
 **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 1-833-265-6427 or visit mhbp.arml.org. 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 1-833-265-6427 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 \$6000/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> . This <u>deductible</u> applies to medical claim only. |
| 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 https://www.healthcare.gov/coverage/preventive-care- |
| 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 in-network medical providers, \$4,500,\$5,200, or \$6,000/individual & \$8,000/family; for out-of-network medical, 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 <u>in-network</u> covered services. If you have family members in this <u>plan</u> , they must 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>Premiums</u> , <u>out-of-network</u> charges, <u>balance billing</u> charges, penalties for failure to pre-certify, health care this <u>plan</u> doesn't cover. | Even though you pay theses expenses, they don't count toward the <u>out-of-pocket limit</u> . |

| Important Questions | Answers | Why This Matters: |
|--|---|---|
| Will you pay less if you use a <u>network provider</u> ? | Yes. See www.arml.org/services/mhbp/ or call 1-501-978-6137 for a list of network providers. | 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), but in this situation, balance billing is prohibited. Balance billing is also prohibited if you receive emergency care from an <u>out-of-network provider</u> . Check with your provider 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 referral. |

 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 <u>provider's office</u> or <u>clinic</u> | Primary care visit to treat an injury or illness | \$20 <u>copayment</u> /office visit and 20% coinsurance | \$20 <u>copayment</u> /office visit and 50% coinsurance, you may be balance billed | \$20 <u>copayment</u> per office visit code, <u>deductible</u> does not apply. If you receive services in addition to office visit code, such as diagnostic tests, <u>coinsurance</u> applies after <u>deductible</u> has been met. |
| | <u>Specialist</u> visit | \$20 <u>copayment</u> /office visit and 20% coinsurance | \$20 <u>copayment</u> /office visit and 50% coinsurance, you may be balance billed | \$20 <u>copayment</u> per office visit code, <u>deductible</u> does not apply. If you receive services in addition to office visit code, such as diagnostic tests, <u>coinsurance</u> applies after <u>deductible</u> has been met. |
| | <u>Preventive care/screening/immunization</u> | No Charge | <u>Plan</u> will pay 100% of <u>allowed amount</u> , you may be <u>balance billed</u> . | You may have to pay for services that aren't <u>preventive</u> . Ask your provider if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. Age and frequency schedules may apply. |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | 20% <u>Coinsurance</u> | 50% <u>Coinsurance</u> | None. |
| | Imaging (CT/PET scans, MRIs) | 20% <u>Coinsurance</u> | 50% <u>Coinsurance</u> | Coverage is limited to 2 PET scans/year. |

[* For more information about limitations and exceptions, see the [plan](http://www.arml.org/services/mhbp/) or policy document at www.arml.org/services/mhbp/]

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| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.arml.org/services/mhbp/ and in section 3 of your policy booklet. | Generic drugs | \$10 <u>copay</u> /prescription | Not covered | Certain preventive drugs are covered at No Charge. |
| | Preferred brand drugs | \$30 <u>copay</u> /prescription | Not covered | Coverage limited to a 30-day supply per prescription. |
| | 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 | This difference in total costs is a penalty and will not count towards your <u>out-of-pocket limit</u> . Coverage is limited to a 30-day supply per prescription. |
| | <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 get Prior Authorization by calling 844-853-9400. Total cost applied to <u>deductible</u> . |
| | Specialty drugs 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 surgery by calling 888-295-3591. There is a \$1,500 penalty for failure to pre-certify. |
| | Physician/surgeon fees | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | |
| If you need immediate medical attention | <u>Emergency room care</u> | \$250 <u>copayment</u> and 20% <u>coinsurance</u> | \$250 <u>copayment</u> and 20% <u>coinsurance</u> | \$250 <u>copayment</u> is waived if admitted for observation or to inpatient hospital. |
| | <u>Emergency medical transportation</u> | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | None. |
| | <u>Urgent care</u> | \$20 <u>copayment</u> and 20% <u>coinsurance</u> | \$20 <u>copayment</u> /office visit and 50% <u>coinsurance</u> , you may be balance billed | \$20 <u>copayment</u> per office visit code, <u>deductible</u> does not apply. If you receive services in addition to office visit code, such as diagnostic tests, coinsurance applies after deductible has been met. |

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|--|--|------------------------|------------------------|--|
| 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 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 40 visits annually. |
| | Inpatient mental/behavioral health services | 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 for failure to pre-certify. |
| | Substance abuse disorder services – inpatient/outpatient | 20% <u>coinsurance</u> | Not covered | Coverage is limited to 1 treatment plan (which may include at least 30 annual inpatient days, and 40 annual outpatient visits), per year at MHBP Designated Chemical Dependency Centers. You must pre-certify by calling 888-295-3591. |
| If you are pregnant | Prenatal and Postnatal care | 20% coinsurance | 50% coinsurance | Postnatal care extends up to 90 days post-delivery. You must pre-certify an extended inpatient stay by calling 888-295-3591. There is a \$1,500 penalty for failure to pre-certify. |
| | Delivery and all inpatient services | 20% <u>coinsurance</u> | 50% coinsurance | |
| 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 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 for failure to pre-certify. |
| | <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 for failure to pre-certify. |
| | <u>Durable medical equipment</u> | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | Pre-certification required for some DME. |
| | <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 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 <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .) | | | |
|--|--|---|--|
| <ul style="list-style-type: none"> Acupuncture Cosmetic surgery Dental care (Adult & Child) Infertility treatment | <ul style="list-style-type: none"> Long-Term Care Care when traveling outside the U.S. Private-duty nursing | <ul style="list-style-type: none"> Routine eye care (Adult & Child) Routine Foot Care Weight loss programs (see below) | |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.) | |
|--|--|
| <ul style="list-style-type: none"> Bariatric surgery is only covered under the MHBP Bariatric Weight Loss Program. Please consult section 2 of your policy booklet for further information. | <ul style="list-style-type: none"> Chiropractic care as a component of the 40-visit combined annual limit for all <u>habilitation services</u>. Hearing aids |

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 Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/ebsa/healthreform>. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how 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: www.arml.org/services/mhbp or call 1-833-265-6427.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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 1-833-265-6427]

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 <u>plan's</u> overall <u>deductible</u> | \$500* |
| ■ <u>Specialist copayment</u> | \$20 |
| ■ Hospital (facility) <u>coinsurance</u> | 20% |
| ■ Prescription copayment (generic) | \$10/RX |

This EXAMPLE event includes services like:

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

| | |
|---------------------------|-----------------|
| Total Example Cost | \$12,800 |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$500* |
| <u>Copayments</u> | \$60** |
| <u>Coinsurance</u> | \$2,000 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Peg would pay is | \$2,560 |

Managing Joe's Type 2 Diabetes

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

| | |
|---|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$500* |
| ■ <u>Specialist copayment</u> | \$20 |
| ■ PCP <u>copayment</u> | \$20 |
| ■ 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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$500 |
| <u>Copayments</u> | \$120** |
| <u>Coinsurance</u> | \$1074 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Joe would pay is | \$1,474 |

Mia's Simple Fracture

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

| | |
|---|--------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$500* |
| ■ <u>Emergency room penalty</u> | \$250 |
| ■ Hospital (facility) <u>coinsurance</u> | 20% |
| ■ Other <u>coinsurance</u> | 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:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| <u>Deductibles</u> | \$500 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$230 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$250 |
| The total Mia would pay is | \$980 |

[* For more information about limitations and exceptions, see the plan or policy document at www.arml.org/services/mhbp/]

*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.