

**MUNICIPAL HEALTH BENEFIT FUND SEMINAR  
AGENDA**

**October 13, 2017**

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8:30 – 9:00 a.m.	<b>Registration</b>	
9:00 – 10:00 a.m.	<b>Welcome and Opening Remarks</b>	Don Zimmerman, Executive Director Arkansas Municipal League
	<b>MHBF Plan Changes 2018</b>	Tracey Cline-Pew, Director Municipal Health Benefit Fund
10:00 – 10:30 a.m.	<b>Prescription Benefit Updates</b>	Dwight Davis and SmarterRx
10:30 – 10:45 a.m.	<b>BREAK</b>	
10:45 – 11:15 a.m.	<b>Telemedicine Update</b>	Robbie Linn, eDoc America
11:15 – 11:45 a.m.	<b>American Fidelity’s Enrollment Platform, Flexible Spending Accounts &amp; Other Services to Benefit Your Organization</b>	Charles Angel American Fidelity
11:45 a.m. – 1:00 p.m.	<b>LUNCH</b>	
	<b>Understanding Your Municipal Health Benefits -</b>	
1:00 – 1:15 p.m.	<b>What You Need to Know About Enrollment &amp; Eligibility</b>	Purity Ingram, Enrollment & Eligibility Supervisor
1:15 – 1:30 p.m.	<b>What You Need to Know About Customer Service &amp; Provider Relations</b>	Beth Chappell, Customer Service & Provider Relations Supervisor
1:30 – 1:45 p.m.	<b>What You Need to Know About Precertification and Clinical Review</b>	Jill Sloan, LPN, Clinical Supervisor
1:45 – 2:00 p.m.	<b>MHBF’s Bariatric Weight Loss Program</b>	Jennifer Elliott, LPN Bariatric Program Coordinator
2:00 – 2:15 p.m.	<b>Let’s Get Healthy</b>	David Baxter, Wellness Coordinator
2:15 – 2:30 p.m.	<b>Ask an MHBF Expert Q &amp; A</b>	MHBF Director & Department Supervisors
2:30 – 3:00 p.m.	<b>Closing Remarks/Door Prizes</b>	Don Zimmerman, Executive Director Tracey Cline-Pew, MHBF Director

# MHBF 2018

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PLAN CHANGES & IMPORTANT REMINDERS

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# Amended & Restated Declaration of Trust

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The Declaration of Trust that formed the Municipal Health Benefit Fund (“Fund”) has been amended.

- The Fund Booklet is now tied to Declaration of Trust.
- Further defines processes and protocols throughout the document.
- Clarifies the role of the Board of Trustees.

# Participation Agreement

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Groups have never been required to enter into a formal agreement for membership in the Fund.

This will change for 2018 and each group will execute a Participation Agreement.

All the terms are the same, but this will formalize the process and provide documentation.





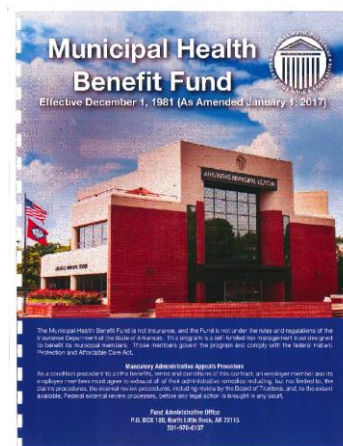
# 2018 FUND BOOKLET

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The 2018 Fund Booklet has undergone another transformation.

Many of the enrollment and eligibility requirements can now be found in the Participation Agreement that each group will be required to execute.

The contents are consistent throughout and easier to understand.



# 2018 Required Notices

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HIPAA Privacy Notice

Health Insurance Marketplace Coverage Options Notice

Summary of Benefits and Coverage

Acknowledgement (7 years)



# Enrollment Forms

## Certificate of Notice and Acceptance of Plan Provisions

Public Health Service Act Exemption<sup>2</sup>  
Continuation of Coverage (COBRA)  
Beneficiary Designation  
Effective December 1, 1981 (as Amended Each

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.arnl.org/mhbf](http://www.arnl.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 provided benefits for the Plan does not necessitate illness or condition. By signing below you health care provider's authorization requested by the may be necessary to your authorization for benefits payable also your eligible covered remain in effect until Plan. An electronic or tion shall be consider for purposes of medi

You may revoke your or that of your eligibl written revocation to If you or your eligibl status by dropping co ferent group then a n employees are require and Acceptance of Pl

### Municipal Health Benefit Fund Enrollment/Change/Termination Form

<b>Employee Information - All Fields Required</b>		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: _____			
<input type="checkbox"/> Active Status: Full Time / Part Time _____ Full Time Employee position held: _____			
<input type="checkbox"/> Retiree Member (years of service) _____ Awarded in: _____			
Elected Official _____ (office) Member of _____ Team/Committee on _____			
Volunteer Fire Fighter _____ Auxiliary Police _____			
Life Amount: _____		Option A: Yes _____ No _____	
AD&D Amount: _____		Option B: Yes _____ No _____	

**What do you want to do?**

☐ Enroll in this plan  
☐ Refusal of Benefits  
☐ Add/Drop a dependent from your plan  
☐ Cancel coverage: General Rule: \_\_\_\_\_ (termination of employment / Reversion to Insurer / Member Death / Med  
☐ Change coverage: Single to Family Family to Single Retiree Spouse (date of decision)  
☐ Change Beneficiary: \_\_\_\_\_ Change Name: \_\_\_\_\_

Superseding form number: 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 Options are available to you through your Employer**

☐ Life and AD&D ☐ Dental ☐ Vision ☐ Family  
☐ Life and AD&D ☐ Dental ☐ Vision ☐ Family

ADD/DOE	Name	Date of Birth	Social Security Number	Relationship	Other Ins. (yes or no)

I hereby accept the form of Group Life, AD&D, Unemployment, Life and Medical Benefits previously contracted for by my employer with the Municipal Health Benefit Fund, the amount for which I am or may become eligible and authorize until revoked by me in writing the execution by my employer of any and all actions sufficient to cover my contribution towards the program under the said 3. Initial Health Benefit Fund

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Employee signature not required for termination)  
Group Plan Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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. <b>Please complete this form and return it as soon as possible.</b>			
Member/Employee Name	Member/Employee SSN or ID#	Name of Employer/Group	
Current Mailing Address		City	State Zip Code
<b>1. PLEASE ANSWER THIS QUESTION</b>			
Do you or any family member covered as your dependent by MHBF, have any other medical, dental or vision insurance coverage?			
Yes <input type="checkbox"/> 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 <input type="checkbox"/> If No, please sign and date the bottom of this form (Section 4) and return this form to us as soon as possible.			
<b>2. OTHER INSURANCE INFORMATION (More space provided on the back of this form)</b>			
<b>COMPLETE IN FULL (If Other Insurance is Medicare, Please go to Section 3 of this form)</b>			
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: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Drug Card Services	Type of Policy: <input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> Medicaid <input type="checkbox"/> Retiree Coverage		
<b>Persons Covered by Other Insurance</b>			
Name	Social Security Number	Date of Birth	Relationship to Policy
<b>3. Medicare Information (PLEASE PROVIDE COPY OF MEDICARE CARD)</b>			
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: <input type="checkbox"/> Age 65 or Older <input type="checkbox"/> Disability * <input type="checkbox"/> 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			
Effective Date of Part A		Effective Date of Part B	Effective Date of Part D
Reason for Medicare Eligibility: <input type="checkbox"/> Age 65 or Older <input type="checkbox"/> Disability * <input type="checkbox"/> 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 BEING DELAYED OR DENIED.			MHBF Use Only

# Certificate of Notice and Acceptance of Plan Provisions

If you have a 2015 Certificate of Notice and Acceptance on file for an employee, another will not need to be completed provided they remain covered with your group.

Forms must be completed by:

- New employees;
- Employees moving to another employer with MHBF coverage;
- All employees of a group new to MHBF 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.warml.org/mhbf](http://www.warml.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 illness or condition in subsequent Plan years.  
By signing below you authorize any hospital, physician or health care provider and/or paper 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/Employer: \_\_\_\_\_  
Signature of Member (Include Address of COBRA Member) \_\_\_\_\_  
Member/Employer: \_\_\_\_\_  
Print Your Full Member Name \_\_\_\_\_  
Home Telephone Number: \_\_\_\_\_  
Date Signed: \_\_\_\_\_

Please list a Beneficiary and their relationship to you for your Life Benefits  
Beneficiary: \_\_\_\_\_  
Print Name (Last) \_\_\_\_\_  
Beneficiary's Date of Birth: \_\_\_\_\_  
Print Date (MM/DD/YYYY) \_\_\_\_\_  
Print Date (MM/DD/YYYY) \_\_\_\_\_

This portion is to be completed by Employer Representative and mailed to:  
Municipal Health Benefit Fund, P.O. Box 186, North Little Rock, AR 72115  
City/County of: \_\_\_\_\_  
Group Representative: \_\_\_\_\_  
This form should be returned to your Employer.

MHBF USE ONLY

# Enrollment/Change/Termination Form

Enrollment in the Plan

**Coverage Declination**

Add/Drop Dependent

Cancel Coverage

Address Change

Name Change

Coverage Change (Individual/Family)

Status Change (Marriage/Divorce)

Employee Termination

**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: _____	
<input type="checkbox"/> Active/Inactive Full Time/Part Time _____ Full Time Employee position held: _____	
<input type="checkbox"/> Retiree Member (yes/no) _____ / Worked in _____	
Elected Official _____ (office) _____ Member of _____ Team/Committee _____	
Volunteer Fire Fighter _____ Auxiliary Police _____	

**Life Annuity:**

Amount	Option A: US	Option B: US
YES	NO	YES

Option A: US	Option B: US
YES	NO

**What do you want to do?**

☐ Enroll in this plan ☐ Return from Military Leave

☐ Renewal of the policy ☐ Renewal Outside DWP Only\*

☐ Add/Drop a dependent from your plan

☐ Cancel coverage: Current Date: \_\_\_\_\_ Termination of employment / Retirement in this / Member Death / Medicare

☐ Change coverage: Single to Family \_\_\_\_\_ Family to Single \_\_\_\_\_ Retiree Spouse \_\_\_\_\_ (date of divorce)

Change Beneficiary: \_\_\_\_\_ Change Name: \_\_\_\_\_

Supporting Documentation MUST be submitted for this type.

**What level of coverage do you want?** **Please check with your City Clerk or HR Dept. to be sure what Options are available to you through your Employer:**

☐ Employee Only ☐ Life and ACOD ☐ Dental ☐ Vision (if employee level)

☐ Family ☐ Life and ACOD ☐ Dental ☐ Vision (Family level)

Employee	Name	Date of Birth	Social Security Number	Date of Death	Retiree	Other Name	Reason for Change

I hereby warrant the truth of Group Life, ACOD, Life and Dental for which I am presently contractually bound by my agreement with the Municipal Health Benefit Fund. It is acknowledged for all of them or may become eligible and authorize enforcement by making the contract by my employee. On the day of annuals sufficient cover my contribution towards the program assets and 3. annual health benefit fund.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_ AHEF use only

Group Rep. Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Multiple Coverage Inquiry Form

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

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

**Failure to provide this information can result in claims being delayed or denied.**

# 2018 Benefit Changes

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# 2018 Changes

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Participation Agreement (Group)

Copayment for specialty drugs has changed.

Verification for volunteer firefighters must now be signed by Fire Chief and City Official.

When a branded drug has a generic equivalent available, the patient will pay the difference between the cost of the generic and branded drug if they chose to fill the branded drug.

Impotence/ED medications will be limited to four (4) per month. The daily form of Cialis will be excluded.



# 2018 Changes

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The following drugs were added to exclusion list because of generic or alternative availability: Qudexy XR, Topiramate XR, Celexa, Lexapro, Prozac, Paxil, Zoloft, Rexulti, Auvi-Q, EpiPen, etc. You can find a complete list at [www.arml.org/MHBF](http://www.arml.org/MHBF).

*The Fund utilizes an evidence-based program. Drug therapies are evaluated and based on clinical evidence it is determined which are covered by the plan.*



# 2018 Changes

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MHBF has changed pharmacy consultants. In the coming months, members will begin receiving new cards indicating SmarterRx as the contact for member and provider services. The telephone number is the same.

If you do not have a new card by the first of the year, don't worry!! The card you have now will continue to work. The processing codes have not changed.



PHOTO ILLUSTRATION: SHUTTERSTOCK/ T.BAKER/ GINN MONEY

# How Members Can Reduce Out-of-Pocket Costs

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# Common Mistakes that Increase Out-of-Pocket Costs

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

Using the emergency room for non-emergency events.

Failing to check in-network status of a provider. (80% vs. 50%)

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

Paying a health provider's bill prior to receiving an EOB. When in doubt, call us.

Never hesitate to call MHBFF 501-978-6137 with any questions or concerns you may have.



# More Money Saving Tips

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

Keep wellness visits strictly wellness.

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

Turn in Accident Claim Forms or other required documentation.

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



# More . . .

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

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

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

Don't forget that eDoc America, along with their 24-hour Registered Nurse Advice Line is a part of your benefit package.

**Do not hesitate to call and ask questions. MHBF is here to help.**



# Final Thoughts

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Every employee signs a Certificate of Notice and Acceptance of Plan Provisions. By signing this form, each member is acknowledging that they have read and understand the benefits provided by the Fund and agree to the terms contained therein. Encourage employees to actually read the Fund Booklet and become familiar with the plan.

Educate your employees about their benefits.

Know that we are here to help.





Municipal Health Benefit Fund  
Prescription Drug Program  
Plan Update for January 1, 2018

October 13, 2017

# Summary of 1/1/2018 Changes

- Clinical Management Tools
  - Dispensing Limits
  - Step Therapy
  - Reference Pricing
  - Plan Exclusion
- Align Pharmacy Network
- SmarterRx / EBRx (UAMS) / RxBenefits Partnership with MHBF

# Dispensing (Quantity) Limits

## How do Dispensing (Quantity) Limits work?

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

## Purpose:

To promote safe and effective medication therapy and to reduce the likelihood of wastage.

## Example(s): *(new for 1/1/2018)*

- **Men's Health** – oral medications used to treat Erectile Dysfunction (ED) will be limited to 4 pills/month. The “daily” form of Cialis (2.5mg, 5mg strengths) will be excluded from plan coverage.

# Step Therapy

**How does Step Therapy work?** Requirement that the presence of a specific drug and/or condition exists before a particular drug can be used.

**Purpose:** To promote appropriate and cost-effective drug therapy in a step-wised fashion.

**Example(s):**

**Respiratory Agents** – Advair, Dulera, Symbicort and Airduo (*new for 1/1/2018*)

- To obtain one of these agents, the patient must have at least 90 days of inhaled steroid use out of the past 120 days in their medication profile.
- Patients 40 years or older are exempt from this initiative.

# Reference Pricing Example



# Reference Pricing - Examples

## *Additions to Reference Pricing (new for 1/1/2018)*

- **Selected Antidepressants** – Brand name Celexa, Lexapro, Prozac, Paxil, Zoloft
- **Selected Antihypertensives** – candesartan (generic Atacand / HCT), Inderal LA, Inderal XL, Innopran XL
- **ADHD Agents** – Cotelpla XR, Mydayis
- **Anti-Migraine Agents (Triptans)** – naratriptan (generic Amerge)

## *Removal from Reference Pricing (new for 1/1/2018)*

- **Generic Crestor (rosuvastatin)** and other historically high-cost generics

# Exclusion from Coverage

## How does Exclusion work?

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

## Purpose:

To protect the Fund from the financial exposure related to expensive low-value drugs and/or unproven drugs.

# Exclusions - Examples

- Selected Anticonvulsants (Qudexy XR, Trokendi XR, Topiramate XR)
- Epinephrine Auto Injector (Auvi-Q, Epi-Pen)
- Kits (various)
- Misc. Dermatological Products
- Hyaluronic Acid Knee Injections (Synvisc, Euflexxa, Gel-One, others)
- Selected Multiple Sclerosis Agents



# Align Pharmacy Network

- What is the Align network?
- How does the Align network operate?
- How will the pharmacy network operate after 1/1/2018?
- What does this change mean to MHBF and its members?

# SmarterRx / EBRx (UAMS) / RxBenefits Partnership with MHBF

- **SmarterRx** – provides Pharmacy Benefit Manager (PBM) contract evaluation and management, oversight of pharmacy vendor relationships, oversight of the prescription drug program
- **EBRx (UAMS)** – provides an evidence-based prescription drug program, defines the drug formulary and drug coverage rules, handles prior authorization requests for drugs, handles physician appeals for denied drug requests
- **RxBenefits** – provides pharmacy benefit management services (claims processing, pharmacy network, member call center, member communications, ID Cards)

# Information Regarding Prescription Drug Benefit

- **On-line** – updated lists pertaining to Quantity Limits, Step Therapy, Reference Pricing and Exclusion are found on the MHBF website:

[www.arml.org/Services/Benefit Programs/Municipal Health Benefit Fund](http://www.arml.org/Services/Benefit%20Programs/Municipal%20Health%20Benefit%20Fund)

- **Phone** – phone numbers for EBRx (UAMS) and RxBenefits are forthcoming in the Municipal Health Benefit Fund Booklet

The background of the slide features a close-up photograph of several autumn leaves scattered across a light-colored, textured surface. The leaves are in various stages of decay, with colors ranging from bright red to pale yellow. The texture of the surface appears to be a mix of light and dark patches, possibly a stone or concrete floor. The overall composition is centered around the text, which is overlaid on the image.

# **Enrollment & Eligibility**

## Premium Accounting



# Premium Due Dates

- All premiums are due by the 1<sup>st</sup> of every month and considered late after the 5<sup>th</sup> of the month.
  - Premiums received after the 5<sup>th</sup> of the month are considered for late fees.
    - Late fees are \$10 for the group, plus \$1 for every member in the group.
- Please make sure a copy of all pages of the billing is sent with the remittance of payment.

# Waiting Periods

- Due to ACA regulations, MHBF can not allow a waiting period beyond 60 days.
  - New employees will be eligible for coverage the first day of the month following 60 consecutive days of employment.
  - New employees with hire dates of the 1<sup>st</sup> or 2<sup>nd</sup> of the month, that full month is counted as part of the 60 day waiting period.
  - If an employee transfers from one of our groups to another, they will transfer without a waiting period.

# Forms

- MHBF documents every change that is made, for auditing purposes.
  - For that reason, we have a form for everything processed.
  - MHBF has a multi-use form Enrollment/Change/Termination form.
  - Enrollments require; Enrollment form, Certificate of Notice and Acceptance, Multiple Coverage Inquiry and a copy of social security card for everyone listed.



# Forms continued

- Changes require; Change form, supporting documentation (reason of change), Certificate of Notice and Acceptance (if adding spouse), Multiple Coverage Inquiry, and copies of social security cards for addition of dependents.
- Terminations require; Termination form. Please remember to have a current address as this is used for Cobra purposes. Also, list last day of employment for termination date.
- Change of address; We mail out correspondence every day. If they change their address with you, we need this form.



# Things to Remember

- Make sure all forms are completed to its entirety. Anything missing could delay enrollment, ID cards, changes, terminations or even claims payment.
- You do not have to wait until billing to turn in paperwork. It can be mailed, emailed or even faxed to your representative.
- If you ever have any questions or doubts; call us, that's what we are here for. 😊

# Customer Service & Provider Relations

What You Need to Know



# Provider Relations

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



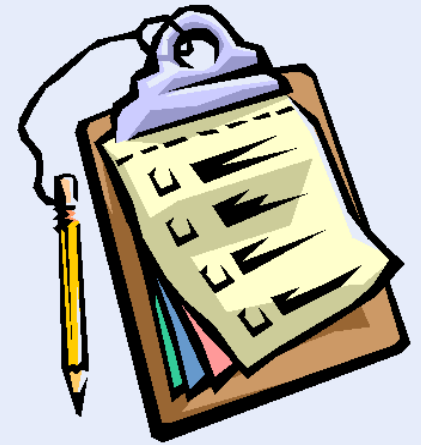


# Referring A Provider

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

- Go to [arml.org](http://arml.org)
- Click on the MHBF tab
- Click on Preferred Provider Directory
- Click on Provider Request Form

When you are finished completing the form, click submit and an email is sent directly to our office.



# Help Locating an In-Network Provider



- [www.arml.org](http://www.arml.org)
- Contact Provider Relations Department
- Contact Customer Service

# Customer Service

- Copies of EOB's
- Verifying if precertification is required for a service
- Balance billing issues
- Clarification of benefits





# Frequently Asked Benefit Questions

- Calling to get claim status or information on your spouse?
  - Requires Authorization to Disclose
    - Form is located in the back of the MHBFB book or request one from MHBFB Customer Service
- How to file an appeal?
  - Write a letter to the Claims Review Team
  - Mail to MHBFB @ PO Box 188 North Little Rock, AR 72115
  - Response will be returned within 60 days
- What are the office visit benefits?
  - Office visits are reimbursed at 100% after a \$20 copay
  - All other services performed in the office are reimbursed at 80%, subject to deductible.





## Frequently Asked Questions (continued)

- I had surgery at an In-Network facility. When I received the EOB for my anesthesia services, it states the services were paid at 50%, why?
  - Anesthesia services were performed by an Out-of-Network provider.
  - MHBF tries to contract with every provider utilized by our members however, providers do not have to accept a contract.
- When precertification is required for a service, is it my responsibility to call MHBF or the providers?
  - It is the responsibility of the member to contact MHBF.
- Are flu shots covered at the pharmacy?
  - Yes, when charges are filed through Optum.



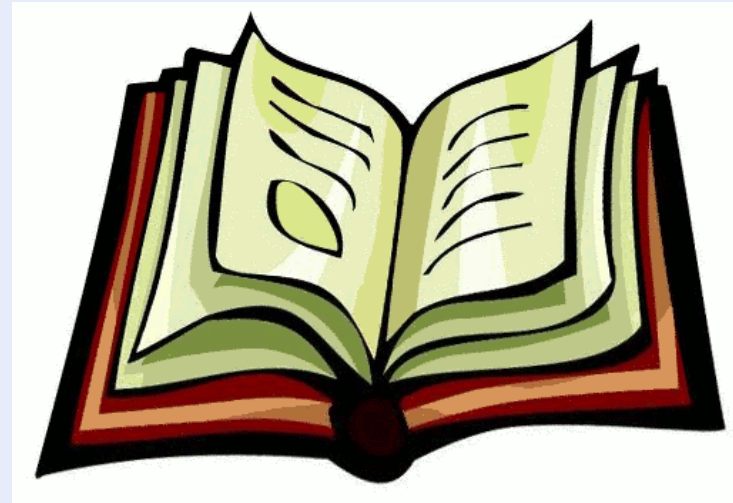


## Frequently Asked Questions (continued)

- I went to the doctor for my annual exam but my claim did not pay as wellness, why?
  - A true wellness visit does not have any medical diagnosis associated with it. If you go to the doctor for a wellness exam and you are diagnosed with any medical condition, receive a prescription or get a refill prescription for a condition already diagnosed, this does not qualify as wellness.
- I saw my chiropractor for low back pain. MHBF sent a form for me to fill out. Why?
  - The diagnosis billed on the claim may have suggested an accident or injury. In this case you have to complete the Accident Claim Form and Two Page Questionnaire in order for MHBF to determine there is no other liability.

# MHBF Booklet

- Online at [arml.org/mhbf](http://arml.org/mhbf)
- Your city's Human Resources
- Call MHBF Customer Service



# Important Phone Numbers



Municipal Health Benefit Fund  
(501) 978-6137

Option 1 – Precertification

Option 3 – Verify Network Status  
(Provider Relations)

Option 6 – Customer Service

Option 7 – Premium Accounting



# Clinical Review

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Jill Sloan, LPN

Clinical Supervisor

MHBF



# Clinical Team

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- Clinical Reviewers
  - Jennifer Elliott, LPN
  - Deb Hudson, LPN
  - Jill Sloan, LPN
  - Amanda Woodyard, LPN
- Precertification Specialist
  - Stephanie Stroncek





# Precertification

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- Precertification is prior notification to the Utilization Review Program before services are received by the covered individual.



It is the **member's**  
responsibility to precertify.

A penalty deductible of **\$1500**  
will apply for failure to  
precertify.



# What to Pre-certify?

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- Ambulatory Surgical Procedures
- Botox Injections
- Mohs Procedures
- PET Scans
- Inpatient Hospital Confinements
- Observation Hospital Confinements over 23 hours
- Durable Medical Equipment if purchase price or annual rental cost exceeds \$2000
- Prosthetic Devices with purchase price exceeding \$2000
- Home Health and Hospice Care
- Wound Care & Hyperbaric Oxygen Treatments
- Special Benefits Programs





# Special Benefits

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- Bariatric Weight Loss Program
  - These services will be covered exclusively through the Metabolic & Bariatric Surgery Accreditation & Quality Improvement Program (MBS-AQIP).
- Chemical Dependency Treatment
  - Services must be rendered at an MHBF Chemical Dependency Treatment Center to be covered.
- Transplants
  - Transplants must be performed at an MHBF Designated Transplant center to be covered.



# How to Pre-Certify

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- Call the MHBF Pre-cert line
  - 888-295-3591
  - If it is after hours, a weekend or a holiday **LEAVE A MESSAGE:**
    - Name
    - Member ID or Date of Birth
    - Return telephone number
    - Brief message of what you need



# Nurse Review Process

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- Medical Records are requested
- Documentation of *conservative treatment* that has been attempted and failed
- Radiology reports or test results
- Once the information is received, it is reviewed with the MCG Guidelines to ensure that it meets medical necessity.



# MCG Guidelines

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- MCG Guidelines present best practices for treating common conditions in a variety of care setting and assist healthcare professionals in providing quality care by reducing the under-use, over-use and misuse of medical and surgical resources.
- The MCG Guidelines are written by a professional healthcare staff consisting of physicians, nurses and medical consultants.



# How Long Does It Take?

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- Generally it takes 2-3 business days to complete a pre-cert.
- Clinical information is requested, if additional information is needed, your physician will be contacted. It often takes several calls to a physicians office to get all the information needed for a pre-cert.



# Appeals

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- If an adverse determination is made the ordering physician and member will receive a letter with an explanation as to why the determination was made.
- If you disagree with an adverse determination you may submit an appeal in writing within 60 days of receiving the denial letter.
- Include medical information to support your appeal.
- The appeal will be reviewed by a physician who was not involved in making the initial decision. These reviews occur bi-weekly.



# Non-Emergency Surgical Procedures

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- A procedure to improve health or quality of life when the medical condition is not considered immediately life-threatening. Non-emergency procedures are pre-scheduled to a specific date and are not considered emergent in nature.
- Annual benefit of 2 per calendar year.

# Sleep Studies



- Annual benefit of 1 per calendar year.
- Sleep studies do not require a precert.





# Claims Review

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- Claims are reviewed to ensure that the providers are accurately billing for services
- Claims are reviewed to ensure that they are processed correctly per the contract

# MBS-AQIP Bariatric Weight Loss Program



# MBS-AQIP

## Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program

- Program is designed with a goal of weight loss surgery in mind
- However, you can enroll in the program for supervised weight management under the guidance of a dietician, if you meet requirements

# MHBF designated providers

- Dr. John Wilder Baker
- Baptist Health Medical Center
- Non-designated provider: If morbid obesity treatment is preformed at a non-designated facility or by a non-designated provider or if medical case management is refused then the pre-obesity, obesity and post-obesity care and charges are not covered
- No benefits for services done prior to enrollment with MHBF

# Why Dr. Baker and Baptist?

- Dr. Baker is the Medical Director of the Baptist Health Weight Loss Center
- Dr. Baker is Co-Director of the Baptist Health Bariatric Program
- Has performed over 2,500 bariatric surgeries
- Committee lead for Arkansas Medical Board and the General Assembly
- Operation New Life Mission in Honduras teaching advanced laparoscopic surgeries to physicians and students
- Past President of the American Society for Metabolic & Bariatric Surgery and currently serves on the board of directors
- Former chief surgical resident LSU
- Author and co-author of numerous studies
- Dietician(s) registered thru the state, commission on dietetics and has a master's degree
- 24 hour access to surgeons/staff thru PMD or TWISTLE

# Dr. John Wilder Baker, Baptist Health Medical Center

## **Program:**

- Minimum of 6 months
- Must have a BMI of at least 40%; or 35% with a co-morbidity
- Requires consecutive, monthly weight management
- If you live locally or have been previously enrolled/disqualified you are required to do weight management with Dr. Baker
- Dietician supervision is recommended but not required as long as PCP is willing to follow program

## **Requirements:**

- Application with pre-determination
- No retro authorization requests
- No transfer or care or waiver of requirements
- 19 years of age or older
- PCP referral
- Letter of recommendation from PCP
- Medical records
- Possible clearance based on medical diagnoses (example: history of cancer, cardiac etc.)

# Requirements

- Bariatric Psych evaluation
- Laboratory work
- Sleep study
- Sleep apnea-download of chip with compliance
- Dietary test
- Seminar
- Smoke free-willing to consent to random nicotine tests
- Sobriety x 5 years
- Extended weight management
- Additional testing/clearance based on medical history

# Baptist Health Policy regarding elective surgery

## **Patient health requirements:**

- Weight at time of surgery must be 400 pounds or less
- Women: BMI of less than 60%
- Men: BMI of less than 55%

## **Financial requirements:**

- Requires co-insurance and any remaining deductible 2 weeks prior to surgery
- Anesthesia, sleep medicine, laboratory, ancillary charges billed post operative



# Costs:



- Deductible
- \$20 office co-pay for each visit
- Co-insurance for labs, diagnostic testing, surgery requirements
- Vitamins, liquid diet, lifelong requirements

- Plan pays 80% of all program requirements
- If you are required to have a Colonoscopy, EGD, Carotid screening or Chest x-ray as a program requirement these will not be paid under wellness benefits

# MHBF MBS-AQIP Facts

## 2013-present

- 166 members enrolled in the program
- 95 members disqualified for non-compliance or have dropped out
- 60 members have had surgery
- 11 active members in the program with upcoming surgeries
- 5 fired from program

## Surgeries 2013-present

- 44 Sleeve gastrectomy
- 15 Gastric bypass
- 1 Lap band



# Covered surgeries

## **New bariatric patients:**

- Gastric bypass
- Gastric sleeve
- Biliopancreatic diversion
- Lap band (case by case basis)

## **Revision or conversion:**

- Old records, operative reports, diagnostic test results
- Bypass or stomach stapling- documentation that the anastomosis/staple site no longer in tact
- Lap band-removal of band 6 months prior to any conversion

# Surgery

Minimum of 2 night stay in-patient, first night usually ICU

Post op liquid diet for a minimum of 2 weeks

Post op restrictions-no driving for 7 to 10 days and no lifting for 6 weeks



# Post operative

## **Follow up**

- 2 weeks post op
- 1 month post op
- 3 months post op
- 6 months post op
- 1 year post op
- Annually for life
- Depending on your medical history and tolerance to surgery labs every 3-6 months for life

# Non-compliance

## Warnings:

- It is the member's responsibility to submit all of the required monthly paperwork, failure to do so can result in disqualification
- MHBF: Warning letter and given 2 weeks to provide documentation
- If disqualified for non-compliance you must wait until January of the following year to re-apply and will be required to do all services thru Dr. Baker
- Dr. Baker: First and second offense: If you miss or cancel lab work or office visit you will get a warning letter and you will be given a time frame to reschedule

## Fired:

- You will not be seen for any office visits or complications and you will not be consulted if you are an ER admit
- MHBF will not pay any bariatric related charges once you are fired (example: labs, office visits, ER visits, diagnostic testing)
- 5 patients fired since 2013

# Non-covered food/supplemental requirements

- The fund will not cover food, shakes, vitamins and supplements pre or post op
- HMR shakes (liquid diet) minimum of 2 weeks pre-op and 2 weeks post op \$150 per 1 month supply
- Vitamins/protein supplements lifelong
- Non-menopausal women: Calcium, Iron, ADEK



# Compliance and skin removal

- Member must have had surgery thru MHBFB program and be a minimum of 2 years post op with 100% compliance thru the pre and post surgery/case management process
- Non-compliance with office visits, required labs and not following pre-operative diet requirements and not documenting weight loss effort can disqualify you for skin removal
- Must be at a % of your goal weight and have a stable weight for 6 months
- If you are still loosing weight you are not eligible
- Documentation of skin impeding movement, skin breakdown, irritation or rash
- Eligible skin removal: arms, thighs, back and pannicula (apron)
- Non-eligible cosmetic: abdominoplasty(tummy tuck), breast implants or breast lift, breast reduction



# Bariatric Support

- Support Groups
- Exercise Groups
- E-doc America (dietician, MD, Kinesiology, therapist)
- David Baxter



Jennifer Elliott, LPN  
Bariatric Program Case  
Manager

[jelliott@arml.org](mailto:jelliott@arml.org)

501-978-6137  
extension  
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AMENDED AND RESTATED

DECLARATION OF TRUST

MUNICIPAL HEALTH BENEFIT FUND (THE "FUND")

This Declaration, initially made on the 16<sup>th</sup> day of November 1981, and amended effective January 7, 2008, by the Member cities and towns joining herein, and is amended and restated by the Member cities and towns effective \_\_\_\_\_, 2017, witnesseth:

WHEREAS, Ark. Code Ann. § 25-20-101 et seq provides that any governmental powers, privileges, or authority exercised or capable of exercise by a local governmental unit of this state alone may be exercised and enjoyed jointly with any other local governmental unit of this state.

WHEREAS, the local governmental units joining herein pursuant to Arkansas law, specifically but not limited to Ark. Code Ann. § 14-54-101 et seq and § 25-20-101 et seq, desire to establish a trust fund to be used as a means for providing group life, dependent life, and accidental death and dismemberment insurance; disability income, health and dental coverage, and other employee welfare benefits for employees, former employees, officials and former officials of member local governmental units.

WHEREAS, the trustees as hereinafter articulated have consented to act as Trustees of the Fund (The "Trustees"), under the provisions of this Declaration of Trust ("Declaration").

NOW, THEREFORE, in consideration of the mutual promises hereinafter made, the local governmental units joining herein hereby establish a trust fund to be known as the Municipal Health Benefit Fund (The "Fund") and hereby agree to maintain the Fund by the contribution of such amounts as may be determined by the Trustees to be necessary to carry out the purposes of this Trust.

PART I. PURPOSES OF THE TRUST

A. The Fund is created for the purpose of providing and maintaining adequate group life, accidental death and dismemberment and dependent life insurance, disability income, health and dental coverage, and such other employee welfare benefits as determined by the Trustees in their sole discretion from time-to-time (collectively, the "Benefits") for the benefit of the member local governmental units ("Members") and their employees, former employees, officials, and former officials ("Member Employees").

B. The Trustees shall effectuate this Declaration by securing appropriate insurance coverage and setting up the Fund to provide the Benefits.

C. Members must also be a member in good standing with the Arkansas Municipal League (the "League") under whatever membership provisions and qualifications the League may require.

## PART II. DEFINITION OF TRUST FUND

The term "Fund" as used herein shall mean the trust estate known as the Municipal Health Benefit Fund which shall consist of the policies purchased hereunder together with all experience refunds or other sums payable to the Trustees on account of such policies; all monies received by the Trustees as contributions from the Members; and any other property received and held by the Trustees for uses, purposes and trusts set forth in this Declaration.

## PART III. APPLICATION OF THE FUND

The Trustees shall use and apply the Fund to pay or provide for the initial cost and the payment of premiums on the policies in the Fund when such premiums shall become due; to accept and apply all required dues, assessments, and premium payments from Members as required in order to provide the Benefits; to pay Benefits to Member Employees of the Fund according to the governing terms for the respective Benefits; and for all such other uses and purposes as determined by the Trustees to be necessary and proper in order to provide the Benefits.

## PART IV. POWERS AND DUTIES OF THE TRUSTEES

The Trustees shall have the following duties and powers:

1. To provide and keep in good standing such policies of group life, dependent life and accidental death and dismemberment or other insurance coverage as may be deemed necessary to provide Benefits. They shall set up and maintain the Fund to provide disability income, health, dental, and other employee welfare benefits as they determine and provide such reinsurance or other coverage as deemed necessary to provide Benefits.
2. They shall, in their names as Trustee, have the right and power to assess the Members in such amounts as may be necessary to fulfill the purposes of this Trust. Such assessments shall be made in such amounts that the Member shall each pay an amount proportionate to the Benefits provided by the Trustees for such Members and Member Employees.
3. If any assessment is not paid by a Member the Trustees may, without notice, terminate the Member's rights under this Fund and discontinue the Benefits as may be provided for the benefit of such Member and Member's Employees.

4. The Trustees shall have the right to inspect the records of Members so far as they are pertinent to the purposes of this Declaration and may require such reports from Members as may be necessary to the administration of the Fund.
5. The Trustees shall keep true and accurate books of account and records of all their transactions.
6. The Trustees may promulgate such rules and regulations not inconsistent with the terms hereof as may, in their discretion, be proper or necessary for the sound and efficient administration of the Fund. The rules and regulations shall be set forth in a Fund Booklet published at least annually, to Members and Member Employees. Use by the Fund of electronic based communications and internet sites constitutes timely and complete publication. A Participation Agreement between the Member and the Fund shall be fully executed as may be required by the Fund Administrator.
7. The Trustees shall not receive compensation for the performance of their duties, but shall be entitled to be reimbursed for expenses.
8. The Trustees shall not be personally liable for any obligation to pay Benefits or premiums incurred by them as Trustees or for any action pursuant to this Declaration in good faith taken or omitted, nor for any action taken or omitted by any agent, employee, or attorney selected with reasonable care. The Trustees may delegate any of their ministerial powers or duties hereunder to an agent or employee.
9. Notwithstanding anything to the contrary herein, the League, the Trustees of the Fund, the Administrator of the Fund, and the Fund shall not be obligated, directly or indirectly to pay any sum except from the Fund's monies and assets and then only to the extent that funds are available in the Fund.
10. The Executive Director of the League shall serve as Administrator of the Fund.
11. The Trustees shall act as a board of review on all appeals from the decisions of the Administrator and decisions of the Trustees on such appeals shall be final and binding upon all parties.

#### PART V. TRUSTEES

A. The Fund shall be administered by five (5) Trustees, one from each Arkansas Congressional District and one at large from the state of Arkansas, all of whom must be employees or officials of Member incorporated cities or towns elected only by the incorporated city and town Members participating in the Fund at the Annual Convention

of the League. Those Member Employees that do not work for a city or town or are not an elected or appointed official of a city or town in Arkansas are not eligible to serve as a Trustee.

B. Upon election, the Trustees declare that they will receive and hold the Fund as Trustees by virtue of this Declaration for the uses, purposes and trusts and with all the powers and duties of the Fund.

C. Whenever a Trustee ceases to be an employee or officer of a Member city or town participating in the Fund, he or she will thereby cease to be a Trustee of this Fund and his or her successor will be chosen by the remaining Trustees to serve until the annual election of Trustees. During the vacancy, the remaining Trustees shall have the power to act pursuant to the provisions of this Declaration, provided, however, no act or decision may be made without the consent or approval of a majority of the total number of Trustees.

D. Meetings of the Trustees shall be held at the call of the Administrator or any three (3) Trustees. A majority of the Trustees shall constitute a quorum for the transaction of business. All decisions of the Trustees shall be made by the vote of at least a majority of the quorum of Trustees.

E. Trustees may be removed for cause by majority vote of the Trustees but only after the Trustee is given notice of the possibility of removal and an opportunity to be heard during a Trustee meeting.

#### PART VI. TERMINATION OF THE TRUST

A. This Trust shall terminate under any of the following circumstances:

1. Upon notice of termination in writing to the then participating Members by the Trustees of the Fund.
2. Upon notice of termination in writing to the Trustees by all the then participating Members.
3. At such time as the total number of covered Member Employees shall become less than 600.

B. Upon termination of this Trust, the Trustees shall distribute to the then participating Members in shares proportionate to their contributions any funds which they have in their hands or which they may receive after such termination by virtue of this Trust.

#### PART VII. WITHDRAWAL FROM THE FUND

Any Member may terminate its connection with the Fund upon giving thirty (30) days' notice in writing to the Trustees of such intention to withdraw. Upon withdrawal, Members

monetary reserves remain in the Trust unless the Trust is terminated as provided for in Part VI of this Declaration.

#### PART VIII. ADMISSION TO THE TRUST (FUND)

Members shall be admitted as parties to this Fund upon written application for benefits under said Fund and by entering into a Participation Agreement with the Fund. The Fund Administrator shall have the authority to execute on behalf of the Trustees such Participation Agreement and any other documents related to a Member becoming a party to the Fund.

#### PART IX. AMENDMENT OF DECLARATION

This Declaration may be amended by a majority vote of the entire number of Trustees or a majority vote of the City or Town Members who are parties hereto, except that the general purposes of the Trust shall not be changed.

#### PART X. SITUS AND CONSTRUCTION OF TRUST

This Declaration and all questions pertaining to its validity, construction and administration shall be construed under and regulated by the laws of the State of Arkansas and where applicable, federal law.

**PARTICIPATION AGREEMENT  
IN THE  
MUNICIPAL HEALTH BENEFIT FUND**

THIS AGREEMENT, entered into this \_\_\_\_\_ day of \_\_\_\_\_, 2017, effective as of \_\_\_\_\_ (hereinafter called the "Effective Date") by and between the City of \_\_\_\_\_, Arkansas (the "City") and the Municipal Health Benefit Fund (the "Fund").

**WITNESSETH**

WHEREAS, the Fund is a multi-employer, self-funded trust fund created by Declaration of Trust dated November 16, 1981, as amended (the "Declaration of Trust"), to provide health and welfare benefits to employees of participating municipalities who are members of the Arkansas Municipal League; and

WHEREAS, the City wishes to become a Participating Employer in the Fund to provide health and welfare benefits to its eligible Employees; and

WHEREAS, by virtue of the authority granted to it in the Declaration of Trust, the Fund agrees to accept the City as a Participating Employer in the Fund.

NOW, THEREFORE, for and in consideration of the promises and of the mutual covenants herein contained, the parties hereby agree as follows:

1. Beginning on the Effective Date, the City agrees to become a Participating Employer in the Fund and to make payments to the Fund on behalf of its eligible Employees to provide the following benefits for the following premium amounts:

Medical Coverage

\_\_\_\_\_ \$500 Deductible  
\_\_\_\_\_ \$1,200 Deductible  
\_\_\_\_\_ \$2,000 Deductible

\_\_\_\_\_ Dental Coverage

\_\_\_\_\_ Vision Coverage

\_\_\_\_\_ Life Insurance

\_\_\_\_\_ Disability Income Benefits

\_\_\_\_\_ Option A  
\_\_\_\_\_ Option B



MUNICIPAL HEALTH BENEFIT FUND  
PARTICIPATION AGREEMENT

2. By execution of this Participation Agreement, the City adopts and agrees to be bound by all of the terms and provisions of the Fund, as amended from time to time. The City further agrees to timely make all required premium payments to the Fund in accordance with the Fund's procedures.
3. The City acknowledges receipt of the proposal dated \_\_\_\_\_, 20\_\_\_\_. In accordance with the eligibility provision outlined in the proposal, the City hereby certifies and agrees that it will at all times while a Participating Employer in the Fund comply with the Eligibility Requirements of the Fund as set forth in Exhibit A attached hereto and incorporated herein. The City acknowledges that its participation in the Fund is contingent upon its compliance with the Eligibility Requirements.
4. By signature below, the City agrees to and does become a party to the Fund as a Participating Employer. The City hereby acknowledges receipt of a copy of the Declaration of Trust and the Municipal Health Benefit Fund Booklet.
5. By execution of the Participation Agreement by the Plan Administrator, the Fund accepts the City as a party to the Fund pursuant to the authority vested in the Plan Administrator by the Declaration of Trust. The Fund agrees to receive the City's premiums and to hold, administer and invest such funds and to pay claims to Employees in accordance with the terms and provisions of the Fund, as amended from time to time.
6. The terms of the Fund as in effect from time to time, shall fully apply to the City as of the Effective Date, with the imposition of any additional terms or conditions set forth in this Agreement.
7. The City acknowledges that, pursuant to the Declaration of Trust, the Fund may be terminated by giving written notice to member cities and other public entities at their regular business addresses. Pursuant to the Fund Booklet, the Fund agrees to provide such written notice by regular mail sixty (60) days prior to termination. The Fund's Trustees may also amend the terms of the Fund. It is the responsibility of the City to notify its Employees of any amendments or changes to the Fund.
8. All capitalized terms used in this Participation Agreement and all Exhibits hereto shall have the same meanings given to them in the Municipal Health Benefit Fund Booklet, unless otherwise defined in this Agreement.

IN WITNESS WHEREOF, the parties have caused this Participation Agreement to be executed on their behalf on the date first written above.

[signature page follows]

MUNICIPAL HEALTH BENEFIT FUND  
PARTICIPATION AGREEMENT

CITY:

\_\_\_\_\_

By: \_\_\_\_\_

Its: \_\_\_\_\_

MUNICIPAL HEALTH BENEFIT FUND:

By: \_\_\_\_\_

Don A. Zimmerman  
Plan Administrator

MUNICIPAL HEALTH BENEFIT FUND  
PARTICIPATION AGREEMENT

EXHIBIT A

ELIGIBILITY REQUIREMENTS

Since all eligible employees must be offered coverage, the City's participation in the Fund is expressly contingent upon the City's continued compliance with the following Eligibility Requirements:

The Eligible Class of employees who may be Covered under the Fund includes all employees of the City in any of the following classes. The City **must** include employees in Class 5, and may elect to include employees in the other classes, as part of the Eligible Class.

Class 1 – Active elected officials

Class 2 – Members of boards and commissions

Class 3 – Volunteer firefighters (See below for further details)

Class 4 – Auxiliary police

Class 5- All full-time active employees of the City who work at least thirty (30) hours per week.

Class 6 – Retired members age 55 or over (See Retiree Coverage for further details)

For each class to which it offers benefits, the City must meet the following criteria:

1. All eligible Employees have been offered Coverage, and
2. A list of all eligible Employees accepting Coverage has been submitted to the Fund, during an Open Enrollment Period and/or in the event of a Change of Status Event such as new hire, birth of a child, or divorce; and
3. Seventy-five (75%) percent of all eligible Employees elect Coverage under the Fund, and
4. A list of all eligible Employees opting out of Coverage, along with proof of Coverage through a Spouse, Medicare and/or another carrier has been submitted to the Fund during an Open Enrollment Period or at the time of qualifying Change of Status Event.

Volunteer Firefighters (Class 3)—to qualify for Coverage under the Fund, volunteer firefighters must actively participate in more than:

- 50 percent of fire calls.
- 50 percent of training sessions.
- Verification of participation must be certified in writing under penalty of perjury by the Fire Chief.
- Certification must be submitted to the Fund each year on or before December 31.

MUNICIPAL HEALTH BENEFIT FUND  
PARTICIPATION AGREEMENT

If the City offers Coverage to any of the Classes 1 through 4, then the Coverage must be offered to all members of the class. When Coverage is offered to a class, the City shall require all members of that class to sign up for the Coverage or submit a refusal form. A minimum of seventy-five percent (75%) of classes 2, 3 and 4 must sign up for Coverage, or none of the class may be Covered. Those persons in Classes 2, 3 and 4 who are eligible for Medicare are excluded from the seventy-five percent (75%). The City must maintain Coverage on seventy-five percent (75%) of each participating class (2, 3, 4 or 5) for Coverage to continue.

The City must offer medical Coverage to all eligible Employees working thirty (30) hours or more a week and must ensure that the Employee's share of the premium is affordable. The City may use one of three "safe harbors" allowed by IRS regulation to determine affordability. The W-2 wages safe harbor is most frequently used. It is satisfied if the City ensures that the Employee's share of the premium does not exceed 9.5 percent of the Employee's current W-2 wages for the cost of employee only (single) coverage for full-time active employees. Other safe harbors are (1) the rate of pay safe harbor, and (2) the federal poverty line safe harbor. If the City meets the requirements of the safe harbor, the offer of coverage is deemed affordable for purposes of Code section 4980H(b) regardless of whether it is affordable to the Employee under section 36B of the Code.

Medicare. Classes 1 through 4 are not eligible for the medical Coverage provided under the Fund if they are eligible for Medicare.

Active elected officials (Class 1) who are on Medicare are eligible for dental, vision, drug card and hearing aid Coverage. However, enrollment in all parts of Medicare, Parts A, B and D, is required for active elected officials (Class 1) choosing to continue Coverage under the dental, vision, drug card and hearing aid Coverage benefits. However, seventy-five percent (75%) of each participating class (2, 3, 4 or 5) must participate for Coverage to continue.

**Municipal Health Benefit Fund**  
**P.O. Box 188**  
**North Little Rock, AR 72115**  
**501-978-6137**  
**[www.arml.org/mhbf](http://www.arml.org/mhbf)**

**Your Information.**  
**Your Rights.**  
**Our Responsibilities.**

---

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

### **Your Rights**

You have the right to:

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

### **Your Choices**

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

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

### **Our Uses and Disclosures**

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan

- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

## **Your Rights**

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

### **Get a copy of health and claims records**

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

### **Ask us to correct health and claims records**

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

### **Request confidential communications**

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

### **Ask us to limit what we use or share**

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

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

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

## **Get a copy of this privacy notice**

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

## **Choose someone to act for you**

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

## **File a complaint if you feel your rights are violated**

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

## **Your Choices**

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

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

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

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

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

## **Our Uses and Disclosures**

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

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



## **Help manage the health care treatment you receive**

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

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

## **Run our organization**

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

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

## **Pay for your health services**

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

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

## **Administer your plan**

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

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

## **How else can we use or share your health information?**

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

[www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

## **Help with public health and safety issues**

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

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

## **Do research**

We can use or share your information for health research.

## **Comply with the law**

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

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

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

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

We can use or share health information about you:

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

## **Respond to lawsuits and legal actions**

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

## **Our Responsibilities**

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

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

## **Changes to the Terms of this Notice**

This privacy notice is based upon "Model Notices of Privacy Practices" provided by the United States Department of Health and Human Services on their website as of September 19, 2017. HHS may change the regulatory law governing Privacy Practices or may change their model notice. If so, the MHBf will comply with the law and will change the terms of this notice. The changes will apply to all information we have about you. We will provide you with a copy of the new notice and the notice will be available on our web site.

## **Other Instructions for Notice**

- September 19, 2017
- Privacy Official: Katie Bodenhamer, 501-374-3484, ext. 126, [kbodenhamer@arml.org](mailto:kbodenhamer@arml.org).



# New Health Insurance Marketplace Coverage Options and Your Health Coverage

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## 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.<sup>1</sup>

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

### How Can I Get More Information?

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

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

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<sup>1</sup> 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](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.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.

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

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.\* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? \$ \_\_\_\_\_

b. How often?    ☐ Weekly    ☐ Every 2 weeks    ☐ Twice a month    ☐ Monthly    ☐ Quarterly    ☐ Yearly

Date of change (01/01/2018)

\* 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)



Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services  
Municipal Health Benefit Fund: MHBf

Coverage Period: 01/01/2018 – 12/31/2018  
Coverage for: Individual + Family | Plan Type: PPO



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

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

Important Questions	Answers	Why This Matters
What is the overall <u>deductible</u> ?	\$500, \$1,200, or \$2,000/individual; or \$6,000/family	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For <u>network providers</u> \$4,000 individual / \$8,000 family; for <u>out-of-network providers</u> there is no limit. For pharmacy providers \$2,600 individual / \$5,200 family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Copayments</u> , <u>deductibles</u> , <u>premiums</u> , <u>balance-billing</u> charges, penalties for failure to precertify, out-of-state and <u>out-of-network</u> care and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://www.arml.org/services/mhbf/">www.arml.org/services/mhbf/</a> or call 1-501-978-6137 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .





All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

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



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



If you need help recovering or have other special health needs	<u>Habilitation services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	These services will be combined to allow a maximum of 40 visits annually with physical therapy, speech therapy, occupational therapy, and chiropractic services.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Coverage is limited to 15 days annually. You must pre-certify by calling 888-295-3591. There is a \$1,500 penalty deductible for failure to pre-certify.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Hospice services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Coverage is limited to 90 days per lifetime. You must pre-certify by calling 888-295-3591. There is a \$1,500 penalty deductible for failure to pre-certify.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered
	Children's glasses	Not covered	Not covered	Not covered
	Children's dental check-up	Not covered	Not covered	Not covered

#### Excluded Services & Other Covered Services:

##### Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (adult)
- Routine foot care

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

- Bariatric surgery is only covered under the MBS-AQIP Program. Please consult section 2 of your policy booklet for further information.
- Chiropractic care as a component of the 40-visit combined annual limit for all habilitation services.
- Hearing aids
- Weight loss program coverage is limited to two weight loss program visits annually, or only as otherwise covered under the MBS-AQIP Program. Please consult section 2 of your policy booklet for further information.

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

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

**Does this plan provide Minimum Essential Coverage? Yes.**

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

**Does this plan meet the Minimum Value Standards? Yes.**

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

#### **Language Access Services:**

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

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



## About these Coverage Examples:



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

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

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

#### This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
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#### In this example, Peg would pay:

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

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

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

#### This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
--------------------	---------

#### In this example, Joe would pay:

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

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

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

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
--------------------	---------

#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$500*
Copayments	\$250**
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$950</b>

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

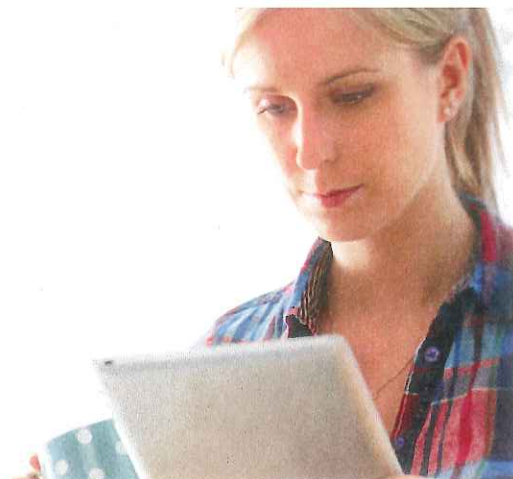
\*\*Copayments include copayments for office visits as well as prescriptions, along with any other services listed in the table beginning on page 2 of this document that require copayments. These example scenarios may require the payment of multiple copayments (for example, for multiple visits or prescriptions)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

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





# Managing your medications online



**optumrx.com** is a fast, easy and secure way to get the information you need to make the most of your pharmacy benefit.

## Website features and tools

Log into or register on **optumrx.com** and you will be able to:

- Search for drug prices and lower-cost alternatives
- View your claims history
- Enroll in text message reminders
- Manage medications for household members<sup>1</sup>
- View your real time benefits

## While on the go

Access your pharmacy benefits and manage your prescriptions from your smartphone or tablet with the **OptumRx app**.<sup>3</sup>

- View your prescription claim history
- Locate a pharmacy
- Find drug prices and lower-cost options
- Access your ID card, if your plan allows
- Set up refill reminders

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We want you to get the most out of your pharmacy plan.  
The more you know, the more you can save.  
Visit **optumrx.com** today.

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## My medication reminders

Set up text message reminders to help you remember when to take your medication. Text message reminders have been shown to improve medication adherence in persons taking long-term or maintenance medications.<sup>2</sup>

Download the OptumRx App now from the Apple® App Store or Google Play™.



The company does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.

Free services are provided to help you communicate with us, such as letters in other languages or large print. You may also ask to speak with an interpreter. To ask for help, please call the toll-free phone number listed on your ID card.

ATENCIÓN: Si habla **español (Spanish)**, La compañía no discrimina por raza, color, nacionalidad, sexo, edad o discapacidad en actividades y programas de salud.

Se brindan servicios gratuitos para ayudarle a comunicarse con nosotros, como cartas en otros idiomas o en letra grande. También puede solicitar comunicarse con un intérprete. Para solicitar ayuda, llame al número de teléfono gratuito que figura en su tarjeta de identificación.

請注意：如果您說中文 (**Chinese**)，公司不会基于种族、肤色、国籍、性别、年龄或残疾而在健康计划和活动中歧视任何人。

为帮助您与我们沟通，我们提供一些免费服务，例如用其他语言书写的信件或大字体。您也可以要求与口译员对话。欲寻求帮助，请拨打您的 ID 卡上列出的免费电话号码。

1. Dependents or spouses you have access to.
2. Adherence rates quantified using OptumRx internal data for oral anti-diabetic medications among Medicare Part D Beneficiaries, May 2012.
3. App is available for download on both Apple and Android devices.



OptumRx specializes in the delivery, clinical management and affordability of prescription medications and consumer health products. We are an Optum® company — a leading provider of integrated health services. Learn more at [optum.com](https://www.optum.com).

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# Customer Service



OptumRx® administers your pharmacy benefit plan on behalf of your plan sponsor, and we're here to help. In addition to answering questions about your plan, we may be able to help you save money on your prescription medications. We're committed to you and your well-being, so we make it easy for you to get information that can help you and your doctor make informed decisions about medication therapies.

## Easy-to-Use Website

Our website, **optumrx.com**, is fast and easy to use. You can manage your account, get medication pricing, find medication information and more.

- **Locate a pharmacy:** A handy tool to quickly find participating pharmacies near you
- **My account dashboard:** Lets you manage your online account and get pharmacy benefit plan information
- **Health tools:** Find up-to-date wellness information and learn more about your personal health

**Plus, now you can manage your prescriptions from anywhere, any time.**

Simply download the OptumRx App® to your smartphone or tablet.



## Dedicated Customer Service

When you call OptumRx at **1-855-253-0843**, you get real-time answers and information from our friendly and knowledgeable Customer Service Advocates. They are available to help you 24 hours a day, 7 days a week.

**Online:**  
**optumrx.com\***

**Phone:**  
**1-855-253-0843**

**Smart Phone/Tablet:**  
**OptumRx App\***

\*Registration required to obtain plan specific details