**Your Choices**

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

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

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

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

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

**Our Uses and Disclosures**

**How do we typically use or share your health information?**

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

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

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

Run our organization

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

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

Pay for your health services

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

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

Administer your plan

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

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

How else can we use or share your health information?

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

Help with public health and safety issues

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

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

We can use or share your information for health research.

Comply with the law

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

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

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

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

We can use or share health information about you:

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

Respond to lawsuits and legal actions

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

Our Responsibilities

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

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

This privacy notice is based upon “Model Notices of Privacy Practices” provided by the United States Department of Health and Human Services on their website as of September 19, 2017. HHS may change the regulatory law governing Privacy Practices or may change their model notice. If so, the 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 web site.

Other Instructions for Notice

- Privacy Official: Katie Bodenhamer, 501-374-3484, ext. 126, kbodenhamer@arml.org.
Acknowledgement of Receipt

I hereby acknowledge that I have received a copy of the following Notifications from my employer.

● HIPAA Privacy Notice
● Health Insurance Marketplace Coverage Options Notice, and the
● Summary of Benefits and Coverage for the 2018 Fund Year

I also acknowledge that I may also access these Notifications at:

http://www.arml.org/services/mhbf/

______________________
Employee’s Name (please print)

______________________
Employee’s Signature

______________________
Date

Do not send to MHBF – this must be returned to your employer.
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.²

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

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

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

² 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. Employer Identification Number (EIN)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Employer address</td>
<td>6. Employer phone number</td>
</tr>
<tr>
<td>7. City</td>
<td>8. State</td>
</tr>
<tr>
<td>10. Who can we contact about employee health coverage at this job?</td>
<td></td>
</tr>
<tr>
<td>11. Phone number (if different from above)</td>
<td>12. Email address</td>
</tr>
</tbody>
</table>

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

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

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

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

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

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

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?  

**Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?  

(Continued)  

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

14. This employer offers a health plan that meets the minimum value standard.  

(Continue)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

- **a.** How much would the employee have to pay in premiums for this plan?  
- **b.** How often?  
  - Weekly  
  - Every 2 weeks  
  - Twice a month  
  - Monthly  
  - Quarterly  
  - Yearly

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

16. What change will the employer make for the new plan year?  

- Employer won't offer health coverage  
- Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

- **a.** How much will the employee have to pay in premiums for that plan?  
- **b.** How often?  
  - Weekly  
  - Every 2 weeks  
  - Twice a month  
  - Monthly  
  - Quarterly  
  - Yearly

Date of change (01/01/2018)

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

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

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$500, $1,200, or $2,000/individual; or $6,000/family</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Preventive care services are covered before you meet your deductible.</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>For network providers $4,000 individual / $8,000 family; for out-of-network providers there is no limit. For pharmacy providers $2,600 individual / $5,200 family</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Copayments, deductibles, premiums, balance-billing charges, penalties for failure to precertify, out-of-state and out-of-network care and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.amrl.org/services/mhbf/">www.amrl.org/services/mhbf/</a> or call 1-501-978-6137 for a list of network providers.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency medical transportation</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>---------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$20 copay/visit and 20% coinsurance</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient mental/behavioral health services</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Inpatient mental/behavioral health services</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Substance abuse disorder services – inpatient/outpatient</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>$20 copay on first visit and 20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>20% coinsurance</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>If your child needs dental or eye care</th>
<th>Children's eye exam</th>
<th>Not covered</th>
<th>Not covered</th>
<th>Not covered</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Children's glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children's 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 Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.):**

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (adult)
- Routine foot care
- Weight loss program coverage is limited to two weight loss program visits annually, or only as otherwise covered under the MBS-AQIP Program. Please consult section 2 of your policy booklet for further information.

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

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

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

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

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

Language Access Services:

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

Questions: Call 501-978-6137 or visit www.arml.org/services/mhbf/. For help understanding any of the underlined terms used in this document, please see the Glossary located at https://www.healthcare.gov/sbc-glossary/ or call 501-978-6137 to request a free copy.
About these Coverage Examples:

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

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

- The plan's overall deductible: $500*
- Specialist copayment: $20
- Hospital (facility) coinsurance: 20%
- Prescription copayment (generic): $10/Rx

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

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

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$500*</td>
</tr>
<tr>
<td>Copayments</td>
<td>$60**</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$2,500</td>
</tr>
</tbody>
</table>

What isn't covered

- Limits or exclusions: $60
- **The total Peg would pay is**: $3,120

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

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

The plan would be responsible for the other costs of these EXAMPLE covered services.

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

- The plan's overall deductible: $500*
- Specialist copayment: $20
- Prescription copayment (generic): $10/Rx
- Prescription copayment (brand): $30/Rx

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

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

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$500*</td>
</tr>
<tr>
<td>Copayments</td>
<td>$800**</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$600</td>
</tr>
</tbody>
</table>

What isn't covered

- Limits or exclusions: $60
- **The total Joe would pay is**: $1,960

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

- The plan's overall deductible: $500*
- Emergency room care copayment: $250
- Hospital (facility) coinsurance: 20%
- Other coinsurance: 20%

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

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

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$500*</td>
</tr>
<tr>
<td>Copayments</td>
<td>$250**</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$200</td>
</tr>
</tbody>
</table>

What isn't covered

- Limits or exclusions: $0
- **The total Mia would pay is**: $950