Reference Pricing (RP)

The Reference Pricing program is used when evidence shows one product in a class of drugs is not any more effective than the other drugs within the same therapeutic class. The plan uses a lower cost medication as a “reference” to determine how much of the cost of a drug the plan will cover. If a member requires a higher priced product, the Plan pays the “referenced price” and the member is responsible for the remainder of the cost.

Refer to the Preferred Drug List (PDL) for the prescription drug therapeutic categories that are currently under the Reference Pricing program for the pharmacy benefit plan. These products are indicated on the Preferred Drug List with (RP).

Example: For calcium regulators, the medications Actonel, Atelvia, Boniva and ibandronate are referenced priced. The plan pays up to $0.10 per pill/unit. The member is responsible for the remaining cost.

New Generics (NG)

When a new generic drug is released, it will be placed at the same Tier as its Brand counterpart. For example, when a Tier 2 medication becomes available as a generic, the new generic preparation will also be place at Tier 2. The Branded product will no longer be Tier 2 and instead be subject to the “Brand/Generic” pricing incentive (See SPD page 46). **Please note that these new generics will not have the standard Tier 1 copayment that older generic products have**.

Timely Filing

In the event that a medication is not processed through the prescription drug program at the time of service, the member has 180 days from the date the prescription is filled to submit for member reimbursement. **Please note that paper claims submitted by a member are subject to the same coverage criteria as any other prescriptions. Paper claims are processed at the same discounted pharmacy rate that would apply had the pharmacy processed the claim. Member reimbursement will be applied after the plan discount and member copayment are determined. This may result in a member reimbursement less than what is expected. Submission of materials does not guarantee payment**

Arkansas State and Public School Employees Preferred Drug List (PDL) - Effective January 2018

This PDL is a list of the most commonly prescribed drugs. It is not all-inclusive and is not a guarantee of coverage. Plan Benefit Design is the final determinate of coverage. For drugs not listed, please call the pharmacy program number listed on the back of your ARBenefits ID card for benefit coverage information.

PLEASE NOTE: Use of generic drugs can save both you and your health plan money. Generics that are new to the market will require a copyment equal to its branded product. These are indicated in the PDL with *(NG) and are shown in bold type. These new generics will not have the standard Tier 1 copayment that older generic products have. In addition, brand-name medications that are available in the generic form may still appear in a tiered copay box, however, they will require a generic drug copayment PLUS the difference in the plan's cost between the generic and equivalent brand-name drug. If the brand name product is a reference-priced medication*(RP), the equivalent new generic will also become reference-priced instead of applying the difference in brand/generic cost. *Brand drugs with an equivalent generic available are non-covered on the Classic and Basic plans.*

Specialty drugs *may require* prior authorization (PA) by EBRx (1-866-564-8258) to ensure appropriate usage. These medications are indicated in the PDL located under Tier 4.

Compounded medications require a Tier 3 copay for Premium plan members. Deductible and/or coinsurance will apply for Classic and Basic plan members. General benefit guidelines apply.

Medications listed as reference priced are considered non-covered on the Classic and Basic plans.

Key: Certain drugs (*) may be subject to Day Supply (DS), Quantity Limits (QL), Prior Authorization (PA), Step Therapy (ST), Contingent Therapy (CT), New Generics (NG) or Reference Pricing (RP) requirements according to Benefit Design. **Items indicated as *(RP) require special copayment pricing and do not apply to the standard tier copayments. This PDL is subject to change at any time.**

	Tier 1	Tier 2	Tier 3	Tier 4
ANTI-INFECTIVES				
Antibiotics-Cephalosporins	cefaclor, cefadroxil, cefpodoxime, cefprozil, cephalexin, cefdinir	Cedax, Spectracef, Suprax 400 mg capsule*(QL)		
Antibiotics-Macrolides	erythromycin, azithromycin*(QL), clarithromycin	Zmax Suspension		
Antibiotics-Fluoroquinolones	ciprofloxacin, levofloxacin			
Antibiotics-Penicillins	amoxicillin, amoxicillin/clavulanate, ampicillin, penicillin			
Antibiotics-Other	minocycline		Adoxa, linezolid*(PA) (**NG**)	
Antifungals	fluconazole, itraconazole*(PA), ketoconazole, nystatin, terbinafine			
Antiretrovirals	abacavir, didanosine, lamivudine, lamivudine/zidovudine, nevirapine, zidovudine	Isentress*(PA), Isentress Chewable*(PA), Prezista tablets, Reyataz, Sustiva, Viracept, Viread	Epivir, Evotaz, Prezcobix, Reyataz powder, Vitekta	Aptivus, Atripla, Combivir, Crixivan, Descovy, Emtriva, Epzicom, Invirase, Isentress Powder*(PA), Kaletra, Lexiva, Odefsey, Prezista soln*(PA), Rescriptor, Tivicay, Trizivir, Truvada, Selzentry*(PA), Stribild tablet*(QL)*(PA)

	Tier 1	Tier 2	Tier 3	Tier 4
Antivirals-Flu	amantadine, rimantadine	Tamiflu	Relenza	
Antivirals-Herpes	acyclovir, famciclovir, valacyclovir			
Antivirals-Other-Interferons/Interferon combinations	ribavirin*(PA)			Zepatier*(PA)
CARDIOVASCULAR				
Antihyperlipidemic-HMG (Statins) **(NOTE: See Wellness/Preventive section.)**	atorvastatin, lovastatin, pravastatin, rosuvastatin, simvastatin			
	***(RP) Reference Priced Antihyperlipidemic-HMG (Statins): Plan pays $0.30 per unit. Member is responsible for remaining cost.**	Altoprev, Crestor 5mg, 10mg & 20mg, fluvastatin, Lescol XL, Lipitor, Mevacor, Pravachol, Zocor		
Other Antihyperlipidemic Agents	cholestyramine resin, colestipol, gemfibrozil	Welchol tablet	ezetimibe*(PA)	
Antiplatelet Agents	clopidogrel, dipyridamole, dipyridamole/aspirin, anagrelide, cilostazol	Effient	Brilinta	
Anticoagulants	warfarin	Eliquis, Xarelto		
ACE Inhibitors and ACE Inhibitors combinations	amlodipine/benazepril, captopril, captopril hctz, enalapril, fosinopril, lisinopril, lisinopril hctz, moexipril/hctz, perindopril, quinapril/hctz, ramipril, trandolapril, trandolapril/verapamil			
Angiotensin II Rec Antagonist (ARB)/Direct Renin Inhibitor (DRI)	amlodipine/valsartan, irbesartan, irbesartan/HCTZ, losartan, losartan/HCTZ, telmisartan, valsartan, valsartan/HCTZ			
	***(RP) Reference Priced Angiotensin Receptor Blockers (ARB): Plan pays $0.81 per unit. Member is responsible for remaining cost.**	**amlodipine/valsartan HCT*(NG)**, Atacand, **candesartan*(NG)**, Atacand HCT, candesartan cilexetil/HCTZ, Avalide, Avapro, Azor, Benicar, Benicar HCT, Cozaar, Diovan, Diovan HCT, Edarbi, Edarbyclor, Exforge, Exforge HCT, Hyzaar, Micardis, Micardis HCT, Tekturna, Tekturna HCT, Teveten, Teveten HCT, Twynsta, **telmisartan/amlodipine*(NG)**		

	Tier 1	Tier 2	Tier 3	Tier 4
Beta Blockers	acebutolol, atenolol, bisoprolol, labetalol, metoprolol, metoprolol hctz, metoprolol XL, propranolol, propranolol hctz			
Calcium Channel Blockers	amlodipine,diltiazem, felodipine, nicardipine, verapamil			
CENTRAL NERVOUS SYSTEM				
ADHD Medications	amphetamine salts IR*(QL), dexmethylphenidate tablets, dextroamphetamine*(QL), methylphenidate*(QL), methylphenidate ER*(QL), modafinil*(PA)*(QL), amphetamine salts XR*(QL)	Concerta*(QL), Daytrana*(QL), Nuvigil*(PA, QL), Strattera*(QL), atomoxetine*(**NG**)(QL)	Adderall XR*(QL), dexmethylphenidate ER*(**NG**), Dexedrine*(QL), Metadate CD*(QL), ER*(QL), Ritalin LA*(QL), Vyvanse*(QL)	
	***(RP) Long Acting Amphetamines: Plan pays $2.50 per unit. Member is responsible for remaining cost.**	Long Acting Amphetamines are ***reference priced*** for members 26 years of age or older; ****Quantity Limits*** will still apply to ***reference priced*** long acting amphetamines. Adderall XR*(QL), amphetamine salts extended release*(QL), Dexedrine*(QL), dextroamphetamine extended release*(QL), Vyvanse*(QL)		
Alzheimers	donepezil, galantamine, galantamine ER, rivastigmine	**memantine*(NG)(PA), rivastigmine patch*(NG)**		
Analgesics-Narcotic	codeine-apap*(QL), fentanyl patch, hydrocodone combinations*(QL), meperidine, morphine sulfate, oxycodone combinations*(QL), oxycodone controlled release 12HR		Fentora Tablet*(QL)*(PA), Oxycontin, Percocet*(QL), Percodan, Tylenol/w Codeine*(QL)	
Analgesics-NSAIDs (**NOTE:** Topical NSAIDs are not covered by the plan.)	diclofenac tabs, etodolac, ibuprofen, indomethacin, ketorolac*(QL), meloxicam, naproxen/sodium, sulindac			
Anticonvulsants	carbamazepine, levetiracetam, phenytoin, valproic acid, gabapentin, lamotrigine, divalproex delayed release, divalproex SR, topiramate, oxcarbazepine, zonisamide		Banzel*(PA), Fycompa, Potiga*(PA)	
Fibromyalgia	gabapentin			
	***(RP) Reference Priced Anticonvulsants: Plan pays $0.35 per unit. Member is responsible for the remaining cost.**	Lyrica		

	Tier 1	Tier 2	Tier 3	Tier 4
Antidepressants-Other	amitriptyline, bupropion immediate release and SR, bupropion XL, desipramine, imipramine, mirtazapine, nortriptyline			
Antidepressants (SNRIs)	duloxetine, venlafaxine, venlafaxine XR capsule			
	***(RP) Serotonin norepinephrine reuptake inhibitors (SNRIs): Plan pays $0.75 per unit. Member is responsible for remaining cost.**	Cymbalta, Effexor XR, venlafaxine extended release ***tablets***		
Antidepressants (SSRIs)	citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine, sertraline			
	***(RP) Selective serotonin reuptake inhibitors (SSRIs): Plan pays $0.30 per unit. Member is responsible for remaining cost.**	Lexapro, Luvox CR, fluvoxamine ER, Paxil, Paxil ER, paroxetine ER, Pexeva, Zoloft		
Anti-Parkinson	carbidopa/levadopa, entacapone, pramipexole, ropinirole, selegiline,	**rasagiline*(NG)**, Tasmar	**pramipexole SR*(NG)**	Nuplazid*(PA)
Antipsychotic Agents	clozapine, olanzapine/fluoxetine, olanzapine, olanzapine ODT, risperidone, quetiapine, ziprasidone	Abilify Tablet*(PA), **Aripiprazole tablet*(NG)(PA)**, Seroquel XR*(QL)	Abilify Solution*(PA), Equetro	Invega Sustenna, Invega Trinz*(PA)
Migraine Products	rizatriptan*(QL), rizatriptan ODT*(QL), sumatriptan tablets*(QL)		sumatriptan injectables*(QL)	
	***RP Migraine Medications. Plan pays $0.50 per unit. Member is responsible for remaining cost.**	almotriptan (QL), Axert*(QL), Frova*(QL), Frovatriptan (QL), Naratriptan (QL), Relpax (QL), Zolmitriptan (QL), Zolmitriptan ODT (QL)		
	***RP Migraine Medications. Plan pays $6.00 per prescription. Member is responsible for remaining cost.**	Sumatriptan Nasal Sprays (QL), Zomig nasal sprays(QL)		

	Tier 1	Tier 2	Tier 3	Tier 4
Multiple Sclerosis Drugs				Aubagio tablet*(PA)*(QL), Avonex*(PA), Betaseron*(PA), Extavia, Gilenya, **glatopa*(NG)**, Rebif*(PA), Tecfidera*(PA)*(QL)
Sedative Hypnotics	temazepam 15mg, temezapam 30mg, triazolam, zaleplon, zolpidem			
	***(RP) Reference Priced Sedatives/Hypnotics: Plan pays $0.15 per unit. Member is responsible for remaining cost.**	Ambiem, Ambien CR, zolpidem ER, eszopiclone*(NG), Lunesta, Rozerem, Sonata, temazepam 7.5mg, temazepam 22.5mg		
Skeletal Muscle Relaxants	cyclobenzaprine, metaxalone, tizanidine, dantrolene, baclofen, chlorzoxazone			
ENDOCRINE				
Diabetes-Insulin	no generics available at this time	Humulin R 100, Humulin N, Humulin 70/30, Humulin R U-500 Kwikpen, Humalog, Lantus, Toujeo		
Diabetes-Non-Insulin Injectable antihyperglycemic agents	no generics available at this time	Victoza*(PA)		
Diabetes-Insulin Sensitizing Agents	metformin, pioglitazone			
Diabetes-Insulin Secreting Agents	chlorpropamide, glimepiride, glipizide, glyburide, nateglinide, repaglinide, tolazamide			
Diabetes – SGLT2		Jardiance*(PA), Synjardy*(PA), Synjardy XR*(PA)		
Diabetes-Combinations	Glyburide/Metformin, pioglitazone/metformin*(PA), piogiltazone HCL/glimepiride*(PA)			
Diabetes-Other Medications	acarbose	Glyset		

	Tier 1	Tier 2	Tier 3	Tier 4
Diabetic Supplies	***Diabetic testing strips*** will now require a copay. Several *Tier 1* options are available. Covered test strips are listed below. Other diabetic testing supplies (lancets and needles) will be provided at a $0 copay to members actively enrolled in the ***Diabetes Management Program*** .			
	Advocate, Agamatrix, Element, Embrace, Relion, Truetest, Truetrack, Prodigy, Wavesense Presto		Onetouch Ultra Blue, Onetouch Viero, Onetouch Basic, Bayer Contour, Bayer Breeze, Accu-Chek Aviva, Accu-Chek Compact, Accu-Chek Smartview, Accu-Chek Comfort Curve, Freestyle, Freestyle Lite	
Thyroid Agents	levothyroxine, Levoxyl			
GASTROINTESTINAL/URINARY				
Digestive Aids	pancrelipase	Creon, Viokace, Zenpep		
Gallstone Solubilizing Agents	ursodiol			
H-2 Antagonists	cimetidine, famotidine, nizatidine, ranitidine			
Proton Pump Inhibitors	lansoprazole OTC, omeprazole 10mg, omeprazole 20mg, omeprazole 40mg, omeprazole OTC, pantoprazole 20 & 40 mg, pantoprazole inj, Prevacid 24hr OTC, Prilosec OTC		Zegerid powder packets	
	***(RP) Reference Priced Proton Pump Inhibitors: Plan pays $0.30 per unit. Member is responsible for remaining cost.**	Aciphex, **rabeprazole*(NG)**, Dexilant, esomeprazole, lansoprazole non-OTC, Nexium, Nexium OTC, omeprazole/sodium bicarb capsule, Prevacid, Prilosec, Protonix, Zegerid capsule		
Bowel Preparation Drugs	*See Wellness/Preventive under the Miscellaneous section for agents covered with no copay.	Colyte, Golytely, MoviPrep		
Overactive Bladder Agents	oxybutynin immediate release			
	***(RP) Reference Priced Overactive Bladder Agents: Plan pays $0.51 per unit. Member is responsible for remaining cost.**	Detrol, tolterodine, Detrol LA, tolterodine (extended release), Ditropan XL, Enablex, Myrbetriq, trospium, trospium ER, Vesicare, oxybutynin extended release		
Inflammatory Bowel	budesonide, sulfasalazine	Delzicol	Apriso*(QL), Canasa, Entocort EC	Lialda, Pentasa

	Tier 1	Tier 2	Tier 3	Tier 4
Hyperparathyroid Agents	calcitriol	Hectorol, Zemplar	Rocaltrol	
MEN'S HEALTH				
Erectile Dysfunction		Muse*(QL)*(PA), Stendra*(QL)*(PA), **sildenafil*(NG)**(QL)(PA)	Cialis*(QL)*(PA), Levitra*(QL)*(PA), Staxyn *(QL)*(PA)	
Hormone Replacement	Testostrone Injectable(s)*(PA)			
Prostate Health	doxazosin, tamsulosin, terazosin	**Dutasteride*(NG)**	Rapaflo	
RESPIRATORY				
Nasal Products	azelastine, flunisolide, fluticasone			
	***(RP) Reference Priced Nasal Steroids: Plan pays up to $26.00 for a one month supply. Member is responsible for remaining cost.**	Beconase AQ, Flonase, Nasonex, Rhinocort AQ, budesonide, QNasl		
Leukotriene Modulators	montelukast, zafirlukast*(ST)			
**Steroid Inhalants	budesonide solution	Asmanex, QVAR		
**Beta Agonists-Short Acting	metaproterenol	ProAir Respi Click		
**Beta Agonists-Long Acting	no generics available at this time	Foradil*(ST), Serevent Diskus*(ST)	Perforomist*(ST)	
**Inhaled Corticosteroids / Long Acting Beta Agonists		Dulera*(ST), Symbicort*(ST)		
**Long-Acting Muscarinic Agents + Long-Acting Beta Agonists		Stiolto Respimat		
**Long-Acting Anticholinergics		Spiriva, Spiriva Respimat		
**Respiratory-Other	albuterol/ipratropium, ipratropium, theophylline 200mg extended release	Combivent		Nucala*(PA), Xolair*(PA)

*** NOTE - NO OTHER BRAND-NAME MEDICATIONS ARE COVERED IN THE RESPIRATORY DRUG CATEGORIES THAT ARE MARKED WITH **. ONLY THOSE LISTED IN THIS PDL ARE COVERED. ALL OTHER BRANDED PRODUCTS ARE EXCLUDED FROM COVERAGE.**

	Tier 1	Tier 2	Tier 3	Tier 4
TOPICAL				
Ears	ofloxacin		Ciprodex	
Eye-Glaucoma	brimonidine, latanoprost, levobunolol, timolol, dorzolamide, dorzolamide - timolol	Alphagan P 0.1% (if no generic available), Azopt, Betimol, Betoptic, Lumigan	Alphagan P 0.15%, Cosopt, Timoptic, Trusopt, Xalatan	
Eye-Allergy	azelastine, cromolyn, epinastine, ketorolac, ketotifen fumarate	Acuvail	Alocril, Alomide, Bepreve, Elestat, Emadine, Lastacaft, **olopatadine*(NG**), Patanol	
Eye-Miscellaneous	levofloxacin 0.5%	Alrex, Lotemax (ointment & suspension *ONLY*)	Vigamox, Zirgan	
Skin-All	betamethasone, clotrimazole/betamethasone topical lotion, lidocaine*(PA), mometasone	Desonate Gel, Elidel	Diprolene AF, Ertaczo, Finacea Gel, Venelex Ointment	Dupixent*(PA)
Skin-Acne	benzoyl peroxide, benzoyl peroxide/erythromycin, clindamycin, clindamycin phosphate-benzoyl peroxide gel, Amnesteem, Claravis, sulfacetamide sodium 10% topical solution, tretinoin*(PA age 26 & over)	Retin-A 0.05% topical solution*(PA age 26 & over), Retin-A micro*(PA age 26 & over)	Aczone Gel, Retin-A (other strengths)*(PA age 26 & over)	
WOMEN'S HEALTH				
Combination HRT	Norethindrone Acetate/TE/Ethinyl Estradiol 1mg/5mcg	FemHRT 0.5mg/2.5mg, Prefest, Premphase, Prempro, Prempro Low Dose	Activella, Climara Pro, Combipatch	
Contraceptives	Plan will pay 100% for all *COVERED GENERIC contraceptives*. *COVERED BRANDS* with **no** generic available will be covered by the plan under ***Tier 3*** **(limited to *oral* forms).** *** *Brand/Generic difference/penalty pricing will apply if member chooses a COVERED BRAND where a generic is available.**** **Examples of COVERED GENERICS paid at 100%:** Amethia, Aviane, Azurette, Camrese, Camrese Lo, Cryselle, Daysee, Elinest, Emoquette, Enpresse, Gianvi, Gildess, Introvale, Jolessa, Junel 1/20, Junel 1.5/30, Junel FE 1/20, Junel FE 1.5/30, Kariva, Lessina, Levora, Loryna, Low-Ogestrel, Levonest, Lutera, Marlissa, Microgestin, Mono-Linyah, MonoNessa, Myzilra, Necon, Nortrel, Ocella, Ogestrel, Orsythia, Portia, Previfem, Quasense, Reclipsen, Sprintec, Sronyx, Syeda, Tilia, Trinessa, Trinessa Lo, Tri-Linyah, Tri-Lo- Estarylla, Tri-Sprintec, Tri-Lo-Sprintec, Trivora, Wymzya, Vestura, Viorele, Zarah, Zenchent **Examples of COVERED BRANDS paid at 100%:** Nuvaring and Ortho-Evra	LoLoestrin FE	

	Tier 1	Tier 2	Tier 3	Tier 4
Hormone Replacement Therapy (HRT)	estradiol	Alora, Cenestin, Estrace Cream, Estrogel, Menest, Premarin, Prometrium, Vagifem, Vivelle-Dot	Climara, Enjuvia, Estrace Tablet, Estring, Femring	
Osteoporosis-Calcium Regulators	alendronate, calcitonin nasal spray	Miacalcin Injection		
	***(RP) Reference Priced Calcium Regulators: Plan pays up to $0.10 per pill/unit. Member is responsible for remaining cost.**	Actonel, Atelvia, Boniva, ibandronate, **risedronate sodium*(NG)**		
Osteoporosis-Hormone Receptor Modulators	raloxifene			Prolia*(PA)
Prenatal Vitamins	CompleteNate, CO-Natal FA, MACNATAL CN DHA, M-Vit, Mynatal Plus, Mynatal-Z, OB-Natal One, PNV-Select, Prenafirst, PrenataPlus, Prenatabs FA, Prenatal Low Iron, Se-Tan DHA, Taron EC Calcium, Taron-Prex, Trinatal RX 1, Ultimatecare One, Vinate IC	Concept DHA, Concept OB, Folcal DHA, Folcaps Omega 3, Folivane-PRx DHA NF, Gesticare DHA, Levomefolate DHA, Levomefolate PNV, L-Methylfolate PNV DHA, Tamdem DHA, Virt-PN, Zatean-PN	Complete-RF Prenatal, Folivane-OB, HemeNatal OB+DHA, NatalVit, Prenatal Vitamins Plus, Prenaissance Balance/Plus, O-Cal FA, O-Cal Prenatal, Venatal-FA, Venate, Vol-Nate, Vol-Plus, VP-CH-PNV, Zatean-CH	
Vaginal Products	clotrimazole, fluconazole 150*(QL), metronidazole vag gel, terconazole	Gynazole-1	Clindesse, Diflucan 150mg*(QL), Metrogel Vaginal, Terazol	
MISCELLANEOUS				
Antiemetics	granisetron*(QL), ondansetron*(QL)	Emend*(QL), Varubi	Anzemet*(QL)**,** Sancuso*(QL)	
Antipsoriatics	acitretin	Tazorac*(PA)	Zithranol Shampoo	Amevive*(PA)
Gout	allopurinol, colchicine		Uloric*(PA), Zyloprim	
Growth Hormone	no generics available at this time			Humatrope*(PA), Genotropin*(PA), Norditropin*(PA), Nutropin/AQ*(PA), Saizen*(PA), Serostim*(PA), Tev-Tropin*(PA)
Immunosuppressive Agents	azathioprine, cyclosporine, mycophenolate mofetil, tacrolimus capsule			Myfortic, Nulojix*(PA), Prograf capsule, Prograf injection, Rapamune, Simulect
Rheumatoid Arthritis	methotrexate, leflunomide	Trexall*(PA)		
Saliva Stimulants	cevimeline			

	Tier 1	Tier 2	Tier 3	Tier 4
Targeted Immune Modulators (Step Therapy--Use Preferred Agents First) (NOTE: Samples of medication will not be recognized as a means of establishing prior drug use.)		Enbrel*(PA), Humira*(PA)		Actemra*(PA), Cimzia*(PA), Cosentyx*(PA), Entyvio*(PA), Inflectra*(PA), Kevzara*(PA), Kineret*(PA), Orencia*(PA), Otezla*(PA), Remicade*(PA), Rituxan*(PA), Simponi*(PA), Stelara*(PA), Tysabri*(ST), Xeljanz*(PA)
Wellness/Preventive	The following medications are covered 100% by the plan due to federal regulations. *Aspirin, Folic Acid, Iron Supplement (for children up to 1 year of age), Vitamin D (for adults age 65 and older) *Chantix & bupropion when enrolled in the ARBenefits Smoking Cessation Program *All preventive vaccines recommended by the CDC advisory Committee on Immunization Practices *Generic bowel prep products (Gavilyte-C/G/H/N, Peg 3350/Electrolytes, Peg-Prep, Peg-3350/KCL Sol /Sodium, Trilyte *Some statin medications may be covered with a $0 copay for eligibile members. Preventive care restrictions apply.			

Specialty Drug List--January 2018

*This Specialty Drug List includes medications that are classified as **Tier 4** drugs (by plan coverage) and **most** will require pre-authorization by EBRx (1-866-564-8258) when obtained from the pharmacy or administered in the physician's office.*

***NOTE:** Samples of medication will not be recognized as a means of establishing prior drug use during the step therapy/prior authorization criteria review for Targeted Immune Modulators (ex; Humira, Enbrel, etc).*

ACROMEGALY

Sandostatin
Sandostatin LAR
Somatuline Depot
Somavert

ALPHA-1 ANTITRYPSIN DEFICIENCY

Aralast
Prolastin

BOTULINUM TOXINS

Botox
Dysport
Myobloc
Xeomin

CRYOPYRIN-ASSOCIATED PERIODIC SYNDROMES

Arcalyst

CYSTIC FIBROSIS

Cayston
Kalydeco
Orkambi
Pulmozyme

ENZYME DEFICIENCY OR LYSOSOMAL STORAGE DISEASE

Aldurazyme
Cerezyme
Cystadane
Cystaran
Elaprase
Fabrazyme
Lumizyme
Myozyme
Naglazyme
Orfadin
Sucraid
Zavesca
Zemaira

HORMONAL THERAPIES

Eligard
Firmagon
Supprelin LA
Synarel
Vantas
Zoladex

IGF-1 Deficiency

Increlex

IMMUNE DEFICIENCY & RELATED DISORDERS

Bivigam
Flebogamma
Gamastan S/D
Octagam

IMMUNE THROMBOCYTO-PENIC PURPURA

Promacta

IRON OVERLOAD

Exjade
Ferriprox
Jadenu

MACULAR DEGENERATION

Eylea
Macugen
Visudyne

MULTIPLE SCLEROSIS

Aubagio
Avonex
Betaseron
Extavia
Gilenya
Glatopa
Rebif
Tecfidera
Tysabri

GROWTH HORMONE & RELATED DISORDERS

Saizen
Serostim
Somavert
Tev-Tropin
Zorbtive

HEMATOPOIETICS

Aranesp
Epogen
Granix
Leukine
Mozobil
Neulasta
Neumega
Procrit
Zarxio

HEMOPHILIA & RELATED BLEEDING DISORDERS

Advate
Adynovate
Alphanate
Alphanine SD
Alprolix
Bebulin
Bebulin VH
Benefix
Feiba NF
Feiba VH
Helixate FS
Hemofil M
Humate-P
Idelvion
Koate-DVI
Kogenate FS
Monoclate-P
Mononine
NovoEight
NovoSeven RT
Obizur
Profilnine SD
Recombinate
Stimate
Wilate
Xyntha

HEPATITIS B

Baraclude
Epivir HBV
Hepsera
Lamivudine
Tyzeka
Vemlidy

HEPATITIS C

Zepatier

HEREDITARY ANDIOEDEMA

Cinryze

HIV

Aptivus
Atripla
Combivir
Complera
Crixivan
Prezista
Rescriptor
Retrovir
Reyataz
Selzentry

ONCOLOGY – ORAL

Cyclophosphamide
Gleevec
Hycamtin
Ibrance
Imbruvica
Jakafi
Matulane
Mekinist
Myleran
Nexavar
Revlimid
Sprycel
Sutent
Tafinlar
Tarceva
Targretin
Tasigna
Temodar
Thalomid
Tykerb
Votrient
Xeloda
Xtandi
Zelboraf
Zolinza
Zydelig

ONCOLOGY - SUPPORTIVE CARE

Elitek
Xgeva
Zometa

OSTEOPOROSIS

Prolia
Reclast

PULMONARY ARTERIAL HYPERTENSION

Adcirca
Adempas
Flolan
Letairis
Opsumit
Remodulin
Revatio
Tracleer
Tyvaso
Uptravi
Veletri
Ventavis

RESPIRATORY SYNCYTIAL VIRUS

Synagis

TRANSPLANT

Cellcept
Gengraf
Myfortic
Neoral
Nulojix
Prograf
Rapamune
Sandimmune
Zortress

OTHER THERAPIES

Aranesp
Dupixent
Esbriet
Nucala
Soliris
Vivitrol

HIV (CONTINUED)

Descovy
Edurant
Egrifta
Emtriva
Epzicom
Fuzeon
Genvoya
Intelence
Invirase
Isentress
Kaletra
Lexiva
Norvir
Odefsey
Stavudine
Stribild
Sustiva
Triumeq
Trizivir
Truvada
Tybost
Videx
Viracept
Viramune
Viread
Zerit
Ziagen

OTHER THERAPIES (CONTINUED)

Invega Sustenna
Invega Trinz
Krystrexxa
Xenazine
Xolair

What does ARBenefits cover for Medicare Primary Retirees?

Medicare Does Not Pay	ARBenefits Retiree Plan Covers
Part A Hospital Services	
Inpatient hospital deductible each benefit period	ARBenefits pays the deductible
Copayment per day for days 61-90 in a hospital	ARBenefits pays the copayment per day
Copayment per day for days 91-150 (Lifetime Reserve)	ARBenefits pays the copayment per day
100% of Medicare - Allowable expenses for additional 365 days after Medicare hospital benefits stop completely	ARBenefits pays
Calendar year blood deductible (First 3 Pints of Blood) If deductible is not met by the replacement of blood	ARBenefits pays
Copayment per day for days 21-100 in a Skilled Nursing Facility	ARBenefits pays the copayment per day
Part B Physician and Medical Services	
Part B deductible	ARBenefits pays the deductible
Normally 20% of Medicare-approved amount (Part B Coinsurance) and 20% of Medicare-approved charges for Durable Medical Equipment (After Part B Deductible Is Met)	ARBenefits pays 20% of the Medicare-approved amount
Medicare Part B excess charges 100% (*This benefit would apply when you receive services from a physician that does not accept Medicare assignment.*)	ARBenefits pays 100% of the Part B excess charges when you receive services from a physician that does not accept Medicare.

Coordination of Benefits with Medicare

- **The ARBenefits Medicare Premium Plan for Retirees will coordinate as if Medicare Part A and Part B are both in force at the time of service. If the member does not have Part B, the Plan will pay as though the member does have Medicare Part B and the member will have full financial responsibility for incurred claims.**

- **The Plan will cover services for our Medicare Primary members as for our active and non-Medicare members. Even if Medicare does not cover a particular vaccine/service/etc., the plan will cover if we provide coverage for our active and non-Medicare members.**

- **Coverage will be determined based on the level of coverage outlined in the SPD for active and non-Medicare members - services paid at 100% will be no-charge. For all other services deductible, copay and coinsurance will apply when applicable.**

- **All physician, hospital, and medical services offered to Medicare Primary Retirees on the ARBenefits Plan are subject to the provisions of the Schedule of Benefits listed in the Summary Plan Description. The ARBenefits Plan does not allow all services allowed by Medicare. Please review the SPD carefully to determine if a service is covered.**

- **The ASE Medicare Primary plan includes prescription drug coverage, and members do not need to enroll in a Medicare Part D plan. ARBenefits does not coordinate benefits with Medicare Part D plans.**

Prescription Drug Benefit for Medicare Primary Retirees	
State Retiree	Medications eligible for coverage will fall into one of three categories: • Tier I Generic -- $15 Copayment • Tier II Formulary Brand (Preferred) -- $40 Copayment • Tier III Non-Formulary Brand (Non-Preferred) -- $80 Copayment • Tier IV Specialty -- $100 Copayment • Reference Pricing • Brand to Generic Incentive
Public School Retiree	• Not Covered (Option of taking Medicare Part D)

Certificate of Creditable Coverage Information

Important Notice from Arkansas State and Public School Life and Health Insurance Board about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Arkansas State and Public School Life and Health Insurance Board and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Arkansas State and Public School Life and Health Insurance Board has determined that the prescription drug coverage offered by the ARBenefits Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year during Medicare's open enrollment window, or if you lose group coverage.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

Your current coverage pays for other health expenses in addition to prescription drug. If you decide to join a Medicare drug plan, your ARBenefits Plan "will not" coordinate benefits with your Medicare prescription drug plan.

If you are an ARBenefits State Retiree and decide to join a Medicare drug plan or Medicare Advantage plan and drop your current State of Arkansas, Department of Finance and Administration, Employee Benefits Division, ARBenefits Plan Medical and Prescription coverage, you and your dependents **"will not"** be able to get this coverage back.

If I am a Medicare Primary Public School Retiree, What happens to my Current Coverage if I decide to join a Medicare Drug Plan? Nothing. Medicare primary Public School Retirees do not have prescription drug coverage under the ARBenefits Plan and should choose a Part D option to retain prescription drug coverage.

If you are an ARBenefits Public School Retiree and decide to join a Medicare drug plan or Medicare Advantage plan and drop your current State of Arkansas, Department of Finance and Administration, Employee Benefits Division, ARBenefits Plan Medical coverage, you and your dependents **"will not"** be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Arkansas State and Public School Life and Health Insurance Board and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage

Please contact the Employee Benefits Division at (877) 815-1017 and press #1.

For More Information about Your Options under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help, paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Exclusions and Limitations

What are the limitations and exclusions of the Plan?

This section contains general exclusions and limitations of the Plan. Unless specifically stated in the text, the exclusion or limitation applies to both active and retiree members equally. Other parts of this SPD may contain additional exclusions or limitations and this SPD should be viewed in its entirety. Listed below are services, treatments, medical procedures, supplies, and other elements, which are specifically excluded from coverage or have limited coverage under the Plan:

Abortion: Abortions are not covered except in cases where a physical disorder, injury, or illness, including a life threatening condition caused by or arising from the pregnancy itself, places the woman in danger of death.

Acupuncture: Services related to acupuncture are not covered.

Ambulance Services: $2000 per member per trip for emergency ground transportation or medically necessary direct transfer from one inpatient facility to another inpatient facility of equal or greater acuity level. Air ambulance service is not covered for international air evacuation.

Biofeedback: Hypnotherapy, biofeedback, and other forms of self-care or self-help training, and any related diagnostic testing are not covered.

Chelation Therapy: Services or supplies provided as, or in conjunction with, chelation therapy, except for treatment for acute metal poisoning, are not covered.

Chiropractic Services: Benefit limited to fifteen (15) visits per member per plan year.

Clinical Trials - In general, the Plan will cover routine patient costs including all items and services provided by the plan for qualified individuals enrolled in a clinical trial. Routine patient costs do NOT include the item (drug(s)), device or service itself; items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or services that are clearly inconsistent with standards of care for particular diagnoses.

If there is an in-network provider offering the clinical trial, the plan will approve the clinical trial participation with that provider as prudent.

Convenience Items: While not a complete list, personal convenience items such as: assistive talking devices, automobile / van conversion, or addition of patient lifts, hand controls, or wheel chair ramps, and home modifications such as overhead patient lifts and wheelchair ramps are not covered.

Cosmetic Services: All services, procedures, or complications related to or complications resulting from cosmetic surgery are not covered.

Court Ordered or Third-Party Recommended Treatment: For a service that is not normally covered by the plan, e.g., drug testing for employment or vaccines for overseas travel, coverage will not be provided even if the service is required or recommended by a third party, ordered by a court,

or arranged by law enforcement officials.

Custodial Care: Services or supplies for custodial, convalescent, domiciliary, supportive, or maintenance care, and non-medical services to assist with activities of daily living are not covered.

Dental Care: Dental implants, abutments, dental restorations, and services or supplies are not covered except when required following injury due to traumatic force, or as a result of Sjogren's syndrome. Orthognathic surgery, Orthodontics, and braces, regardless of age, are not covered. General dental appliances purchased "over the counter" are not covered.

Coverage is provided for the following:

- Treatment and x-rays necessary to correct damage to non-diseased teeth or surrounding tissue caused by an accident or Sjogren's syndrome occurring on or after effective date
- Treatment or correction of a non-dental physiological condition caused by Sjogren's syndrome.
- Injury that has resulted in severe functional impairment
- Treatment for tumors or cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof, and floor of the mouth.
- Removal of impacted or partially impacted wisdom teeth.
- Pre-treatment of dental services in connection with treatment of cancer of the head or neck.

ARBenefits will follow Arkansas Code 23-86-121(b) concerning coverage for anesthesia and hospitalization for dental procedures.

Diabetes: Diabetic lancets and needles used for Diabetics will be paid 100% by the plan for participants enrolled in the Diabetic Management Program. Otherwise not covered.

Domestic Partners: Domestic partners of the same or opposite sex are not covered.

Donor Services: Services or supplies incident to organ and tissue transplant, or other procedures when you act as the donor are not covered except for services that use your own cells and tissue. When the member is the potential transplant recipient, expenses for testing of a donor who is found to be incompatible are not covered.

Employment Screenings: Any screenings, vaccinations, drug testing required for employment are not covered.

Enteral Feeding: Enteral tube feedings are not covered except when it is the sole source of nutrition, approved by a physician, and pre-approved. Refer to the Utilization Management section on page 18 for more information.

Excess Charges: The part of an expense for care and treatment of an injury or sickness that is in excess of the allowable charge is not covered.

Exercise Programs: Exercise programs are not covered even when prescribed to treat or manage

health conditions.

Experimental/Investigational: Any treatment, procedure, facility, equipment, drug, device, or supply deemed by your Benefit Coordinator or ARBenefits to be experimental or investigational as defined in this SPD, is not covered.

Eye Care: LASIK, epikeratophakia procedures, Low Vision Enhancement System (LVES), and eyeglasses and contact lenses are not covered. As an exception, the plan will cover the initial acquisition of eyeglasses or contact lenses following cataract surgery.

Family Planning and Infertility Services: Any services or supplies provided for, in preparation for, or in conjunction with the following are not covered:

- Elective or voluntary abortions and complications from these procedures
- Sterilization reversal (male or female)
- Sex therapy
- Surrogate mother services or in-vitro fertilization
- Services related to infertility are covered up to diagnosis.

Foot care: Only covered for members with diabetes associated foot care complications.

Genetic Testing: Services related to genetic testing are limited to those approved by your Benefit Coordinator's coverage policies.

Hair Loss: Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a physician are not covered.

Hearing or Talking Aids: Members are eligible for up to $1,400 in hearing aid coverage for each ear every three years.

Learning Disabilities: Services or supplies provided for learning disabilities such as reading disorder, alexia, developmental dyslexia, dyscalculia, spelling difficulty and other learning disabilities are not covered. Certain services may fall under Autism spectrum and would be covered for that diagnosis.

Long Term Care: Services or supplies furnished by a residential long-term care institution such as nursing homes, youth homes, or any similar institution are not covered.

Medical Records Fees: Charges for completion of insurance forms or for acquisition of medical records are not covered.

Midwives: Midwives services are only covered when working under the direction of a collaborative physician.

Missed Appointments: If you fail to keep an appointment with a provider, and charges for the

appointment are incurred, those charges are not covered.

Naturopath/Homeopath Services: Naturopathic or homeopathic remedies for treatment of any condition are not covered.

Non-Covered Services: Services not specifically included as a benefit in this SPD, complications related to non-covered services, services provided after exceeding the benefit maximum for specified services, and services for which the member is responsible for payment such as non-covered out-of-network charges are not covered. Charges for services above the contracted rates are not covered.

Non-Medicare Covered Durable Medical Equipment: Medical equipment and supplies that are not covered by Medicare are specifically excluded and not covered by the Plan. Examples of excluded items include but are not limited to the purchase or rental of air conditioners, air purifiers, water beds, saunas, tanning beds, motorized transportation equipment except with prior approval, automobile/van conversion or addition of patient lifts, hand controls, or wheel chair ramps, home modifications such as overhead patient lifts and wheelchair ramps, exercise equipment, or similar items. Replacement or repair of durable medical equipment and prosthetic devices is covered only when medically necessary due to normal wear and tear. Disposable items are not covered.

Not Medically Necessary: Services and supplies, which are not medically necessary, are not covered except for preventive health services for which coverage is otherwise specifically listed. Hospitalization that is extended for reasons other than medical necessity, e.g. lack of transportation, lack of caregiver at home, inclement weather, and other social reasons not justifying coverage for extended hospital stay is not covered.

Nurse Hotline: Premium plan members can have the co-payment for emergency room (ER) admission waived if the patient is referred to the ER by the hotline nurse.

Nutritional Supplements: Regular formulas, special formulas, and food additives are not covered except for formulas necessary for the treatment of phenylketonuria (an inherited condition that may cause severe intellectual disability), and other inheritable diseases.

Prescription Drugs and Medications: Medications obtained by prescription through your pharmacy plan will have associated charges as determined by the Plan. IV or injectable medications administered in a physician office, your home, or in an outpatient medical setting will be paid by the Plan. Subject to co-pays, deductibles and/or coinsurances. Normal coverage policies apply.

What types of prescription drugs are not covered?

- Over the Counter products that may be bought without a written prescription. This does not apply to insulin syringes, diabetic needles or lancets (when enrolled in the Diabetes Management program), and Asprin, which are specifically covered with a prescription from your doctor.
- Devices of any type, even though such devices may require a prescription. This includes (but is not limited to) therapeutic devices or appliances such as implantable insulin pumps and

ancillary pump products. Glucometers for diabetic glucose testing are covered as durable medical equipment
- Biological serum.
- Implantable time-released medications except for certain birth control products listed on the Preferred Drug List as covered.
- Experimental or investigational drugs, or drugs prescribed for experimental indicators.
- Drugs approved by the FDA for cosmetic use only.
- Compound chemical ingredients or combination of federal legend drugs in a Non FDA approved dosage form.
- Fertility medications
- Nutritional supplements except for inherited metabolic conditions only.
- Prescription or over-the-counter medications imported or purchased from another country.

If a drug is not covered by the plan, the member will be responsible for the entire cost.

Private Duty Nursing: Private duty nursing services and/or homecare aides are not covered.

Private Room: Unless prescribed by your physician as medically necessary, private rooms are not covered if you are hospitalized and a semi-private room is available.

Prosthetics and Orthotic Devices: Benefit limited to one (1) prosthetic device that aids in bodily functioning or replaces a limb after an accident or surgical loss and two (2) orthotic devices used for correction or prevention of skeletal deformities. All prosthetic and orthotic devices must be deemed medically necessary. In order for a device to be covered, it must be an appliance that is defined by the Medicare DME manual. Repair or replacement of devices due to normal growth or wear is a covered benefit, but maintenance and repairs resulting from misuse or abuse is not covered and is the responsibility of the member. General orthotic devices, splints or bandages purchased “over the counter” for the support of strains and sprains; orthopedic shoes which are not attached to a covered brace, elastic stockings, garter belts, specially ordered, custom made or built-up shoes, cast shoes, and shoe inserts designed to support the arch or effect changes in the foot alignment are not covered. Shoes and inserts are not covered except in cases of diagnosis of diabetes. Jobst stockings are covered if ordered by a physician. ARBenefits will follow Arkansas Act 950, which requires coverage of prosthetic and orthotic devices and services at a rate no less than 80% of Medicare and not subject to any limitations not imposed on other services.

Six (6) bras per year will be covered following a mastectomy.

Reconstructive Surgery: Reconstructive procedures are covered as correction of defects due to accidents or defects caused by treatment of covered services. An example of a covered reconstructive surgery includes the reconstruction of the breast on which a cancer-related surgery has been performed and reconstruction of the other breast to produce a symmetrical appearance.

The following procedures performed on a child under eighteen (18) years of age are not considered cosmetic services: correction of a cleft palate or hair lip, removal of a port-wine stain on the face, correction of a congenital abnormality or accident/injury repair. The circumstances for coverage are

very limited.

Rehabilitation Services – Out-Patient: The plan does not provide benefits for maintenance therapy. Maintenance Therapy refers to therapy in which you actively participate that is provided to you after no continued significant and measurable improvement is reasonably or medically anticipated.

Rehabilitative Treatment or Therapy: Any services, or therapy provided for developmental delay, developmental speech, or language disorder, developmental coordination disorder and mixed developmental disorder is covered but may be subject to pre-approval procedures. Refer to the Utilization Management section.

If rehabilitative services, physical therapy, occupational therapy, or speech therapy, are provided at the same time as a visit to a Specialist MD, the rehab co-pay will be waived for members on the Premium plan. All plan deductibles and coinsurance apply.

Relative Giving Services: Professional services performed by a person who ordinarily resides in your home, or is related to you such as a spouse, parent, child, brother or sister, grandparent and grandchild, whether the relationship is by blood or exists in law are not covered.

Gender Changes/Sex Therapy: Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change are not covered. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment or other treatment of sexual dysfunction including sex therapy.

Short Stature Syndrome: Any services related to the treatment of short stature syndrome except for growth hormone deficiency are not covered.

Telephone Consultation: Telephone calls by a plan provider to you for consultation or medical management, or for coordinating care with other health care professionals including reporting or obtaining tests and / or laboratory results are not covered.

Transplant Procedures: Coverages provided for transplant services are subject to medical necessity review through Case Management (See Utilization Management Section). Refer to the Schedule of Benefits. Benefit is limited to two (2) organ transplants of the same organ per member per lifetime. Coverage is provided for transplant services subject to the benefit maximums and requirements. Approved transplant providers and facilities MUST provide transplant services. The following transplant procedures and services are not covered:

- Animal to human transplants
- Artificial or mechanical devices designed to replace human organs
- Services provided beyond the benefit maximums
- Organ transplants that are not medically necessary
- Organ transplants considered experimental or investigational
- Small bowel transplantation
- Pancreas transplant not done simultaneously with kidney transplant with diabetes and End Stage Renal Disease

- Solid organ transplantation in patients for carcinoma except for liver transplants for patient with hepatoma confined to the liver

Note: Transplants are only covered if provided in an In-Network facility.

Travel or Accommodations: Travel or transportation and accommodations are covered only in connection with approved organ transplants. This benefit requires prior approval in accordance with the procedures established in this SPD.

Vocational Rehabilitation: Vocational rehabilitation services, vocational counseling, employment counseling, or services to assist you in gaining employment are not covered.

Workers Compensation: Treatment of any work related injury or illness is not covered by the plan.

Wound Vacuum Assisted Closure (VAC) Devices: Wound Vacuum Assisted Closure (VAC) Devices related services are only covered when approved through Utilization Management.

Members must call Employee Benefits Division at 501-682-9656 or 1-877-815-1017 to enroll in the Bariatric Pilot Program beginning 1/2/18 to be eligible for surgery

Bariatric Pilot Program Requirements as of 1/1/18

Members previously enrolled are subject to former requirements.

ARBenefits will provide coverage for bariatric surgery to include:

A) Gastric bypass surgery

B) Adjustable gastric banding surgery

C) Sleeve gastrectomy surgery

D) Duodenal switch biliopancreatic diversion

The Arkansas State and Public School Life and Health Insurance board must approve additional procedures. The surgical procedure must be pre-certified by your surgeon and supported as medically necessary by your primary care physician prior to surgery.

Eligibility Criteria

1. Only Arkansas State and Public School Employees, aged 25-65, with a BMI greater than or equal to 35 will be considered for bariatric surgery (no dependents or spouses).
2. **ALL** participants are required to enroll in a Disease Management Program.
3. The Employee under the plan must have been a plan participant for a minimum of one plan year prior to enrollment in the bariatric program.

Participation Criteria

1. Candidates must follow the enrollment procedure outlined below:
    a) The Employee must enroll by telephone contact with the Employee Benefits Division (EBD) (877-815-1017) to be considered for Bariatric Surgery. All participants must enroll into three (3) months of nurse coaching with an Active Health nurse. A Bariatric Program form will be sent to the member for completion and member will be responsible for sending it back to ARBenefits.
    b) Telephone contact with the coaches must be documented monthly, no less than 20 days nor more than 40 days between contacts. **(Responsibility for maintaining contact with the coach is the Employee's.)**
    c) The Employee under the plan **must** agree in writing to comply with at least one-year post surgery, physician-supervised treatment plan, and be followed monthly by an ARBenefits Case Manager. **Failure to comply with this requirement will result in the denial of payment for bariatric claims.**

2. A three-month physician-supervised nutrition and exercise program to include: Low calorie diet or diet program recommended specifically for the Employee by his/her physician; increased physical activity and behavior modification. The program and the member's compliance with the program must be documented in the medical records at least monthly. This supervision is required for a minimum of 3 months, and must continue monthly up to the scheduled date of the bariatric procedure. If surgery is delayed, monthly supervisory visits must be maintained and documentation provided to the plan.

a) Member participation in a physician-supervised nutrition and exercise program must be documented in the medical record by the attending physician who supervised the member's participation. Records must document compliance with the program and member **MUST** show progress of weight loss or no net weight gain. Member's weight must be documented at each physician visit.
NOTE: A physician summary letter is **NOT** sufficient
b) Nutrition and exercise programs must be at least 3 months duration or longer and be documented. This documentation needs to accompany the request for approval. All employees will be expected to continue participation in the managed weight loss up to the date of surgery.
c) ALL participants must enroll in a Disease Management Program

3. Surgery must be completed within one year after enrollment in the program.

Active Health Management will not be able to provide pre-certification until all necessary documentation has been obtained.

a) Documentation required for pre-certification regarding participation by an employee under the plan must be submitted by the chosen Bariatric Surgeon.
b) Letter from the physician monitoring/supervising the weight loss prior to surgery is to include:
    1) Recommendation of member for bariatric surgery.
    2) Documentation of all possible medically related causes of obesity (such as thyroid or endocrine disorders).
    3) Weight History – Including all weight, exercise, dietary, and behavior modification encounters with documented progress of weight loss or no net gain of weight. (In-network providers only will be covered by ARBenefits.)
c) Records of all studies/procedures such as, but not limited to, sleep study, cardiac studies (stress test, echocardiogram, and cardiac catheterization), and operations on the stomach or intestines, hernia repair.
d) Detailed Post-Op follow-up treatment plan signed by member and surgeon must accompany the request for pre-certification.

NOTE: This pilot will only cover the First Bariatric procedure per lifetime. (Employees who have had previous bariatric procedures are ineligible for this Pilot.) Any and all of the above requirements may be subject to change.

Complaints and Appeals

Members who have been denied a service or requested change have the option to file a complaint or, an appeal with EBD. Appeals regarding pharmacy decisions will need to be made by the provider through EBRX.

Complaint - An expression of dissatisfaction either oral or written.

Appeal - A request to change a previous Adverse Benefit Determination (ABD) made by the Benefit Coordinator or EBD based on coverage or eligibility as defined by Plan Documents.

Types of appeals include claims payment or denial, benefit coverage, eligibility, or termination of coverage.

Excluded services are not subject to appeal but a letter of complaint requesting a review of the allowable benefit can be sent to the Board via the Quality Assurance department at EBD.

Members will not suffer any sanctions or penalties resulting from submitting a complaint or appeal.

Duly Authorized Representative – Person or Persons designated in writing by the member to act on their behalf.

Who do I call regarding questions about a claim?

Member:

If a claim for benefits is denied either in whole or in part, your medical plan's Benefit Coordinator can perform a re-review of the claim and will provide you with a notice explaining the reason(s) for the denial. For medical claims, this notice will be in the form of the Explanation of Benefits (EOB). If you have questions about how a claim was paid or why it was denied, you should contact your Benefit Coordinator at the phone numbers provided in this SPD. The Benefit Coordinator will explain, in detail, how and why the claim was paid or denied. If you are unsatisfied with the results of this inquiry, the next step is to file a written appeal with EBD.

Plan Provider:

Plan Providers may not appeal to EBD, but should follow the appeal process of the appropriate Benefit Coordinator. If it is a medical claim the Benefit Coordinator is Health Advantage or QualChoice. If it is a pharmacy claim, the Benefit Coordinator is EBRx.

How do I file an appeal?

Members must file an appeal using the ARBenefits Appeal Request Form. If a Duly Authorized Representative is making an appeal for you, an Authorization to Release Information form must be completed and on file with ARBenefits. Forms may be located at www.ARBenefits.org (Forms & Publications). Appeals will not be accepted if they are received without the required Appeal Request Form.

Appeals must be submitted separately for each individual and each issue.

EBD Appeals Department is in accordance with federal mandates for notification of receipt of appeal.

First Level Review:

First level reviews must be filed within 180 days of receiving your Notice of Adverse Benefit Determination.

In preparing your appeal, you or your duly authorized representative will have the right to present documents and other information pertinent to your claim. A complete review of your claim will be performed by the Appeals Department. You will be notified of the appeal determination within thirty (30) days of EBD's receipt of your appeal.

Second Level Review:

If you are not satisfied with the determination received on the first level review, you may request a second level review. The appeal must be received within sixty (60) days of the notification of denial by the first level appeal. This request must also be made in writing following the established appeal process used when filing the first level appeal, and should contain any additional information not presented during the first level review.

All second level reviews are presented to the EBD Appeals Committee; a three-person panel. Designees may be named for any member on a case-by-case basis due to absence or recusals.

A member of the Appeals Department will present the information to the Appeals Committee along with all information presented by you and gathered from any outside resource such as medical professionals or other insurance carriers.

The Appeals Committee will review and make a determination of your appeal within thirty (30) days after the receipt of your second level appeal.

What is an expedited appeal?

An expedited appeal may be requested related to a claim involving urgent or ongoing care. The request may be made in writing or by telephone followed by written confirmation. Expedited appeals will be progressed to Second Level Review with the Committee hearing the appeal within 72 hours of the request. You or your duly authorized representative will be notified of the appeal decision within one (1) business day of the determination.

What is an external review?

If you are still unsatisfied with the determination of the Appeals Committee regarding a medical or pharmaceutical appeal, you have the right to request an external appeal by an Independent Review Organization (IRO). The IRO will consider issues such as medical necessity or experimental / investigational status of a procedure or medication. Your request for an external review must be in writing to the EBD Appeals Department following the established appeal process within four (4) months of the notification of denial by the second level appeal. The determination of the IRO is binding upon the plan.

Eligibility appeals are not eligible for external review.

Who is an authorized representative?

Any person to whom you have given express written consent to represent you during the appeal, a person authorized by law to provide substituted consent for you, a family member if you are unable to provide consent, or your treating health care professional if you are unable to provide consent and a family member is unavailable. The authority of an authorized representative shall continue for the period specified in your written consent or until you are legally competent to represent yourself and notify EBD in writing that the authorized representative is no longer required.

Members without computer access should contact their agency/district health insurance representative (HIR) or EBD Member Services to have a form faxed or mailed.

Coverage Continuation – Retirement

Am I eligible?

An employee who terminates active employment and is enrolled for health coverage on their last day of employment may continue coverage as a retiree if all of the following conditions are met:

- Is an active member of one of the following retirement plans and drawing their retirement annuity?
    - Arkansas Public Employees' Retirement System (APERS), including members of the legislative division and the contract personnel of the Arkansas National Guard;
    - Arkansas Teacher Retirement System (ATERS);
    - Arkansas State Highway Employees' Retirement System;
    - Arkansas Judicial Retirement System; or
    - Alternative Retirement Plan – documentation required that you are drawing on the annuity.
- Elects to continue insurance coverage within thirty (30) days of the qualifying event
- The retiree makes the appropriate contribution required to continue the coverage from the date that employment ends or the date enrolled in the plan.

Members of the General Assembly and state elected constitutional officers must have ten (10) years vested service in one of the listed retirement systems, and drawing an annuity, to be eligible to enroll in the retiree health insurance plan.

Retirement Health Enrollment Options

Option 1: If you meet the eligibility requirements, you have the option to enroll in the current retirement health insurance plan when you initially begin drawing your retirement annuity or terminate active coverage under a state or public school plan – within 30-days of the qualifying event. Coverage will be effective the first of the month following the date on the Election Form.

Option 2: You have the option to decline the insurance (eligible but not enrolling) and enroll later with a qualifying event if you are currently enrolled in another employer group health plan. You will have a thirty (30) day window in which to apply for coverage after the involuntary loss of that coverage. You will have to provide proof of employer group coverage from the time you became eligible to enroll in retirement health insurance until the time of your qualifying event. Coverage will be effective the first of the month following the date on the Election Form.

Rehired Retirees

If a Medicare retiree goes back to work as an active employee as a state or public school employee, and is eligible for benefits, MUST come off the retirement health insurance and enroll onto the active plan. Once the employee terminates employment again, the employee has the option to re-enroll in

the retirement health plan within 30 days of the loss of benefits. If an employee chooses not to enroll in the retirement health plan at the second time of termination, and obtains health insurance outside of the State and Public School Health Plan, the employee will not have a qualifying event to enroll a second time in the retirement health insurance.

A non-Medicare retiree that goes back to work as an active state or public school employee and is eligible for benefits MAY come off the retirement health insurance and enroll in the active plan. Once the employee terminates employment again, the employee has the option to re-enroll in the retirement health plan within 30 days of the loss of benefits. If an employee chooses not to enroll in the retirement health plan at the second time of termination, and obtains health insurance outside of the State and Public School Health Plan, the employee will not have a qualifying event to enroll a second time in the retirement health insurance.

If a retiree does not elect, decline or meet the Arkansas Legislative Code eligibility requirements for retirement health insurance during their thirty-day election period, it is not an option to return to active employment as a rehired retiree to re-establish eligibility. Eligibility is determined at the initial time you elect to become an active retiree and begin drawing your retirement annuity.
Arkansas Legislative Code

ACA 21-5-411 (a)(2)(B)(C)(i)

(C) (i) Except as provided in subdivision (a)(2)(C)(ii) of this section, an active retiree's failure to make an election to participate in the program during the thirty-day election period or an active retiree's election to decline participation in the program is final.

RECIPROCITY SERVICE

Vesting Schedule:

Employment service prior to July 1, 1997 requires ten (10) years of fully vested service.
Employment service after July 1, 1997 requires five (5) years of fully vested service.

- An employee fully vested as a state employee AND fully vested as a public school employee (a participating member under both APERS and ATRS and drawing a retirement annuity from each) may choose to enroll in either the ASE or PSE retiree health plan. Verification by EBD is required.
- Effective July 1, 1997 – Vesting for retirement changed from a ten (10) year vesting to five (5) years. Service prior to July 1, 1997 is still held to the ten (10) year vesting.
- A member, who is not fully vested under either system, will enroll in the retiree health plan with the most vested years.

How do I enroll?

- Notify EBD within thirty (30)-days of termination by submitting an Election form and a Spousal Affidavit if you are continuing coverage for a spouse from your active health plan coverage. Coverage will be effective the first of the month following the date on the Election

Form.

May I add a spouse or dependents at the initial enrollment onto the retirement health plan?

- At your initial enrollment in retirement health insurance coverage, you may only continue coverage on your spouse/dependents that are currently covered on your active plan at the time of your enrollment in the retirement plan.
- You may add newly acquired dependents, i.e., newborn children, adopted children, or a new spouse within thirty (30) days of the event with supporting documentation.
- A spouse cannot be on the retirement health plan as a dependent if they are currently employees and have health insurance available through their employer. You may bring them onto your plan if they experience a qualifying event of loss of employer group health coverage, but you must apply within (30) days of the event by completing an Election Form, Spousal Affidavit and provide proof of continued group health coverage up until their qualifying event and submitting to EBD. You must also provide a copy your Marriage License.
- Retirees DO NOT have an open enrollment to add dependents to their plan, but Non-Medicare retirees have the option to change plans.
- If a retiree has a spouse on their plan that is also a retired member of a state or public school retirement system, they can make a one-time option and split off on separate plans, or they can move from separate plans to an employee/spouse plan. This is a one-time option and member cannot return to the former plan except for death of the policy holder.
- At open enrollment, a retiree who is fully vested under both the State & Public School retirement systems can make a one-time option and change to the other retirement system. The vesting requirement does not include reciprocity service.

MEDICARE ELIGIBLE MEMBERS/DEPENDENTS

Member and dependents are required to send EBD a copy of their Medicare card.

If Medicare is due to End Stage Renal Disease (ESRD), ARBenefits is required to be primary for a period of 30 months. During this 30-month period, your premium will remain as a non-Medicare retiree. When the 30-month period is ended, Medicare will become Primary and ARBenefits will be secondary. At that time your premium will reduce to the appropriate Medicare premium. It is the member's responsibility to notify EBD of an ESRD or disability status.

When a retiree or spouse reaches the age of 65, or becomes eligible for Medicare, the only plan option is the Medicare Primary Plan. When this occurs, the member and dependents will automatically be moved to the Medicare Primary Plan at the Premium level if they are currently enrolled in the Classic or Basic Plan. Medicare will become the Medicare member's primary insurance with QualChoice as their secondary insurance and will not be required to use the QualChoice network of providers. However, anyone on the Medicare Primary plan who is not eligible

for Medicare will be required to use the QualChoice network to receive in-network benefits.

You have the option to terminate coverage on your spouse when he/she becomes Medicare eligible and not be moved to the Medicare Primary Plan, if you wish to remain on the Classic or Basic Plan. You must submit an Election Form, to EBD, requesting termination of the spouse 60-days prior to the eligibility date of the Medicare for the spouse, so that the plan change will not automatically occur. If you wait until after the plan change has been made, you cannot change back to your original plan until Open Enrollment for the next January effective date.

Ninety (90) days prior to your spouse becoming age 65, EBD will send you a letter informing you of the automatic move to the QualChoice Plan, due to your spouse's Medicare eligibility. If you wish to avoid this move and drop coverage on your spouse, we have included a form that you will need to complete and send back to EBD sixty (60) days prior to your spouse becoming age 65.

Approximately 60-days prior to you and/or your spouse becoming age 65, EBD will send you a letter requesting your Medicare information and a copy of your Medicare card. Please identify if your coverage is due to age, disability or End State Renal Disease.

EBD is able to identify members/spouses who are age 65 but are unable to identify members who become Medicare eligible due to disability or End Stage Renal Disease (ESRD), please notify EBD so that we can make certain your claims are paid according to Medicare rules. We also will need a copy of your Medicare card.

Medicare-Primary Retirees and/or dependents will have the Medicare Primary Plan for insurance coverage through QualChoice, with the flexibility to visit any physician or hospital as long as they accept Medicare assignment. The Medicare Primary Plan will coordinate your benefits coverage with Medicare Parts A & B and the plan will pay secondary to Medicare. Coverage for all other non-Medicare members on the policy will be on the QualChoice network at the Premium level. The Public School Medicare-Primary Retirees do not have prescription drug coverage and are encouraged to examine Medicare Part D for additional coverage.

Note: The ARBenefits Medicare Premium Plan for Retirees will coordinate as if Medicare Part A and Part B are both in force at the time of service. If the member does not have Part B, the Plan will pay as though the member does have Medicare Part B and the member will have full financial responsibility for incurred claims.

Terminating Retirement Health Plan Coverage

Once you have exercised your one-time option to enroll in the retirement health insurance plan and request that the coverage be terminated, the decision is final and you will no longer be eligible to participate in the plan.

The only exception to this rule is if you cancel to go back as an active employee with a state or public school agency, and are eligible for active benefits. You can re-enroll in the plan once you terminate active employment again.

Death of Retiree

- If a retiree dies, and has covered dependents at the time of death, the dependents have the right to continue coverage under the Plan. Dependent children may be covered until they reach the maximum age limit for a dependent child. A surviving spouse may continue coverage under the plan provided payments are made timely. If a surviving spouse or dependent that was covered under the plan declines to enroll or cancels coverage after electing coverage, then the surviving spouse/dependent has no further privileges under the plan. Surviving dependents cannot add other dependents to the plan.
- A Surviving Spouse/Dependent Packet will be sent to the dependent(s) once we have received notification of the death of the retiree. EBD requires a copy of the Death Certificate. Surviving dependents will have 30-days from the date of the letter to submit an Election Form to EBD for enrollment.
- If a spouse/dependent is not eligible to draw a survivor annuity from the retiree, premiums must be setup to be bank drafted monthly.

NOTE:
If the spouse and/or dependents do not enroll in the retirement health plan or COBRA within their respective enrollment periods, all privileges under the plan are terminated.

Coverage Continuation – COBRA

What is COBRA?

In 1986, Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA). COBRA provides certain former employees, retirees, spouses, former spouses, and dependent children the right to temporary continuation of health coverage. To be eligible for COBRA coverage, you must have been enrolled in your employer's health plan when you worked and the health plan must continue to be in effect for active employees. COBRA covers group health plans sponsored by an employer (private sector or state/local government) that employed at least 20 employees on more than 50 percent of its typical business days in the previous calendar year. Both full- and part-time employees are counted to determine whether a plan is subject to COBRA. There are three basic requirements that must be met in order for you to be entitled to elect COBRA continuation coverage:

- Your group health plan must be covered by COBRA
- A qualifying event must occur
- You must be a qualified beneficiary for that event

There may be other coverage options for you and your family. When key parts of the health care law take effect, you'll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

Who is eligible?

A qualified beneficiary is an individual who was covered by a group health plan on the day before a qualifying event occurred that caused him or her to lose coverage. The individual may be an employee, an employee's spouse, or an employee's dependent child. In certain cases, a retired employee, the retired employee's spouse, and the retired employee's dependent children may be qualified beneficiaries. In addition, any child born to or placed for adoption with a covered employee during the period of COBRA coverage is considered a qualified beneficiary. Agents, independent contractors, and directors who participate in the group health plan may also be qualified beneficiaries. Qualifying events are defined as events that cause an individual to lose his or her group health coverage. The type of qualifying event determines who the qualifying beneficiaries are and the amount of time that a plan must offer the health coverage to them under COBRA.

The following are qualifying events that would allow an individual to become eligible for COBRA:

Employees

- Voluntary or involuntary termination of employment for reasons other than gross misconduct
- Reduction in the number of hours of employment

Spouses

- Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct
- Reduction in the hours worked by the covered employee
- Covered COBRA participant becomes entitled to Medicare
- Divorce or legal separation of the covered employee/retiree
- Death of the covered employee/retiree

Dependent Children

- Loss of dependent child status under the plan rules
- Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct
- Reduction in the hours worked by the covered employee
- Covered COBRA participant becomes entitled to Medicare
- Divorce or legal separation of the covered employee/retiree
- Death of the covered employee/retiree

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after Employee Benefits Division has been notified by your insurance representative that a qualifying event has occurred.

This means your insurance representative must terminate your coverage through the appropriate benefit system.

COBRA coverage will not be offered to employees/dependents who drop coverage during the Open Enrollment period, or to LWOP members whose coverage is terminated due to non-payment of premiums.

Medicare is Primary for COBRA participants who are enrolled in Medicare when they initially enroll onto the COBRA Plan.

What is the process for election of COBRA coverage?

The employer must notify Employee Benefits Division of a qualifying event within 30 days after an employee's death, termination, reduced hours of employment.

The employee, spouse or dependent must notify the employer and or/the, Employee Benefits Division within 30 days after a divorce, legal separation, or a child's ceasing to be covered as a dependent under the plan rules.

Plan participants and beneficiaries generally must be sent an election notice not later than 14 days after the Employee Benefits Division receives notice that a qualifying event has occurred. The individual then has 60 days to decide whether to elect COBRA continuation coverage. The person

has 45 days after electing coverage to pay the initial premium. Benefit coverage will not be reactivated until premiums have been paid.

How long does coverage last?

When the qualifying event is the end of employment or reduction of your hours of employment, COBRA continuation coverage lasts for up to 18 months. However, coverage can be extended in some cases.

COBRA coverage lasts for up to 36 months when the qualifying event is the death of an employee, enrollment of the COBRA participant in Medicare (Part A, Part B, or both), divorce or legal separation, or a dependent child losing eligibility.

Disability Extension Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage or if you are disabled at the time you elect COBRA, you and your entire family can received up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. You must notify the Employee Benefits Division within 60 days of the Social Security Administration's determination. If documentation is not provided within the first 60 days of coverage, the disability extension will be denied.

Second Qualifying Event

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, for a maximum of 36 months. This extension is available to the spouse or dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated.

Declining Coverage

A qualified beneficiary must elect coverage within the first 60 days after the qualifying event or date on the election form, whichever is later. Failure to do so will result in loss of the right to elect continuation coverage. A qualified beneficiary may change prior rejection of continuation within the 60-day period.

Continuation coverage will be terminated before the end of the maximum period if any required premium is not paid on time, if a qualified beneficiary becomes covered under another group health plan that does not impose any pre-existing exclusion for a pre-existing condition of the qualified beneficiary (note: there are limitations on plans' imposing a pre-existing condition exclusion and such exclusions will become prohibited beginning in 2014 under the Affordable Care Act).

For more information, contact your agency insurance representative, the Employee Benefits Division, or the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA).

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, visit the U.S.

Department of Labor’s Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll free number at 1-866-444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit website at www.healthcare.gov.

Notice of COBRA Continuation Coverage Rights

Continuation Coverage Rights Under COBRA

Introduction

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under Federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a special enrollment opportunity for a 30-day special enrollment for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualified events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;

- Your spouse's employment ends;
- You become divorced from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends;
- The parents become divorced;
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee.

For all other qualifying events (divorce or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to Employee Benefits Division (EBD). You must submit an ARBenefits Election form, along with supporting documentation (such as a divorce decree or death certificate), which can be found at www.arbenefits.org.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security Administration (SSA) to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. If the qualified beneficiary is determined to be disabled, you must notify Employee Benefits Division within 60 days of the determination by the SSA. Failure to notify Employee Benefits Division within 60 days will result in the extension being denied. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify Employee Benefits Division of that fact within 60 days of SSA's determination by providing a copy of your Award Letter with your request for an extension of your COBRA coverage

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan if the first qualifying event had not occurred. You must notify Employee Benefits Division within 60 days after a second qualifying event occurs or the extension will be denied.

Adding newly acquired dependents to COBRA health coverage after the qualifying event?

Newly acquired dependents through birth, adoption, placement for adoption, and marriage may be added to your plan if you apply within 30-days of the qualifying event.

Termination of COBRA Coverage

Continuation coverage will be terminated before the end of the maximum period if any required premium is not paid on time. Continuation coverage may also be terminated for any reason the Plan would terminate coverage of participant or beneficiary not receiving continuation coverage (such as fraud). **Acceptance of payment neither guarantees coverage nor ensures eligibility.**

If you are enrolled in COBRA and become eligible for Medicare, your COBRA continuation coverage will be terminated.

If you are already on Medicare when you elect COBRA coverage, the Plan will pay as Primary to Medicare. For more information, please see your Summary Plan Description (SPD).

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

How much does continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent of the cost to the group health plan, including both employer and employee contributions for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150 percent.)

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment for continuation coverage with the Election Form. However, you must make your first payment for continuation coverage within 45 days after the date of your election. (This is the date the Election Notice is postmarked.) If you do not make your first payment for continuation coverage within those 45 days, you will lose all continuation coverage rights under the Plan. If payment is not made at the time of election, coverage will not be reinstated until payment is received. Your first payment must cover the cost of continuation coverage from the time your coverage under the Plan would have otherwise terminated up to the time you make the first payment. You are responsible for making sure the amount of your first payment is enough to cover this entire period.

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Under the Plan, these periodic payments for continuation coverage are due on the 1st of the month. If you make a periodic payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break. The Plan will not send periodic notices of payments due for these coverage periods.
Payments for continuation coverage should be sent to:

US Mail: Employee Benefits Division
P. O. Box 15610
Little Rock, Arkansas 72231-5610

FedEx/UPS: Employee Benefits Division
501 Woodlane St., Ste 500
Little Rock, Arkansas 72201

If your first payment, or any subsequent payment, is not received by the date on which payment is due, or, if you submit a payment that is returned by your bank as, "NON-SUFFICIENT FUNDS (NSF)" or which can otherwise not be processed before the expiration of your grace period, you will lose your option to continue coverage. ***Please note: effective January 1, 2011, a maximum fee of $28.00 is required on all items returned by your bank.***

Grace periods for periodic payments

Although periodic payments are due on the 1st of the month, you will be given a grace period of 30 days to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan. Acceptance of payments by the state does not guarantee coverage. Failure to pay premiums by the due date, regardless of being notified, is the responsibility of the participant. The 30-day grace period rule applies also to payments made by third-party payers (i.e. Kidney Foundation or family members) on your behalf. It is your responsibility to make sure payment has been made timely. Coverage will automatically be terminated and cannot be reinstated if the correct monthly premium is not paid by the end of the month. Acceptance of payment neither guarantees coverage nor ensures eligibility. Legal action will be taken to recover any benefits provided to an enrollee who was not eligible for coverage.

For more information

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Public Health Service Act, including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. For more information about the Marketplace, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep Employee Benefits Division informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to Employee Benefits Division.

Plan Contact Information

Employee Benefits Division
P.O. Box 15610
Little Rock, AR 72231
Toll free: (877) 815-1017
askebd@dfa.arkansas.gov

Glossary

Active Retiree - Retiree who is currently drawing retirement benefits from one of the participating retirement agencies.

Advanced Imaging Services – Computed Tomography Scanning (CT Scan), Magnetic Resonance Angiography or Imaging (MRI/MRA), Nuclear Cardiology and Positron Emission Tomography (PET Scan).

Allowable Charge - The maximum amount a plan will pay for a covered health care service. May also be called “eligible expense,” “payment allowance,” or “negotiated rate.” If your provider charges more than the plan’s allowed amount, you may have to pay the difference

Annual Out of Pocket Maximum – The maximum amount a member pays for covered medical and pharmacy expenses during a single plan year.

Annual Open Enrollment Period – Annual period where eligible employees can enroll, or elect changes to their plan.

Behavioral Health Care Provider - A psychiatrist, psychologist, hospital, health care professional, or counselor that specializes in offering mental health or substance abuse treatment or counseling.

Benefit Coordinator – Health insurance companies EBD contracts with to process member health claims, and/or provide education and services to members.(Health Advantage & QualChoice)

Benefit Year/Contract Year/Plan Year – Twelve (12) month period where benefits are effective. ARBenefit plan year runs from January 1 – December 31.

Case Management - Process used by a health professional to manage health care. Case managers assist in getting necessary services, and evaluate the use of facilities and resources.

COBRA (Consolidated Omnibus Budget Reconciliation Act) – Federal law which allows health insurance continuation of coverage when it would otherwise end due to ineligibility of an insured employee or a covered dependent.

Coinsurance – Coinsurance is the amount the member is responsible to pay for covered services, after the deductible is satisfied, and prior to meeting the out-of-pocket maximum.

Co-pay - Fixed amount a member pays for medical services such as a doctor's office visit, a prescription or emergency room visit.

Cosmetic Services - Any non-medically necessary surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease state, physical appearance or disfigurement caused by an accident, birth defect, to correct or naturally improve a physiological function.

Covered Services - Services, drugs, supply and equipment for which coverage benefits are available under the health care plans

Custodial Care Services - Any type of care, including room and board, that (a) does not require the skills of professional or technical personnel; (b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-hospital skilled nursing facility care; (c) is a level such that the member has reached the maximum level of physical or mental function and is not likely to make further significant improvement.

Deductible - Amount the member or members must pay before the plan starts to contribute for medically necessary covered services.

Dependent - Any member of your family who meets the eligibility requirements, and is enrolled in your insurance plan.

Disease Management - A coordinated, disease-specific educational program that seeks to provide access to information and benefit management for you and your providers regarding possible ways to reduce morbidity from preventable complications.

Durable Medical Equipment (DME) - Any equipment that provides therapeutic benefits to a patient in need because of certain medical conditions and/or illnesses.

EBD - Employee Benefits Division. The Employee Benefits Division (EBD) manages the group health and life insurance plans and other select benefits to build quality programs for eligible members while promoting customer service, education, accessibility and affordability.

Effective Dates of Coverage: Approved date in which benefits or changes elected by a member begin.

Eligible Retiree – An employee who is vested in one of the participating retirement systems, and was enrolled in the ARBenefits plan their last day of employment.

Emergency Care - emergency care refers to emergency medical attention given to an individual who needs it. It includes those medical services required for the immediate diagnosis and treatment of medical conditions which, if not immediately diagnosed and treated, could lead to serious physical or mental disability or death.

Experimental (Investigational) - the use of a service or supply including, but not limited to, treatment, procedure, facility, equipment, medication, or device that the Plan or its representative does not recognize as standard medical care of the condition, disease, illness, or injury being treated. The following criteria are the basis for determination that a service or supply is investigational:

a) Services or supplies requiring federal or other governmental body approval, such as medications and devices that do not have unrestricted market approval from the U.S. Food and Drug Administration (FDA) or final approval from any other governmental regulatory body for use in treatment of a specified condition. Any approval that is granted as an interim step in the regulatory process is not a substitute for final or unrestricted market

approval.

b) There is insufficient or inconclusive scientific evidence in peer-reviewed medical literature to permit the Plan or its representative's evaluation of the therapeutic value of the service or supply

c) There is inconclusive evidence that the service or supply has a beneficial effect on health outcomes

d) The service or supply under consideration is not as beneficial as any established alternatives

e) There is insufficient information or inconclusive scientific evidence that, when utilized in a non-investigational setting, the service or supply has a beneficial effect on health outcomes and is as beneficial as any established alternatives.

If your physician disagrees with the Benefit Coordinator's decision, your physician may make written request to EBD for reconsideration of coverage. The physician will be required to provide "reliable evidence" as outlined in this section of the SPD.

HIPAA (Health Insurance Portability and Accountability Act of 1996) – United States legislation that provides data privacy and security provisions for safeguarding medical information.

Home Health Agency - An organization, licensed by appropriate regulatory authority, who renders care through a program for the treatment of a patient in the patient's home.

Hospice Care A coordinated, interdisciplinary program designed to meet the special physical, psychological, spiritual and social needs of the terminally ill member and his or her covered family members, by providing palliative and supportive medical, nursing and other services through at-home or inpatient care.

Hospital - An institution licensed by the appropriate agency, which is primarily engaged in providing diagnostic and therapeutic facilities on an Inpatient basis for the surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of physicians.

Inactive Retiree – A person who is vested in a participating retirement system, but not yet drawing benefits.

In-Network Services - Services you receive from providers that are in the Benefit Coordinator's network. (Health Advantage & QualChoice)

Long Term Care - Refers to a continuum of medical and social services designed to support the needs of people living with chronic health problems that affect their ability to perform everyday activities.

Medically Necessary – Health-care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

Mental Health Services - The diagnosis or treatment of a mental disease, disorder, or condition as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM) IV, or any other diagnostic coding system.

Non-diseased Tooth – A tooth that is stable, functional, free from decay and advanced periodontal disease.

Nurse Hotline – 24x7 hotline available for members who wish to seek the advice of a nurse. If referred to the emergency room by the hotline nurse, the emergency room co-pay will be waived for members on the Premium plan.

Outpatient Care - All care received outside of acute care facilities.

Out-of-Network Services - A provider that does not have an agreement or contract with the Benefit Coordinator to provide services.

Out-of-Pocket Expenses – Co-pay, deductible or coinsurance.

Primary Care Physician or PCP - The physician who is primarily responsible for providing, arranging, and coordinating all aspects of health care.

Primary Insured - The primary employee or retiree that has completed the application process and is currently paying premiums.

Professional Services - Medically necessary covered services rendered by physicians and other health care providers.

Qualifying Event – A life change that can make you eligible for a special enrollment period.

Skilled Nursing Facility – A health facility which gives care after a member leaves the Hospital for a condition requiring a higher level of care.

Spouse - Husband or wife of an employee as a result of a marriage that is legally recognized.

Urgent Care - The diagnosis and treatment of medical conditions which are serious or acute, which requires medical attention within 24 hours but pose no immediate threat to life and health.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of August 10, 2017. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Arkansas Diamond Deferred Compensation Program (457) Management Policy

(State Employees Only)

I. Program Management

A. Responsibilities

1. EBD

a) Provides oversight and administration for the Arkansas Diamond Deferred Compensation Program offered to state employees.

b) Contracts currently with two companies to provide consulting, investment and record keeping for the 457 program: Stephen's Inc. and Voya Financial.

2. Agency Representatives are responsible for ensuring that information provided by the vendor or EBD is appropriately entered into their payroll system.

II. Employee Eligibility

A. All state employees, and

B. Are receiving compensation (no minimum working hours required).

C. Enrollment is available at any time.

III. Contributions/Withdrawals

A. Contributions may be stopped at any time.

B. Annual contribution limits apply.

C. Access to withdraw funds from the account is only available upon termination or retirement, except for a few limited circumstances as outlined by IRS Code and plan document.

IV. Automatic Enrollment (New employees Only)

A. All new hires 1/1/14 and forward will be automatically enrolled unless they elect to opt out.

B. Anyone wanting to opt out of automatic enrollment on day 1, can do so through their Health Insurance Representative (HIR).

C. Anyone failing to opt out on day 1 will need to contact Voya Financial at 1-800-905-1833.

ARBenefits complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. EBD does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

ARBenefits

• Provides free aids and services to people with disabilities to communicate effectively with us, such as:

○ Qualified sign language interpreters

○ Written information in other formats (large print, audio, accessible electronic formats, other formats)

• Provides free language services to people whose primary language is not English, such as:

○ Qualified interpreters

○ Information written in other languages

If you need these services, contact the Civil Rights Coordinator

If you believe that ARBenefits has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator

Employee Benefits Divison

PO Box 15610

Little Rock, AR 72231

Phone: 1-877-815-1017 x1, Fax: 501-682-1168

Email: AskEBD@dfa.Arkansas.gov

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Civil Rights Coordinator Amy Tustison is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Notice of Privacy Practices
From the State of Arkansas
Department of Finance and Administration
Employee Benefits Division

This notice describes how claims or medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Introduction

Employee Benefits Division (EBD) is responsible for managing health benefits for the State of Arkansas and the Public School Employees. As a group health plan, EBD is required by law to maintain the privacy of protected health information. The Notice of Privacy Practices describes the types of information, its uses and disclosures and your rights regarding that information. It is intended to inform you of how we use and release or "disclose" your protected health information held by us.

"Protected health information" (PHI), means information that is individually identifiable and is protected by privacy regulations. Examples include information regarding the health care treatment, payment, or operations that can identify you or your dependents. This information is obtained from enrollment forms for health care coverage, surveys, healthcare claims, specialist referrals, case management services, your medical records, and other sources. You might provide protected health information by telephone, fax, letter, or e-mail. Other sources of protected health information include, but are not limited to: healthcare providers, such as insurance administrators, network providers and claim processors (hereafter referred to as business partners or affiliates). When used with health related information, any of the following would be considered protected health information:

- Name, address, and date of birth
- ID number and Social Security Number
- Marital status, age, photo, gender
- Postal code
- Information regarding dependents
- Job classification, job tenure, education level
- Other similar information that relates to past, present or future medical care

Disclosures of protected health information not requiring authorization

The law allows the use and disclosure of protected health information (with the exception of genetic information) without the authorization of the individual for the purpose of treatment, payment, and/or health care operations, which includes, but is not limited to:

- Treatment of a health condition
- Payment for treatment
- Business planning and development
- Claims administration
- Coordination of benefits
- Insurance underwriting
- Enrollment into the group health plan
- Premium billing
- Eligibility for coverage issues
- Payment of claims
- Complaint review
- Appeals review
- Regulatory review and legal compliance
- Case Management
- Fraud abuse detection or compliance
- Utilization Review

Special Note on Genetic Information

EBD is prohibited by law from collecting or using genetic information for purposes of underwriting, setting premium, determining eligibility for benefits or applying any preexisting condition exclusion under an insurance policy or health plan. Genetic information means not only genetic tests that you have received, but also any genetic tests of your family members, or any manifestations of a disease or disorder among your family members. We may obtain and use genetic information in making a payment or denial decision or otherwise processing a claim for benefits under your health plan or insurance policy, to the extent that genetic information is relevant to the payment or denial decision or proper processing of your claim.

Uses and disclosures for treatment

Your protected health information will be obtained from or disclosed to health care providers involved in your or your dependents treatment.

Uses and disclosures for payment

Your protected health information will be obtained from and disclosed to individuals involved in your treatment for purposes of payment. Your protected health information may be shared with persons involved in utilization review, or other claims processing.

Uses and disclosures for health care operations

Your protected health information will be used and disclosed for plan operations including but not limited to underwriting, premium rating, auditing, pharmacy management programs, dental benefits, to contact you regarding new or changed health plan benefits, case management and business planning. In order to ensure the privacy of your protected health information, EBD has developed privacy policies and procedures. During the normal course of business, EBD may share this information with its business partners or affiliates that have signed a contract specifying their compliance with EBD's privacy policies.

Marketing and Fundraising

EBD will never use or disclose your personal information for marketing or fundraising purposes.

NOTE: Only the minimum necessary amount of information to complete the tasks listed above will be disclosed. For disclosures of personal health information in situations, other than outlined above, EBD will ask for your authorization to use or disclose your protected heath information. EBD will use or disclose information in these circumstances pursuant to the specific purpose contained in your authorization.

- Usually, only the person to whom the protected health information pertains may make authorization.
- In some circumstances, authorization may be obtained from a person representing your interests (such as in the case where you may be incapacitated and unable to make an informed authorization) or in emergency situations where authorization would be impractical to obtain.
- Any 3rd party acting as your advocate (for example, a family member, your employer, or your elected official) would require an authorization.

In the event that your PHI is disclosed in a manner not covered under this NPP or in violation of our privacy and security policies, you will be notified via first class mail.

Forms

Forms may be obtained from EBD or our website (www.ARBenefits.org)

- Authorization for Release of Protected Health Information
- Revoking Authorization for Release of Protected Health Information

Your Rights

By law, EBD must have your written permission (an "authorization") to use or release your protected health information for any purpose other than payment or healthcare operations or other limited exceptions outlined here or in the Privacy regulation. You may take back ("revoke") your written permission at any time, unless if we have already acted based on your permission.

- You have the right to review and copy your protected health information maintained by EBD. If you require a copy of PHI, the first request will be provided to you at no cost. A reasonable fee will be charged for shipping additional or subsequent copies.
- You have a right to request a copy of this information in electronic form as agreed to by EBD and the covered individual (to the extent the information is electronically producible). The request must be made in writing.
- You can request a paper copy of the Notice of Privacy Practices from EBD.
- You have the right to request an accounting, or list, of non-routine disclosures of your protected health information that is contained in a designated record set that was used to make decisions about you by EBD. This request must be made in writing. The listing will not cover your protected health information that was given out to you or your personal representative, that was given out for payment or healthcare operations, or that was given out for law enforcement purposes.
- You have the right to request a restriction on the protected health information that may be used and/or disclosed. You have the right to request that communication regarding your protected health information from EBD be made at a certain time or location. This request must be in writing and EBD reserves the right to refuse the restriction. If EBD disagrees, you may have a statement of your disagreement added to your protected health information.
- Psychotherapy notes cannot be released without explicit written authorization. EBD does not collect this type of information. Requests for disclosure of psychotherapy notes should be made directly to the treating physician.
- You have the right to receive confidential communication of PHI at alternate locations and by alternate means. (For example, by sending your correspondence to a P.O. Box instead of your home address) if you are in danger of personal harm if the information is not kept confidential.
- You have the right to ask to limit how your PHI is used and given out to pay your claims and perform healthcare operations. Please note that EBD may not be able to agree to your request.
- You have the right to pay your claim in full and request that your provider not share your PHI with your health plan or anyone else (as long as you pay 100% of the cost of the service).

To Exercise Your Rights

If you would like to contact EBD for further information regarding this notice or exercise any of the rights described in this notice, you may do so by contacting EBD's Member Services Department at the following toll free number:

1-877-815-1017 **press #1**

We will not penalize or in any other way retaliate against you for filing a complaint with the Secretary or with us. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant problems; and (4) be filed within 180 days of the time you became or should have become aware of the problem.

EBD's Privacy Office:

EBD Privacy Officer
P.O. Box 15610
Little Rock, AR 72231
Phone: (501) 682-9656
Toll Free: (877) 815-1017 (press #1)
Fax: (501) 682-1168

Or you can send your complaint to the Office for Civil Rights:

Office for Civil Rights, U.S. Department of Health and Human Services
1301 Young Street - Suite 1169
Dallas, TX 75202
Phone: (214) 767-4056
TDD: (214) 767-8940
Fax: (214) 767-0432

To email the Office for Civil Rights, send your message to: OCRCompliant@hhs.gov

Under the HIPAA regulations and guidelines, there can be no retaliation for filing a complaint. You should notify EBD and OCR immediately in the event of any retaliatory action.

Changes to Privacy Practices

If EBD changes its privacy policies and procedures, an updated Notice of Privacy Practices will be provided to you. We are required by law to abide by the terms of this notice. We reserve the right to change this notice and make the revised or changed notice effective for claims or medical information we already have about you as well as any future information we receive. When we make changes, we will notify you by sending a revised notice to the last known address we have for you or by alternative means allowed by law or regulation. We will also post a copy of the current notice on www.ARBenefits.org

Changes to 2018 SPD

Date	Section	Change
1/23/18	Schedule of Benefits	Schedules now reflect out-of-network transplants are not covered.