The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-501-978-6137 or visit www.arml.org/services/mhbp/. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-501-978-6137 to request a copy.

### Important Questions

<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.arml.org/services/mhbp/or">www.arml.org/services/mhbp/or</a> call 1-501-978-6137 for a list of network providers.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies. All payments subject to usual and customary allowables.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</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><strong>Network Provider (You will pay the least)</strong>: $20 copayment/visit and 20% coinsurance; <strong>Out-of-Network Provider (You will pay the most)</strong>: $20 copayment/visit and 50% coinsurance</td>
<td>You may have to pay for services that aren’t preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Your deductible does not apply to copayments.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$20 copayment/visit and 20% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>50% coinsurance</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>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>$10 copay/prescription</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>$30 copay/prescription</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>$50 copay/prescription</td>
<td>Not covered</td>
</tr>
<tr>
<td></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>Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs up to $1,000</td>
<td>$100 copay/prescription</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs over $1,000</td>
<td>$200 copay/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>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$250 copay/visit and 20% coinsurance</td>
<td>$250 copayment is waived if admitted to inpatient hospital. Your deductible does not apply to copayments.</td>
</tr>
</tbody>
</table>

More information about prescription drug coverage is available at www.arml.org/services/mhbp/ and in section 3 of your policy booklet.
<table>
<thead>
<tr>
<th>If you need immediate medical attention</th>
<th>Emergency medical transportation</th>
<th>20% coinsurance</th>
<th>20% coinsurance</th>
<th>Coverage is limited to 2 ground and 2 air transports annually.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Urgent care</td>
<td>$20 copay/visit and 20% coinsurance</td>
<td>$20 copay/visit and 20% coinsurance</td>
<td>Your deductible does not apply to copayments.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Coverage is limited to 30 days annually. You must pre-certify by calling 888-295-3591. There is a $1,500 penalty deductible for failure to pre-certify.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient mental/behavioral health services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Coverage is limited to 24 visits annually.</td>
</tr>
<tr>
<td></td>
<td>Inpatient mental/behavioral health services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Coverage is limited to 10 days annually. You must pre-certify by calling 888-295-3591. There is a $1,500 penalty deductible for failure to pre-certify.</td>
</tr>
<tr>
<td></td>
<td>Substance abuse disorder services – inpatient/outpatient</td>
<td>20% coinsurance</td>
<td>Not covered</td>
<td>Coverage is limited to 1 treatment plan, whether inpatient or outpatient, per lifetime at MHBP Designated Chemical Dependency Centers. You must pre-certify by calling 888-295-3591. Consult section 2 of your policy booklet for more information.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>$20 copay on first visit and 20% coinsurance</td>
<td>$20 copay on first visit and 50% coinsurance</td>
<td>Postnatal care extends up to 90 days post-delivery. You must pre-certify an extended inpatient stay by calling 888-295-3591. There is a $1,500 penalty deductible for failure to pre-certify. Your deductible does not apply to copayments.</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Coverage is limited to 20 visits annually. You must pre-certify by calling 888-295-3591. There is a $1,500 penalty deductible for failure to pre-certify.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Coverage is limited to 30 days for acute care and 15 days for sub-acute care annually. You must pre-certify by calling 888-295-3591. There is a $1,500 penalty deductible for failure to pre-certify.</td>
</tr>
</tbody>
</table>

Questions: Call 501-978-6137 or visit www.arml.org/services/mhbp/. For help understanding any of the underlined terms used in this document, please see the Glossary located at https://www.healthcare.gov/sbc-glossary/ or call 501-978-6137 to request a free copy.
<table>
<thead>
<tr>
<th>If you need 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.</td>
</tr>
<tr>
<td></td>
<td>Hospice services</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 penalty deductible for failure to pre-certify.</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

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

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

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

<table>
<thead>
<tr>
<th>Peg is Having a Baby</th>
<th>Managing Joe’s type 2 Diabetes</th>
<th>Mia’s Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>(9 months of in-network pre-natal care and a hospital delivery)</td>
<td>(a year of routine in-network care of a well-controlled condition)</td>
<td>(in-network emergency room visit and follow up care)</td>
</tr>
</tbody>
</table>

- **The plan’s overall deductible**: $500*
- **Specialist copayment**: $20
- **Hospital (facility) coinsurance**: 20%
- **Prescription copayment (generic)**: $10/Rx
- **Prescription copayment (brand)**: $30/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

<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

<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

---

*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.