MHBF PLAN CHANGES 2016

Pat Planek, Director
Municipal Health Benefit Fund

REQUIRED NOTICES TO EMPLOYEES UNDER ACA

You must provide your employee with ALL of the following:

- HIPPA Privacy Notice
- Health Insurance Marketplace Coverage Options Notice
- Summary of Benefits and Coverage
- Copies of these items are in your packets

You must maintain a record demonstrating that these notices were provided to your employee and retain these records for seven (7) years.

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 20___ 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

EFFECTIVE DATE REQUIREMENTS

SINGLE COVERAGE

If you have single coverage, family coverage may be added during Open Enrollment or on the first day of the following month after any of the following *Qualifying Events:*

1. New dependents acquired via:

- *Marriage*
- *Birth*
- *Adoption*
- *Court order to provide coverage to an eligible child; Child Support/Medical Support Order*

2. Loss of Spouse's health coverage due to loss of their employment.

Change of Status form and copy of supporting documentation of the Qualifying Event is required within 30 days of the date of the Qualifying Event

If you do not add the newly acquired dependent(s) by submitting a completed Change of Status Form within 30 days of when they become eligible, you may not enroll them until January 1 of the next year or the next Open Enrollment period.

FAMILY COVERAGE

- If you have family coverage, an eligible newborn can be added to your coverage on the newborn's date of birth.
- The newborn must be added within 90 days of their date of birth regardless if SSN is received.
- If the newborn is not added within 90 days of their date of birth they will not be eligible for coverage until the next Open Enrollment period.
- This FAMILY COVERAGE *newborn exception* **does not** apply to any other Qualifying Event grace period.

FAMILY COVERAGE

- If you have FAMILY COVERAGE, and want to add an otherwise eligible dependent, a Change of Status and copy of supporting documentation of the Qualifying Event is required within 30 days of the date of the Qualifying Event.
- If you do not add an otherwise eligible dependent(s) by submitting a completed Change of Status form within 30 days of when they become eligible, you may not enroll them until January 1 of the next year or on the next Open Enrollment period.

BENEFIT CHANGES

Health

LIMITATION CHANGES

- Chiropractic Services, Physical Therapy, Speech Therapy, Habilitative and Occupation Therapy Services
  - These therapeutic services, when provided in an outpatient clinical setting, will be combined to allow for an annual maximum of 40 visits.
  - The services of a Licensed or Registered Therapist, are covered if the treatment meets the following criteria:
    - Is part of a documented treatment plan
    - Is medically necessary
    - Is for a condition that is the result of a disease or injury
    - Is not excluded elsewhere in the Plan; and
    - Is prescribed by a licensed physician

  - *** Please note that Chiropractic Services are covered only for an eligible member five (5) years and older and that Temporomandibular Joint Dysfunction (TMJ) is not a covered benefit under Chiropractic Services but is covered under optional Dental Benefits coverage.*

ORGAN TRANSPLANT

- Organ Transplant benefits are all inclusive and limited to two (2) per lifetime.

PREVENTATIVE

- Annual Routine Preventative Benefits are reimbursable at 100% of allowable, subject to usual, reasonable and customary charges and are not subject to deductibles and benefit percentages.
- To be considered as a preventative care benefit the provider's bill must designate a routine preventative diagnosis code, with the proper CPT code and diagnosis pointer to be considered as preventative service.
- Preventative benefits are not payable when done at Flu Clinics, Health Fairs or other public or private venues. Flu shots when billed through the Drug Card Benefit and administered by a participating Pharmacy may be covered.

FORMS

CERTIFICATE OF NOTICE AND ACCEPTANCE OF PLAN PROVISIONS

Life-time Certificate of Notice & Acceptance

Any covered member who has signed a 2015 Certificate will be grandfathered into this one-time Certificate change.

- If you have a signed 2015 certificate on file, you will not be required to sign another Certificate for 2016 and beyond; unless
  - You move from one employer group to another; or
  - Leave your job for an extended period of time and then go to work for another participating employer group, or;
  - Are a new employee of a participating employer group; or
  - Are an employee of a new participating employer group.

*** If you have Family Coverage, a spouse's signature will no longer be required****

BENEFIT CHANGES

Life

ACCIDENTAL DEATH AND DISMEMBERMENT

- For benefits to be paid to an **un-emancipated minor child named as a beneficiary**, the minor child must be under the care of a parent or legal guardian. Proof of guardianship will be required.
- In this instance the term child shall include:
  - An employee's natural child from birth less than 19 years of age
  - An employee's adopted child or stepchild under legal guardianship, if such child depends primarily on the employee for support and maintenance and lives with the employee in a regular parent-child relationship
  - An employee's grandchild who is under legal guardianship or legal custody of the employee

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

PACKET

YOUR PACKETS INCLUDE:

- 2016 MHBF Plan Year Information
- Summary of Benefits and Coverage (SBC)
- Certificate of Notice an Acceptance of Plan Provisions
- Your Information. Your Rights. Our Responsibilities
- ACA Checklist

MUNICIPAL HEALTH BENEFIT FUND
P.O. BOX 188
NORTH LITTLE ROCK, AR 72115
(501) 978-6137
FAX (501) 537-7265

CHANGE OF ADDRESS

Name of City/Entity		Group Number	
Name of Member / Employee		SSN	
Old Mailing Address			
City	State	Zip	Phone Number ( )

New Mailing Address			
City	State	Zip	Phone Number ( )

Do you need additional combination Medical ID/ Prescription Cards? ☐ Yes ☐ No

Member/Employee Signature _____ Date _____

Please send this form to MHBF at the above address or fax number.

MUNICIPAL HEALTH BENEFIT FUND
P O BOX 188
NORTH LITTLE ROCK, ARKANSAS 72115
(501) 978-6137
FAX (501) 537-7265

Verification of Eligibility Policy, Paid Leave, and FMLA forms for Full-Time Active Employees

The Municipal Health Benefit Fund (Fund) has received numerous questions regarding the attached Verification of Eligibility form, Paid Leave (i.e. Sick & Vacation Hours), and FMLA eligibility. We would like to explain why the Fund uses these forms and why they are required.

The Fund receives medical and other information on your employees on a daily basis. Occasionally, the information we received gives us cause to question if the employee still meets the Plan's eligibility requirements to continue coverage. Plan eligibility requirements have been designed by the Fund's Board of Trustees and its advisors to insure the Plan remains capable of providing valuable health care benefits to members covered by the Plan at an affordable cost for both the member and the participating employers. When eligibility requirements are ignored or undermined, it adds burdens to other participants in the group. The Fund seeks to remain financially strong and to remain capable of providing benefits at coverage rates that are, to the best of our abilities, relatively stable. This is why we must sometimes verify that employees are still eligible for coverage.

We use the Eligibility Verification form when the information we receive suggests that the employee has been off work for an extended period of time due to an illness, injury, or other reason. This form is used to determine when the employee went on leave and the employee's available paid leave time or FMLA time (if applicable) as of that date. Documentation is needed as well. That's why we ask for you to also provide to us attendance and payroll records from the date of absence. If we receive no response after two (2) weeks, pharmacy benefits shall be pended as well as all claims for the employee and dependents, and we will again require verification information and documentation to be returned in two (2) weeks' time. Failure to respond to the second request will result in the termination of coverage for the employee and dependents in question, triggering COBRA notifications, etc.

Please keep in mind that these forms are sent to every employer group when there is a question regarding the eligibility of an employee. Also note prior to approving an employee for FMLA, public employers with less than fifty (50) employees are not eligible for FMLA. If you are an employer with fifty (50) or more employees then the employee seeking FMLA must have worked at least 1250 hours within the year. If both requirements are met, please submit a copy of the completed FMLA forms required by the U.S. Department of Labor.

Sometimes these requests bring questions as to the nature of the employee's health. Due to the Federal HIPAA laws, we are not able to disclose Protected Health Information (PHI) including (but not limited to) claims and correspondence from the employee and/or their providers of health services unless the employee has authorized you to obtain this information by properly submitting an Authorization to Disclose form to the Fund. This form along with other Fund documents can be found on our website, http://www.arrnl.org/benefitprograms.html.

Thank you for helping the Municipal Health Benefit Fund provide valuable health care benefits at an affordable cost and don't hesitate to call us if you need help with Eligibility and Enrollment.

Groups A-Heber Springs	**Christy Cody**	**Ext. 140**
Groups Helena-Marvell (AML Staff)	**Purity Ingram**	**Ext. 116**
Groups Maumelle-Yorktown Water	**Chanel Forte**	**Ext. 235**

MUNICIPAL HEALTH BENEFIT FUND

PHONE No. (501) 978-6137 Option 5
FAX No. (501) 537-7265, Attention: Enrollment

ELIGIBILITY VERIFICATION WORKSHEET

To be eligible for coverage, an employee must work or receive pay for at least 30 hours per week.
MHBF coverage ends the last day of the month the employee leaves employment or their salary ceases, whichever is the earlier date.

Please complete this form in full and return with the requested documentation so that MHBF may determine if the employe listed below is eligible to continue coverage as an active employee. The completed form can be returned to the fax number above or in the return envelope provided.

All claims are pending the receipt of this information and supporting documentation.
Failure to respond within two weeks of the date of this request may result in the termination of the employees coverage.

Employee Name	Group Name
Employee ID#	Group No.

1) **Date of this request (MHBF use only)** _____

2) Is the employee **actively** working 30 or more hours per week? ☐ Yes ☐ No
(Actively working means the employee is physically at work performing his/her job duties for at least 30 hours per week)

3) Copies of the current attendance and payroll records **MUST** be submitted with this form

4) If No, is the employee currently on:

☐ Paid Leave - Beginning date of Paid Leave _____
Amount of Paid leave available as of the date of this request _____

☐ Unpaid Leave - Beginning date of Unpaid leave/absence _____

☐ FMLA only for groups with 50 + employees- Beginning date of FMLA _____
(Family Medical Leave Act)

☐ Worker's Compensation Leave - Beginning date of W/C Leave _____

5) If the employee is NOT on PAID leave, FMLA or Worker's Compensation Leave they are not eligible for coverage with MHBF and MUST be removed from the group's coverage in compliance with Federal COBRA regulations.

6) Other comments: _____

_____ _____
Signature of Group Representative Date Signed

Municipal Health Benefit Fund

Enrollment/Change/Termination Form

Employee Information - All Fields Required Group Number:

Group Name:	Social Security Number:
Date of Birth:	Gender: Male / Female
First Name:	Last Name:
Full Address (street, city, state, zip code):	

Phone: (_____) _____

Marital Status: Single_____ Married_____ Divorced_____ Effective Date:_____

☐ Active Member: Full Time Hire Date_____ Full Time Employee (position held)_____

☐ Retiree Member (years of service_____/Vested in_____)

Elected Official _____ (office) Member of _____ Board/Commission

Volunteer Fire Fighter_____ Auxiliary Police_____

Life Amount	AD&D Amount	Option A Dis.		Option B Dis.	
		YES	NO	YES	NO

What do you want to do?

☐ **Enroll** in the plan

☐ **Refusal** of Benefits

☐ **Add/Drop** a dependent from your plan

☐ **Return** from Military Leave

☐ **Elected Officials D/D/V Only****

☐ **Cancel** coverage: Cancel Date_____Termination of employment / Reduction in hours / Member Death / Medicare

☐ **Change** coverage: Single to Family_____Family to Single_____ Remove Spouse_____(date of divorce)

Change Beneficiary_____ Change Name_____

Supporting Documentation MUST be submitted for changes.

What level of coverage do you want?

☐ Employee Only

☐ Family

Please check with your City Clerk or HR Dept. to be sure what Options are available to you through your Employer

☐ Life and AD&D ☐ Dental ☐ Vision (Employee level)

☐ Life and AD&D ☐ Dental ☐ Vision (Family level)

Add/Drop	Name	Date of Birth	Social Security Number	Male/Female	Relation	Other Ins. yes or no	Reason for Change

I hereby accept the form(s) of Group Life, AD&D, Dependent Life and Medical Benefits presently contracted for by my employer with the Municipal Health Benefit Fund in the amount(s) for which I am or may become eligible and authorize until revoked by me in writing the deduction by my employer from my earning of amounts sufficient to cover my contribution towards the premium under the said Municipal Health Benefit Fund.

Employee Signature: _____ **Date:** _____

(Employee signature not required for termination)

Group Rep. Signature: _____ **Date:** _____

MHBF use only

Certificate of Notice and Acceptance of Plan Provisions

Public Health Service Act Exemptions
Continuation of Coverage (COBRA)
Beneficiary Designation
Effective December 1, 1981 (as Amended Each Plan Year)

You must sign this form on your behalf and your dependents.

You must return this signed form to your employer.

If you do not sign and return this form to your employer the Fund will not provide you or your dependents with coverage.

When you sign the form you are agreeing that you have received a copy of the Privacy Notice and the Summary of Benefits and Coverage (SBC). These are two separate documents.

By signing the form you also acknowledge that you may obtain a copy of the Municipal Health Benefit Fund Booklet at www.arml.org/mhbf and that you agree to accept the terms and conditions of the Municipal Health Benefit Fund.

The Fund's Plan is subject to Federal law, including, the Patient Protection and Affordable Care Act and the Consolidated Omnibus Budget Reconciliation Act of 1987 (COBRA). COBRA provides for the extension of coverage under the Plan should certain special life events take place. (See the Declaration of Trust on page 1 of the Fund Booklet for more information).

Federal law also allows the Fund to exempt the Fund from some requirements imposed by Federal law. The Fund has done so. (See page 1.)

You further acknowledge that although the Plan may have provided benefits for an illness or condition in past years, the Plan does not necessarily provide benefits for those illnesses or conditions in subsequent Plan years.

By signing below you authorize any hospital, physician or health care provider and/or payer to furnish any information requested by the Municipal Health Benefit Fund that may be necessary to determine benefits payable.

Your authorization for the release of records to determine benefits payable also provides for the release of records of your eligible covered dependents. Your authorization shall remain in effect until changed or updated by you or the Plan. An electronic or photo-static copy of this authorization shall be considered effective and valid as the original for purposes of medical authorization only.

You may revoke your medical authorization on your behalf or that of your eligible covered dependent by providing a written revocation to the Fund.

If you or your eligible dependent(s) changes their coverage status by dropping coverage or changing coverage to a different group then a new certificate must be signed. All new employees are required to execute this Certificate of Notice and Acceptance of Plan Provisions.

Member/Employee: _____ _____
Signature of Member (Includes Retiree or COBRA Member) Social Security Number

Member/Employee: _____ _____
Print Your Full Member Name Date of Birth

Home Telephone Number: _____ Date Signed: _____

Please list a Beneficiary and their relationship to you for your Life Benefits

Beneficiary: _____ _____
Print Name Clearly S=Spouse C=Child SC=Step Child AC=Adopted Child

Beneficiary's Date of Birth _____

This portion is to be completed by Employer Representative and mailed to:
Municipal Health Benefit Fund, P.O. Box 188, North Little Rock, AR 72115

City/Entity of: _____

Group Representative: _____

Save Form

Print Form

Clear Form

MHBF USE ONLY

This form should be returned to your Employer.

MUNICIPAL HEALTH BENEFIT FUND
MULTIPLE COVERAGE INQUIRY

This completed form is Mandatory at time of enrollment of a new Employee & Mandatory on a yearly basis.

In order to pay your claims quickly and accurately, we need complete information on any other insurance that you or your dependents (covered by MHBF) may have. **Please complete this form and return it as soon as possible.**

Member/Employee Name	Member/Employee SSN or ID#	Name of Employer/Group	
Current Mailing Address	City	State	Zip Code

1. PLEASE ANSWER THIS QUESTION

Do you or any family member covered as your dependent by MHBF, have any other medical, dental or vision insurance coverage?

Yes ☐ If Yes, please complete sections 2, 3 and 4 (space has been provided on the back of this form for persons with more than one health care plan).

No ☐ If No, please sign and date the bottom of this form (Section 4) and return this form to us as soon as possible.

2.OTHER INSURANCE INFORMATION (More space provided on the back of this form)

COMPLETE IN FULL (If Other Insurance is Medicare, Please go to Section 3 of this form)

Name of Insurance Company		Insurance Company Phone Number ( )	
Insurance Company Address (Street or PO Box, City, State and Zip Code)		Employer that provides this coverage	
Name of Policy Holder	Policy Holder Identification No.	Effective Date	Termination Date *

Type of Coverage ☐ Medical ☐ Dental ☐ Vision ☐ Drug Card Services

Type of Policy ☐ Single ☐ Family ☐ Medicaid ☐ Retiree Coverage

Persons Covered by Other Insurance

Name	Social Security Number	Date of Birth	Relationship to Policy

3. Medicare Information (PLEASE PROVIDE COPY OF MEDICARE CARD)

Name of Medicare Policy Holder		Medicare Identification Number
Effective Date of Part A	Effective Date of Part B	Effective Date of Part D

Reason for Medicare Eligibility: ☐ **Age 65 or Older** ☐ **Disability *** ☐ **Renal Disease**

*** If you are eligible for Medicare due to a Disability please attach a copy of Social Security Disability Approval Letter.**

Name of Spouse or other Dependent who has Medicare		Medicare Identification Number
Effective Date of Part A	Effective Date of Part B	Effective Date of Part D

Reason for Medicare Eligibility: ☐ **Age 65 or Older** ☐ **Disability *** ☐ **Renal Disease**

*** If you are eligible for Medicare due to a Disability please attach a copy of Social Security Disability Approval Letter.**

NOTE: ALL CLAIMS ON YOU & YOUR COVERED DEPENDENTS WILL BE HELD UNTIL THIS INFORMATION IS RECEIVED. FAILURE TO RESPOND TO MAY RESULT IN CLAIMS BEGIN DELAYED OR DENIED.

MHBF Use Only

4.IF YOU ARE DIVORCED AND/OR COVERING CHILDREN FROM A PREVIOUS RELATIONSHIP OR COVERING STEPCHILDREN

Name of Dependent	Who does the dependent reside with	Relationship to Member/Employee

Is there a Court or Child Support Order in place establishing financial responsibility for the dependent(s) health coverage:
☐ Yes ☐ No **A copy of court order must accompany this form.**

Name of Dependent	Who does the dependent reside with	Relationship to Member/Employee

Is there a Court or Child Support Order in place establishing financial responsibility for the dependent(s) health coverage:
☐ Yes ☐ No **A copy of court order must accompany this form.**

Name of Dependent	Who does the dependent reside with	Relationship to Member/Employee

Is there a Court or Child Support Order in place establishing financial responsibility for the dependent(s) health coverage:
☐ Yes ☐ No **A copy of court order must accompany this form.**

OTHER INSURANCE INFORMATION

(If Other Insurance is Medicare, Please go to the Medicare Information section of this form.)

Name of Insurance Company	Insurance Company Phone Number ( )
Insurance Company Address (Street or PO Box, City, State and Zip Code)	**Employer that provides this coverage**

Name of Policy Holder	Policy Holder Identification No.	Effective Date	Termination Date *

*** If the other coverage has terminated please attach a copy of the termination letter**

Type of Coverage ☐ Medical ☐ Dental ☐ Vision ☐ Drug Card Services
Type of Policy ☐ Single ☐ Family ☐ Medicaid ☐ Retiree Coverage

Persons Covered by Other Insurance

Name	Social Security Number	Date of Birth	Relationship to Policy Holder

NOTE: ANYTIME ANY OF THIS INFORMATION CHANGES MHBF MUST BE NOTIFIED WITH AN UPDATED FORM AND A CERTIFICATE OF COVERAGE SHOWING THAT THIS OTHER INSURANCE TERMED .

Signature of Member/Employee Date

(rev04/14)

RxResults℠

Prescription Benefits Updates: OptumRx PBM Change & Specialty Drug Market

November 18, 2015

www.rxresults.com

Presentation Topics

- PBM transitions
- 2016 MHBF plan changes
- Specialty drug market

PBM Transitions

PBM Transitions

- Prior to 4/1/2015 – Restat
- 4/1/2015 – Catamaran
- 10/1/2015 – OptumRx (United Healthcare)

Restat to Catamaran

- Acquisition of Restat completed in 2013
- Migration of plan specification required
- New preferred drug list
- Unknowingly, other plan changes occurred
- No new ID cards were distributed

Catamaran to OptumRx

- OptumRx is the 3rd largest PBM in the U.S.
- No expected claims system changes
- Same account management team
- New ID cards

2106 MHBF Plan Changes

MHBF 2016 Plan Changes

- New drugs to market
  - Some having no evidence of better performance
  - "Me too" drugs
- High cost generics
- Over-the-counter drugs
- Older brand drugs now with generics
- Comprehensive drug list – "Municipal Health Benefit Fund Member Handout effective 2016"
- Letters to impacted members

Noteworthy Specific Changes

- Over-the-counter co-payments - $0/$5 → $4/$10
  - Antihistamines (Claritin®, Zyrtec®, Allegra®)
  - Gastric acid reducers (Prilosec®, Prevacid®, Nexium®)
- New cholesterol drug class – PCSK9 inhibitors
- Nasal steroids excluded
- Topical testosterone excluded
- Topical pain killers excluded

Specialty Drug Market

Common Attributes of a Specialty Drug

- Treats rare or complex conditions
- Often requires special handling, storage or administration
- Typically a very high cost drug
- Involves significant patient education and management
- Usually a biotechnology drug

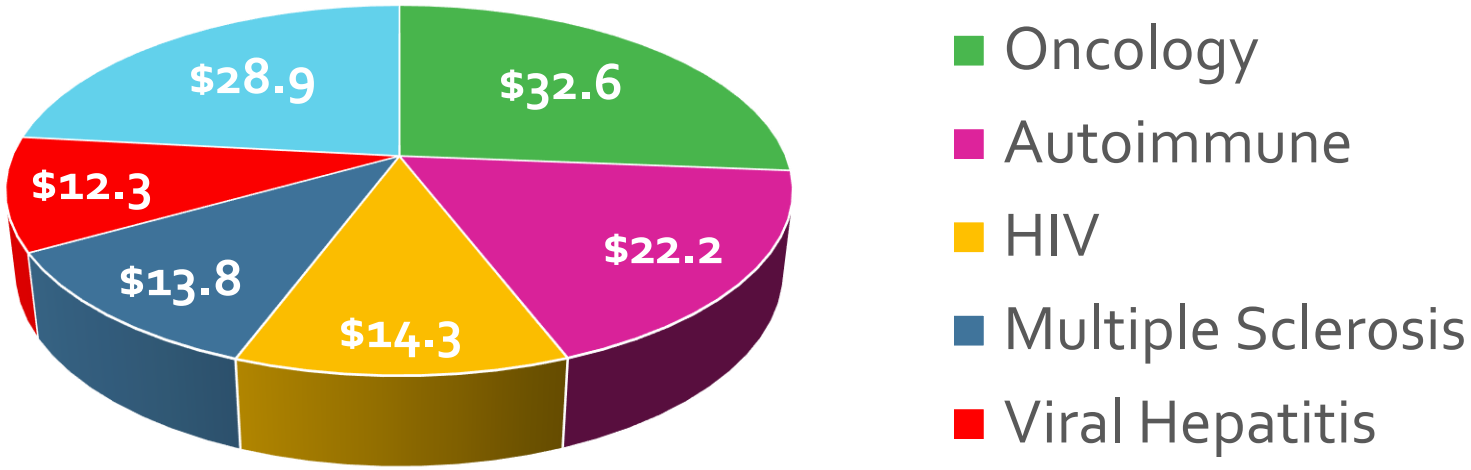
Specialty Drugs by the Numbers

	MHBF	Nationally
Percent Specialty Rxs	0.5%	1.0%
Percent of Plan Total Cost	22% (4Q 2014) 30% (3Q 2015)	33% (2014) 50% (2020 Proj)
Average Specialty Rx Cost	$1,500 (3Q 2015)	$3,700 (2014 avg)

National statistics source: IMS Health, National Sales Perspectives, Dec 2014

Specialty Drugs by the Numbers

U.S. 2014 Cost ($Billions)



- $124 billion in 2014 – up 26.5% from 2013
- 35% of increase was Hepatitis C medications

Source: IMS Health, National Sales Perspectives, Dec 2014

Specialty Drugs by the Numbers

- Growth in specialty drug Rxs was nearly 4 times that of traditional drugs in 2014[1]
- Manufacturer drug research & development shift to specialty drugs[2]
- 78% of all costs on new branded drugs in 2014 was from specialty drugs.[2]

1 CVS Health Insights , Spring 2015
2 IMS Health, National Sales Perspectives, Dec 2014

Relief from Biosimilars?

- Unlikely to be fully interchangeable with innovator products
- Will be more like brand-to-brand competition between drugs
- Biosimilar drug discounts expected to be only 10-30%

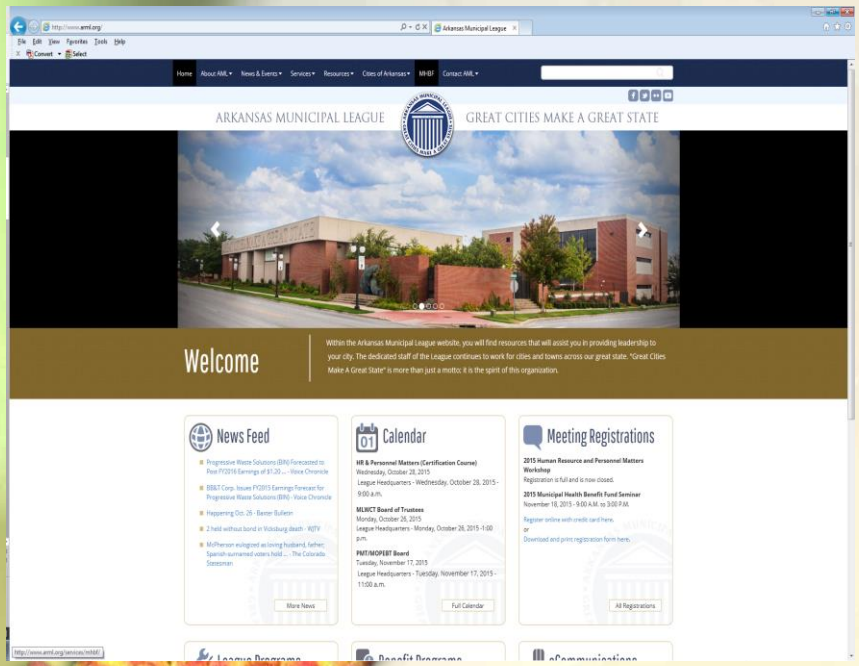
Thank you!

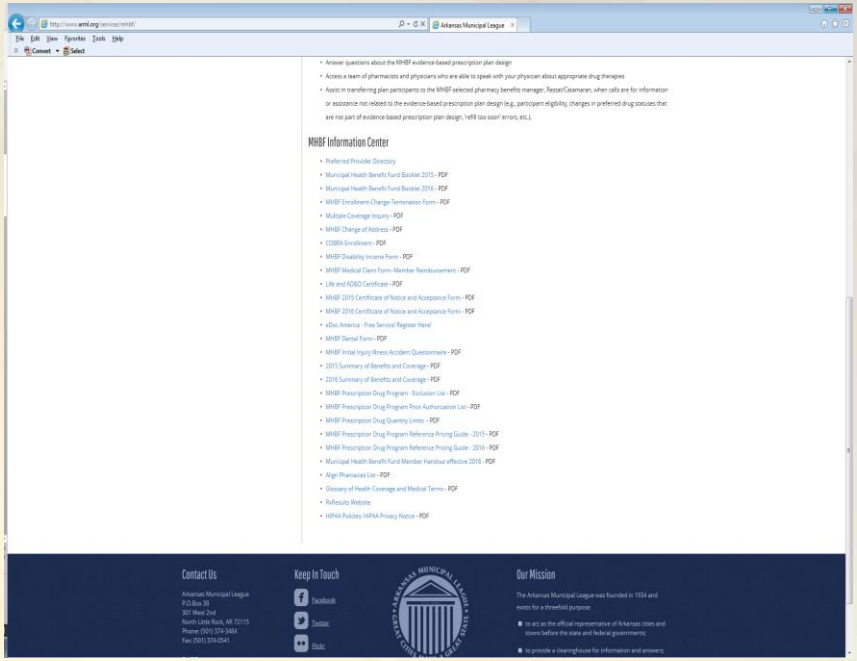
Enrollment & Eligibility

Forms

Where are the forms found?

The AML website (www.aml.org), click on (MHBF) Municipal Health Benefit Fund.





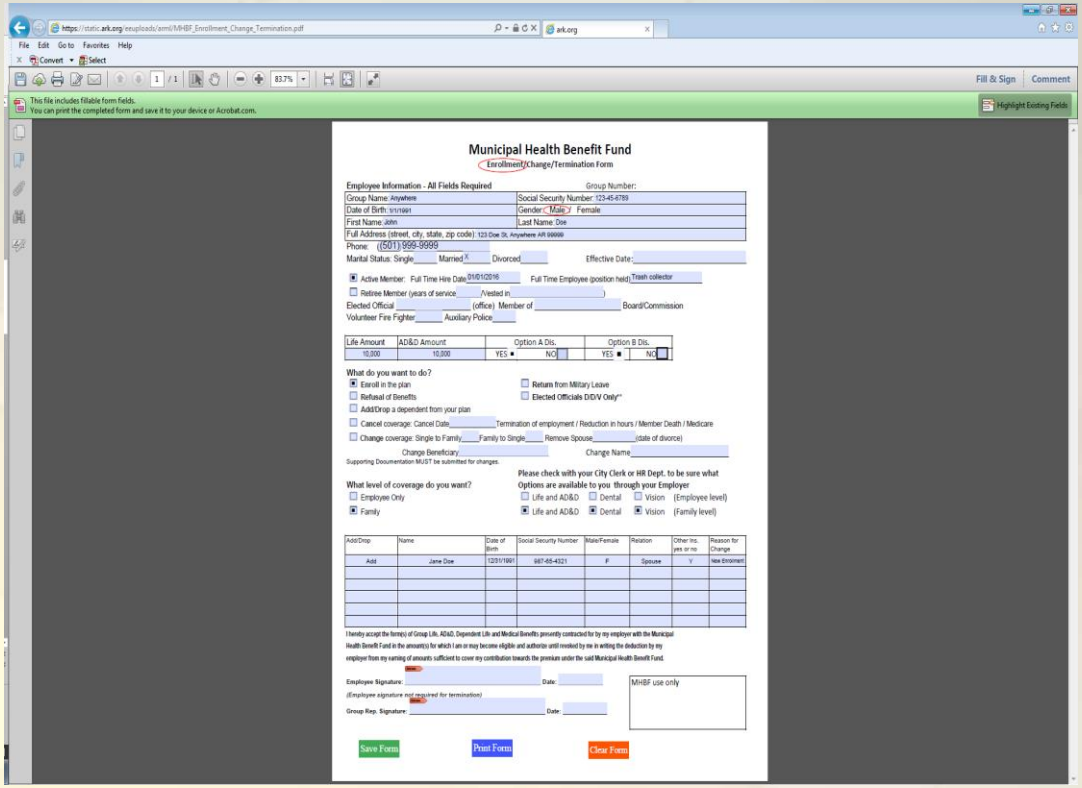
Enrollment

To enroll a member, MHBF must have the following completed documents:

1. **Enrollment form**
2. **Multiple Coverage Inquiry**
3. **Certificate of Notice and Acceptance**
4. **Copy of social security cards for each person enrolling.**

***MHBF has a 60 day waiting period. This is calculated from their full time hire date. The member will be enrolled the first of the month following that period.**

***All supporting documents are needed at enrollment.**



Municipal Health Benefit Fund

Enrollment/Change/Termination Form

Employee Information - All Fields Required

Group Number:

Group Name: Anywhere | Social Security Number: 123-45-6789

Date of Birth: 1/1/1991 | Gender: Male / Female

First Name: John | Last Name: Doe

Full Address (street, city, state, zip code): 123 Doe St, Anywhere AR 99999

Phone: (501) 999-9999

Marital Status: Single ____ Married X Divorced ____ Effective Date: ____

Active Member: Full Time Hire Date: 01/01/2016 Full Time Employee (position held): Trash collector

Retiree Member (years of service ____ /Vested in ____)

Elected Official ____ (office) Member of ____ Board/Commission

Volunteer Fire Fighter ____ Auxiliary Police ____

Life Amount	AD&D Amount	Option A Dis.	Option B Dis.
10,000	10,000	YES ● NO ☐	YES ● NO ☐

What do you want to do?

- ● Enroll in the plan
- ☐ Refusal of Benefits
- ☐ Add/Drop a dependent from your plan
- ☐ Cancel coverage: Cancel Date ____ Termination of employment / Reduction in hours / Member Death / Medicare
- ☐ Change coverage: Single to Family ____ Family to Single ____ Remove Spouse ____ (date of divorce)
- Change Beneficiary ____ Change Name ____

Supporting Documentation MUST be submitted for changes.

- ☐ Return from Military Leave
- ☐ Elected Officials D/D/V Only*

Please check with your City Clerk or HR Dept. to be sure what Options are available to you through your Employer

What level of coverage do you want?

- ☐ Employee Only — ☐ Life and AD&D ☐ Dental ☐ Vision (Employee level)
- ● Family — ● Life and AD&D ● Dental ● Vision (Family level)

Add/Drop	Name	Date of Birth	Social Security Number	Male/Female	Relation	Other Ins. yes or no	Reason for Change
Add	Jane Doe	12/31/1991	987-65-4321	F	Spouse	Y	New Enrollment

I hereby accept the form(s) of Group Life, AD&D, Dependent Life and Medical Benefits presently contracted for by my employer with the Municipal Health Benefit Fund in the amount(s) for which I am or may become eligible and authorize until revoked by me in writing the deduction by my employer from my earning of amounts sufficient to cover my contribution towards the premium under the said Municipal Health Benefit Fund.

Employee Signature: ____ Date: ____

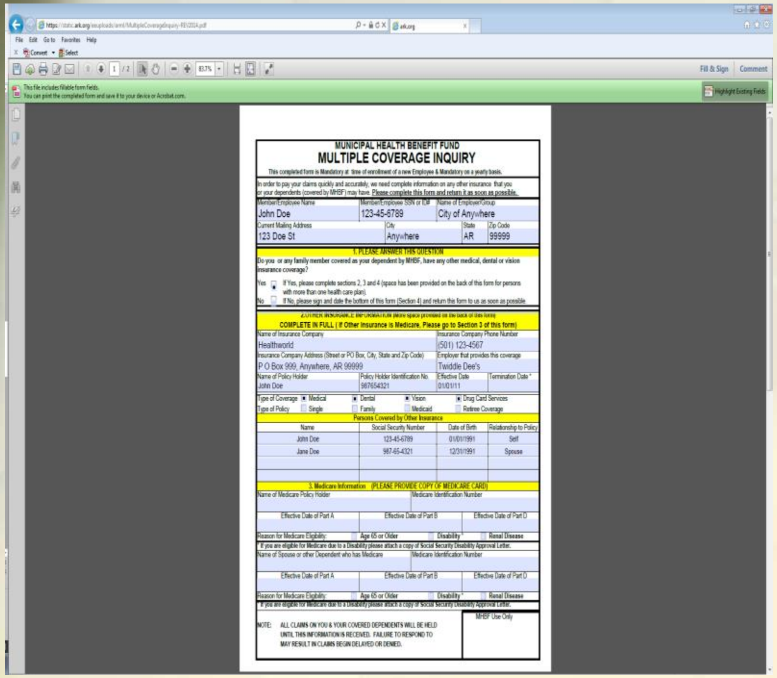
(Employee signature not required for termination)

Group Rep. Signature: ____ Date: ____

MHBF use only

Save Form | Print Form | Clear Form

Multiple Coverage Inquiry



MUNICIPAL HEALTH BENEFIT FUND

MULTIPLE COVERAGE INQUIRY

This completed form is Mandatory at time of enrollment of a new Employee & Mandatory on a yearly basis.

In order to pay your claims quickly and accurately, we need complete information on any other insurance that you or your dependents (covered by MHBF) may have. Please complete this form and return it as soon as possible.

Member/Employee Name	Member/Employee SSN or ID#	Name of Employer/Group
John Doe	123-45-6789	City of Anywhere

Current Mailing Address	City	State	Zip Code
123 Doe St	Anywhere	AR	99999

1. PLEASE ANSWER THIS QUESTION

Do you or any family member covered as your dependent by MHBF, have any other medical, dental or vision insurance coverage?

Yes ☒ If Yes, please complete sections 2, 3 and 4 (space has been provided on the back of this form for persons with more than one health care plan).

No ☐ If No, please sign and date the bottom of this form (Section 4) and return this form to us as soon as possible.

2. OTHER INSURANCE INFORMATION (More space provided on the back of this form)

COMPLETE IN FULL (If Other Insurance is Medicare, Please go to Section 3 of this form)

Name of Insurance Company	Insurance Company Phone Number
Healthworld	(501) 123-4567

Insurance Company Address (Street or PO Box, City, State and Zip Code)	Employer that provides this coverage
P O Box 999, Anywhere, AR 99999	Twiddle Dee's

Name of Policy Holder	Policy Holder Identification No.	Effective Date	Termination Date *
John Doe	987654321	01/01/11	

Type of Coverage ☒ Medical ☒ Dental ☒ Vision ☒ Drug Card Services

Type of Policy ☐ Single ☐ Family ☐ Medicaid ☐ Retiree Coverage

Persons Covered by Other Insurance

Name	Social Security Number	Date of Birth	Relationship to Policy
John Doe	123-45-6789	01/01/1991	Self
Jane Doe	987-65-4321	12/31/1991	Spouse

3. Medicare Information (PLEASE PROVIDE COPY OF MEDICARE CARD)

Name of Medicare Policy Holder	Medicare Identification Number

Effective Date of Part A	Effective Date of Part B	Effective Date of Part D

Reason for Medicare Eligibility: ☐ Age 65 or Older ☐ Disability * ☐ Renal Disease

* If you are eligible for Medicare due to a Disability please attach a copy of Social Security Disability Approval Letter.

Name of Spouse or other Dependent who has Medicare	Medicare Identification Number

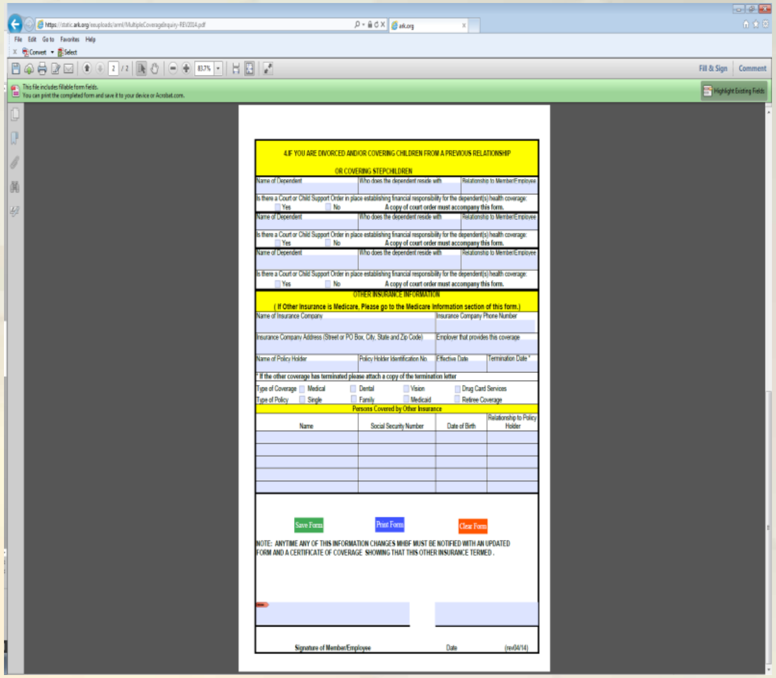
Effective Date of Part A	Effective Date of Part B	Effective Date of Part D

Reason for Medicare Eligibility: ☐ Age 65 or Older ☐ Disability * ☐ Renal Disease

* If you are eligible for Medicare due to a Disability please attach a copy of Social Security Disability Approval Letter.

NOTE: ALL CLAIMS ON YOU & YOUR COVERED DEPENDENTS WILL BE HELD UNTIL THIS INFORMATION IS RECEIVED. FAILURE TO RESPOND TO MAY RESULT IN CLAIMS BEGIN DELAYED OR DENIED.

MHBF Use Only



4.IF YOU ARE DIVORCED AND/OR COVERING CHILDREN FROM A PREVIOUS RELATIONSHIP OR COVERING STEPCHILDREN

Name of Dependent	Who does the dependent reside with	Relationship to Member/Employee

Is there a Court or Child Support Order in place establishing financial responsibility for the dependent(s) health coverage:
☐ Yes ☐ No A copy of court order must accompany this form.

Name of Dependent	Who does the dependent reside with	Relationship to Member/Employee

Is there a Court or Child Support Order in place establishing financial responsibility for the dependent(s) health coverage:
☐ Yes ☐ No A copy of court order must accompany this form.

Name of Dependent	Who does the dependent reside with	Relationship to Member/Employee

Is there a Court or Child Support Order in place establishing financial responsibility for the dependent(s) health coverage:
☐ Yes ☐ No A copy of court order must accompany this form.

OTHER INSURANCE INFORMATION

(If Other Insurance is Medicare, Please go to the Medicare Information section of this form.)

Name of Insurance Company	Insurance Company Phone Number

Insurance Company Address (Street or PO Box, City, State and Zip Code)	Employer that provides this coverage

Name of Policy Holder	Policy Holder Identification No.	Effective Date	Termination Date *

* If the other coverage has terminated please attach a copy of the termination letter

Type of Coverage ☐ Medical ☐ Dental ☐ Vision ☐ Drug Card Services

Type of Policy ☐ Single ☐ Family ☐ Medicaid ☐ Retiree Coverage

Persons Covered by Other Insurance

Name	Social Security Number	Date of Birth	Relationship to Policy Holder

Save Form | Print Form | Clear Form

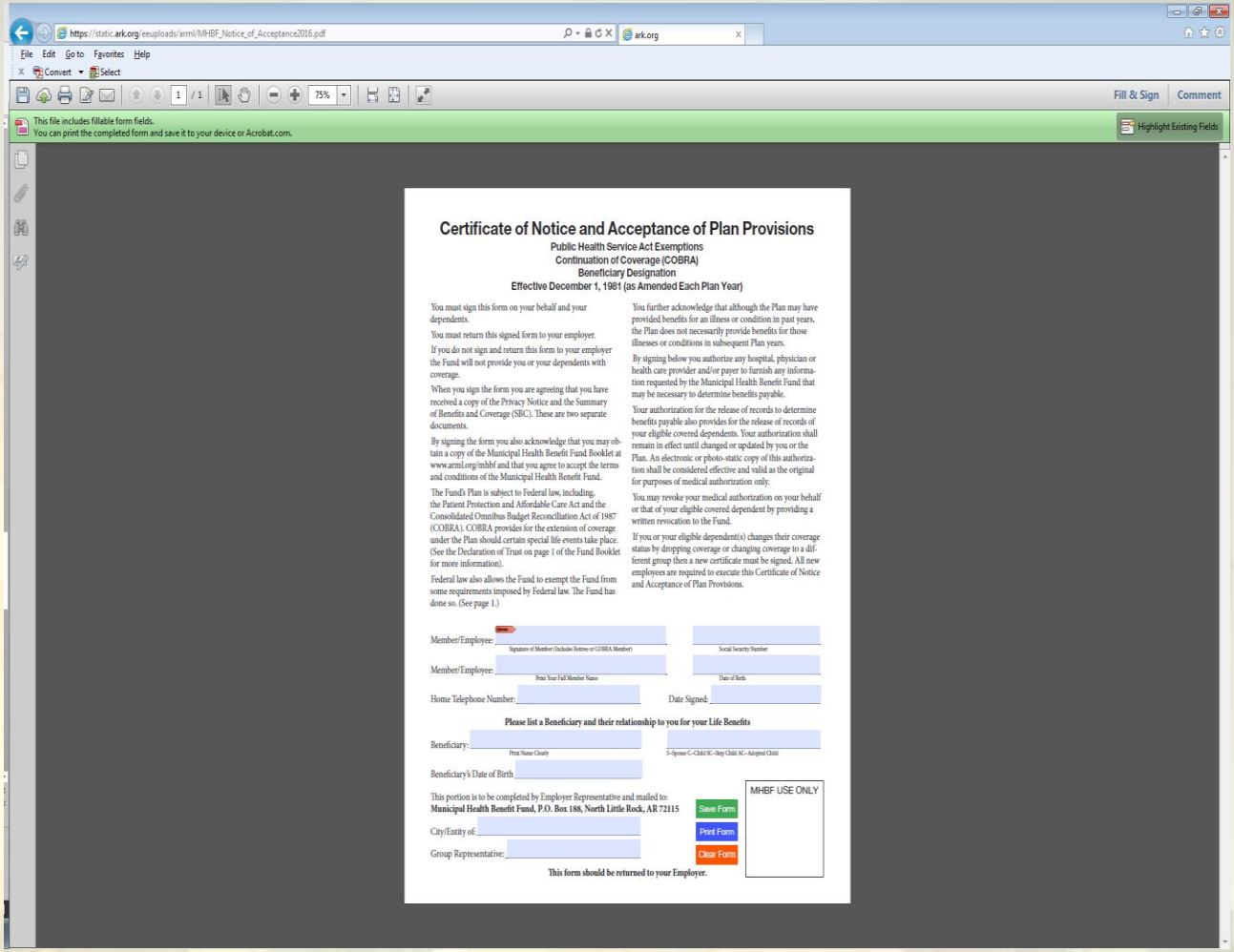
NOTE: ANYTIME ANY OF THIS INFORMATION CHANGES MHBF MUST BE NOTIFIED WITH AN UPDATED FORM AND A CERTIFICATE OF COVERAGE SHOWING THAT THIS OTHER INSURANCE TERMED .

Signature of Member/Employee Date (rev04/14)

Certificate of Notice and Acceptance

*By signing this form the employee is acknowledging they have read and agree to the benefits, exclusions, and guidelines in the booklet.

*This form is no longer needed yearly. Only if employee is new, changes groups, or has a lapse in coverage.



Certificate of Notice and Acceptance of Plan Provisions

Public Health Service Act Exemptions
Continuation of Coverage (COBRA)
Beneficiary Designation
Effective December 1, 1981 (as Amended Each Plan Year)

You must sign this form on your behalf and your dependents.

You must return this signed form to your employer.

If you do not sign and return this form to your employer the Fund will not provide you or your dependents with coverage.

When you sign the form you are agreeing that you have received a copy of the Privacy Notice and the Summary of Benefits and Coverage (SBC). These are two separate documents.

By signing the form you also acknowledge that you may obtain a copy of the Municipal Health Benefit Fund Booklet at www.arml.org/mhbf and that you agree to accept the terms and conditions of the Municipal Health Benefit Fund.

The Fund's Plan is subject to Federal law, including the Patient Protection and Affordable Care Act and the Consolidated Omnibus Budget Reconciliation Act of 1987 (COBRA). COBRA provides for the extension of coverage under the Plan should certain special life events take place. (See the Declaration of Trust on page 1 of the Fund Booklet for more information).

Federal law also allows the Fund to exempt the Fund from some requirements imposed by Federal law. The Fund has done so. (See page 1.)

You further acknowledge that although the Plan may have provided benefits for an illness or condition in past years, the Plan does not necessarily provide benefits for those illnesses or conditions in subsequent Plan years.

By signing below you authorize any hospital, physician or health care provider and/or payer to furnish any information requested by the Municipal Health Benefit Fund that may be necessary to determine benefits payable.

Your authorization for the release of records to determine benefits payable also provides for the release of records of your eligible covered dependents. Your authorization shall remain in effect until changed or updated by you or the Plan. An electronic or photo-static copy of this authorization shall be considered effective and valid as the original for purposes of medical authorization only.

You may revoke your medical authorization on your behalf or that of your eligible covered dependent by providing a written revocation to the Fund.

If you or your eligible dependent(s) changes their coverage status by dropping coverage or changing coverage to a different group then a new certificate must be signed. All new employees are required to execute this Certificate of Notice and Acceptance of Plan Provisions.

Member/Employee: _____ _____
Signature of Member (Includes Retiree or COBRA Member) | Social Security Number

Member/Employee: _____ _____
Print Your Full Member Name | Date of Birth

Home Telephone Number: _____ Date Signed: _____

Please list a Beneficiary and their relationship to you for your Life Benefits

Beneficiary: _____ _____
Print Name Clearly | S–Spouse C–Child SC–Step Child AC–Adopted Child

Beneficiary's Date of Birth _____

This portion is to be completed by Employer Representative and mailed to:
Municipal Health Benefit Fund, P.O. Box 188, North Little Rock, AR 72115

City/Entity of: _____

Group Representative: _____

Save Form | Print Form | Clear Form

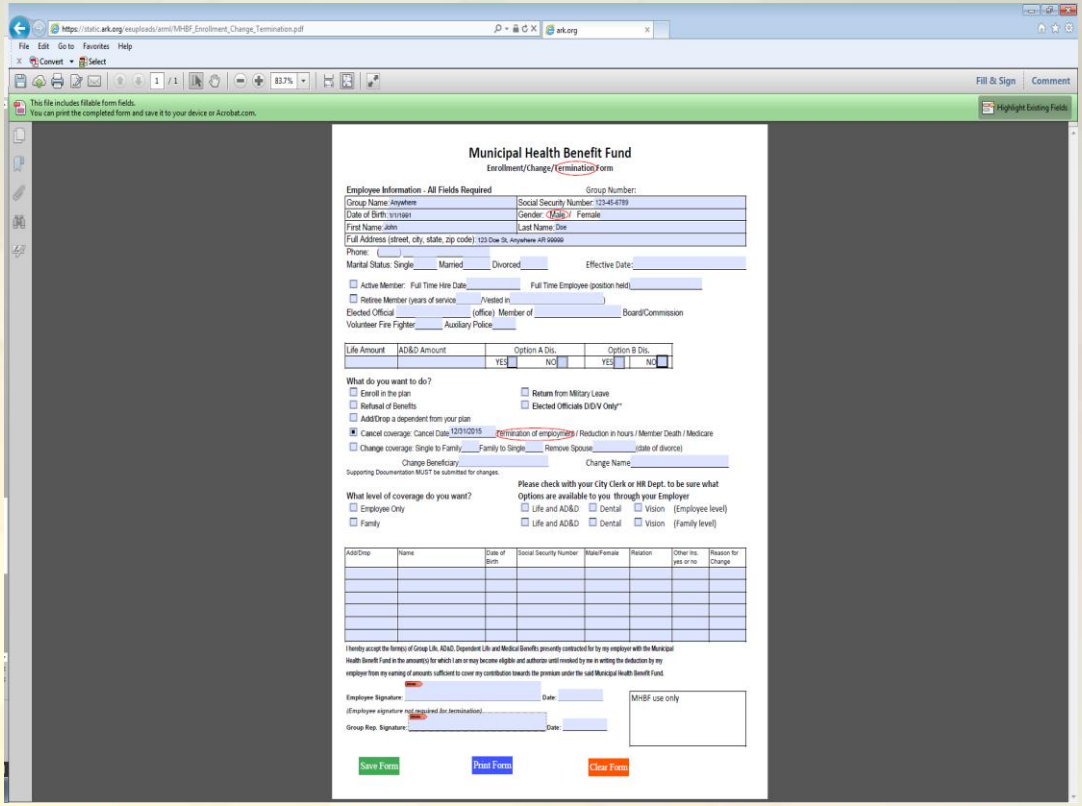
MHBF USE ONLY

This form should be returned to your Employer.

Termination Notice

Why it is so important that MHBF receives the termination notice as soon as possible:

- **Federal COBRA Regulations have a strict timeframe in which an individual who has lost their coverage must be notified and because MHBF sends out the COBRA notification we must have this document as soon as possible.**
  - **Failure to properly notify an individual of their loss of coverage within the Federal COBRA timeframe can result in the city being fined by the Federal Government , up to $110 per day for each day you are out of compliance .**
  - **The address you provide on this document is where the COBRA notice will be mailed in compliance with the Federal mandate.**



Municipal Health Benefit Fund

Enrollment/Change/Termination Form

Employee Information - All Fields Required

Group Number:

Group Name: Anywhere	Social Security Number: 123-45-6789
Date of Birth: 1/1/1981	Gender: (Male) / Female
First Name: John	Last Name: Doe
Full Address (street, city, state, zip code): 123 Doe St, Anywhere AR 99999	

Phone: ( ) -

Marital Status: Single ____ Married ____ Divorced ____ Effective Date: ____

☐ Active Member: Full Time Hire Date ____ Full Time Employee (position held) ____

☐ Retiree Member (years of service ____ /Vested in ____)

Elected Official ____ (office) Member of ____ Board/Commission

Volunteer Fire Fighter ____ Auxiliary Police ____

Life Amount	AD&D Amount	Option A Dis.		Option B Dis.	
		YES	NO	YES	NO

What do you want to do?

☐ Enroll in the plan ☐ Return from Military Leave

☐ Refusal of Benefits ☐ Elected Officials D/D/V Only**

☐ Add/Drop a dependent from your plan

◉ Cancel coverage: Cancel Date 12/31/2015 Termination of employment / Reduction in hours / Member Death / Medicare

☐ Change coverage: Single to Family ____ Family to Single ____ Remove Spouse ____ (date of divorce)

Change Beneficiary: ____ Change Name: ____

Supporting Documentation MUST be submitted for changes.

What level of coverage do you want?

☐ Employee Only ☐ Family

Please check with your City Clerk or HR Dept. to be sure what Options are available to you through your Employer

☐ Life and AD&D ☐ Dental ☐ Vision (Employee level)

☐ Life and AD&D ☐ Dental ☐ Vision (Family level)

Add/Drop	Name	Date of Birth	Social Security Number	Male/Female	Relation	Other Ins. yes or no	Reason for Change

I hereby accept the forms) of Group Life, AD&D, Dependent Life and Medical Benefits presently contracted for by my employer with the Municipal Health Benefit Fund in the amount(s) for which I am or may become eligible and authorize until revoked by me in writing the deduction by my employer from my earning of amounts sufficient to cover my contribution towards the premium under the said Municipal Health Benefit Fund.

Employee Signature: ____ Date: ____

(Employee signature not required for termination)

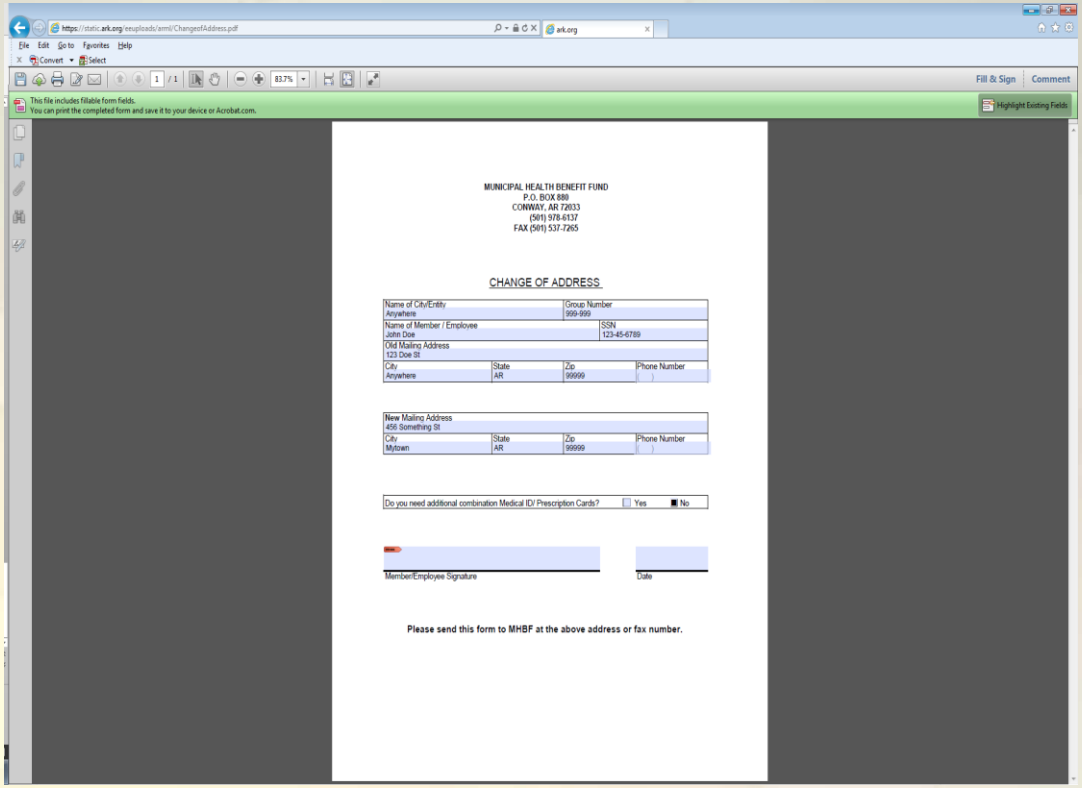
Group Rep. Signature: ____ Date: ____

MHBF use only

Save Form Print Form Clear Form

Change of Address

Due to HIPAA, it is very important to keep an updated address on file. Any correspondence we send will go to the current address we have in the system. Any time an employee changes an address with you, it should be changed with us.



MUNICIPAL HEALTH BENEFIT FUND
P.O. BOX 888
CONWAY, AR 72033
(501) 978-6137
FAX (501) 537-7265

CHANGE OF ADDRESS

Name of City/Entity		Group Number
Anywhere		999-999
Name of Member / Employee		SSN
John Doe		123-45-6789
Old Mailing Address		
123 Doe St		
City	State	Zip / Phone Number
Anywhere	AR	99999

New Mailing Address		
456 Something St		
City	State	Zip / Phone Number
Mytown	AR	99999

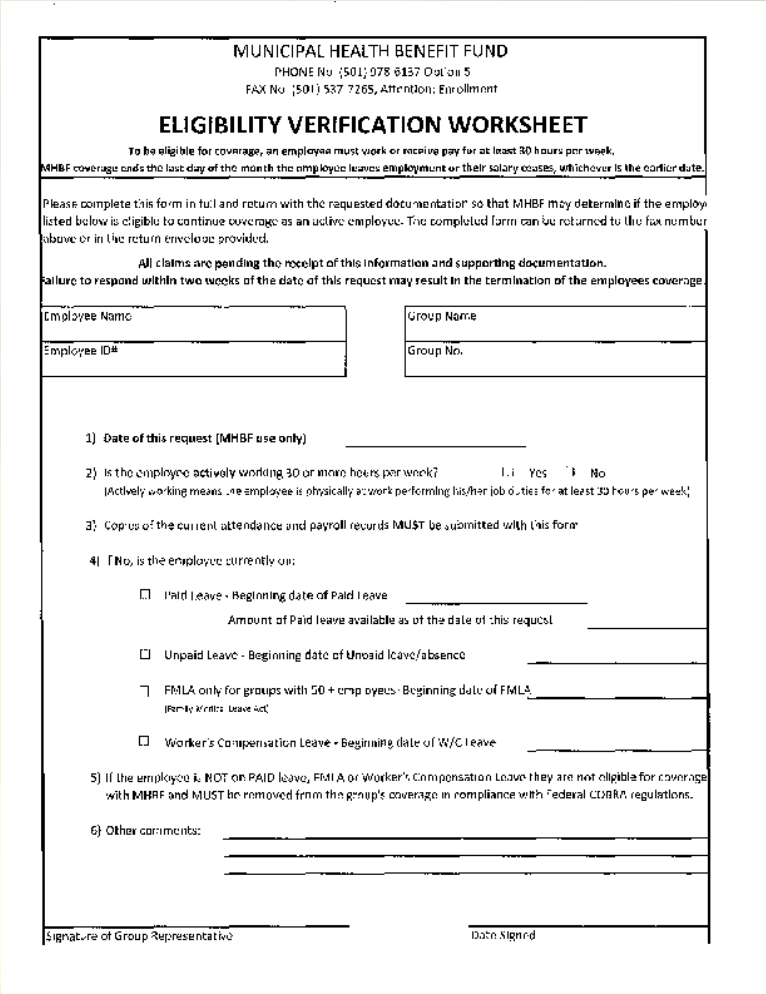
Do you need additional combination Medical ID/ Prescription Cards? ☐ Yes ■ No

Member/Employee Signature _____ Date _____

Please send this form to MHBF at the above address or fax number.

Eligibility Verification

- **Eligibility verification forms are sent to groups when an employee is off of work for a period of time.**
- **Due to Federal COBRA and FMLA Regulations, it is very important that we receive all documentation as soon as possible.**



MUNICIPAL HEALTH BENEFIT FUND
PHONE No. (501) 978-6137 Option 5
FAX No. (501) 537-7265, Attention: Enrollment

ELIGIBILITY VERIFICATION WORKSHEET

To be eligible for coverage, an employee must work or receive pay for at least 30 hours per week.
MHBF coverage ends the last day of the month the employee leaves employment or their salary ceases, whichever is the earlier date.

Please complete this form in full and return with the requested documentation so that MHBF may determine if the employee listed below is eligible to continue coverage as an active employee. The completed form can be returned to the fax number above or in the return envelope provided.

All claims are pending the receipt of this information and supporting documentation.
Failure to respond within two weeks of the date of this request may result in the termination of the employees coverage.

Employee Name	Group Name
Employee ID#	Group No.

1) **Date of this request (MHBF use only)** _____

2) Is the employee actively working 30 or more hours per week? ☐ Yes ☐ No
(Actively working means the employee is physically at work performing his/her job duties for at least 30 hours per week)

3) Copies of the current attendance and payroll records MUST be submitted with this form

4) If No, is the employee currently on:

☐ Paid Leave - Beginning date of Paid Leave _____
Amount of Paid leave available as of the date of this request _____

☐ Unpaid Leave - Beginning date of Unpaid leave/absence _____

☐ FMLA only for groups with 50 + employees - Beginning date of FMLA _____
(Family Medical Leave Act)

☐ Worker's Compensation Leave - Beginning date of W/C Leave _____

5) If the employee is NOT on PAID leave, FMLA or Worker's Compensation Leave they are not eligible for coverage with MHBF and MUST be removed from the group's coverage in compliance with Federal COBRA regulations.

6) Other comments: _____

Signature of Group Representative _____ Date Signed _____

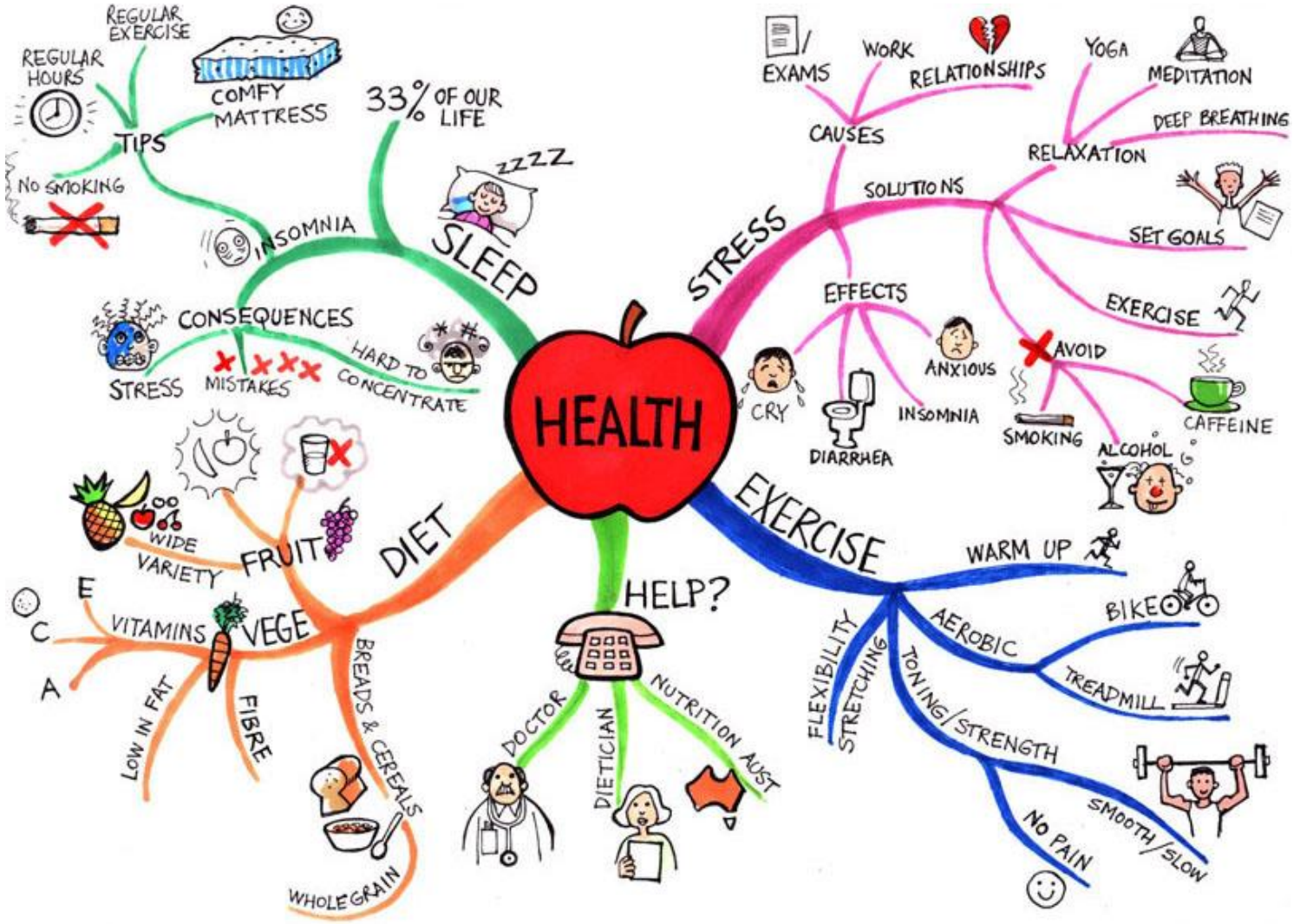
Dr. Charlie Smith, M.D.
Director of the Primary Care Service Line at UAMS

HEALTH

What is it and How Can I achieve it?

Components of Health

- Exercise
- Weight
- Nutrition
- Sleep
- Alcohol
- Tobacco
- Stress



Exercise

- Aerobic
  - Minimum 30 min/5 days per week
- Weights
  - 2 15-20 min sessions/week
- Stretching
  - Minimum twice weekly

Weight

- BMI 25 or under
- Diets don't work
- Weight gain is gradual over the years
- Weight loss also requires patience and persistence
- Don't expect more than one/two pounds/week
- Consider iPhone apps as tools to help
- Calories in/calories out (combination of diet and exercise)

Nutrition

- Not just total calories, but the right type of calories
- Balance (fruits, vegetables, protein, grains)
- Minimize starch and white flour (biscuits, white bread, pasta)
- Salads with protein (chicken or seafood, etc)
- Avoid sugar, sweet tea, sweet fruit juices, sugary cereal
- High fiber (bran muffins, bran cereal, oatmeal (steel cut), fresh stuff
- Red meat once or twice week only (lean)
- Avoid fried food (French fries, fried chicken, catfish, hushpuppies, etc)

Sleep

- Consistency
- Sleep Hygiene
- Avoiding sleep meds
- Sleep apnea/snoring
- Effects of alcohol
- At least 7 hours/night

Alcohol

- Can be beneficial (social, increased HDL, stress reduction)
- How much is too much?
- Is it interfering with your work, life, relationships
- Traffic violations involving alcohol

Tobacco

- Never too late to quit
- If 40 pack year history, get a low dose CT scan
- Chantix, Wellbutrin, Nicotine replacement
- Can't be healthy and continue to smoke

Stress

- Everyone has it
- Coping is key
- Exercise is essential as stress reduction strategy
- Don't isolate
- Tools include yoga, meditation, exercise, hobbies, activities with friends.

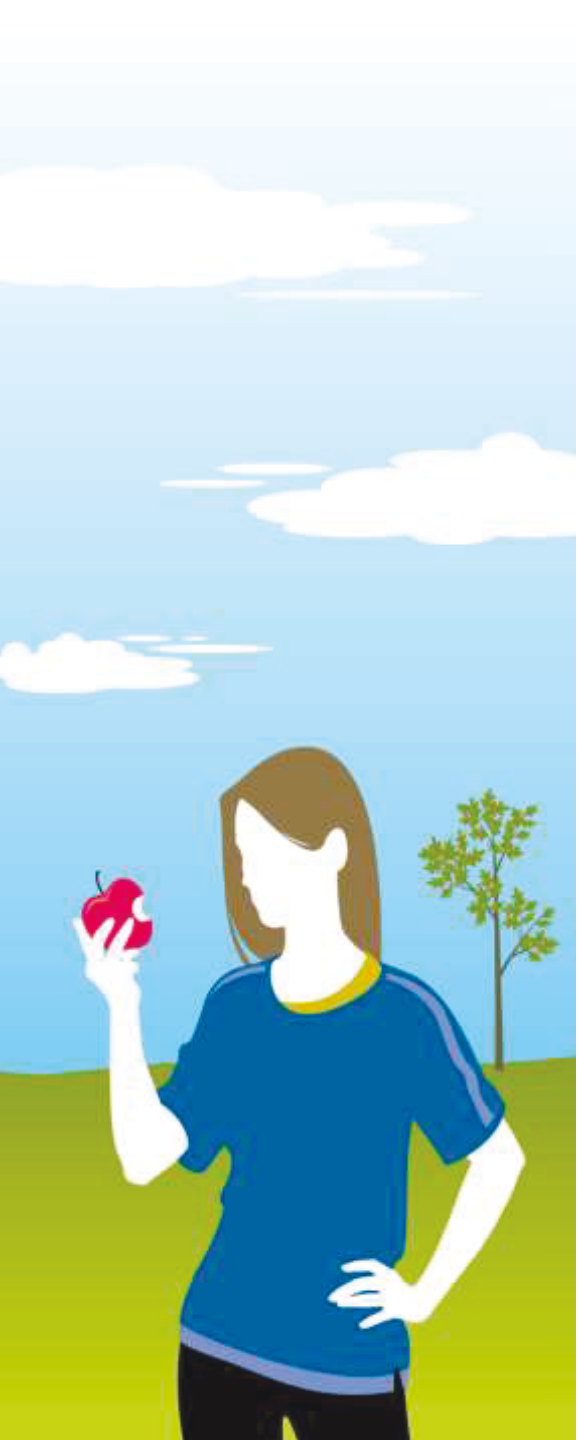
Develop a Path to Better Health

- Plan to achieve healthy weight status
- Modify diet
- Optimize exercise program (add stretching and weights)
- Increase sleep to minimum 7 hours (sleep clinic if necessary)
- Stop smoking
- Cut down on alcohol
- Consider adding one or more stress reduction activities

Affordable Care Act (ACA)

"What You Need to Do Now"

Presented By:
Five Points



Who is Five Points?

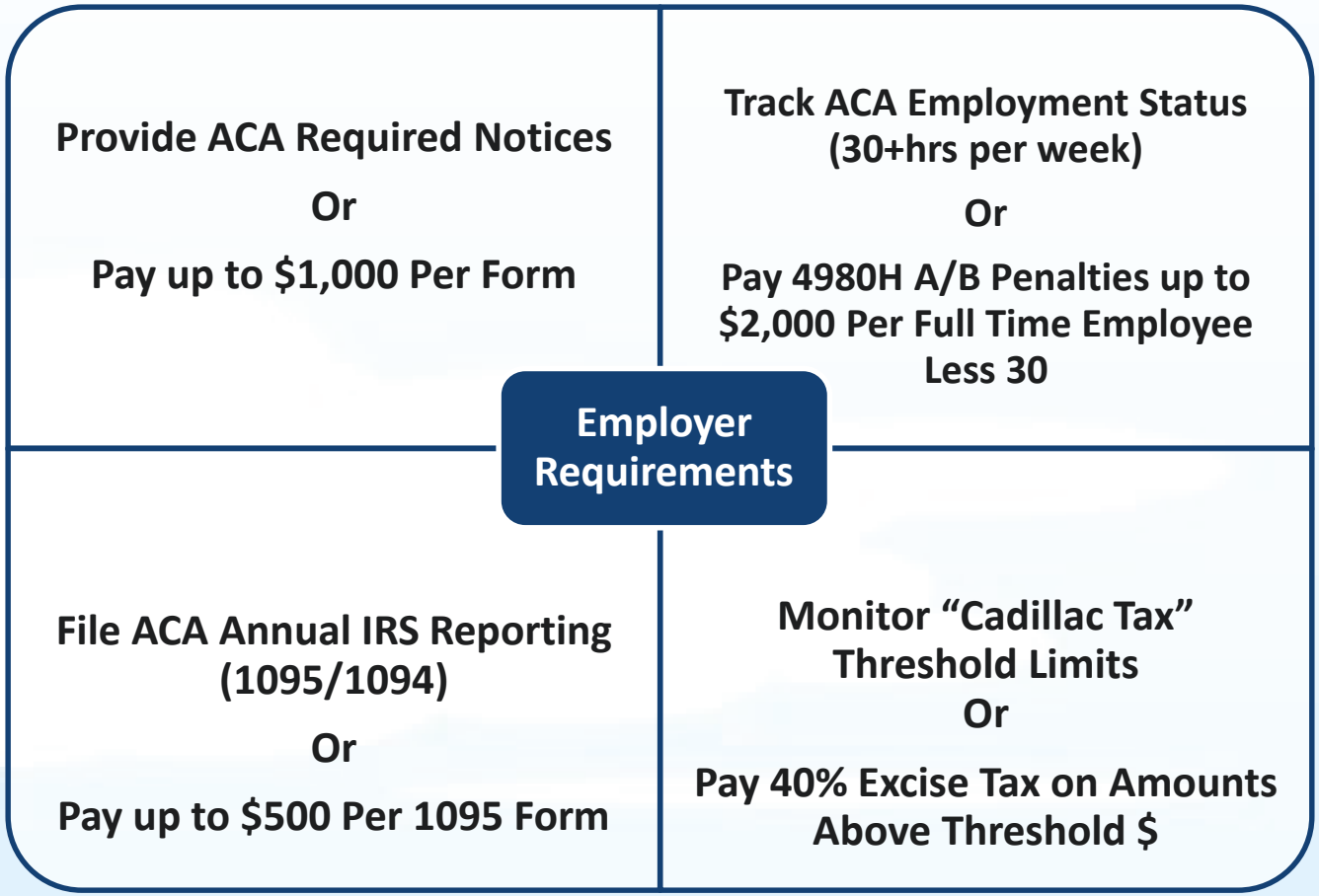
- Been in business since 1989
- Specialize in benefits and HR apps for schools, government, and hospitals:
  - ACA education and consulting
  - ACA tracking and reporting software
  - And many other benefits and HR apps
- Exclusive partners with AML for ACA services
- Partners with American Fidelity

myBenefitsChannel.com

One Username. One Password.

- Secure Communications
- Benefits & HR Library
- Online Enrollment
- ACA Compliance Portfolio
- Time & Attendance
- Online Paycheck Stub
- Online W-2 (coming soon)
- Employee Onboarding
- Online Personnel Record & Storage
- Education & Training

The ACA Puzzle



Delays Are Over Effective Jan. 1, 2015!

- ALEs should be able to:
  1. Prove they provided ACA notices timely
  2. Track full and part time employees hours and prove they offered affordable ACA coverage to at least 95% of FT employees
  3. Correctly track and report all data needed for IRS reporting *each month!*
  4. Beginning 2018 track the Cadillac Tax

Are you ready?

IRS Annual Reporting Requirements

IRS Treasury Reporting

- First reporting period begins Jan 1, 2015
- Final requirements have been released!!!
- Form 1094-C (Transmittal)
  - Used by IRS to calculate subsection (a) penalties under Code § 4980H
- Form 1095-C (Statements)
  - Used for FFM and to prove E, S, Ds had coverage for the year

Due Dates
1095-C (Statements)

- Only one 1095-C per recipient!
- Deadline is Jan 31st (2/1/2016)
- Statements are mailed to employees' last known permanent address
- Can deliver statements electronically if certain requirements must be met:
  - Employee affirmative consent, right to request paper, and ability to withdraw
  - Secure delivery - email is not secure!

Due Dates 1094-C (Transmittal)

- Paper forms due Feb 28th (2/29/2016)
- Mail to address provided in instructions
- Must file eFile if 250+ return filings
- Electronic transmittal returns are due March 31, 2016 for 2015
- Third party can be used for filing returns and employee statements

Form 1095-C

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

600116
OMB No. 1545-2251
2015

Part I Employee

1 Name of employee	2 Social security number (SSN)
3 Street address (including apartment no.)	
4 City or town	

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
9 Street address (including room or suite no.)	10 Contact telephone number

Part II

14 Offer o
Coverage (
required co

15 Employ
of Lowest
Monthly Pr
for Self-On
Minimum
Coverage

16 Applica
Section 49
Harbor (en
if applicabl

Part III

- Part I identifies employee and ALE
  - Data typically comes from payroll/W-2
- Part II reports offers of health coverage, plus cost and safe harbor/relief codes
  - Employer will need to manage data
  - ***Used to calculate 4980H (b) penalties***
- Part III reports covered individuals
  - Most health plan providers can provide data, but when?
- ALE responsible for providing copy to employees & IRS

17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Form 1095-C:

- ALE must file:
  - For each FT employee; and
  - If self-insured, for all enrolled PT employees and non-employees (COBRA, retiree, board member, directors, etc.)
- Can use C forms or B forms for non-employees in self-insured, but why complicate things?
  - We recommend using the C forms…
- One Form 1095-C per recipient (ALE members coordinate)

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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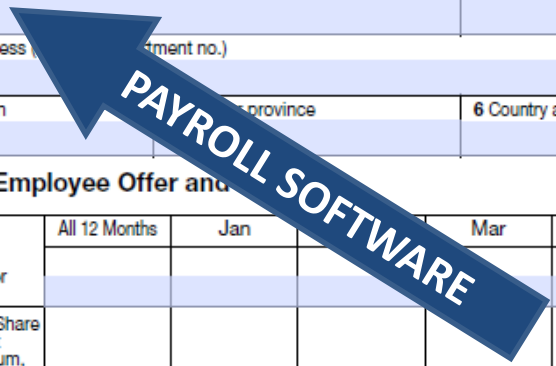
☐ VOID
☐ CORRECTED

600116
OMB No. 1545-2251
2015



Part I Employee

1 Name of employee	2 Social security number (SSN)
3 Street address (including apartment no.)	
4 City or town	5 State or province
6 Country and ZIP or foreign postal code	

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
9 Street address (including room or suite no.)	10 Contact telephone number
11 City or town	12 State or province
13 Country and ZIP or foreign postal code	

Part II Employee Offer and

Plan Start Month (Enter 2-digit number):

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)													
15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Applicable Section 4980H Safe Harbor (enter code, if applicable)													

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each covered individual. ☐

	(a) Name of covered individual(s)	(b) SSN	(c) DOB (If SSN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ **Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c***

☐ VOID
☐ CORRECTED

OMB No. 1545-2251

20**15**

Part I Employee

1 Name of employee	2 Social security number (SSN)

3 Street address (including apartment no.)

4 City or town	5 State or province	6 Country and ZIP or foreign postal code

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)

9 Street address (including room or suite no.)	10 Contact telephone number

11 City or town	12 State or province	13 Country and ZIP or foreign postal code

Part II Employer-Provided Health Insurance Offer and Coverage

Plan Start Month (Enter 2-digit number):

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)												
15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage	$	$	$	$	$	$	$	$	$	$	$	$
16 Applicable Section 4980H Safe Harbor (enter code, if applicable)												

EMPLOYER

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each covered individual. ☐

	(a) Name of covered individual(s)	(b) SSN	(c) DOB (If SSN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Coverage Must Be Affordable

- General rule = Employee cost can't be more than 9.56% of the employee's household income
- ALE won't know household income
- Great news! There are three Affordability Safe Harbors for ALEs to use:
  1. W-2 Safe Harbor
  2. Federal Poverty Line Safe Harbor
  3. Rate of Pay Safe Harbor

Coverage Must Be Affordable

- Have you elected your Safe Harbor?
- If you don't pick a safe harbor you default to the general affordability rule…
- Did you calculate if your lowest cost plan is affordable based on your safe harbor?

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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☐ VOID
☐ CORRECTED

600116
OMB No. 1545-2251
2015

Part I Employee

1 Name of employee	2 Social security number (SSN)
3 Street address (including apartment no.)	
4 City or town	**5** State or province / **6** Country and ZIP or foreign postal code

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
9 Street address (including room or suite no.)	**10** Contact telephone number
11 City or town / **12** State or province	**13** Country and ZIP or foreign postal code

Part II Employee Offer and Coverage

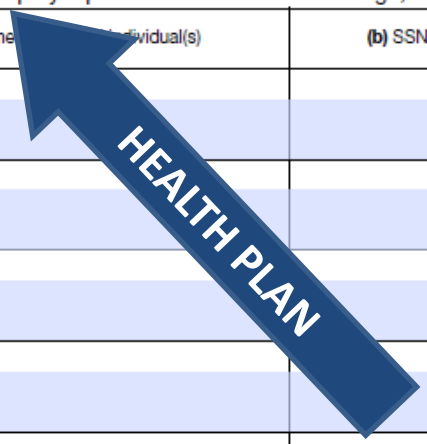
Plan Start Month (Enter 2-digit number):

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)													
15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Applicable Section 4980H Safe Harbor (enter code, if applicable)													

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each covered individual. ☐

	(a) Name of covered individual(s)	(b) SSN	(c) DOB (If SSN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐



Form 1094-C Transmittal

120116

Form **1094-C**

Department of the Treasury
Internal Revenue Service

Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns

▶ **Information about Form 1094-C and its separate instructions is at *www.irs.gov/form1094c***

☐ CORRECTED

OMB No. 1545-2251

2015

Part I **Applicable Large Employer Member (ALE Member)**

1 Name of ALE Member (Employer)

2 Employer identification number (EIN)

3 Street address (including room or suite no.)

4 City or

7 N

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21 Is ALE

☐ No

If "No," do not complete Part IV.

22 **Certifications of Eligibility (select all that apply):**

☐ **A.** Qualifying Offer Method ☐ **B.** Qualifying Offer Method Transition Relief ☐ **C.** Section 4980H Transition Relief ☐ **D.** 98% Offer Method

Under penalties of perjury, I declare that I have examined this return and accompanying documents, and to the best of my knowledge and belief, they are true, correct, and complete.

▶ Signature ▶ Title ▶ Date

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 61571A Form **1094-C** (2015)

- Transmittal is 3 pages
- Part I & II - Transmits 1095-Cs
- Part II – Identifies the ALE and eligibility for transitional relief and simplified reporting (appears to add work!)
- Part III Reports MEC offer to FT employees & transition relief
  - ***Used to calculate 4980H (a) penalties!***
- Typically payroll and health plans won't have data needed
  - Pay hours is likely to be different than HCR average hours

120116

Form **1094-C**

Department of the Treasury
Internal Revenue Service

Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns

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☐ CORRECTED

OMB No. 1545-2251

2015

Part I Applicable Large Employer Member (ALE Member)

1 Name of ALE Member (Employer)		2 Employer identification number (EIN)
3 Street address (including room or suite no.)		
4 City or town	5 State or province	6 Country and ZIP or foreign postal code
7 Name of person to contact		8 Contact telephone number
9 Name of Designated Government Entity (only if applicable)		10 Employer identification number (EIN)
11 Street address (including room or suite no.)		
12 City or town	13 State or province	14 Country and ZIP or foreign postal code
15 Name of person to contact		16 Contact telephone number

For Official Use Only

17 Reserved . . . . . ☐

18 Total number of Forms 1095-C submitted with this transmittal . . . . . ▶

19 Is this the authoritative transmittal for this ALE Member? If "Yes," check the box and continue. If "No," see instructions . . . . . ☐

Part II ALE Member Information

20 Total nu…rms 1095-C filed by and/or on behalf of ALE Member . . . . . ▶

21 Is ALE M…ber of an Aggregated ALE Group? . . . . . ☐ Yes ☐ No

If "No," do not co…rt IV.

22 **Certifications of Eli…lect all that apply):**

☐ **A.** Qualifying Offer Meth… ☐ **B.** Qualifying Offer Method Transition Relief ☐ **C.** Section 4980H Transition Relief ☐ **D.** 98% Offer Method

DISTRICT

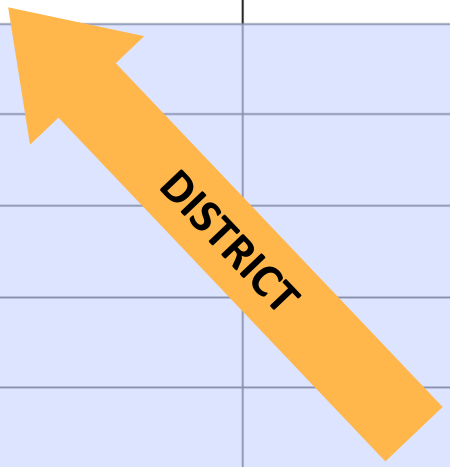
Under penalties of perjury, I declare that I…ined this return and accompanying documents, and to the best of my knowledge and belief, they are true, correct, and complete.

▶ Signature ▶ Title ▶ Date

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 61571A Form **1094-C** (2015)

Part III ALE Member Information—Monthly

		(a) Minimum Essential Coverage Offer Indicator		(b) Full-Time Employee Count for ALE Member	(c) Total Employee Count for ALE Member	(d) Aggregated Group Indicator	(e) Section 4980H Transition Relief Indicator
		Yes	No				
23	All 12 Months	☐	☐			☐	
24	Jan	☐	☐			☐	
25	Feb	☐	☐			☐	
26	Mar	☐	☐			☐	
27	Apr	☐	☐			☐	
28	May	☐	☐			☐	
29	June	☐	☐			☐	
30	July	☐	☐			☐	
31	Aug	☐	☐			☐	
32	Sept	☐	☐			☐	
33	Oct	☐	☐			☐	
34	Nov	☐	☐			☐	
35	Dec	☐	☐			☐	



Full-Time Employee Defined

- Full-time = 30 hrs/week or 130 hrs/month
- Includes PTO - vacation, sick time, etc.
- Hourly credit for any paid, or entitled to pay, hours worked on W2 employees
  - Don’t forget classes like Board Members
- Document actual hours worked for audits

Tracking Hours Worked

- Hourly employees requires actual hours
- Non-hourly employees have two options:
  - Actual hours worked (paper time sheets and/or electronic time tracking)
  - Or, use the equivalency method
  - 1 hour worked in a day = 8 hours credit per day, or 1 hour worked in a week = 40 hours credit
  - This is where payroll records potentially fall short!

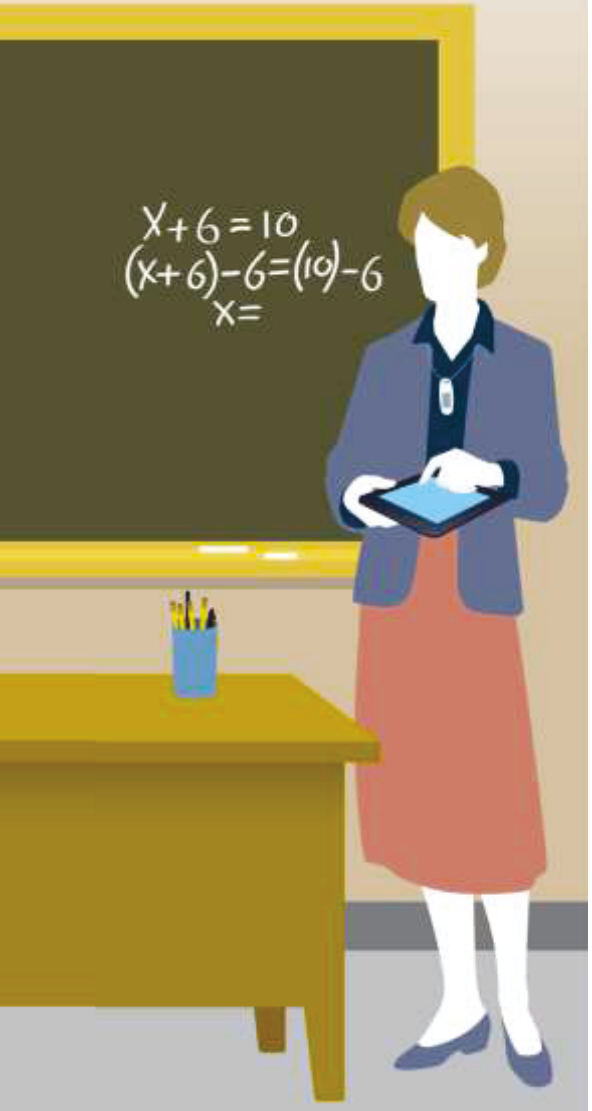
Monthly Measurement Verses "Look Back" Method

The General Measurement Rule

- Employers measure average hours on an on-going monthly basis
- This creates a lack of flexibility in scheduling your workforce, and also subjects ALEs the Code § 4980H (a) and (b) penalties each month
- For these reasons the “Look Back” measurement method was created
- If you did not adopt the “Look Back” method in 2014 you will be in the monthly measurement method for at least 2015

The VHE "Look Back" Method

- Allows ALEs to calculate employees average hours in the past to determine eligibility
- Methodology = Measurement Period, Administrative Period, and Stability Period
- Typically a 12 month measurement period
- Stability periods must match MP
- Provides flexibility to work part-time, seasonal, and VHEs more than 30 hour per week in peak demand periods!



Credits are Applied to:

- Educational breaks in service of 4+ weeks like summer breaks and sub breaks
  - Subject to 501 Hour Limit on Credits…
- PTO such as vacation, disability, etc. uncertain how workers comp will be handled
- Special unpaid leaves such as FMLA, Military Leaves, and Jury Duty
- Rehired employees within 13 weeks (26 weeks for schools) of termination date
- Unlikely payroll systems track these rules

Common-Law Employee

Staffing Firm or PEO Members:

- Common-Law Employee Definition – Treas. Reg. Section 31.3401(c)-1(b)/IRS Pub 15-A, Employers Supplemental Tax Guide
  - Does not include Leased employee as defined in Code Section 414(n)(2)
- Very important to work with your legal counsel to make the proper classification determination of employment!

IRS Reporting Penalty Example

- ALE didn't file the IRS return and statements timely or correctly:
  - 400 employees:
  - $500 x's 400 statements = $200,000
- Max penalty for failure to file $6 million

"Good Faith" Relief for 2015

- Short term penalty relief is available for 2015 if you make a "good faith effort"
- This relief is provided only for incorrect or incomplete information reported on the return or statement, including social security numbers, TINs or dates of birth
- No relief is provided for reporting entities that do not make a good faith effort to comply with these regulations or that fail to timely file an information return or statement

Got Risk Tolerance?

- The purpose of ACA IRS reporting is closely tied to 4980H penalties
- Consider a worst case scenario for 400 FTs
  - 4980H (a) penalties = $770,000
  - IRS forms incorrect/untimely = $200,000
  - Willful failure to provide SBCs timely = $400,000
  - **Total potential fines = $1,370,000**

Who Is Responsible?

FIVE POINTS Healthier Benefit Plans

120116

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OMB No. 1545-2251

2015

Part I **Applicable Large Employer Member (ALE Member)**

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3 Street address (including room or suite no.)		
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7 Name of person to contact		8 Contact telephone number
9 Name of Designated Government Entity (only if applicable)		10 Employer identification number (EIN)
11 Street address (including room or suite no.)		
12 City or town	13 State or province	14 Country and ZIP or foreign postal code
15 Name of person to contact		16 Contact telephone number

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19 Is this the authoritative transmittal for this ALE Member? If "Yes," check the box and continue. If "No," see instructions . . . . . ☐

Part II **ALE Member Information**

20 Total number of Forms 1095-C filed by and/or on behalf of ALE Member . . . . . ►

21 Is ALE Member a member of an Aggregated ALE Group? . . . . . ☐ Yes ☐ No

If "No," do not complete Part IV.

22 **Certifications of Eligibility (select all that apply):**

☐ **A.** Qualifying Offer Method ☐ **B.** Qualifying Offer Method Transition Relief ☐ **C.** Section 4980H Transition Relief ☐ **D.** 98% Offer Method

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► Signature ► Title ► Date

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 61571A Form **1094-C** (2015)

Conclusions

- View reporting as your 4980H finals!
- Identify your data sources
- Review your workflow processes
- How and when will you work with vendors?
- Are you going to provide 1095-Cs to employees electronically or paper?
- Determine your resource and cost impact verses your risk tolerance…
- Complete 2015 IRS 1095's Jan – today now!

ACA Compliance – Start With the End in Mind The IRS Audit

Are You Ready to Keep Records for Seven Years?

W-2 Reporting Requirements

FIVE POINTS ICT, Inc.SM
SIMPLE. SMART.

Mandatory Annual SBC's

Material Modification Notices

Health Insurance Marketplace Notices

Ongoing ACA Average Hours Worked Tracking

Annual IRS 1094 & 1095 Reports

Cadillac Tax Tracking (2018)

How We Can Help

- Custom one-on-one consultations
- ACA Compliance apps
- Full service implementation and set up
- Ongoing access to ACA legal experts
- Salaried account managers
- Help reduce your workloads
- Save you time and money
- One user name. One password. One number for all of your ACA needs!

ACA Software

- AML pays 100% of set up fees and ongoing monthly fees for health plan members!
- ACA Compliance Apps Included:
    1. ACA Electronic Notices
    2. ACA Full Time Status
    3. ACA IRS Reporting
    4. Secure Communications
    5. HRIS Data Base
    6. And, Secure Employee Portal
- Includes up to 10 hours set up support

ACA Apps Make Life Easier

- Dashboards tracks it all in one place
- Alerts & reminders keep you on track
- Integrated reporting saves time and reduces mistakes
- eFile & eDelivery saves you money
- Electronic audit reports provides proof
- Ability to integrate with payroll & imports

ACA Software Cost

ACA Compliance Portfolio	Set Up Fee	Annual Per Employee
Includes Core HRIS, ACA tracking, ACA IRS reporting*, and ACA electronic notices apps**	100% Paid By AML	100% Paid By AML
Third Party 1095-C Printing and Mailing Option		$3.50

ACA Consulting

- Highly recommended for all clients
- ACA Compliance Consulting Includes:
  - Initial Assessment/Checklist (Yr. 1 Only)
  - 10 hours access to ACA consultants via phone, webinar or email each year
- Onsite consulting available $400 per hour plus travel expenses
- Unlimited access to searchable ACA knowledge base
- Free unlimited access to live workshops, webinars, videos, and email news blasts

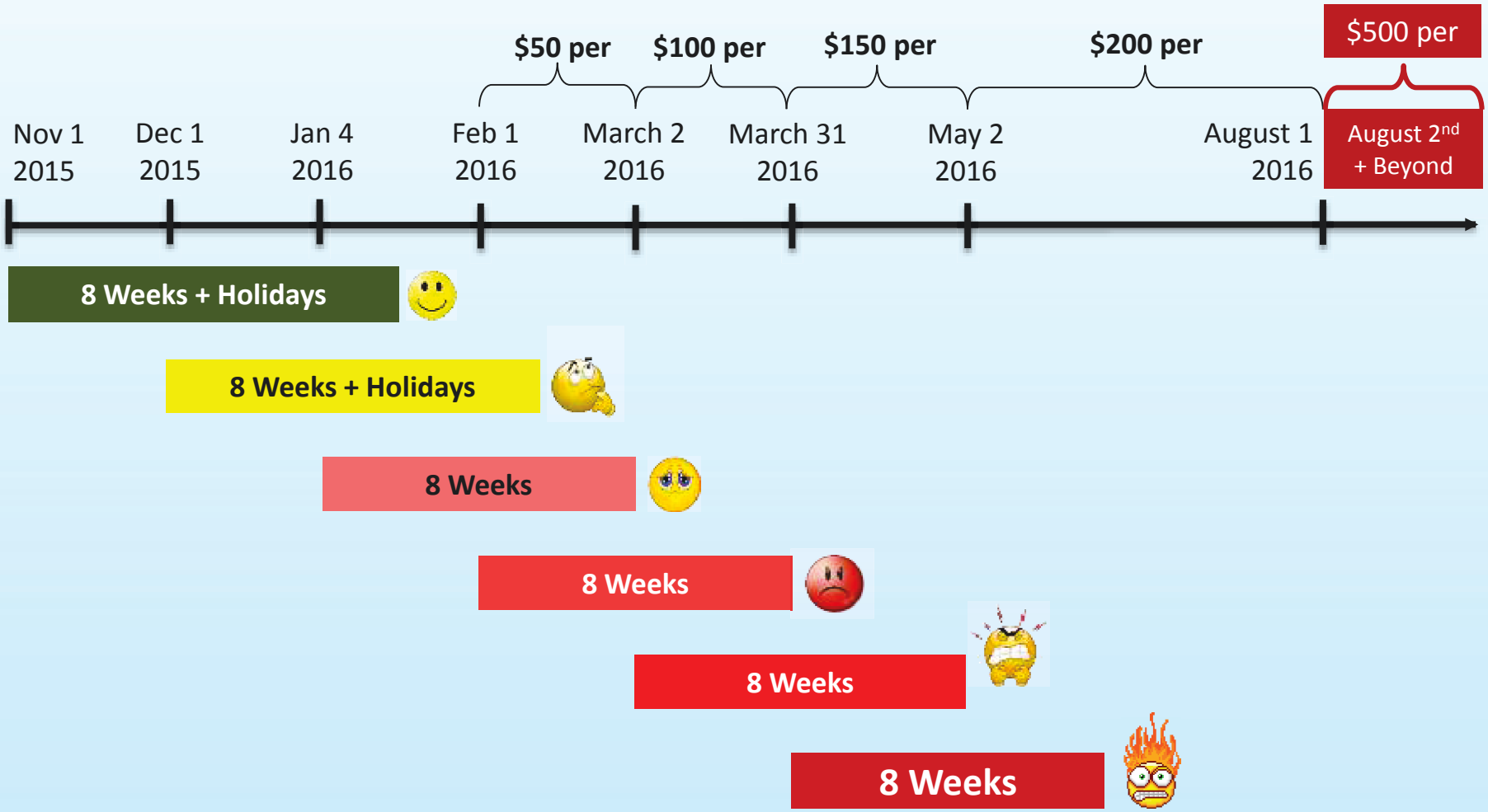
ACA Legal Team

- Sean McLean On Staff Attorney
- Larry Grudzien Attorney at Law
- Waller Lansden Dortch & Davis, LLP
  - James B Bristol
  - Shannon Goff Kukulka
  - Jennifer D. Faucett
- Terry Mann Attorney at Law
- Employee Benefits Institute of America
- American Fidelity ACA consulting services

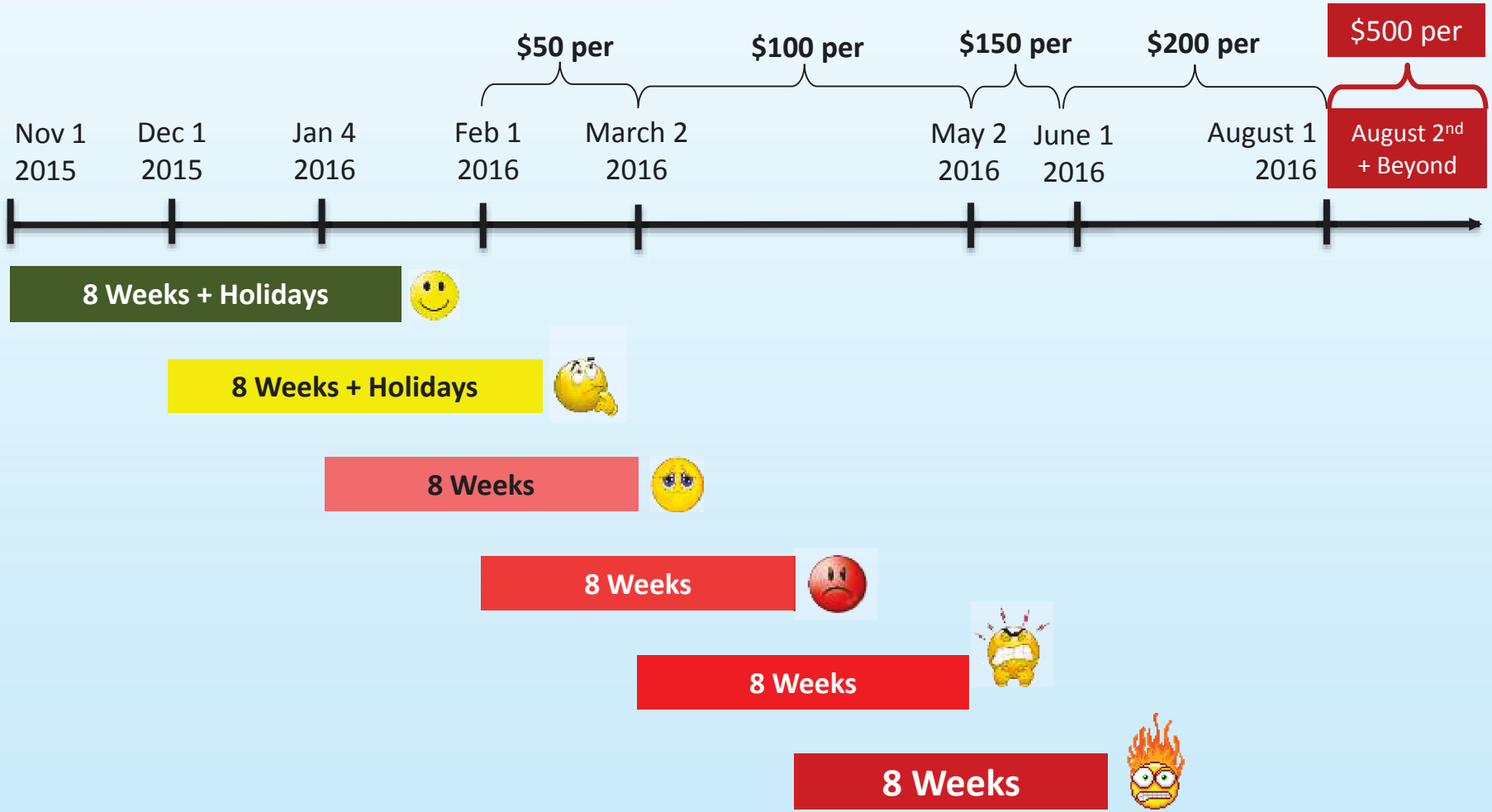
ACA Consulting Cost

ACA Consulting (flat rate per year) Includes up to 10 hours access via email and phone annually + unlimited access to ACA self help library	**First Year**	**Thereafter**
<500 Employees	$3,000	$2,000
500 – 1,000 Employees	$4,000	$2,500
>1,000 Employees	$5,000	$3,500
Additional ACA Consulting Time above base 10 hours, or Clients also pay consultant(s) travel expenses for onsite consulting	$400 per hour	

IRS Reporting Normal Due Dates



IRS Reporting Due Dates With Extensions



How to Get Going

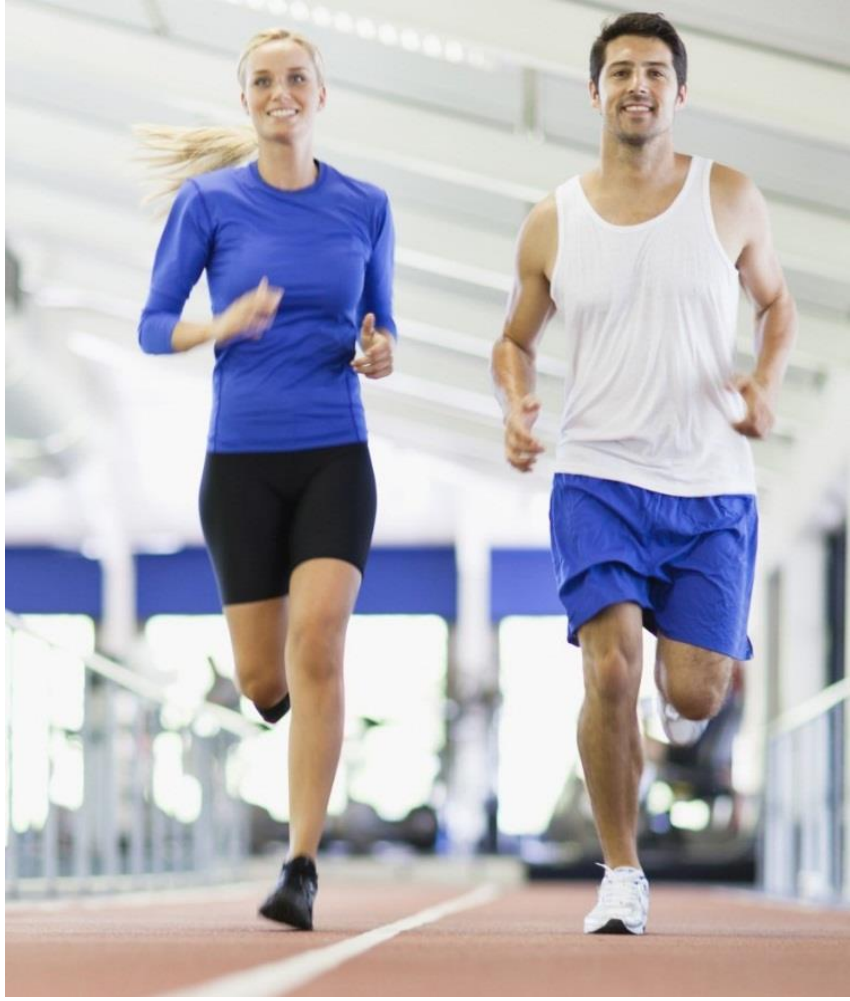
- Complete the Scope of Work (SOW)
- Have someone with authority sign it
- Email or fax it to Five Points
  - Email - support@fivepointsict.com
  - Fax – 615-791-7704
- Five Points will contact you to schedule implementation meeting via phone/webinar
- We are on first come first serve waiting list
- Onsite implementation = $400 per hour and travel expenses

Make smart choices. Simplify your processes. Reduce your workloads.

CONTACT US TODAY!

info@fivepointsict.com | 800.435.5023

Post Office Box 680325 Franklin, Tennessee 37068 800 435.5023 toll-free 615 791.7704 fax www.fivepointsict.com



IMPROVE YOUR HEALTH & WELLNESS

WITH #AMLMOVES

#AMLMOVES IS ABOUT BECOMING MORE ACTIVE

- In conjunction with Mayor Elumbaugh's main goal of promoting health and wellness in both the workplace and the community, the League began its own wellness initiative called **#AMLMoves.**
- Our staff was encouraged to set and begin fitness/wellness goals.
- 28 League staff members signed-up to become wellness leaders through **#AMLMoves.**
- Most importantly, the League wellness leaders wrote their goals down on paper, shared their successes, recognized obstacles they have had to overcome, and created a team atmosphere by sharing on social media.

#AMLMoves Team Member Activity Form

Congratulations on your commitment to an active and healthy lifestyle. This form is designed to assist you in setting wellness goals. Furthermore, with your permission, the information you report could be used to assist and motivate others into adapting healthier lifestyles. The purpose of this form is to guide you to see a clearer path to your own personal wellness plan.

Directions:

Fill out this form

Name: _____

1).What are your wellness/fitness goals?

_____
_____
_____

2). How do you hope to go about accomplishing these goals?

_____
_____
_____
_____
_____
_____

3).What are some specific steps that you are taking in order to become heathier?

_____

#AMLMoves Team Member Activity Form

4).What are some challenges that you have (or had) to overcome in order to maintain your healthy lifestyle?

_____
_____
_____

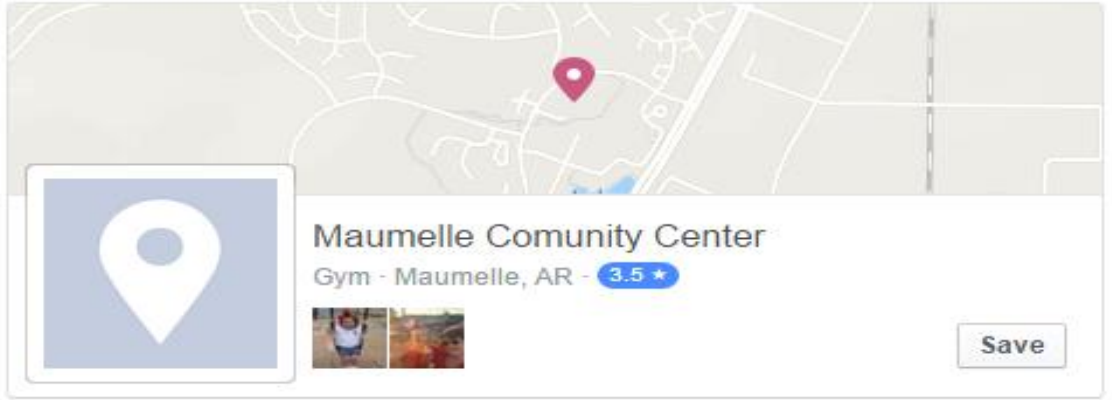
5).What are some of your favorite physical activities that are helping you live a healthier lifestyle?

_____
_____
_____
_____

Save Form Print Form Clear Form

Jamie Hale Adams at Maumelle Comunity Center
September 28 · Maumelle, AR ·

#AMLMOVES.



Maumelle Comunity Center
Gym · Maumelle, AR · 3.5 ★

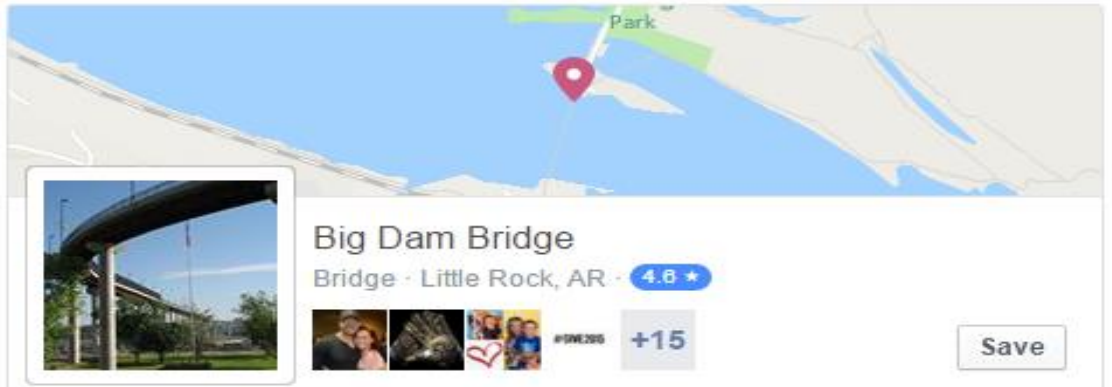
Save

6 Likes

Like Comment Share

Lori Strong Sander at Big Dam Bridge
October 17 at 12:03pm · Little Rock, AR ·

Feels like fall, ya'll. Just walked six miles. #AMLMOVES



Big Dam Bridge
Bridge · Little Rock, AR · 4.6 ★

+15

Save

32 Likes 4 Comments

Like Comment Share

#AMLMOVES TEAM MEMBERS AND WHAT THEY ARE DOING TO BECOME MORE ACTIVE AND WELL

Fitness/Wellness Goals	Challenges	Activities
Fit, Stronger, Eat Healthier, Lose Body fat, Sleep Better, Feel Better Emotionally / Physically, Reduce the Amount of Diet Drinks per day, Increase Muscle Tone, Control Cholesterol and Blood Pressure, Increase Pull-ups, Include Children in Physical Activity	Motivation, Food Cravings, Time, Child Care,	Tennis, Fitness Classes, Yoga Classes, Walking, Running, Listening to Positive Music, Plan Meals in Advance, Weight Lifting, Control Food Portion Sizes, Workout on Breaks at Work, Get up from Desk More Often, Have Healthy Snacks Available, Use an Elliptical Trainer, Team Exercise on Breaks at Work, Bike Riding, Hiking,

#AMLMOVES WELLNESS LEADERS ARE SUCCESSFUL!

- All of our team members are a success simply because they are giving time and attention to their health.
- Two team members who have lost 65 pounds and 72 pounds of unwanted weight this year! They have reached their personal goal and maintained their weight loss by staying in constant touch with what they want to accomplish and by applying the common sense strategy of eating less and moving more.
- Taking the just a little time to invest in your own health will always pay BIG!

START YOUR OWN WORKPLACE WELLNESS INITIATIVE !

CONTACT ME:

David Baxter

ARML, Health & Safety Coordinator

301 West 2nd

North Little Rock, AR 72115

Phone: 501-374-3484 Ext. 110

Fax: 501-374-0541