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/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.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$500, $1,200, or $2,000/individual; or $6,000/family	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.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	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	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.
What is not included in the out-of-pocket limit?	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.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.arml.org/services/mhbf/ or call 1-501-978-6137 for a list of network providers.	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.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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.

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

If you need immediate medical attention	Emergency medical transportation	20% coinsurance	20% coinsurance	Coverage is limited to 2 ground and 2 air transports annually.
	Urgent care	$20 copay/visit and 20% coinsurance	$20 copay/visit and 20% coinsurance	Your deductible does not apply to copayments.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	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.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient mental/behavioral health services	20% coinsurance	50% coinsurance	Coverage is limited to 24 visits annually.
	Inpatient mental/behavioral health services	20% coinsurance	50% coinsurance	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.
	Substance abuse disorder services – inpatient/outpatient	20% coinsurance	Not covered	Coverage is limited to 1 treatment plan, whether inpatient or outpatient, per lifetime at MHBF Designated Chemical Dependency Centers. You must pre-certify by calling 888-295-3591. Consult section 2 of your policy booklet for more information.
If you are pregnant	Prenatal and postnatal care	$20 copay on first visit and 20% coinsurance	$20 copay on first visit and 50% coinsurance	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.
	Delivery and all inpatient services	20% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	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.
	Rehabilitation services	20% coinsurance	50% coinsurance	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.

If you need help recovering or have other special health needs	Habilitation services	20% coinsurance	50% coinsurance	These services will be combined to allow a maximum of 40 visits annually with physical therapy, speech therapy, occupational therapy, and chiropractic services.
	Skilled nursing care	20% coinsurance	50% coinsurance	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.
	Durable medical equipment	20% coinsurance	50% coinsurance	Pre-certification required for DME that's purchase price exceeds $2,000.
	Hospice services	20% coinsurance	50% coinsurance	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.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered
	Children's glasses	Not covered	Not covered	Not covered
	Children's dental check-up	Not covered	Not covered	Not covered

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 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:

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 section.

About these Coverage Examples:

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

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

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:

Cost Sharing	
Deductibles	$500*
Copayments	$60**
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,120**

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:

Cost Sharing	
Deductibles	$500*
Copayments	$800**
Coinsurance	$600
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,960**

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

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:

Cost Sharing	
Deductibles	$500*
Copayments	$250**
Coinsurance	$200
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.