MUNICIPAL HEALTH

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
Municipal Health Benefit Program: MHBP-High Deductible Health Plan (HDHP)

Coverage Period: 01/01/2026-12/31/2026
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 1-833-265-6427 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 deductible?	$2,500/individual or $7,500/family; applies to medical & pharmacy covered costs.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. The deductible applies to medical &
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For in-network medical & pharmacy, $5,000/individual & $10,000 family; for out-of-network medical & pharmacy, there is no limit.	The out-of-pocket limit is the most you could pay in a year for in-network covered services. If you have family members in this plan, they must meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, out-of-network charges, balance billing charges, penalties for failure to pre-certify, health care this plan doesn't cover.	Even though you pay theses expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.arml.org/services/mhbp/ or call 1-501-978-6137 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work), but in this situation, balance billing is prohibited. Balance (cont.) billing is also prohibited if you receive emergency care from an out-of-network provider. Check

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Important Questions	Answers	Why This Matters:
		with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist 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 provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	50% coinsurance	Coinsurance applies after deductible has been met. If you receive services in addition to office visit, additional deductible and coinsurance *may* apply.
	Specialist visit	20% coinsurance	50% coinsurance	Coinsurance applies after deductible has been met. If you receive services in addition to office visit, additional deductible and coinsurance *may* apply.
	Preventive care/screening/ immunization	No Charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance	50% Coinsurance	None.
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	50% Coinsurance	Coverage is limited to 2 PET scans/year.

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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 copay/prescription	Not covered	Total cost of drugs (that aren't preventive) are applied to deductible, then once met, copay applies. Certain preventive drugs are covered at No Charge. Coverage limited to a 30-day supply per prescription.
	Preferred brand drugs	$30 copay/prescription	Not covered	
	Non-preferred brand drugs	$50 copay/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 deductible. Coverage is limited to a 30-day supply per prescription.
	Specialty drugs up to $1,000	$100 copay/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 deductible first, then once met, copay applies.
	Specialty drugs over $1,000	$200 copay/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 deductible first, then once met, copay applies.

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 surgery by calling 888-295-3591. There is a $1,500 penalty for failure to pre-certify.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	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.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None.
	Urgent care	20% coinsurance	20% coinsurance	None.

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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 penalty for failure to pre-certify.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient mental/behavioral health services	20% coinsurance	50% coinsurance	Coverage is limited to 40 visits annually.
	Inpatient mental/behavioral health services	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 penalty for failure to pre-certify.
	Substance abuse disorder services – inpatient/outpatient	20% coinsurance	Not covered	Coverage is limited to 1 treatment plan (which may include at least 30 annual in-patient 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% 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.
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 penalty 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 penalty for failure to pre-certify.
	Habilitation services	20% coinsurance	50% coinsurance	These services will be combined to allow a

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				maximum of 40 visits annually with physical therapy, speech therapy, occupational therapy, and chiropractic services.
	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 penalty for failure to pre-certify.
	Durable medical equipment	20% coinsurance	50% coinsurance	Pre-certification required for some DME.
	Hospice services	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 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 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 & Child)
- Infertility treatment
- Long-Term Care
- Care when traveling outside the U.S.
- Private-duty nursing
- 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 plan document.)

- Bariatric surgery is only covered under the MHBP Bariatric Weight Loss 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

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 htttps://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.

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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

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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	**$2,500**
Specialist coinsurance	**20%**
Hospital (facility) *coinsurance*	**20%**
Other *coinsurance*	**20%**

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:	
Cost Sharing	
Deductibles	$2,500
Copayments	$0
Coinsurance	$2,060
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$4,560**

Managing Joe's Type 2 Diabetes

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

The plan's overall deductible	**$2,500**
Specialist coinsurance	**20%**
PCP coinsurance	**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:	
Cost Sharing	
Deductibles	$2,500
Copayments	$30
Coinsurance	$974
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$3,504**

Mia's Simple Fracture

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

The plan's overall deductible	**$2,500**
Emergency room penalty	**$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	$2,500
Copayments	$250
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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

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