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

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

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

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

Common Medical Event	Services You May Need	Your Cost If You Use an In-	Your Cost If You Use an Out-of-	Limitations & Exceptions
More information about **prescription drug coverage** is available at www.arml.org. **If you need drugs to treat your illness or condition.** More information about **prescription drug**	Reference-Priced drugs	Total cost of the dispensed drug less the total cost of the reference drug per prescription	Not covered	
	Specialty drugs up to $1,000; Specialty drugs up to $1,000.01 or higher	$50/ prescription $100/ prescription	Not covered	Coverage is limited to a 30 day supply per prescription and you must pre-certify by calling 866-285-2935.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center).	20% coinsurance	50% coinsurance	Coverage for non-emergency surgery is limited to 2 surgeries annually. You must pre-certify by calling 888-295-3591. There is a $1,500 deductible for failure to precertify.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room services	$250 copayment per visit and then 20% coinsurance	$250 copayment per visit and then 20% coinsurance	$250 copayment is waived if admitted to inpatient hospital.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Coverage is limited to 2 ground and 2 air transports annually
	Urgent care	$20 copayment and then 20% coinsurance	$20 copayment and then 20% coinsurance	--------None--------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Coverage is limited to 30 days annually. You must pre-certify by calling 888-295-3591. There is a $1,500 deductible for failure to precertify.
	Physician/surgeon fee	20% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	Your Cost If You Use an In-	Your Cost If You Use an Out-of-	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health - outpatient services	20% coinsurance	50% coinsurance	Coverage is limited to 24 visits annually
	Mental/Behavioral health - inpatient services	20% coinsurance	50% coinsurance	Coverage is limited to 10 days annually. You must pre-certify by calling 888-295-3591. There is a $1,500 deductible for failure to precertify.
	Substance abuse disorder – inpatient services	20% coinsurance	Not covered	Coverage is limited to 1 treatment plan, whether inpatient or outpatient per lifetime at MHBF Designated Chemical Dependency Center(s). You must pre-certify by calling 888-295-3591.
	Substance abuse disorder – outpatient services	20 % coinsurance	Not covered	
If you are pregnant	Prenatal and postnatal care	20% coinsurance	50% coinsurance	--------None--------
	Delivery and all inpatient services	20% coinsurance	50% coinsurance	You must pre-certify an extended inpatient stays by calling 888-295-3591. There is a $1,500 deductible for failure to pre-certify.
If you need help recovering or have other special health needs.	Home health care	20% coinsurance	50% coinsurance	Coverage is limited to 20 visits annually. You must pre-certify by calling 888-295-3591. There is a $1,500 deductible for failure to pre-certify.
	Rehabilitation services	20% coinsurance	50% coinsurance	Coverage is limited to 30 days for acute care and 15 days for sub-acute care, annually. You must pre-certify by calling 888-295-3591. There is a $1,500 deductible for failure to pre-certify.

Common Medical Event	Services You May Need	Your Cost If You Use an In-	Your Cost If You Use an Out-of-	Limitations & Exceptions
	Habilitation Services	20% coinsurance	50% coinsurance	These services will be combined to allow a maximum of 40 visits annually with physical therapy, speech therapy, occupational therapy, and chiropractic svcs.
	Skilled nursing care	20% coinsurance	50% coinsurance	Coverage is limited to 15 days annually. You must pre-certify by calling 888-295-3591. There is a $1,500 deductible for failure to pre-certify.
	Durable medical equipment	20% coinsurance	50% coinsurance	--------None--------
	Hospice service	20% coinsurance	50% coinsurance	Coverage is limited to 90 days per lifetime. You must pre-certify by calling 888-295-3591. There is a $1,500 deductible for failure to pre-certify.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	Not covered
	Glasses	Not covered	Not covered	Not covered
	Dental check-up	Not covered	Not covered	Not covered

Excluded Services & Other Covered Services:

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

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

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery is only covered under the MBS-AQUIP Program
- Smoking Cessation Program
- Hearing aids

Your Rights to Continue Coverage:

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

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

Your Grievance and Appeals Rights:

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

Does this Coverage Provide Minimum Essential Coverage?

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

Does this Coverage Meet the Minimum Value Standard?

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

Language Access Services:

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

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

About these Coverage Examples:

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

This is not a cost estimator.

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

See the next page for important information about these examples.

baby
(normal delivery)

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

Sample care costs:

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

diabetes
(routine maintenance of a well-controlled condition)

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

Sample care costs:

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

Patient pays:

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

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

Patient pays:

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

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

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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