MUNICIPAL HEALTH BENEFIT FUND SEMINAR AGENDA

October 28, 2016

8:30 a.m. – 9:00 a.m.	**Registration**	
9:00 a.m. – 10:00 a.m.	**Welcome and Opening Remarks**	Don Zimmerman, Executive Director Arkansas Municipal League
	MHBF Plan Changes 2017	Tracey Pew, MHBF Coordinator Arkansas Municipal League
10:00 a.m. – 10:30 a.m.	**Prescription Benefits Updates**	Alan Gardner, Vice President of Operations RxResults
10:30 a.m. – 10:45 a.m.	**BREAK**	
10:45 a.m. – 11:30 a.m.	**The Obesity Epidemic and Obesity Treatment Plans**	John Baker, MD, FACS MHBF MBS-AQUIP Medical Director
11:30 a.m. – 12:00 p.m.	**ACA Reporting Going Forward**	Wes Dozier, My Benefits Channel
12:00 p.m. – 1:00 p.m.	**LUNCH**	

1:00 p.m. – 2:00 p.m.	**Patient Participation in Medical Care and How eDoc Can Help**	Dr. Charles Smith, MD, Associate Dean Director of Primary Care Service Line
1:30 p.m. – 2:00 p.m.	**We're Here to Help! – MHBF Customer Service & Provider Relations Staff**	Beth Chappell, Supervisor, Pam Adams, Wilma Huckaby, Kate Cantrell, Michelle Philmon, Krystal Berline, Robyn Hayes Arkansas Municipal League
2:00 p.m. – 2:30 p.m.	**Flexible Spending Accounts**	Rob Yetter, Regional Vice President American Fidelity
2:30 p.m. – 3:00 p.m.	**Closing Remarks/Q&A**	Don Zimmerman, Executive Director Arkansas Municipal League Tracey Pew, MHBF Coordinator Arkansas Municipal League

MHBF 2017

PLAN CHANGES & IMPORTANT REMINDERS

REQUIRED NOTICES

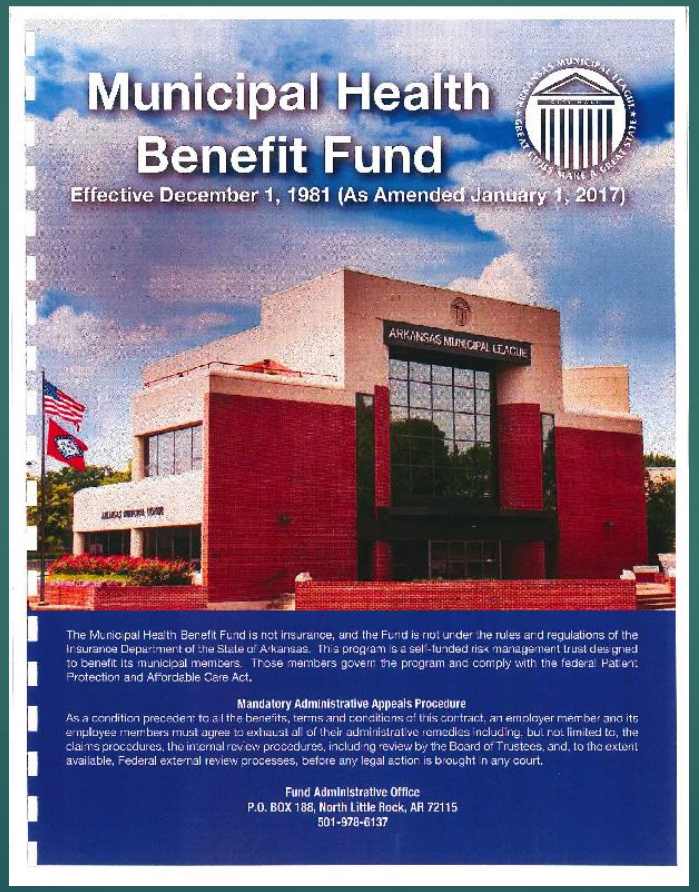
Required Notices to Employees

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

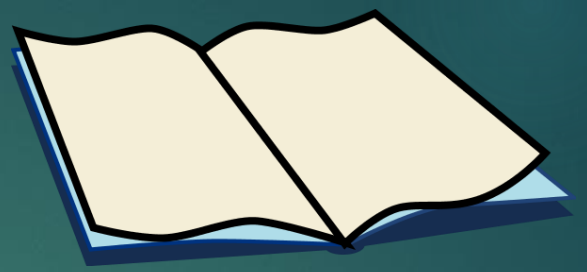
Copies of these notices have been included in your meeting packet, along with an Acknowledgment of Receipt form.

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

2017 MUNICIPAL HEALTH BENEFIT FUND BOOKLET



2017 Fund Booklet



- The 2017 Fund Booklet has been restructured to make it more user-friendly.
- You will now find "Definitions" in the last section of the book.
- The term "elective" surgery has been changed to "non-emergency" surgery to alleviate confusion.
- You will find that many topics/subsections have been relocated. For example, "Tobacco Cessation" is now found in both the Preventative Benefit Section and the Prescription Drug Section.
- Benefit descriptions and clarifications have been made throughout the Fund Booklet.

All changes were made with the end user in mind.

FORMS

Certificate of Notice and Acceptance of Plan Provisions

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: _____

This form should be returned to your Employer.

MHBF USE ONLY

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
	Last Name:

...et, city, state, zip code):

...g.c_____ Married_____ Divorced_____ Effective Date:_____

... Full Time Hire Date_____ Full Time Employee (position held)_____

...(years of service_____Vested in_____)

_____(office) Member of _____Board/Commission

...hter_____ Auxiliary Police_____

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

...nt to do?

...ish ☐ Return from Military Leave
...nefits ☐ Elected Officials D&D/V Only^^
...ge/order from your plan

...ge: Change Date:_____Termination of Employment / Reduction in hrs. / Member Death / M...

...ge: Single to Family Family to Single Remove Spouse (date of divorce)

Change Beneficiary_____ Change Name_____
...letter MUST be submitted for changes.

...verage do you want? Please check with your City Clerk or HR Dept. to be su...
...s) Options are available to you through your Employer

☐ Life and AD&D ☐ Dental ☐ Vision (Empl...
☐ Life and AD&D ☐ Dental ☐ Vision (Famil...

...ame	Date of Birth	Social Security Number	Male/Female	Relation	(Other i... yes o...

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

...: _____ Date: _____
...s not required for termination)

...e: _____ Date:

MHBF use only

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

FORMS: Certificate of Notice and Acceptance of Plan Provisions

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

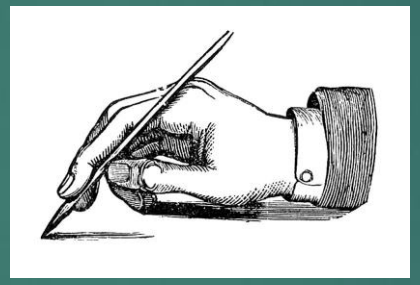
A spouses signature is no longer required on the form.

FORMS: Multiple Coverage Inquiry

- If you or any family member covered as your dependent by MHBF have any other medical, dental or vision insurance coverage, please complete a Multiple Coverage Inquiry.
- If you or any covered dependent have already completed this form and coverage changes, please complete a new form with corrected information.
- If you or any covered dependent drops additional medical, dental or vision coverage, please advise MHBF by completing a new Multiple Coverage Inquiry.
  - Failure to complete this form may result in claims being delayed or denied.

FORMS: Enrollment/Change/ Termination Form

- Use this form for:
  - Enrollment in the Plan
  - Coverage Declination
  - Add/Drop Dependent
  - Cancel Coverage
  - Address Change
  - Name Change
  - Coverage Change – Individual to Family or Family to Individual
  - Status Change – (i.e., marriage, divorce)
  - Employee Termination



2017 BENEFIT CHANGES

Benefit Changes for 2017

- If you have Family Coverage, an eligible newborn can be added to your coverage on the newborn's date of birth. The newborn must be added within sixty (60) days of their date of birth, regardless if SSN is received.
  - In 2016, a member had ninety (90) days to add a newborn to the existing Family Coverage.
  - The guidelines for Individual Coverage remains the same. If you have single/individual coverage, family coverage may be added on the first day of the month after a qualifying event. (i.e., marriage, birth, adoption, etc.) It is important to note that the coverage does not go back to a newborn's date of birth.

Benefit Changes for 2017

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

Alan Gardner with RxResults will address Prescription Benefit changes in more detail later this morning.

BECOMMING A WISE HEALTHCARE CONSUMER

Common Mistakes that Increase Out-of-Pocket Costs

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

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

Helpful Contact Information

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

RxResults℠

Prescription Benefits Updates and Costly Pharmacy Trends

October 28, 2016

www.rxresults.com

2017 MHBF Plan Changes

MHBF 2017 Plan Changes

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

Noteworthy Specific Changes

- Long-acting / extended release ADHD Drugs
  - Coverage limited to cost of immediate release versions (reference priced)
  - Exception for children under 19
- Non-sedating antihistamines excluded
  - Very few are still available in prescription strength
  - Widely available over-the-counter (OTC)
  - Examples: Claritin®, loratidine, Allegra®/ fexofenadine, Clarinex®, etc.
  - Both prescription and OTC strengths excluded

Noteworthy Specific Changes

- Gastric acid reducers (proton pump inhibitors) excluded
  - Widely available over-the-counter
  - Examples: Nexium®, Prilosec®, Dexilant®, omeprazole, etc.
  - Both prescription and OTC strengths excluded
- Certain antifungals
  - Strong TV marketing for new topicals
  - Oral versions just as effective
  - Examples: Jublia®, Cresemba®, Kerydin®

Noteworthy Specific Changes

- Long-acting opioid pain medicines excluded
  - CDC recommendation and call to action for physicians
- Topical non-narcotic analgesics & anesthetics excluded
  - Patches, gels, sprays, lotions, ointments, etc.

Costly Pharmacy Trends

Combination Drugs

- Combining older generic drugs to make new patentable brand drugs
- Examples:
  - Duexis® - $1,841 per 30-day supply

    Combination of ibuprofen (Advil) and famotidine (Pepcid)

    Single ingredients per 30 days

    Ibuprofen: <$10

    Famotidine: <$5

Combination Drugs

- More examples:
  - Vimovo® - $2,054 per 30-day supply

    Combination of naproxen (Naprosyn®) and esomeprazole (Nexium®)

    Single ingredients per 30 days

    Naproxen: <$5

    Nexium 24HR® : <$18
  - Treximet® - $716 per 30-day supply (9 tablets)

    Combination of naproxen (Naprosyn®) and sumatriptan (Imitrex®)

    Single ingrediets

    Naproxen: <$5

    Sumatriptan: <$14

Packaging (Kits, Paks, etc.)

- Packaging drugs with other products or other drugs
- Examples:
  - Tretin-X® - $227 per 30-day supply

    Tretinoin cream, cleanser and moisturizer

    Tretinoin cream: $10

    Cleanser and moisturizer available without prescription
  - PrevPac® - $960 per 14-day supply

    Lansoprazole, amoxicillin and clarithromycin

    Lansoprazole: $38 (or alternative, omeprazole $7)

    Amoxicillin: $6

    Clarithromycin: $72

Delivery Methods

- Using older generic drugs to make new brand drugs with different delivery methods
- Examples:
  - DermacinRx® Lexitral™ PharmaPak- $4,668 for 30-day supply

    Diclofenac and capsaicin applied as drops

    Diclofenac tablet: $18

    Capsaicin cream: $6
  - Intermezzo® - $282 per 30-day supply

    Zolpidem (Ambien®) as a sublingual tablet

    Zolpidem tablet: <$3

Delivery Methods

- More examples – tablets vs. capsules:
  - Generic venlafaxine ER (Effexor XR®)

    Tablets - $92 for 30-day supply

    Capsules - $10
  - Generic tizanidine (Zanaflex®)

    Capsules - $142

    Tablets: $13

Questions?

ACA Reporting Going Forward

About Us

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

ACA Compliance Suite

Secure Communications

Variable Hour Employee Tracking

ACA Electronic Notices

IRS 1094-C & 1095-C Reporting

IRS Form 1094-C Toolkit

ACA Knowledge Base

Today's Agenda

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

Disclosure

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

Phase Out of ACA Transitional Relief

Phased Out Relief Items

1. **Extended Reporting Deadlines –** no longer available.
2. **Good Faith Effort for Informational Returns –** no longer available.
3. **4980H Transitional Relief –** available only for 2015 plan year months (i.e. no longer available in 2016 for calendar year plans)
4. **Non-Calendar Year Transitional Relief –** no longer available.
5. **Six Consecutive Month Period for Determining ALE Status –** no longer available.
6. **Shortened Measurement Period for Employee Status Determinations under Look-Back –** no longer available.
7. **Dependent Coverage Transitional Relief –** no longer available.
8. **MEC for Pay Periods in January 2015 –** no longer available.

New Reporting Deadlines/Penalties

Reporting Deadlines

- **January 31, 2017 –** Deadline to Distribute Form 1095-C to Recipients
- **February 28, 2017** – Deadline to File Paper Forms 1094-C and 1095-C with IRS.
- **March 31, 2017** – Deadline to Electronically File Forms 1094-C and 1095-C with the IRS.
  - Must utilize electronically filing if required to file 250 or more informational returns.

Increased Reporting Penalties

- **$260 –** penalty for failure to timely file a correct informational return with the IRS.
- **$260** – penalty for failure to timely distributed a correct statement to a recipient.
- These penalties can double in circumstances where a failure is due to intentional disregard of the reporting requirement.

1095-C Coding Changes

Decommissioned Codes

- **1I –** Qualifying Offer Transition Relief 2015. Employee (and spouse or dependents) received no offer of coverage; received an offer that is not a qualifying offer; or received a qualifying offer for less than 12 months.
- **2I –** Non-calendar year transition relief applies to this employee.

New Codes

- **1J** – Minimum essential coverage providing minimum value offered to employee and at least minimum essential coverage conditionally offered to spouse; minimum essential coverage not offered to dependent(s).
- **1K** – Minimum essential coverage providing minimum value offered to employee; at least minimum essential coverage offered to dependents; and at least minimum essential coverage conditionally offered to spouse.
- **Conditional Offer of Spousal Coverage –** A conditional offer is an offer of coverage that is subject to one or more reasonable, objective conditions (for example, an offer to cover an employee's spouse only if the spouse is not eligible for coverage under Medicare or a group health plan sponsored by another employer).

COBRA Coding for Continuing Employee

- An offer of COBRA coverage to a continuing employee should be coded, for the remaining months of the reporting year following the COBRA offer, using the appropriate Series 1 offer of coverage code which reflects the specific individuals eligible to enroll in the COBRA coverage.
- Generally, an offer of COBRA coverage is required to be made only to individuals who were enrolled in coverage immediately before the loss of eligibility due to the COBRA qualifying event.

Post Employment Coding for Full-Time Employees

- For the months remaining during the reporting year following a full-time employee's termination, code 1H (no offer of coverage) and code 2A (not an employee) should be listed on lines 14 and 16 of the 1095-C, respectively.
- This simplifies an employer's reporting by placing all terminated full-time employees in the same bucket, whether or not they receive a continuing offer of coverage (COBRA, retiree, or otherwise) or no continuing offer of coverage.

Offers of Coverage to Non-Employees/Non-Full-Time Employees

- Code 1G is generally utilized in line 14 when completing a Form 1095-C for a non-employee or non-full-time employee enrolled in an employer's self-insured health plan.
- In 2015, it was not clear what the appropriate line 14 code should be when an offer of coverage to a non-full-time employee ceased mid-year.
- The Finalized 2016 Instructions for Forms 1094-C and 1095-C clarify that Code 1G applies for the entire year or not at all.

Affordability Safe Harbor Restrictions

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

2016 IRS Reporting Take-a-Ways

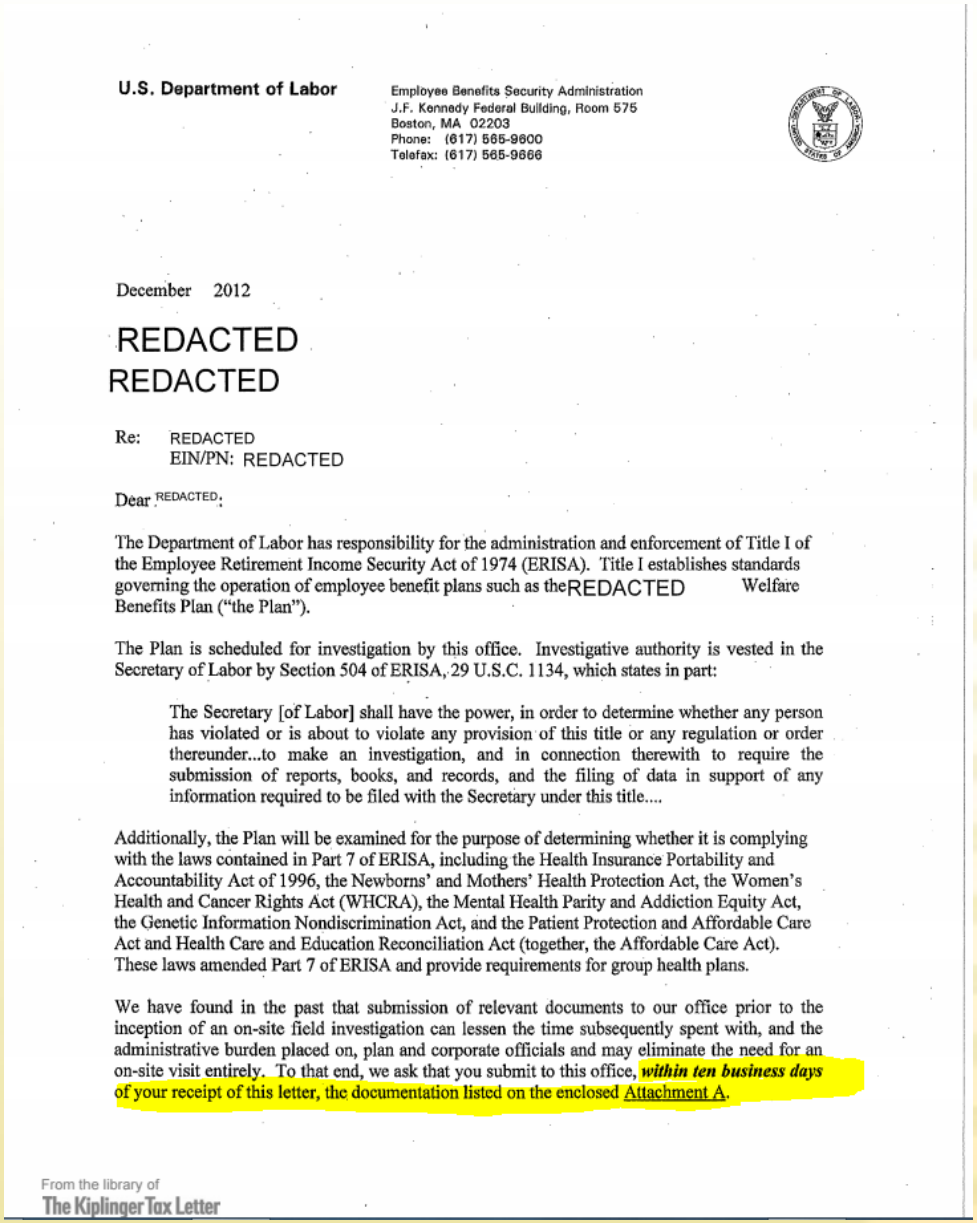
- Transitional relief is gone – the full employer mandate penalties now apply
- Reporting accuracy matters – good faith effort is no longer good enough
- Time is of the essence – no more delays in reporting deadlines
- 1095-C codes/guidance have changed – make sure you understand which changes affect your organization
- Cost of IRS reporting penalties is increasing

Status of ACA Enforcement

Federal Enforcement of ACA

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

Health Plan Audits



U.S. Department of Labor

Employee Benefits Security Administration
J.F. Kennedy Federal Building, Room 575
Boston, MA 02203
Phone: (617) 565-9600
Telefax: (617) 565-9666

December 2012

REDACTED
REDACTED

Re: REDACTED
EIN/PN: REDACTED

Dear REDACTED:

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

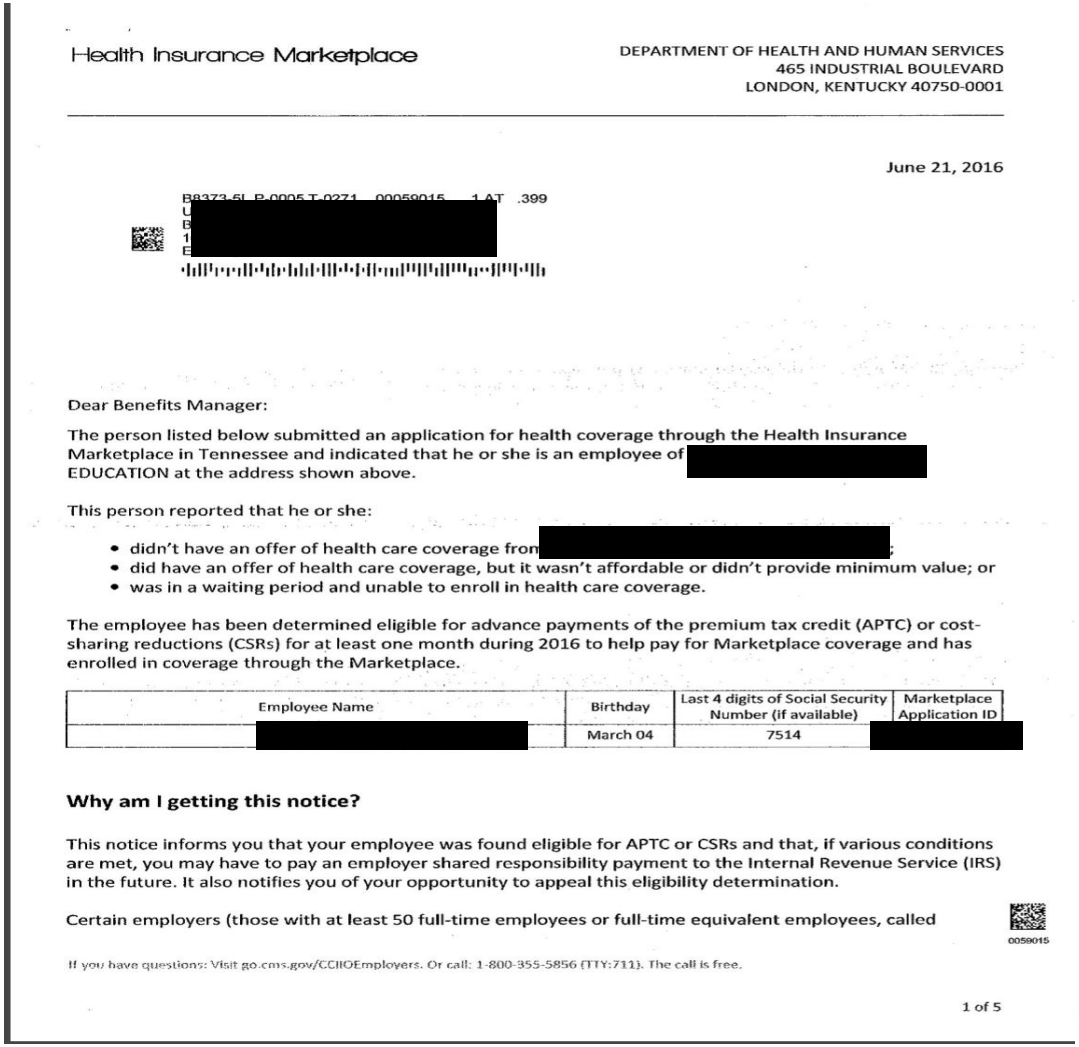
The Plan is scheduled for investigation by this office. Investigative authority is vested in the Secretary of Labor by Section 504 of ERISA, 29 U.S.C. 1134, which states in part:

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

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

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

1411 Certification Letters



Health Insurance Marketplace

DEPARTMENT OF HEALTH AND HUMAN SERVICES
465 INDUSTRIAL BOULEVARD
LONDON, KENTUCKY 40750-0001

June 21, 2016

[redacted]

Dear Benefits Manager:

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

This person reported that he or she:

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

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

Employee Name	Birthday	Last 4 digits of Social Security Number (if available)	Marketplace Application ID
[redacted]	March 04	7514	[redacted]

Why am I getting this notice?

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

Certain employers (those with at least 50 full-time employees or full-time equivalent employees, called

0059015

If you have questions: Visit go.cms.gov/CCIIOEmployers. Or call: 1-800-355-5856 (TTY:711). The call is free.

1 of 5

Penalty Assessments

- No major ACA enforcement activity thus far.
- At this point, IRS should have all the information needed to begin the assessment of penalties under the ACA employer mandate and IRS reporting for 2015.
- Likely the next shoe to drop from an ACA enforcement perspective.

ACA Complete Care

ALE Responsibilities

New W-2 Reporting Requirements

Mandatory Annual SBCs

Material Modification Notices

Health Insurance Marketplace Notices

Ongoing ACA Average Hours Worked Tracking

Annual IRS 1094 & 1095 Reports

1411 Certification Appeals

Cadillac Tax Tracking (2020)

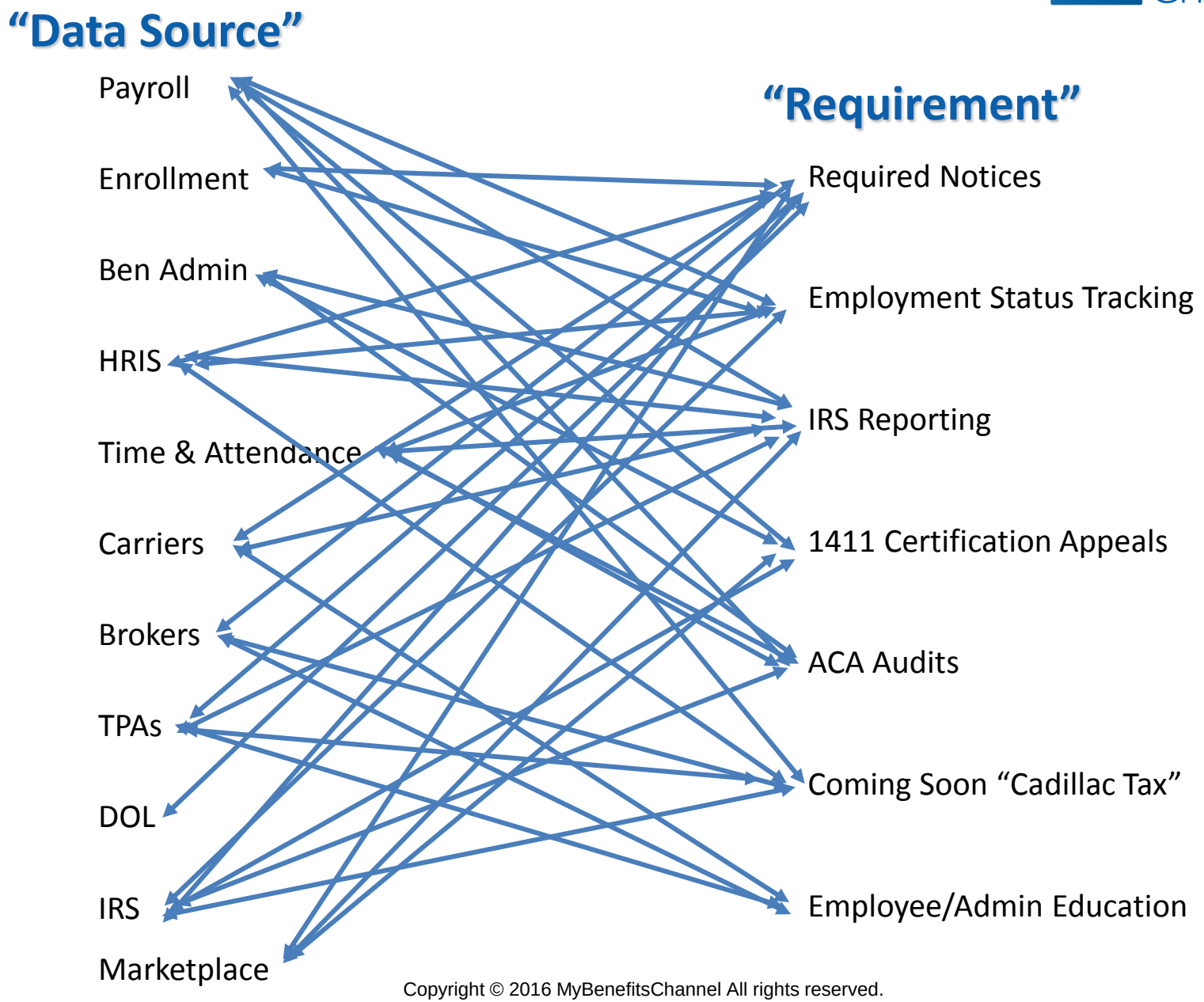
IRS & DOL ACA Audits

Employee & Admin Education

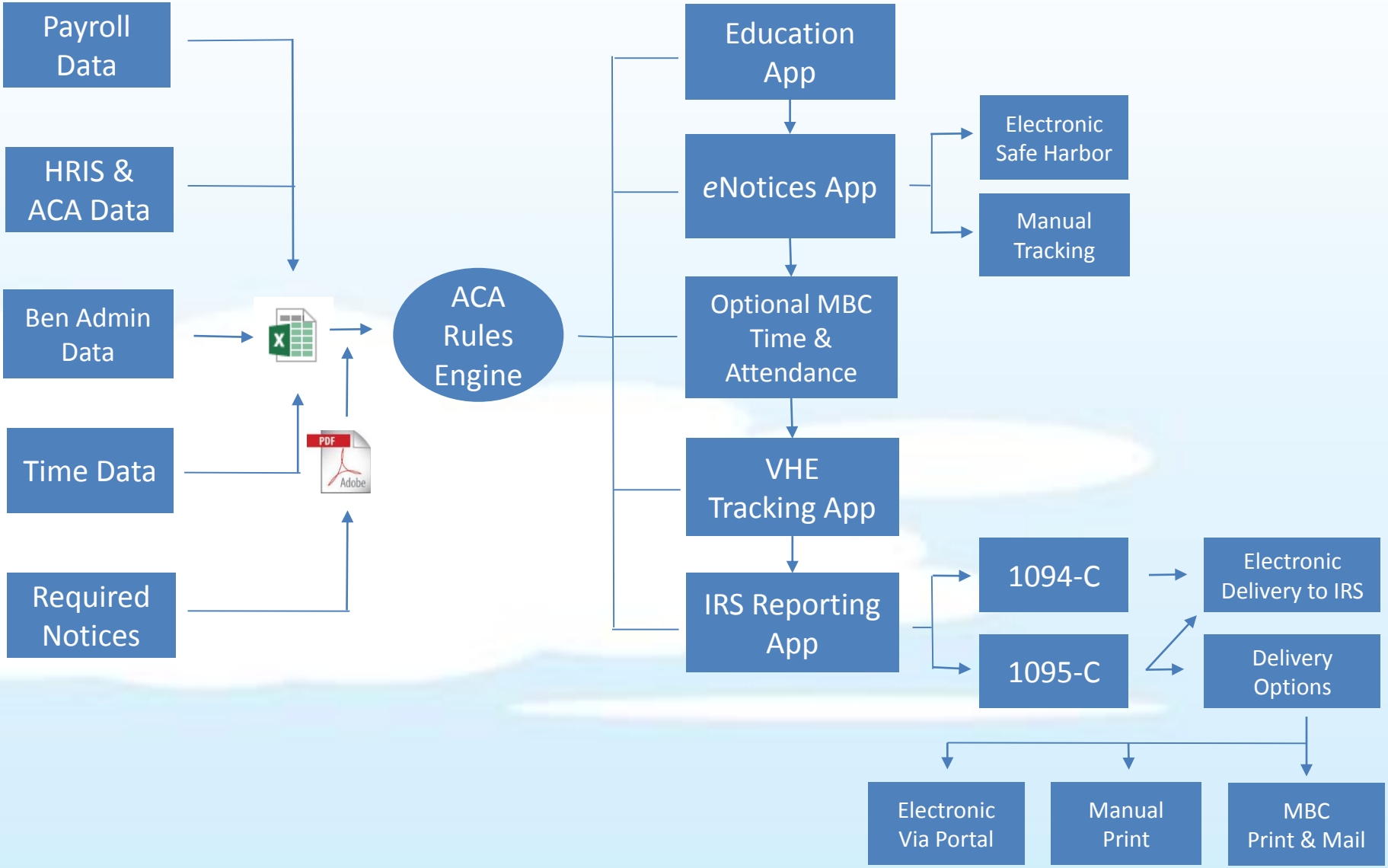
Got Risk Tolerance?

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

The Problem



The Solution



ACA Solutions

- SaaS:
  - MBC provides software, support, and consulting.
  - ALE does the work.
  - Additional consulting service package available.
- ACA Complete Care:
  - Employer provides the data and/or access to data.
  - MBC does all the work, consulting & audit management.
  - MBC team sends you reports to keep you up to date.

ACA Complete Care

- What is ACA Complete Care?:
  - Think FSA/HRA/HSA - TPA service models.
  - Priced on a per employee per month basis.
  - Designed for ALEs who "Do Not" want to do the work, and want to reduce compliance liability.
  - MBC manages 1411 appeals and IRS / DOL / HHS audits.
  - Most employers add the cost to their health plans.
  - It is expected most ALE's will outsource ACA compliance.

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

CONTACT US TODAY!

info@mybenefitschannel.com | 800.435.5023

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

Participatory Medicine

How can eDoc Help?

Dr. Charles W. Smith, Jr.

What is Participatory Medicine?

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

Dr. Charles W. Smith, Jr.

eDocAmerica.com

Home Services About Get eDocAmerica Contact Us Sign in

E-Patient blog

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

Dr. Charles W. Smith, Jr.

Journal of Participatory Medicine

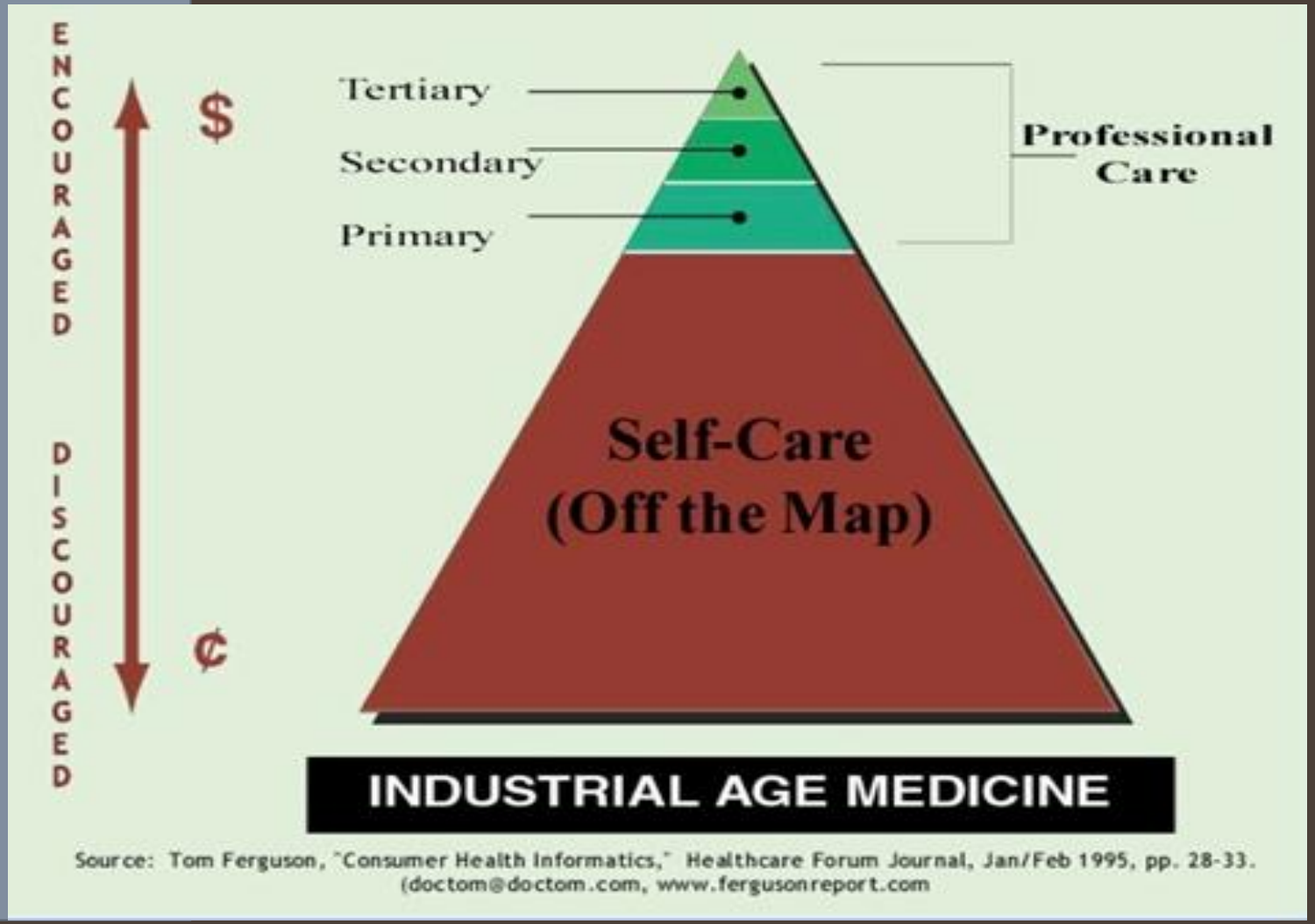
- The Society also publishes an on line Journal, peer reviewed, where articles about participatory medicine are published by professionals as well as by patients.

Dr. Charles W. Smith, Jr.

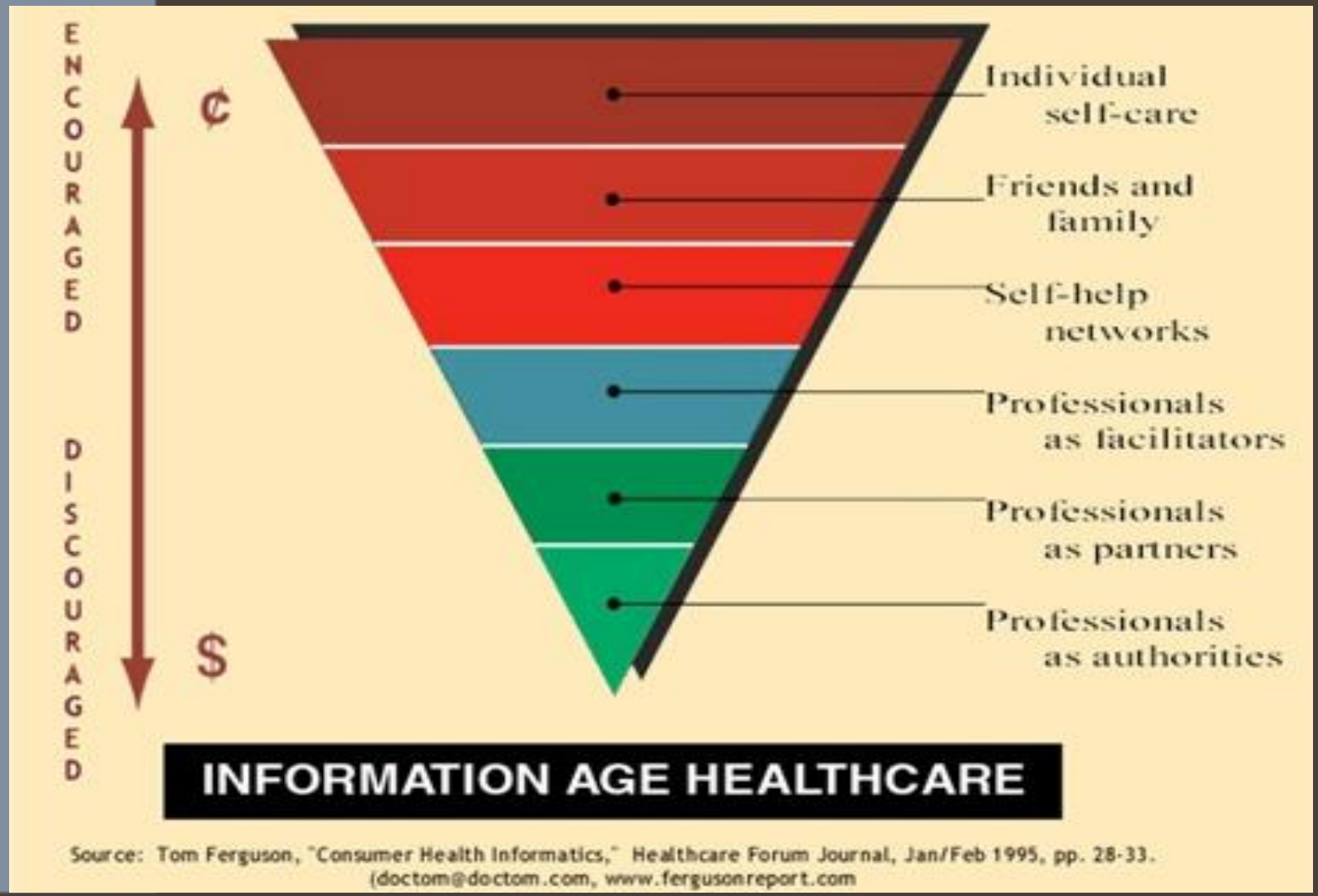
Traditional vs. "Industrial Age" Health Care Model

Focusing on the Central Importance of Self Care

Dr. Charles W. Smith, Jr.



Dr. Charles W. Smith, Jr.



Dr. Charles W. Smith, Jr.

So Who is Really Responsible?

Doctor?

OR

Patient?

Dr. Charles W. Smith, Jr.

How to Become a Participatory Patient

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

Dr. Charles W. Smith, Jr.

Healthier Lifestyle

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

Dr. Charles W. Smith, Jr.

How Can eDoc Help?

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

Dr. Charles W. Smith, Jr.

Customer Service & Provider Relations

WE ARE HERE TO HELP!

Customer Service

We can assist our members with questions like:

'Are MRI's covered under my plan?'
'Can you help me understand my explanation of benefits'
'Does my surgery require precertification?'
'What are my dental benefits?'

Who else can assist with questions?

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

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

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

Important Phone Numbers

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

Option 3 – Precertification
Option 4 – Customer Service
Option 5 – Eligibility
Option 7 – Provider Relations

The Municipal Health Benefit Fund Booklet

Online at arml.org

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

Human Resources

Go to your HR department and request a copy

Call MHBF Customer Service

Call our customer service line and request a copy of the current Fund Booklet – we will mail a copy to the address on file

Provider Relations

A department of the Municipal Health Benefit Fund that maintains a private network of providers for a higher level of benefits for its members.

How to find In-Network providers

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

Provider Relations:
Contact the MHBF Provider Relations department

Customer Service:
Contact the MHBF Customer Service line

Questions

Municipal Health Benefit Fund: MHBF

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

Coverage Period: 01/01/ 2017 – 12/31/2017
Coverage for: Individual + Family| **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.arml.org\benefit_programs.html or by calling 1-501-978-6137.

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

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

- **Copayments** are fixed dollar amounts (for example, $20) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **MHBF PPO In-Network Providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

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

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
More information about **prescription drug coverage** is available at www.arml.org. **If you need drugs to treat your illness or condition.** More information about **prescription drug coverage** is available at www.arml.org	Reference-Priced drugs	Total cost of the dispensed drug less the total cost of the reference drug per prescription	Not covered	
	Specialty drugs up to $1,000; Specialty drugs up to $1,000.01 or higher	$50/ prescription $100/ prescription	Not covered	Coverage is limited to a 30 day supply per prescription and you must pre-certify by calling 866-285-2935.
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 deductible for failure to precertify.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room services	$250 copayment per visit and then 20% coinsurance	$250 copayment per visit and then 20% coinsurance	$250 copayment is waived if admitted to inpatient hospital.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Coverage is limited to 2 ground and 2 air transports annually
	Urgent care	$20 copayment and then 20% coinsurance	$20 copayment and then 20% coinsurance	--------None--------
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 deductible for failure to precertify.
	Physician/surgeon fee	20% coinsurance	50% coinsurance	

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

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	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 svcs.
	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 deductible for failure to pre-certify.
	Durable medical equipment	20% coinsurance	50% coinsurance	-------None-------
	Hospice service	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 deductible for failure to pre-certify.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	Not covered
	Glasses	Not covered	Not covered	Not covered
	Dental check-up	Not covered	Not covered	Not covered

Excluded Services & Other Covered Services:

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

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

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Bariatric surgery is only covered under the MBS-AQUIP Program	• Smoking Cessation Program	• Hearing aids

Your Rights to Continue Coverage:

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

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

Your Grievance and Appeals Rights:

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

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

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

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

About these Coverage Examples:

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

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

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

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

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

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

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

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

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

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

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

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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

Your Information.
Your Rights.
Our Responsibilities.

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

Your Rights

You have the right to:

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

Your Choices

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

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

Our Uses and Disclosures

We may use and share your information as we:

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

Your Rights

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

Get a copy of health and claims records

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

Ask us to correct health and claims records

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

Request confidential communications

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

Ask us to limit what we use or share

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

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

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

Get a copy of this privacy notice

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

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

Your Choices

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

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

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

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

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

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

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

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

Run our organization

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

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

Pay for your health services

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

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

Administer your plan

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

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

How else can we use or share your health information?

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

Help with public health and safety issues

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

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

Do research

We can use or share your information for health research.

Comply with the law

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

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

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

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

We can use or share health information about you:

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

Respond to lawsuits and legal actions

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

Our Responsibilities

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

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

Changes to the Terms of this Notice

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

Other Instructions for Notice

- September 15, 2016
- Privacy Official: Katie Bodenhamer, 501-374-3484, ext. 126, kbodenhamer@arml.org.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

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

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

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. The Municipal Health Benefit Fund plan exceeds the minimum value standard.

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name		4. Employer Identification Number (EIN)
5. Employer address		6. Employer phone number
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above)	12. Email address	

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

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

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

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

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

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices but will help ensure employees understand their coverage choices.

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

Yes (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

No (STOP and return this form to employee)

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

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $
b. How often? Weekly Every 2 weeks Twice a month Monthly Quarterly Yearly

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

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16. What change will the employer make for the new plan year?
Employer won't offer health coverage
Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much will the employee have to pay in premiums for that plan? $
b. How often? Weekly Every 2 weeks Twice a month Monthly Quarterly Yearly

Date of change (01/01/2014)

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* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Evidence-Based Prescription Drug Program Guide – Effective January 1, 2017
Arkansas Municipal League

Effective January 1, 2017, Municipal Health Benefit Fund will expand its integration of an evidence-based prescription drug program with the prescription drug benefit. Changes to the prescription plan are based on recommendations and assistance from RxResults, LLC.

- ***Reference Pricing*** – The plan uses this initiative when there are one or more similarly effective and lower cost drugs in a drug category. When these occur, the benefit plan will only pay the amount it would pay for the lower-cost drugs and patients will pay the difference in cost between the higher-cost drug and the lower-cost alternatives in the form of a higher co-payment. **NOTE: the amount paid in excess of the lower-cost alternative will not count towards the annual maximum out-of-pocket.** Many times, patients have an opportunity to reduce their co-payment expenses by switching to an alternative drug product.
- ***Prior Authorization*** – The plan uses this initiative when it is recommended that qualified personnel review a patient's medical situation or medication history prior to benefit coverage of a particular drug.
- ***Step Therapy*** – The plan uses this initiative to require that a patient first try one or more drug products before the plan will provide benefit coverage for another drug.
- ***Exclusions*** – The plan uses this initiative when there are other lower-cost drug products that are considered equally effective. Refer to the additional Exclusions document for a list of excluded drugs.

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

REFERENCE PRICING

Generic drugs italicized

If you are taking any of these ***drugs with high patient co-payments:***	***Ask your physician if you can switch to these*** ***drug alternatives with lower patient co-payments:***
ADHD/CNS Stimulants	
All long acting amphetamines and methylphenidates, such as, Adderall XR, Adzenys XR, *amphetamine ER*, Aptensio XR, Concerta, Daytrana, Focalin XR, Kapvay, Metadate CD, *methylphenidate ER*, Quillichew CHW, Ritalin LA, Vyvanse	Immediate release *amphetamine-dextroamphetamine, dextroamphetamine, methylphenidate, dexmethylphenidate or clonidine* (for Kapvay) **Children age 19 and under are exempt.**
Antibiotics (alternatives in right column correlate to same line in left column)	
Acticlate, Adoxa, Doryx, *doxycycline hyclate DR, doxycycline capsules 75mg & 150 mg*, Monodox, Oracea, Oraxyl, Periostat, Targadox	Immediate release *doxycycline, (except 75 mg and 150 mg capsules)*
Minocin, *minocycline ER*, Moxatag, Solodyn	Immediate release *minocycline, amoxicillin*
Anticonvulsants – Gabapentin	
Gralise, Horizant, Lyrica, Neurontin, Neurontin Sol, Spritam	*gabapentin or levetiracetam sol* (for Spritam)
Antidepressants	
Cymbalta, Desvenlafaxine ER, *desvenlafaxine, duloxetine*, Effexor XR, Fetzima, Irenka, Khedezla ER, Pristiq, *venlafaxine* Tablet ER (37.5mg, 75mg, 150mg and 225mg)	*bupropion, citalopram, escitalopram, fluoxetine, paroxetine, sertraline,* immediate release *venlafaxine* or *venlafaxine* ER (capsule only)
Antihypertensives (High Blood Pressure Drugs)	
amlodipine/valsartan, amlodipine/valsartan/HCTZ, Amturnide, Atacand/HCT, Avalide, Avapro, Azor, Benicar/HCT, Cozaar, Diovan, Diovan HCT, Edarbi, Edarbyclor, Eprosartan, Exforge/HCT, Hyzaar, Micardis/HCT, Tekamlo, Tekturna/HCT, *telmisartan/amlodipine, telmisartan/HCT*, Tribenzor, Twynsta, Valturna	**Generic ACE Inhibitors**: *benazepril/HCT, captopril/HCT, enalapril/HCT, fosinopril/HCT, lisinopril/HCT, moexepril/HCT, perindopril, ramipril, quinapril/HCT, trandolapril* **Generic ARB Agents:** *losartan/HCTZ, irbesartan, eprosartan*

REFERENCE PRICING

If you are taking any of these ***drugs with high patient co-payments:***	*Ask your physician if you can switch to these* ***drug alternatives with lower patient co-payments:***
Cholesterol Reducers – Fibric Acid Derivatives	
Antara, brand Fenofibric Acid, *fenofibrate* (50,120, 130, 135, 145 & 150 mg only), *fenofibrac cap,* Fenoglide, Fibricor, Lipofen, Lofibra, Lopid, Tricor, Triglide, Trilipix	*fenofibrate* (strengths other than 120, 130mg, 135mg, 145mg & 150 mg are less expensive)
Cholesterol Reducers - Statins	
Advicor, Altoprev, *amlodipine/atorvastatin combination*, Caduet, Crestor (except 40mg strength), *fluvastatin tab 80 mg*, Lescol, Lescol XL, Lipitor, Livalo, Mevacor, Pravachol, *rosuvastatin* (except 40mg strength), Simcor, Vytorin, Zocor	**Preferred generics** : *lovastatin, pravastatin, simvastatin.* **Other generic alternatives** : *atorvastatin, fluvastatin.*
Migraine Agents – Triptans	
almotriptan, Amerge, Axert, Frova, *frovatriptan*, Imitrex (brand only), Imitrex Spray, Maxalt, Onzetra, Relpax, *sumatriptan* spray, SumaChip, Sumavel, Treximet, *zolmitriptan*, Zecuity Pads, Zembrace Inj, Zomig, Zomig spray	*sumatriptan, naratriptan (for Amerge), rizatriptan (for Maxalt)*
Muscle Relaxants	
Amrix, Carisoprodol, Fexmid, Lorzone, *metaxalone*, Norflex, *orphenadrine inj*, Parafon, Robaxin, Skelaxin, Soma, Tabradol, *tizanidine capsules*, Zanaflex	*carisoprodol, chlorzoxasone, cyclobenzaprine, methocarbamol, and tizanidine tablets*
Osteoporosis Agents - Bisphosphonates	
Actonel, brande Alendronate, Atelvia, Binosto, Boniva, Fosamax, Fosamax-D, *ibandronate, risedronate*	*alendronate*
Overactive Bladder – Urinary Antispasmodics	
darifenacin, Detrol/LA, Ditropan XL, Enablex, Gelnique, Myrbetriq, *oxybutynin ER*, Oxytrol, *tolterodine/ER,* Toviaz, *trospium CL, trospium CL ER*, Vesicare	Immediate release *oxybutynin*
Pain Medication / Analgesics (alternatives in right column correlate to same line in left column)	
Anaprox, Arthotec, Celebrex, *celecoxib,* Daypro, *diclofenac/misoprostol, indomethacin cap ER/SR,* Ketoprofen ER, *mefenamic acid* cap, Mobic, Naprelan, Naproxen *naproxen 550mg tablet,* Naproxen CR, *oxaprozin*, Ponstel, Tivorbex, Voltaren-XR, Vivlodex, Zipsor, Zorvolex	generic NSAIDs for Celebrex, *naproxen* (except 550mg) for Naprelan generic immediate release *diclofenac* and *misoprostol* (for Arthrotec)
ConZip, Ryzolt, *tramadol HCL ER*, Ultracet, Ultram (brand only), Ultram ER	immediate release *tramadol*
Duragesic Dis, Lazanda Spray, Subsys Spray	*fentanyl patch*
Sleep Aids – Sedatives/Hypnotics	
Ambien (brand only), Ambien CR, Belsomra, Edluar, *eszopiclone,* Intermezzo, Lunesta, Rozerem, Silenor, Sonata (brand only), *zolpidem ER*, Zolpimist	*zaleplon,* immediate release *zolpidem*

 Updated 10/21/2016

PRIOR AUTHORIZATION

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

STEP THERAPY

Drugs with step therapy requirements	*Conditions*
Antibiotics – Dificid and Vancomycin	
Dificid, *linezolid*, *vancomycin*, Vancocin, Zyvox	Must try *metronidazole* or *metronidazole SR* before coverage
Antiasthmatics – Beta Agonists, including Combination Products	
Advair, Arcapta, Brovana, Dulera, Foradil, Perforomist Neb, Serevent, Symbicort	Coverage allowed if patient has been compliant with an inhaled corticosteroid. **Patients 40 years or older are exempt from step therapy.**

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

MHBF Quantity Limits January 2017

Drug	Limits
Erectile Dysfunction (Limit to men only)	
Caverject	5 mcg, 10 mcg, 20 mcg, 40 mcg vials: 6 units/30 days
Cialis	10 mg & 20 mg: 6 tabs/30 days, 2.5 mg & 5 mg: PA only
Edex	5 mcg, 10 mcg, 20 mcg, 40 mcg vials: 6 units/30 days
Levitra	2.5 mg, 5 mg, 10 mg, 20 mg: 6 tabs/30 days
Muse	125 mcg, 250 mcg, 500 mcg, 1000 mcg pellets: 6 units/30 days
Viagra	25 mg, 50 mg, 100 mg: 6 tabs/30 days
Influenza	
Tamiflu	30mg: 20 caps/180 days 45 mg & 75 mg: 10 caps/180 days Solution: 75 mL/180 days
Migraine	
Amerge	1mg & 2.5 mg: 9 tabs/30 days
Axert	6.25 mg: 6 tabs/30 days 12.5 mg: 12 tabs/30 days
Frova	2.5 mg: 9 tabs/30 days
Imitrex (sumatriptan)	25 mg, 50 mg, 100 mg: #9tabs/30 days Nasal Spray: 12 devices/30 days Injection: 4 injections/30 days
Maxalt & Maxalt-MLT	5 mg & 10 mg: 12 tabs/30 days
Relpax	20 mg & 40 mg: 12 tabs/30 days
Treximet	9 tabs/30 days
Zomig	2.5 mg & 6 mg and ZMT tabs: 12 tabs/30 days Nasal Spray: 12 devices/30 days
Nausea & Vomiting (7 cancer chemo treatment days)	
Anzemet	50 mg: 14 tabs/30 days 100 mg: 7/30 days
Cesamet	1 mg: 42caps/30 days
Emend	40 mg: 1 cap/copay 80 mg: 4 caps/month Trifold Pack (80 mg & 125 mg): 6/month
Kytril (granisetron)	1 mg: 14 tabs/mo.
Kytril (granisol) Solution: 70 mL/mo.	Solution: 70 mL/mo.
Sancuso:	2 patches/mo.
Antipsychotic Agents	
Abilify	2 mg, 5mg, 10 mg, 15 mg, 20 mg, 30mg and disc tab 10 mg: 30/30 days; Disc tab 15 mg: 60/30 days
Abilify 1mg/ml soln	900 ml/30 days
Fanapt	1 mg, 2 mg, 4 mg, 6 mg, 8 mg, 10 mg, 12 mg tablet: 60/30 days (2 tablets per day) Fanapt Pak: 1PAK/30 days
Geodon	20 mg, 40 mg, 60 mg, 80 mg: 60/30 days (2 per day)
Invega	1.5 mg, 3 mg, 9 mg: 30/30 days; 6 mg 60/30 days
olanzapine	2.5 mg, 5 mg, 7.5 mg, 10 mg, 15 mg, 20 mg: 30/30 days
Zyprexa Zydis	5 mg, 10 mg, 15 mg, 20 mg: 30/30 days
risperidone	0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg: 60/30 days (2 per day)
risperidone 1MG/ML SOLN	240ml/30 days; 8ml/day
risperidone mTAB	0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg: 60/30 days (2 per day)
SAPHRIS SUB	5 mg, 10 mg: 60/30 days
Seroquel	25 mg, 50 mg, 100 mg, 200 mg, 300 mg, 400 mg: 60/30 days (2 per day)
Seroquel XR	50 mg, 150 mg: 30/30 days; 200 mg: 90/30 days; 300 mg, 400 mg: 60/30 days
Symbyax	25MG-3MG CAP, 25MG-6MG CAP, 25MG-12MG CAP, 50MG 6MG CAP, 50MG-12MG CAP: 30/30 days (1 per day)

Municipal Health Benefit Plan

Prescription Drug Program – Prior Authorization List - Effective January 1, 2017

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

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

Anti-asthmatic Agents

- Arcapta
- Advair
- Brovana
- Dulera
- Foradil
- Perforomist
- Serevent
- Symbicort

Antibiotics

- *linezolid*
- Vancocin
- *vancomycin*
- Zyvox

Anti-diabetic Agents

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

Antifungals

- Vfend
- *voriconazole*

Cholesterol Reducers

- Crestor 40 mg
- *rosuvastatin 40 mg*
- Zetia

CNS Stimulants (Narcolepsy)

- *armodafinil*
- *modafinil*
- Nuvigil
- Provigil

Dermatologicals

- Lidoderm Dis 5%
- *Lidodcaine pad 5%*

Gout Agents

- Uloric

Miscellaneous Products

- Compounded prescriptions over $200

Nasal Steroids

- *budesonide*
- Pulmicort

Pain Medication/Analgesics

- Actiq lozenges
- Fentanyl lozenges
- Fentora

Specialty/Bio-Tech Drugs

- Filled through Allcare Specialty Pharmacy

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