STATE OF ARKANSAS

OFFICE OF STATE PROCUREMENT
1509 West 7th Street, Room 300
Little Rock, Arkansas 72201-4222

REQUEST FOR PROPOSAL

BID SOLICITATION DOCUMENT

SOLICITATION INFORMATION			
Bid Number:	SP-18-0099	Solicitation Issued:	03/06/2018
Description:	Flexible Spending Accounts / Health Savings Accounts, Cafeteria Plan, and COBRA Services		
Agency:	Arkansas Department of Finance and Administration – Employee Benefits Division		

SUBMISSION DEADLINE FOR RESPONSE			
Bid Opening Date:	04/04/2018	Bid Opening Time:	2:00 p.m., Central Time
Deliver proposal submissions for this Request for Proposal to the Office of State Procurement on or before the designated bid opening date and time. In accordance with Arkansas Procurement Law and Rules, it is the responsibility of Prospective Contractors to submit proposals at the designated location on or before the bid opening date and time. Proposals received after the designated bid opening date and time may be considered late and may be returned to the Prospective Contractor without further review. It is not necessary to return "no bids" to OSP.			

DELIVERY OF RESPONSE DOCUMENTS	
Delivery Address:	Office of State Procurement 1509 West 7th Street, Room 300 Little Rock, AR 72201-4222 Delivery providers, USPS, UPS, and FedEx deliver mail to OSP's street address on a schedule determined by each individual provider. These providers will deliver to OSP based solely on the street address. **Prospective Contractors assume all risk for timely, properly submitted deliveries.**
Proposal's Outer Packaging:	Seal outer packaging and properly mark with the following information. If outer packaging of proposal submission is not properly marked, the package may be opened for bid identification purposes. • Bid number • Date and time of bid opening • Prospective Contractor's name and return address

OFFICE OF STATE PROCUREMENT CONTACT INFORMATION			
OSP Buyer:	Angela Allman	Buyer's Direct Phone Number:	501-371-6156
Email Address:	angela.allman@dfa.arkansas.gov	OSP's Main Number:	501-324-9316
OSP Website:	http://www.dfa.arkansas.gov/offices/procurement/Pages/default.aspx		

SECTION 1 - GENERAL INSTRUCTIONS AND INFORMATION

- ***Do not** provide responses to items in this section unless specifically and expressly required.*

1.1 PURPOSE

A. This Request for Proposal (RFP) is issued by the Office of State Procurement (OSP) on behalf of the Arkansas Department of Finance and Administration – Employee Benefits Division (EBD) to obtain pricing and a contract for the administration and management of the following:

1. For Arkansas State Employees:

   a. Arkansas State Employees (ASE) Section 125 "Cafeteria Plan" (ARCap) which includes the following Benefit Package Options and Qualified Benefits available for pre-tax payments and/or contributions:

      - General Purpose Flexible Spending Account (GPFSA)
      - Limited Purpose Flexible Spending Account for Dental and Vision (LPFSA)
      - Dependent Care Flexible Spending Account (DCAP)

   b. COBRA Administration Services for GPFSA and LPFSA

2. For Arkansas State Employees and Public School Employees (PSE):

   a. Health Savings Account (HSA)

B. The State's main objectives regarding the ARCap and HSA Programs are:

1. To continue providing services to its Members

2. To reduce costs by obtaining the best value for the services required by this RFP

3. To improve communication with ASE and PSE Employees, Members, and Plan Participants in a way that results in well-informed consumers

4. To enhance the Programs by increasing ASE and PSE participation in High Deductible Health Plans (HDHPs), HSAs, and ARCap Programs by 20-25% above the current enrollment totals.

1.2 TYPE OF CONTRACT

A. As a result of this RFP, OSP intends to award a contract to a single Contractor.

B. The anticipated starting date for any resulting contract is July 1, 2018 except that the actual contract start date may be adjusted forward unilaterally by the State for up to three (3) calendar months. By submitting a signed proposal in response to the RFP, the Prospective Contractor represents and warrants that it will honor its proposal as being held open as irrevocable for this period.

C. The initial term of a resulting contract will be for three (3) years. Upon mutual agreement by the Contractor and agency, the contract may be renewed by OSP for up to four (4) additional one-year terms or portions thereof, not to exceed a total aggregate contract term of seven (7) consecutive years.

1.3 ISSUING AGENCY

OSP, as the issuing office, is the sole point of contact throughout this solicitation.

1.4 BID OPENING LOCATION

Proposals will be opened at the following location:

Office of State Procurement
1509 West Seventh Street, Room 300
Little Rock, AR 72201-4222

1.5 ACCEPTANCE OF REQUIREMENTS

A. A Prospective Contractor **must** unconditionally accept all Requirements in the Requirements Section(s) of this RFP to be considered a responsive Prospective Contractor.

B. A Prospective Contractor's proposal will be disqualified if a Prospective Contractor takes exceptions to any Requirements in the Requirements Section(s) of this RFP.

1.6 DEFINITION OF TERMS

A. The State Procurement Official has made every effort to use industry-accepted terminology in this *Bid Solicitation* and will attempt to further clarify any point of an item in question as indicated in *Clarification of Bid Solicitation*.

B. Unless otherwise defined herein, all terms defined in Arkansas Procurement Law and used herein have the same definitions herein as specified therein.

C. The terms "Request for Proposal", "RFP," "Bid Solicitation," and "Solicitation" are used synonymously in this document.

D. **"**Administration Services Start Date" means the date the Contractor **shall** begin providing all administrative, management, and other services required by this RFP, anticipated to be January 1, 2019 and is anticipated to immediately follow the Implementation Period. EBD **shall** have the final determination of the Administrative Services Start Date.

E. "ARCap" means the Arkansas State Employee Cafeteria Plan as established in accordance with Internal Revenue Code Section 125. For the purposes of this RFP, it includes General Purpose Flexible Spending Accounts, Limited Purpose Flexible Spending Accounts, and Dependent Care Flexible Spending Accounts.

F. "ASE" means Arkansas State Employees.

G. "Benefit Package Option" means a Qualified Benefit offered under the ARCap Program.

H. "Business Day" means any day occurring Monday through Friday excluding State Holidays.

I. "CDHP" means Consumer Driven Health Plan(s).

J. "Contractor" means a person who sells or contracts to sell commodities and/or services.

K. "DCAP" means Dependent Care Flexible Spending Account.

L. "Effective Date" means the date on which the ASE or PSE coverage under the Program(s) specified in this RFP commences.

M. "Fiscal Year" means the accounting period used by the State of Arkansas and runs from July 1 through June 30 of the following year.

N. "GPFSA" means General Purpose Flexible Spending Account.

O. "HDHP" means High Deductible Health Plan.

P. "HIR" means Health Insurance Representative.

Q. "HSA" means Health Savings Account.

R. "IIAS" means Inventory Information Approval System and is a point-of-sale technology used by retailers that accept debit cards issued for use with ARCap and HSA Programs.

S. "Implementation Period" means the period of time beginning on the starting date of the contract, anticipated to be July 1, 2018 during which the Contractor **shall** perform all start up and implementation activities required to achieve full implementation by the Administration Services Start Date.

T. "LPFSA" means Limited Purpose Flexible Spending Account.

U. "Member" or "Membership" means an Arkansas State Employee(s) or Public School Employee(s) enrolled in a General Purpose Flexible Spending Account, Limited Purpose Flexible Spending Account, Dependent Care Flexible Spending Account, Health Savings Account, or COBRA.

V. "Open Enrollment" means a time period occurring annually during which insured Arkansas State Employees or Public School Employees may make changes, additions, or deletions to their current coverage, and employees without coverage may apply for coverage. Enrollment and changes made during this annual enrollment period become effective at the beginning of the new Plan Year.

W. "Plan Document" means a collective term covering all official documents of the Programs described in this RFP or to the ASE and PSE Health and Life Insurance Plans. A Plan Document contains important information about the Plan and/or Programs as applicable, such as how to access the benefits of coverage, covered services, exclusions & limitations, Member responsibilities, and rights to appeal or continue coverage.

X. "Plan Participant" means any Arkansas State Employee or Public School Employee who has coverage under the Arkansas State Employee or Public School Employee Health Insurance Benefit Plan but is not enrolled in any one of the ARCap, HSA, or COBRA Programs.

Y. "Plan Year" means the benefit year for Arkansas State Employees, Public School Employees and Retirees Health Insurance and runs from January 1st to December 31st of each year.

Z. "Plan" means the Arkansas State Employees and Public School Employees and Retirees Health and Pharmacy Insurance Benefit coverage, designed and administered by EBD.

AA. "Program(s)" means the Arkansas State Employee Cafeteria Plan (ARCap) inclusive of its Benefits Package Options and Qualified Benefits, the Health Savings Account, and/or COBRA, individually and/or collectively.

BB. "Proposal Submission Requirement" means a task a Contractor **must** complete when submitting a proposal response. These requirements are distinguished by using the term "**shall**" or "**must**" in the requirement.

CC. "Prospective Contractor" means a person who submits a proposal in response to this solicitation.

DD. "PSE" means Public School Employees.

EE. "Qualified Benefit" means a benefit that is excludable from gross income under an express provision of IRS Section 125.

FF. "Requirements" means specifications that a Contractor's product and/or service is responsible for performing during the term of the contract. These specifications will be distinguished by using the term "**shall**" or "**must**" in the requirement.

GG. "Responsive Proposal" means a proposal submitted in response to this solicitation that conforms in all material respects to this RFP.

HH. "State Holiday" includes the following days during each year when State offices are closed:

1. Christmas Day
2. Christmas Eve
3. Dr. Martin Luther King Jr.'s Birthday
4. Independence Day
5. Labor Day
6. Memorial Day
7. New Year's Day
8. President's Day / Daisy Gatson Bates Day
9. Thanksgiving Day
10. Veterans Day

II. "State" means the State of Arkansas. When the term "State" is used herein to reference any obligation of the State under a contract that results from this solicitation, that obligation is limited to the State agency using such a contract.

1.7 RESPONSE DOCUMENTS

A. Original *Technical Proposal Packet*

1. Proposal Submission Requirements

   a. Prospective Contractor **shall** provide the following:

      i. Original signed *Proposal Signature Page*. (See *Technical Proposal Packet.)*

      ii. Original signed *Conflict of Interest Affidavit*. (See *Technical Proposal Packet*.)

      iii. *One (1) original hard copy of the proposal response which includes:*

      - *Technical Proposal* response to the *Information for Evaluation* section included in the *Technical Proposal Packet*.
      - *Response to the Official Bid Price Sheet.*

   b. The *Official Bid Price Sheet*, including the hard copy and electronic copy, **must** be separately sealed from the *Technical Proposal Packet* and should be clearly marked as "Pricing". A Prospective Contractor **shall not** include any pricing in the hard copies or electronic copies of their *Technical Proposal Packet*.

   c. Proposal response **must** be in the English language.

   d. Pricing **must** be proposed in U.S. dollars and cents.

2. The following items should be submitted in the original *Technical Proposal Packet*.

   a. EO 98-04 Disclosure Form. (See *Standard Terms and Conditions, #27. Disclosure*.)

   b. Copy of Prospective Contractor's *Equal Opportunity Policy*. (See *Equal Opportunity Policy*.)

   c. *Voluntary Product Accessibility Template* (VPAT). (See *Technology Access.*)

   d. Proposed Subcontractors Form. (See *Subcontractors.)*

3. **DO NOT** include any other documents or ancillary information, such as a cover letter or promotional/marketing information.

B. Additional Copies and Redacted Copy of the *Technical Proposal Packet and Official Bid Price Sheet*

In addition to the original *Technical Proposal Packet* and the *Official Bid Price Sheet*, the following items should be submitted:

1. Additional Copies of the *Technical Proposal Packet*

   a. Three (3) complete hard copies (marked "COPY") of the *Technical Proposal Packet*.

   b. Four (4) electronic copies of the *Technical Proposal Packet*, preferably on flash drives. CDs will also be acceptable. Do not send electronic copies via email or fax.

   c. All additional hard copies and electronic copies **must** be identical to the original hard copy. In case of a discrepancy, the original hard copy governs.

d. If OSP requests additional copies of the proposal, the copies **must** be delivered within the timeframe specified in the request.

2. Additional Copies of the Official Bid Price Sheet

a. Prospective Contractor should also submit one (1) electronic copy of the *Official Bid Price Sheet*, preferably on a flash drive. A CD will also be acceptable. Do not send electronic copies via email or fax.

i. *The Official Bid Price Sheet*, including the hard copy and electronic copy, **must** be separately sealed from the *Technical Proposal Packet* and should be clearly marked as "Pricing". Prospective Contractor **shall not** include any pricing in the hard copies or electronic copies of their *Technical Proposal Packet*.

3. One (1) redacted (marked "REDACTED") copy the original *Technical Proposal Packet*, preferably on a flash drive. A CD will also be acceptable. Do not send electronic copies via email or fax. (See *Proprietary Information*.)

1.8 ORGANIZATION OF RESPONSE DOCUMENTS

A. It is strongly recommended that Prospective Contractors adhere to the following format and suggestions when preparing their Technical Proposal response.

B. The original *Technical Proposal Packet* and all copies should be arranged in the following order.

- *Proposal Signature Page*.
- Signed *Conflict of Interest Affidavit*
- *Proposed Subcontractors Form*.
- Signed Addenda, if applicable.
- E.O. 98-04 – *Contract Grant and Disclosure Form*.
- *Equal Opportunity Policy.*
- *Voluntary Product Accessibility Template* (VPAT).
- Technical Proposal response to the *Information for Evaluation* section of the *Technical Proposal Packet.*

1.9 CLARIFICATION OF BID SOLICITATION

A. Submit any questions requesting clarification of information contained in this *Bid Solicitation* in writing via email by 4:00 p.m., Central Time on or before March 8, 2018 to the OSP buyer as shown on page one (1) of this *Bid Solicitation*.

1. For each question submitted, Prospective Contractor should reference the specific solicitation item number to which the question refers.

2. Prospective Contractors' written questions will be consolidated and responded to by the State. The State's consolidated written response is anticipated to be posted to the OSP website by the close of business on March 20, 2018. If Prospective Contractor questions are unclear or non-substantive in nature, the State may request clarification of a question(s) and/or reserves the right not to respond to those questions.

B. The Prospective Contractor should notify the OSP designated contact(s) of any term, condition, etc., that precludes the Prospective Contractor from submitting a compliant, Responsive Proposal. Prospective Contractors should note that it is the responsibility of the Prospective Contractor to seek resolution of all such issues, including those relating to the terms and conditions of the contract, prior to the submission of a proposal.

C. Prospective Contractors may contact the OSP buyer with non-substantive questions at any time prior to the bid opening.

D. An oral statement by OSP will not be part of any contract resulting from this solicitation and may not reasonably be relied on by any Prospective Contractor as an aid to interpretation unless it is reduced to writing and expressly adopted by OSP.

E. Prospective Contractors entering into a contract with the State **shall** comply with all the terms and conditions contained herein.

1.10 PROPOSAL SIGNATURE PAGE

A. An official authorized to bind the Prospective Contractor(s) to a resultant contract **shall** sign the *Proposal Signature Page* included in the *Technical Proposal Packet*.

B. Prospective Contractor's signature on this page signifies Prospective Contractor's agreement that any exception that conflicts with a Requirement or Proposal Submission Requirement of this *Bid Solicitation* will cause the Prospective Contractor's proposal to be disqualified.

1.11 SUBCONTRACTORS

A. Prospective Contractor should complete, sign and submit the *Proposed Subcontractors Form* included in the *Technical Proposal Packet*.

B. Additional subcontractor information may be required or requested in following sections of this *Bid Solicitation* or in the *Information for Evaluation* section provided in the *Technical Proposal Packet*. **Do not** attach any additional information to the *Proposed Subcontractors Form*.

C. Should the Prospective Contractor propose to use subcontractors, the Prospective Contractor's proposed subcontractors **shall** have the same experience required in this RFP as the Prospective Contractor is required to have for the particular service(s) to be provided. For example, if the Prospective Contractor proposes the use of a subcontractor to provide COBRA Administration, the proposed subcontractor **shall** have the same qualifications required in this RFP as the Prospective Contractor is required to have for COBRA Administration.

D. Should any part of the requirements in this RFP be fulfilled by subcontractors (including but not limited to subcontractors regarding the HSA custodian, debit card processor, and debit card issuing bank), the Contractor **shall** have any subcontractor utilized sign EBD's HIPAA compliant Business Associates Agreement. The Contractor **shall** submit the HIPAA compliant Business Associates Agreement signed by any utilized subcontractor to EBD within thirty (30) calendar days of contract award. A sample HIPAA compliant Business Associate Agreement is posted as Attachment A to this RFP.

E. EBD reserves the right to have final approval of any proposed subcontractor.

1.12 CONFLICT OF INTEREST AFFIDAVIT

A. The Prospective Contractor **shall** provide a completed and signed *Conflict of Interest Affidavit* located in the *Technical Proposal Packet*.

1.13 PRICING

A. Prospective Contractor(s) **shall** include all pricing on the Official Bid Price Sheet(s) only**.** If any cost not included by the successful Contractor is subsequently incurred in order to achieve successful operation, the successful Contractor **shall** bear this additional cost. The *Official Bid Price Sheet* is provided as a separate excel file posted with this *Bid Solicitation*.

B. To allow time to evaluate proposals, prices **must** be valid for 90 days following the bid opening.

C. The *Official Bid Price Sheet*, including the hard copy and electronic copy, **must** be separately sealed from the *Technical Proposal Packet* and should be clearly marked as "Pricing". DO NOT submit any ancillary information not related to actual pricing on the Official Bid Price Sheet or in the sealed pricing package.

D. The Contractor **shall** provide the services required in this RFP to EBD for the benefit of ASE and PSE Plans. All work performed by the Contractor **must** address the particular needs of the ASE and PSE Plans, respectively. As a result, pricing **must** reflect the administration and management for both Plans.

E. The Official Bid Price Sheet contains five (5) Tabs for the purposes described below.

1. **Tab 1 – Instructions:** Tab 1 provides general instructions for completing the Official Bid Price Sheet. The Prospective Contractor **shall** adhere to all instructions as written.

2. **Tab 2 – Initial Term Estimated Total Cost:** Tab 2 provides an overview of Tab 3 of the Official Bid Price Sheet. The totals in Tab 2 will be used for determining lowest cost.

3. **Tab 3 - Administration and Management Costs**

   - **Table 3.1 – ARCap Administration and Management:** The Prospective Contractor **shall** provide pricing for the monthly administration and management of the ARCap Program for ASE listed on a Per Member Per Month (PMPM) basis. Table 3.1 will be used for determining lowest cost.

   - **Table 3.2 – HSA Administration & Management:** The Prospective Contractor **shall** provide pricing for the monthly administration and management of the HSA Program for ASE and PSE on a Per Member Per Month (PMPM) basis. Table 3.2 will be used for determining lowest cost.

   - **Table 3.3 – Implementation:** The Prospective Contractor **shall** provide a one-time implementation fee. Table 3.3 will be used for determining lowest cost.

   - **Table 3.4 – Training:** The Prospective Contractor **shall** provide a per unit price for each type of training listed. Table 3.4 will be used for determining lowest cost.

   - **Table 3.5 – Open Enrollment/HIR Sessions:** The Prospective Contractor **shall** provide pricing for each per unit Open Enrollment/HIR session provided. Table 3.5 will be used for determining lowest cost.

4. **Tab 4 – COBRA Administration Costs**

   - **Table 4.1 –Modified COBRA Administration for GPFSA and LPFSA:** The Prospective Contractor **shall** provide pricing for modified COBRA Administration. The Prospective Contractor **shall not** include pricing for the administrative functions retained by EBD for GPFSA and LPFSA COBRA Administration as stated in this RFP. Table 4.1 will not be used for determining lowest cost.

   - **Table 4.2 – Full COBRA Administration for GPFSA and LPFSA:** The Prospective Contractor **shall** provide pricing for full COBRA Administration. The Prospective Contractor **shall** include pricing for the assumption and provision of the administrative functions previously retained by EBD but that may be transferred to the Contractor during a contract term as stated in this RFP. Table 4.2 will not be used for determining lowest cost.

   - **Table 4.3 – Adding COBRA Administration for Plan Participants' Voluntary Products (Dental and Vision):** The Prospective Contractor **shall** provide pricing for COBRA Administration for Plan Participants' voluntary dental and vision insurances as instructed on the Official Bid Price Sheet. Table 4.3 will not be used for determining lowest cost.

   - **Table 4.4 – One Time Implementation Required for adding COBRA Administration for Plan Participants' Voluntary Dental and Vision Insurances:** The Prospective Contractor **shall** provide a one-time implementation fee as instructed on the Official Bid Price Sheet. The State will only pay the one-time implementation fee once all implementation activities pertaining to the addition of COBRA Administration for Plan Participants' voluntary dental and vision insurances are complete and approved by EBD. Table 4.4 will not be used for determining lowest cost.

5. **Tab 5 – Other Costs**

   - **Table 5.1 – Additional Services:** The Prospective Contractor should provide pricing for any additional services offered beyond those services required by this RFP as instructed on the Official Bid Price Sheet. Table 5.1 will not be used for determining lowest cost.

   - **Table 5.2 – Adding PSE to ARCap:** The Prospective Contractor **shall** provide pricing for the administration and management of the ARCap Programs for ASE and PSE combined as instructed on the Official Bid Price Sheet. Table 5.2 will not be used for determining lowest cost.

   - **Table 5.3 Implementation Required for Adding PSE to ARCap:** The Prospective Contractor **shall** provide a one-time implementation fee as instructed on the Official Bid Price Sheet. The State will only

pay the one-time implementation fee once all implementation activities pertaining to the addition of PSE to ARCap are complete and approved by EBD. Table 5.3 will not be used for determining lowest cost.

1.14 PRIME CONTRACTOR RESPONSIBILITY

A. A single Prospective Contractor **must** be identified as the prime Contractor.

B. The prime Contractor **shall** be responsible for the contract and jointly and severally liable with any of its subcontractors, affiliates, or agents to the State for the performance thereof.

1.15 INDEPENDENT PRICE DETERMINATION

A. By submission of this proposal, the Prospective Contractor certifies, and in the case of a joint proposal, each party thereto certifies as to its own organization, that in connection with this proposal:

- The prices in the proposal have been arrived at independently, without collusion.
- No prior information concerning these prices has been received from, or given to, a competitive company.

B. Evidence of collusion warrants consideration of this proposal by the Office of the Attorney General. All Prospective Contractors **shall** understand that this paragraph may be used as a basis for litigation.

1.16 PROPRIETARY INFORMATION

A. Submission documents pertaining to this *Bid Solicitation* become the property of the State and are subject to the Arkansas Freedom of Information Act (FOIA).

B. In accordance with FOIA and to promote maximum competition in the State competitive bidding process, the State may maintain the confidentiality of certain types of information described in FOIA. Such information may include trade secrets defined by FOIA and other information exempted from the Public Records Act pursuant to FOIA.

C. Prospective Contractor may designate appropriate portions of its response as confidential, consistent with and to the extent permitted under the Statutes and Rules set forth above, by submitting a redacted copy of the response.

D. By so redacting any information contained in the response, the Prospective Contractor warrants that it has formed a good faith opinion, having received such necessary or proper review by counsel and other knowledgeable advisors, that the portions redacted meet the requirements of the Rules and Statutes set forth above.

E. Under no circumstances will price information be designated as confidential.

F. One (1) complete copy of the submission documents from which any proprietary information has been redacted should be submitted on a flash drive in the *Technical Proposal Packet*. A CD is also acceptable. Do not submit documents via email or fax.

G. Except for the redacted information, the redacted copy **must** be identical to the original hard copy, reflecting the same pagination as the original and showing the space from which information was redacted.

H. The Prospective Contractor is responsible for identifying all proprietary information and for ensuring the electronic copy is protected against restoration of redacted data.

I. The redacted copy will be open to public inspection under the Freedom of Information Act (FOIA) without further notice to the Prospective Contractor.

J. If a redacted copy of the submission documents is not provided with Prospective Contractor's response packet, a copy of the non-redacted documents, with the exception of financial data (other than pricing), will be released in response to any request made under the Arkansas Freedom of Information Act (FOIA).

K. If the State deems redacted information to be subject to FOIA, the Prospective Contractor will be contacted prior to release of the documents.

L. The State has no liability to Prospective Contractor with respect to the disclosure of Prospective Contractor's confidential information ordered by a court of competent jurisdiction pursuant to FOIA or other applicable law.

1.17 CAUTION TO PROSPECTIVE CONTRACTORS

A. Prior to any contract award, address all communication concerning this *Bid Solicitation* through OSP.

B. Do not alter any language in any solicitation document provided by the State.

C. Do not alter the Official Bid Price Sheet.

D. All official documents and correspondence related to this solicitation become part of the resultant contract.

E. The State has the right to award or not award a contract, if it is in the best interest of the State to do so.

F. As requested, provide clarification regarding Prospective Contractor's proposal response to OSP.

G. Qualifications and proposed services **must** meet or exceed the required specifications as set forth in this *Bid Solicitation*.

H. Prospective Contractors may submit multiple proposals.

1.18 REQUIREMENT OF ADDENDUM

A. Only an addendum written and authorized by OSP will modify this *Bid Solicitation*.

B. An addendum posted within three (3) calendar days prior to the bid opening may extend the bid opening and may or may not include changes to the Bid Solicitation.

C. The Prospective Contractor is expected to check the OSP website, http://www.arkansas.gov/dfa/procurement/bids/index.php, for any and all addenda up to bid opening.

1.19 AWARD PROCESS

A. Successful Contractor Selection

The Grand Total Score for each Prospective Contractor, which is the sum of the Technical Score and Cost Score, will be used to determine the ranking of proposals. The State may move forward to negotiations with those responsible Prospective Contractors determined, based on the ranking of the proposals, to be reasonably susceptible of being selected for award.

B. Negotiations

1. If the State so chooses, negotiations may be conducted with the highest ranking Prospective Contractors. Negotiations are conducted at the sole discretion of the State.

2. If negotiations fail to result in a contract, the State may begin the negotiation process with the next highest ranking Prospective Contractor. The negotiation process may be repeated until the anticipated successful Contractor has been determined, or until such time the State decides not to move forward with an award.

C. Anticipation to Award

1. Once the anticipated successful Contractor has been determined, the anticipated award will be posted on the OSP website at http://www.arkansas.gov/dfa/procurement/pro_intent.php.

2. The anticipated award will be posted for a period of fourteen (14) days prior to the issuance of a contract. Prospective Contractors and agencies are cautioned that these are preliminary results only, and a contract will not be issued prior to the end of the fourteen day posting period.

3. OSP may waive the policy of Anticipation to Award when it is in the best interest of the State.

4. It is the Prospective Contractor's responsibility to check the OSP website for the posting of an anticipated award.

D. Issuance of Contract

1. Any resultant contract of this *Bid Solicitation* is subject to State approval processes which may include Legislative review.

2. A State Procurement Official will be responsible for the solicitation and award of any resulting contract.

1.20 MINORITY AND WOMEN-OWNED BUSINESS POLICY

A. A minority-owned business is defined by Arkansas Code Annotated § 15-4-303 as a business owned by a lawful permanent resident of this State who is:

- African American
- American Indian
- Asian American
- Hispanic American
- Pacific Islander American
- A Service Disabled Veteran as designated by the United States Department of Veteran Affairs

B. A women-owned business is defined by Act 1080 of the 91st General Assembly Regular Session 2017 as a business that is at least fifty-one percent (51%) owned by one (1) or more women who are lawful permanent residents of this State.

C. The Arkansas Economic Development Commission conducts a certification process for minority-owned and women-owned businesses. If certified, the Prospective Contractor's Certification Number should be included on the *Proposal Signature Page*.

1.21 EQUAL OPPORTUNITY POLICY

A. In compliance with Arkansas Code Annotated § 19-11-104, OSP is required to have a copy of the anticipated Contractor's *Equal Opportunity (EO) Policy* prior to issuing a contract award.

B. *EO Policies* may be submitted in electronic format to the following email address: eeopolicy.osp@dfa.arkansas.gov, but should also be included as a hardcopy accompanying the solicitation response.

C. The submission of an *EO Policy* to OSP is a one-time Requirement. Contractors are responsible for providing updates or changes to their respective policies, and for supplying *EO Policies* upon request to other State agencies that must also comply with this statute.

D. Prospective Contractors who are not required by law by to have an *EO Policy* **must** submit a written statement to that effect.

1.22 PROHIBITION OF EMPLOYMENT OF ILLEGAL IMMIGRANTS

A. Pursuant to Arkansas Code Annotated § 19-11-105, Prospective Contractor(s) **shall** certify with OSP that they do not employ or contract with illegal immigrants.

B. By signing and submitting a response to this *Bid Solicitation*, a Prospective Contractor agrees and certifies that they do not employ illegal immigrants. If selected, the Prospective Contractor certifies that they will not employ illegal immigrants during the aggregate term of a contract.

1.23 RESTRICTION OF BOYCOTT OF ISRAEL

A. Pursuant to Arkansas Code Annotated § 25-1-503, a public entity **shall not** enter into a contract with a company unless the contract includes a written certification that the person or company is not currently engaged in, and agrees for the duration of the contract not to engage in, a boycott of Israel.

B. This prohibition does not apply to a company which offers to provide the goods or services for at least twenty percent (20%) less than the lowest certifying business.

C. By checking the designated box on the Proposal Signature Page of the response packet, a Prospective Contractor agrees and certifies that they do not, and will not for the duration of the contract, boycott Israel.

1.24 PAST PERFORMANCE

In accordance with provisions of State Procurement Law, specifically OSP Rule R5:19-11-230(b)(1), a Prospective Contractor's past performance with the State may be used to determine if the Prospective Contractor is "responsible". Proposals submitted by Prospective Contractors determined to be non-responsible will be disqualified.

1.25 TECHNOLOGY ACCESS

A. When procuring a technology product or when soliciting the development of such a product, the State of Arkansas is required to comply with the provisions of Arkansas Code Annotated § 25-26-201 et seq., as amended by Act 308 of 2013, which expresses the policy of the State to provide individuals who are blind or visually impaired with access to information technology purchased in whole or in part with state funds. The Prospective Contractor expressly acknowledges and agrees that state funds may not be expended in connection with the purchase of information technology unless that technology meets the statutory Requirements found in 36 C.F.R. § 1194.21, as it existed on January 1, 2013 (software applications and operating ICSs) and 36 C.F.R. § 1194.22, as it existed on January 1, 2013 (web-based intranet and internet information and applications), in accordance with the State of Arkansas technology policy standards relating to accessibility by persons with visual impairments.

B. Accordingly, the Prospective Contractor expressly represents and warrants to the State of Arkansas through the procurement process by submission of a Voluntary Product Accessibility Template (VPAT) for 36 C.F.R. § 1194.21, as it existed on January 1, 2013 (software applications and operating ICSs) and 36 C.F.R. § 1194.22, that the technology provided to the State for purchase is capable, either by virtue of features included within the technology, or because it is readily adaptable by use with other technology, of:

1. Providing, to the extent required by Arkansas Code Annotated § 25-26-201 et seq., as amended by Act 308 of 2013, equivalent access for effective use by both visual and non-visual means.

2. Presenting information, including prompts used for interactive communications, in formats intended for non-visual use.

3. After being made accessible, integrating into networks for obtaining, retrieving, and disseminating information used by individuals who are not blind or visually impaired.

4. Providing effective, interactive control and use of the technology, including without limitation the operating system, software applications, and format of the data presented is readily achievable by nonvisual means.

5. Being compatible with information technology used by other individuals with whom the blind or visually impaired individuals interact.

6. Integrating into networks used to share communications among employees, program participants, and the public.

7. Providing the capability of equivalent access by nonvisual means to telecommunications or other interconnected network services used by persons who are not blind or visually impaired.

C. State agencies cannot claim a product as a whole is not reasonably available because no product in the marketplace meets all the standards. Agencies must evaluate products to determine which product best meets the standards. If an agency purchases a product that does not best meet the standards, the agency must provide written documentation supporting the selection of a different product, including any required reasonable accommodations.

D. For purposes of this section, the phrase "equivalent access" means a substantially similar ability to communicate with, or make use of, the technology, either directly, by features incorporated within the technology, or by other reasonable means such as assistive devices or services which would constitute reasonable accommodations under the Americans with Disabilities Act or similar state and federal laws. Examples of methods by which equivalent access may be provided include, but are not limited to, keyboard alternatives to mouse commands or other means of navigating graphical displays, and customizable display

appearance. As provided in Arkansas Code Annotated § 25-26-201 et seq., as amended by Act 308 of 2013, if equivalent access is not reasonably available, then individuals who are blind or visually impaired **shall** be provided a reasonable accommodation as defined in 42 U.S.C. § 12111(9), as it existed on January 1, 2013.

E. If the information manipulated or presented by the product is inherently visual in nature, so that its meaning cannot be conveyed non-visually, these specifications do not prohibit the purchase or use of an information technology product that does not meet these standards.

1.26 COMPLIANCE WITH THE STATE SHARED TECHNICAL ARCHITECTURE PROGRAM

The Prospective Contractor's solution **must** comply with the State's shared Technical Architecture Program which is a set of policies and standards that can be viewed at: http://www.dis.arkansas.gov/policiesStandards/Pages/default.aspx. Only those standards which are fully promulgated or have been approved by the Governor's Office apply to this solution.

1.27 VISA ACCEPTANCE

A. Awarded Contractor should have the capability of accepting the State's authorized VISA Procurement Card (p-card) as a method of payment for Contractor's monthly invoices.

B. Price changes or additional fee(s) **must not** be levied against the State when accepting the p-card as a form of payment.

C. VISA is not the exclusive method of payment.

1.28 PUBLICITY

A. Do not discuss the solicitation nor your proposal response, nor issue statements or comments, nor provide interviews to any public media during the solicitation and award process.

B. Failure to comply with this Requirement may be cause for a Prospective Contractor's proposal to be disqualified.

1.29 RESERVATION

The State will not pay costs incurred in the preparation of a proposal.

SECTION 2 –REQUIREMENTS

- ***Do not** provide responses to items in this section unless specifically and expressly required.*

2.1 INTRODUCTION

A. This Request for Proposal (RFP) is issued by the Office of State Procurement (OSP) on behalf of the Department of Finance and Administration – Employee Benefits Division (EBD) to obtain pricing and a contract for the administration and management of the following:

1. For Arkansas State Employees (ASE):

a. Arkansas State Employees Section 125 "Cafeteria Plan" (ARCap) which includes the following Benefit Package Options and/or Qualified Benefits available for pre-tax payments and/or contributions:

- General Purpose Flexible Spending Account (GPFSA)
- Limited Purpose Flexible Spending Account for Dental and Vision (LPFSA)
- Dependent Care Flexible Spending Account (DCAP)

b. COBRA Administration Services for GPFSA and LPGSA

2. For Arkansas State Employees and Public School Employees (PSE)

a. Health Savings Account (HSA)

B. The Arkansas State and Public School Life and Health Insurance Board has full policy-making authority for the Plans. The Contractor **shall** adjust services based on any changes the Board makes during the term(s) of the contract.

C. The contract start date is anticipated to be July 1, 2018 with an Administrative Services Start Date anticipated to be January 1, 2019. EBD reserves the right to have the final determination of the Administrative Services Start Date.

2.2 BACKGROUND AND CURRENT ENVIRONMENT

A. The State of Arkansas is strictly providing estimates, statistics, and other information regarding current conditions as a courtesy to Prospective Contractors. The Prospective Contractor **shall not** interpret any given estimate, statistic, and/or any other information regarding current conditions provided in this RFP or Official Bid Price Sheet to be a guarantee of actual contract volume or conditions existing during the term(s) of a contract resulting from this RFP.

B. As established in accordance with Internal Revenue Code Section 125, the Programs described in this RFP allow Qualified Benefits to be paid on a pre-tax basis.

C. At a minimum, the benefits available for pre-tax payments/contributions include certain employee-paid health and life insurance premiums and qualified supplemental products (in regards to the Plan Document), HSAs, GPFSAs, LPFSAs, DCAPs, and COBRA.

D. Currently the State only offers the ARCap Program to ASE, although both ASE and PSE are benefit eligible. The State reserves the right to offer the ARCap to PSE at a future date during the term(s) of any contract resulting from this RFP.

F. Administrative and management services are currently provided by DataPath, Inc.

G. Current employer contributions to Member's HSAs are as follows:

- ASE: $300 / Year for Individuals and $600 / Year for Family

- PSE: No Employer Contribution
- The current employer contributions are expected to continue throughout the life of any resultant contract.

H. Total Plan Enrollment, ARCap and HSA Enrollment/Membership Information:

Total Population & Plan Enrollment	**ASE**	**PSE**
Total Employee Population	44,071	79,443
Total Plan Enrollment	60,470	90,846
ARCap Membership	**ASE**	**PSE**
GPFSA	2924	0
LPFSA	52	0
DCAP	182	0
HSA Qualified Plan Enrollment and HSA Membership	**ASE**	**PSE**
HSA Qualified Health Plan Enrollment	3,757	31,035
HSA Membership	2,983	20,108

I. Enrollment in COBRA for GPFSA and LPFSA has been historically low. For example, the last Plan Year ended having had only four (4) GPFSA and LPFSA participants enrolled in COBRA. The current Plan Year began with zero (0) GPFSA and LPFSA COBRA participants.

J. Currently, 86.7% of debit card claims are auto-adjudicated.

K. Current average balance for HSA Member accounts is $1,162.00.

L. ARCap funding is currently housed by EBD.

M. Currently for ARCap claims reimbursement, 1, 651 Members receive reimbursement via direct deposit and 2,399 via paper check.

N. For additional information regarding current conditions, the Prospective Contractor may reference the 2018 Summary Plan Description listed as Attachment B to this RFP.

2.3 PROSPECTIVE CONTRACTOR QUALIFICATIONS

A. The Prospective Contractor **must** have five (5) years' previous experience in each of the following and currently be administering and maintaining compliance of:

- Section 125 Cafeteria Plans
- General Purpose Flexible Spending Accounts
- Limited Purpose Flexible Spending Accounts
- Dependent Care Flexible Spending Accounts
- Health Savings Accounts
- COBRA Administrative Services

B. The Prospective Contractor **must** have a minimum of five (5) years' experience working with either State, Federal, or local public entities such as cities or counties (preferably in administering and managing a project of similar scope) and **must** be capable of serving the needs of a geographically diverse employer population.

C. Prior to contract award, the Prospective Contractor **shall** be authorized to conduct business in the State of Arkansas.

D. Prior to contract award and throughout the life of any resultant contract including any extensions, the Contractor **shall** maintain the following insurance coverages listing the State of Arkansas as an additional insured:

1. Commercial General Liability insurance with policy limits of not less than $1,000,000 per occurrence and $2,000,000 general aggregate.

2. Cyber Liability Insurance with a minimum policy limit of $600,000.

E. The Contractor and any subcontractors utilized **shall** be located within the United States and **shall** perform all services required in this RFP from within the United States. The Contractor and any subcontractors utilized **shall** create, maintain, and store all data related to any resultant contract within the United States.

2.4 GENERAL REQUIREMENTS

A. The Programs described in this RFP **must** adhere to all State and federal laws. The Contractor **shall** maintain compliance with all applicable State and federal laws as they pertain to the administration and management of the Program(s) described herein. The Contractor **shall** create and modify all forms, Member communication and education pieces, and all other documents and services provided to maintain compliance of applicable State and Federal Laws.

B. Throughout the term(s) of any contract resulting from this RFP and as requested by EBD and/or required by law, the State reserves the right to add or remove any services offered by the Contractor under the scope of any contract resulting from this RFP. These services may be additional services as offered in the Prospective Contractor's proposal and/or newly created services based on improving technology or changes in Federal and/or State mandates which fall under the scope of work. If pricing for these services is not already submitted on the Official Bid Price Sheet, the Contractor **shall** negotiate pricing with EBD if and when the services are added. Pricing **must** be consistent with current contract pricing for similar services and **must** be agreed upon in writing between EBD and the Contractor prior to implementation of the service.

C. The State of Arkansas, EBD, or the Members **shall not** pay any costs the Prospective Contractor fails to include on the Official Bid Price Sheet, such as, but not limited to the following:

1. All fees charged by third parties, including any subcontractors of the Contractor.

2. Printing and mailing expenses.

3. Expenses associated with the education and/or enrollment sessions provided to agencies.

4. Travel costs associated with providing the services specified in this RFP including but not limited to meals, lodging, and airfare.

C. For all required services, the Contractor **shall** bear all costs not included on the Official Bid Price Sheet but subsequently incurred in order to achieve successful operation. If no specific pricing cell is provided for a particular cost of a required service, the Contractor **shall** bear such expense and **shall** figure that expense amount into any of the provided orange pricing cells as appropriate to include that expense in the proposed pricing. ***Do not*** **alter, write, or mark on the Official Bid Price Sheet except to enter the pricing in the designated pricing cells or as otherwise instructed on the Official Bid Price Sheet instructions.**

D. The Contractor **shall** implement specific procedures to ensure adherence to and appropriate reporting for the Performance Standards as stated in Attachment D to this RFP.

2.5 GENERAL PROGRAM REQUIREMENTS

A. The Contractor **shall** provide immediate written notification to EBD of any changes to the Contractor's representatives, management, and/or ownership relative to a resulting contract.

B. The Contractor **shall** have their own bank account dedicated for COBRA administration and for making all required ARCap and HSA payments.

C. The Contractor **shall** provide Members with an Electronic Payment Debit Card on a major card-processing platform that is Inventory Information Approval Systems (IIAS) Compliant.

D. The Contractor **shall** accept enrollment information in a method specified by or acceptable to EBD. Technical details will be determined prior to award or during the Implementation Period as determined by EBD.

E. The Contractor **shall** correctly process all enrollment additions, changes, and deletions, as well as demographic changes within three (3) Business Days of receipt by the Contractor in accordance with applicable State and federal law as they relate to the Qualified Benefits administered and managed under any contract resulting from this RFP.

F. The Contractor **shall** hold all COBRA, ARCap, and HSA account funds in an FDIC insured bank.

G. The Contractor **shall** send an alert to the Member via the Member's chosen method of communication (email, fax, USPS, etc.) when any rejected, unexpected, and/or unintended funding has occurred on the Member's account and **shall** notify EBD within five (5) Business Days via the task system for each occurrence.

    1. The task system is an ARBenefits proprietary system used by EBD for secure communication. During the Implementation Period, EBD will provide the Contractor with sign-on credentials for the task system.

H. For reporting purposes, the Contractor **shall** appropriately separate each Member account and categorize the Member accounts per the applicable funding source with each funding source having its own classification. The Contractor **shall** create a report based on the categorized information and **shall** arrange the report by Agency Number or other category arrangement determined necessary by EBD.

I. The Contractor **shall** correctly credit ARCap and HSA Member accounts.

    1. The Contractor **shall** utilize accounting and business processes that provide for the correct crediting of Member accounts for all circumstances having the potential to result in the incorrect crediting of a Member's account, such as when a Member transfers between agencies, experiences a name change, and for other demographic and changes that may affect proper crediting.

J. During the Implementation Period, or other time as requested by EBD, and with EBD's assistance and approval, the Contractor **shall** establish procedures for Members to follow regarding the process for the submission of documentation and information to the Contractor.

    1. The Contractor **shall** provide the approved procedures, as well as a list of eligible changes allowed by applicable federal law, to each individual State agency's Health Insurance Representative (HIR) in a format requested by EBD or the agency's HIR which may include PDF format, emails, HIR/EBD alerts, brochures, etc. Currently the State of Arkansas consists of 238 agencies with approximately 216 HIRs within those agencies.

K. If requested to do so by the Member, the Contractor **shall** certify to the Member in writing that any qualified expense the Member may question as being "qualified" is in fact "qualified" and therefore eligible for tax-free distribution. The Contractor **shall** provide this service to the Member within five (5) Business Days of request by the Member.

L. The Contractor **shall** modify any Program design based upon EBD's needs, desires, utilization results, revenues, and/or surplus funds, or other necessity as directed by EBD.

M. The Contractor **shall** routinely review (e.g. during weekly/monthly meetings) the overall effectiveness of the Program(s) and provide EBD with consultation and recommendations regarding Program(s) design and/or needed administrative adjustments.

N. Prior to distribution, the Contractor **shall** coordinate with, submit to, and receive approval from EBD's Communications Manager for the following:

    1. All Member communications

    2. All education and enrollment material

O. EBD will provide the contact information for the Communications Manager and other pertinent contacts during the Implementation Period.

P. The Contractor **shall** have administrative authority on new ARCap accounts and HSAs established after the Implementation Period as specified in this RFP as well as any existing ARCap accounts and HSAs with the outgoing Contractor by which the Member has facilitated a transfer to the Contractor of this RFP.

Q. The Contractor **shall** be liable for any penalty or interest payable to the Internal Revenue Service or Arkansas Department of Finance and Administration and assessed against EBD, the Plan, or Program(s) if the penalty and/or interest assessed results from the information or services provided by the Contractor, or the failure of the Contractor to provide information or services.

R. The Contractor **shall** provide a strategic communication campaign targeted toward ASE and PSE employees, Members, and Plan Participants.

1. The communication campaign **must** contain strategies that will aid EBD in achieving its objectives as stated in this RFP.

2. The Contractor may conduct the communications campaign via email or other electronic format or via standard format such as USPS.

3. The Contractor **shall** have such communications approved by EBD's Communications Manager prior to distribution.

S. To aid EBD with the appeals process, the Contractor **shall** track electronic communications sent to Members. The Contractor **shall** provide tracked communications to EBD within three (3) Business Days of request by EBD.

2.6 KEY PERSONNEL

A. The Contractor **shall** provide and assign a dedicated account manager solely dedicated to EBD and the contract resulting from this RFP and this account manager **shall** be the primary point of contact for EBD. The Contractor **shall** provide the dedicated account manager with written authorization to perform certain functions which **shall** include but not be limited to the following:

1. Overseeing all matters arising and resulting from the administration and management of the ARCap, COBRA, and HSA Programs.

2. Working with EBD on the administration and management of the Programs as necessary to fulfill EBD's objectives and the requirements of this RFP and as requested by EBD.

3. Making all final decisions regarding claims, administrative issues, and/or programmatic issues arising from the operation of the Programs and possessing the final decision-making authority necessary to make such calls.

4. Creating reports and files using information collected from the administration of the Programs specified in this RFP.

5. Responding to EBD requests for data as needed.

B. EBD reserves the right to meet and/or interview the dedicated account manager and/or other key personnel assigned by the Contractor to any contract resulting from this RFP prior to the Contractor officially assigning the dedicated account manager and/or other key personnel to the EBD account.

C. At any time during the term(s) of any contract that may result from this RFP, the Contractor **shall** replace the dedicated account manager, key personnel, and/or any member of the Contractor's team having direct access to EBD, Members, and/or Plan Participants if requested by EBD.

1. Upon receipt of request, the Contractor **shall** remove or facilitate the removal of the dedicated account manager, key personnel, or other team member from State property within one (1) Business Day of receipt of notification from EBD.

2. The Contractor **shall** replace the dedicated account manager, key personnel, or team member with a person having equal to or greater qualifications than the person being replaced.

3. The Contractor **shall** perform the necessary replacement procedures without disruption to daily operations as they pertain to the requirements of this RFP.

D. The Contractor **shall** provide written notification within one (1) Business Day to EBD regarding any assignment changes in the dedicated account manager, management team members, and other key personnel.

2.7 IMPLEMENTATION

A. The Contractor **shall** perform all start-up and implementation activities necessary to achieve full implementation by the anticipated Administration Services Start Date, including but not limited to the following:

1. Establishing interface with the Arkansas Administrative Statewide Information System (AASIS).

2. Transferring data from the current Contractor's system to the system used by the Contractor of this RFP

3. Distributing the toll-free customer service telephone number to Members using mediums such as brochures to HIRs, Member alerts, and newsletters.

4. Providing the process Members will use to transfer accounts from the out-going Contractor to the Contractor of this RFP using such mediums as brochures, Member alerts, and newsletters.

5. Distributing transition letters and other items necessary for a smooth transition to Members, Plan Participants, EBD staff, agency and public school HIRs, and/or other designated parties. Contractor may distribute items either electronically or via USPS.

6. Distributing the electronic payment debit card to Members via USPS.

7. Providing education and enrollment services beginning a minimum of one (1) week prior to the beginning of the Open Enrollment period as specified in this RFP. (See Section 2.14 *Enrollment Services*)

8. All other activities which are needed for the successful implementation and performance of the services outlined in this RFP.

B. Prior to the Administration Services Start Date, the Contractor **shall** allow EBD or EBD's authorized representative to test the Contractor's website structure and pages and to review content for usability as determined by EBD.

1. The Contractor **shall** resolve all usability concerns identified by EBD or EBD's authorized representative within two (2) Business Days of the Contractor's receipt of notification from EBD.

C. Prior to award, the Contractor **shall** provide EBD with the following information for each member of the implementation team:

1. Name

2. Title

3. Telephone number

4. Fax number

5. Email address

D. At the beginning of the Implementation Period, the Contractor **shall** attend an initial 1 to 3-day meeting(s) with EBD to be held at EBD offices located in Little Rock, Arkansas. At a minimum, the account manager assigned to the EBD account and the Contractor's implementation team **shall** attend the meeting(s) in person. It is anticipated the date(s) of the meeting(s) will coincide to some degree with the award date of any contract resulting from this RFP, anticipated to be July 1, 2018.

E. During the Implementation Period, the Contractor **shall** meet with EBD as requested by EBD, anticipated to be weekly. At a minimum, the Contractor's assigned account manager and implementation team **shall** attend the meetings and **shall** provide status updates regarding implementation and other pertinent information.

1. The Contractor may attend the anticipated weekly meetings via telephone and/or video conferencing at EBD's discretion. However, should a situation arise during the Implementation Period where EBD determines in-person attendance is warranted, the Contractor **shall** attend the meetings in person as requested by EBD at EBD offices in Little Rock, Arkansas.

F. Neither EBD nor the State of Arkansas will pay any kind of administration or management fee during the Implementation Period for any reason. The State will pay applicable administration and management fees beginning the month of the Administration Services Start Date as stated in this RFP anticipated to be January 1, 2019. EBD reserves the right to have the final determination of the Administrative Services Start Date.

G. The one-time implementation fee recorded in Table 3.3: *Implementation* will be payable at the end of the Implementation Period when all Implementation is complete and approved by EBD.

2.8 ARCap ADMINISTRATION

A. The Arkansas State Employee Cafeteria Plan (ARCap) allows Qualified Benefits to be paid on a pre-tax basis. At a minimum, the Contractor **shall** administer and manage the following Benefit Package Options and Qualified Benefits contained under the umbrella of the ARCap:

1. General Purpose Flexible Spending Accounts

2. Limited Purpose Flexible Spending Accounts for Dental and Vision

3. Dependent Care Flexible Spending Accounts

B. The Contractor **shall** establish, administer, and service the ARCap Program for the benefit of all ASE choosing to open one or more of the Benefit Package Option accounts.

C. The Contractor **shall** maintain compliance of the ARCap Program with all applicable State and federal laws.

D. The Contractor **shall** provide claims processing for the ARCap Program and **shall** allow for reimbursement options to the Member via check or direct deposit as elected by the Member.

E. The Contractor **shall** provide processing and issuance of an electronic payment card (debit card) to all ARCap Members.

F. The Contractor **shall** process the contributions to, and provide distribution and customer service assistance for, the Member regarding the ASE Members' ARCap accounts.

G. The Contractor **shall** facilitate Member's access to their GPFSAs, LPFSAs, and DCAPs funds.

H. During the term(s) of the contract, should EBD elect to provide the ARCap to PSE, the Contractor **shall** provide the same services to PSE as required in this RFP for ASE.

2.9 HSA ADMINISTRATION

A. Per Act 1135 of the Regular Session of 2015, any ASE or PSE who elects coverage on one of the Consumer Driven Health Plans (CDHP) is being advised to open a HSA. The intent of the law was to allow for both employer and employee contributions to the Member's HSA. As of the issuance of this RFP, the State of Arkansas only contributes to HSAs held by an ASE Member. PSE Members of an HSA may begin to receive employer contributions to their HSAs in the future. Should this occur, the Contractor **shall** service the HSAs of PSE Members per ASE requirements of this RFP.

B. The Contractor **shall** maintain compliance of the HSA Program with all applicable State and federal laws.

C. The Contractor **shall** provide administration and claims processing for the Members' HSAs.

D. The Contractor **shall** provide access to Members' funds held in their HSA accounts. The Contractor **shall** provide payment options to the Member via check or direct deposit as elected by the Member.

E. The Contractor **shall** provide processing and issuance of an electronic payment card (debit card) for all HSA Members.

F. The Contractor **shall** process the contributions to, and provide distribution and customer service assistance for, the Member regarding the Members' HSAs.

G. The Contractor **shall** make HSA funds available to the Member for investment purposes.

H. The Contractor **shall** be responsible for the administration of individually owned Health Savings Accounts for both ASE and PSE that have separated employment with their respective employer for any reason. The Contractor **shall** maintain the investment options of such HSAs after account amounts reach certain levels which could vary by institution.

1. Any fees incurred to administer any individually owned HSA **must** be between the Contractor and the individual who has separated employment. Neither EBD nor the State will pay for any fees incurred to administer any individually owned HSA existing after employment has been separated.

I. EBD has no authority to force or recommend any existing HSA Member move their active HSA from the outgoing Contractor to the awarded Contractor resulting from this RFP.

1. Member HSAs established and existing with the outgoing Contractor at the expiration or termination of the outgoing Contractor's contract may stay in force at the discretion of the Member. Neither EBD, the employer, nor the State of Arkansas will contribute to accounts chosen by the Member to remain with the outgoing Contractor and will not pay any administrative fees associated with those HSAs.

2. EBD, the employer, and the State of Arkansas will pay administration fees and employer contributions only to an HSA created with the Contractor of this RFP or a transfer of an HSA from the outgoing Contractor to the Contractor of this RFP.

J. The Contractor **shall** assume full responsibility, including financial liability, to the HSA Member for any miscommunication(s) and/or erroneous information provided to the Member and related to the Member's HSA account. If corrective action(s) is required, the Contractor **shall** have the contemplated corrective action(s) approved by EBD prior to the implementation of the corrective action(s).

K. Should changes occur during the term(s) of the contract that affect the amounts of employer contributions to a Member's HSA such as by new legislation, the Contractor **shall** perform the services as specified in this RFP regardless of the amount of employer contributions.

2.10 COBRA ADMINISTRATION

A. As outlined in Title XXII of the Public Health Service (PHS) Act, 42 U.S.C. §§ 300bb-1 through 300bb-8, employees who separate employment may be eligible to continue coverage of certain eligible Benefit Package Options and certain supplement products for a period of time which can be from 18 to 36 months.

B. The Contractor **shall** provide COBRA Administration to ARCap Members who have separated employment and elected COBRA continuation. The Contractor **shall** provide COBRA Administration to those ARCap Members in the same manner as is required in this RFP for ARCap Administration for the following Benefit Package Options:

- LPFSA
- GPFSA

1. EBD currently distributes COBRA communication pieces such as initial notices, COBRA election forms, coupon books, etc. to ARCap Members who have separated employment. As such, EBD will send notification to the Contractor when an ARCap Member elects COBRA continuation after employment separation.

    a. Upon receipt of notification from EBD that an ARCap Member has elected COBRA continuation for their GPFSA or LPFSA after employment separation, the Contractor **shall** begin providing COBRA Administration for the separated ARCap Member's GPFSA or LPFSA as applicable, per the requirements of this RFP for ARCap Administration.

    b. At some point during the contract term(s), EBD may determine the administrative function of distributing COBRA communication pieces to separated ARCap Members, currently provided by EBD, will be transferred to and assumed by the Contractor of this RFP as part of the COBRA Administration services provided to EBD. As such, the Prospective Contractor **shall** provide pricing for both modified COBRA Administration (where EBD retains the administrative function of distributing COBRA communication pieces), and full COBRA Administration (where the Contractor assumes the administrative function of distributing COBRA communication pieces) as instructed on the Official Bid Price Sheet.

    c. Should EBD make such a determination during the contract term(s), the Contractor **shall**, upon receipt of notification from EBD regarding such determination, assume the administrative function of distributing COBRA communication pieces to those ARCap Members who have separated employment. The Contractor **shall** provide and distribute COBRA Administration communication pieces that are specifically related to the COBRA Administration of GPFSAs and LPFSAs via USPS including but not limited to welcome packets, initial notices, and COBRA Election Forms.

2. The Contractor will not be required to directly bill COBRA recipients for LPFSA or GPFSA. This procedure is not anticipated to change during the terms of any resultant contract.

3. Currently, there are no ARCap Members who have separated employment participating in COBRA for GPFSAs and LPFSAs. However, EBD anticipates the participation levels to fluctuate throughout the life of the resultant contract. As such, the Prospective Contractor **shall** provide pricing as stated on the Official Bid Price Sheet.

C. COBRA Administration Services for separated Plan Participants' enrolled in dental and vision voluntary products through the Arkansas State Employees, Public School Employees and Retirees Health Insurance are currently provided by EBD.

1. At some point during the contract term(s), EBD may determine COBRA Administration for separated Plan Participant's dental and vision voluntary insurance products, currently provided by EBD, will be transferred to and assumed by the Contractor of this RFP as part of the COBRA Administration provided to EBD. As such, the Prospective Contractor **shall** provide pricing in Tables 4.3 and 4.4 for this service as instructed on Official Bid Price Sheet. The one-time implementation fee recorded in Table 4.4 will only be payable when all Implementation is complete and approved by EBD.

2. Should EBD make such a determination during the contract term(s), the Contractor **shall**, upon receipt of notification from EBD regarding such determination, provide all implementation activities necessary for adding COBRA Administration for Plan Participants' voluntary dental and vision insurance products.

3. After all implementation is complete and approved by EBD, the Contractor **shall** begin providing COBRA Administration to EBD for separated Plan Participants' voluntary dental and vision insurances.

4. As part of the COBRA services provided to EBD for voluntary products, the Contractor and **shall** provide and distribute COBRA communication pieces specifically related to dental and vision voluntary products to separated Plan Participants via USPS including but not limited to the following:

    a. Welcome Packet

    b. Initial Notice

c. COBRA Election Form

d. Termination Notice

e. Coupon Book

5. Currently, there are 151 Plan Participants who have elected COBRA continuation for their voluntary dental and vision insurances.

D. In the past twelve (12) month period, the following COBRA notices have been mailed via USPS. EBD does not have any historical information regarding the volume of COBRA communication pieces beyond what is provided below.

1. 5,851 COBRA initial notifications

2. 1,677 COBRA qualifying event notifications

2.11 SYSTEM AND WEBSITE REQUIREMENTS

A. The Contractor **shall** have a comprehensive and technical administration system(s) capable of the full-service administration and management of the Programs described in this RFP.

B. The Contractor **shall** have the comprehensive and technical administration system(s) required for successful rendering of services required by this RFP in full operation and production for a minimum of one (1) year prior to responding to this RFP. This one (1) year requirement does not apply to modifications, enhancements, or fixes to existing system(s).

C. The Contractor **shall** submit advance written notice to EBD regarding any major conversion for, or related to, the Contractor's system(s) used to deliver the services required in this RFP. The Contractor **shall not** undertake any major conversion for, or related to, the Contractor's system(s) used to deliver services required in this RFP without prior approval from EBD. EBD reserves the right to reject any proposed conversion. This requirement does not apply to program fixes, modifications, or enhancements.

D. The Contractor **shall** develop a single, secure, trusted link between the ARBenefits Member page and the Contractor's website for use by Members and Plan Participants.

E. The Contractor **shall** provide website hosting with secure Member sign-on.

1. The Contractor's website **must** have Member account information accessible to Members via the secure sign-on.

2. The Contractor **shall** make monthly statements available for HSA Members to view and print online via the secure sign-on.

3. The Contractor **shall** provide website maintenance only between the hours of 12 a.m. and 6 a.m. CST.

4. The Contractor **shall** notify EBD via email a minimum of thirty (30) calendar days prior to the implementation of any changes to the Contractor's website.

a. The Contractor **shall** allow EBD or EBD's authorized representative to test the Contractor's newly implemented website structure and pages and to review content for usability as determined by EBD.

b. The Contractor **shall** resolve all usability concerns identified by EBD or EBD's authorized representative within two (2) Business Days of the Contractor's receipt of notification from EBD.

2.12 ELIGIBILITY AND TESTING

A. The Contractor **shall** utilize Eligibility and Testing processes as required by applicable federal law(s).

B. The Contractor **shall** perform all non-discrimination and HSA testing as required by applicable federal law(s).

C. On an ongoing basis, the Contractor **shall** notify EBD via the task system or secure email and the Member via the Member's chosen notification method (email, fax, USPS, etc.) regarding the details of any failed test.

D. On an ongoing basis, the Contractor **shall** provide recommendations to EBD regarding any failed test in order to prevent reoccurrence of such finding(s) and/or failure(s).

2.13 CUSTOMER SERVICE

A. The Contractor **shall** provide all labor, equipment, facilities, supplies, and/or any other goods and/or services necessary to fulfill the requirements of this RFP and provide EBD, Members, and Plan Participants with quality administrative and customer service.

B. The Contractor **shall** provide a call center with toll-free access to trained, live, English-speaking customer service representatives.

C. The Contractor **shall** provide continuous, uninterrupted, toll-free customer service access Monday through Friday (excluding State Holidays) during the hours of 8:00 a.m. – 5:00 p.m. CST and **shall** return calls within one (1) Business Day for issues and questions requiring additional research.
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D. The Contractor **shall** record and archive 100% of telephone calls, including but not limited to telephone calls regarding enrollment and applications.

1. The Contractor **shall** retain all archived telephone calls a minimum of eighteen (18) months after the end of each Plan Year.

2. The Contractor **shall** retrieve any archived telephone call(s) and **shall** provide the archived call(s) to EBD in either WAV file, CD, or DVD format within seven (7) Business Days of request from EBD.

E. For reporting purposes, the Contractor **shall** track all customer service calls in order to provide reporting to EBD for such items as call drivers and categories of call volume, or as requested by EBD.

F. The Contractor **shall** provide comprehensive customer service to all ASE and PSE Plan Participants and Program Members.

2.14 ENROLLMENT SERVICES

A. The Contractor **shall** provide education and enrollment materials and services to Plan Participants, Members, EBD staff, and HIRs located at individual State agencies and public schools, and other designated parties beginning at least one (1) week prior to the Open Enrollment period of each Plan Year and throughout the Plan Year as determined necessary by EBD.

B. The Contractor **shall** design and produce education and enrollment materials such as payroll stuffers, pre-enrollment newsletters, enrollment booklets, and/or other items as determined necessary by EBD and as applicable to ASE and PSE new hires, Members, and Plan Participants. At a minimum, the Contractor **shall** include the following in the education and enrollment materials provided:

a. Eligibility Rules.

b. Enrollment Procedures.

c. Customer Service Contact Information.

d. Information that effectively communicates the advantages and benefits of ASE participation in the ARCap Program.

e. Information that effectively communicates the advantages and benefits of ASE and PSE participation in an HSA.

f. Procedures for submitting documentation and information.

g. Listing of eligible status changes as allowed by applicable law.

h. Additional information as determined necessary by EBD.

C. The Contractor **shall** supply the education and enrollment materials in the quantities requested by EBD, State agencies, and/or school districts.

D. The Contractor **shall** provide education and enrollment materials in Spanish if requested by EBD, State agencies, and/or school districts. Historically, the State has not utilized Spanish material. However, the Contractor **shall** have the capability to produce and provide EBD, State agencies, and/or school districts with Spanish material should the need arise for this service during the terms of any contract resulting from this RFP.

E. The Contractor **shall** distribute the education and enrollment material to Plan Participants, Members, ASE and PSE new hires, and other designated parties electronically (preferably via email) and **shall** also make the education and enrollment materials available for distribution in paper format should EBD determine the distribution of paper copies is necessary. The Contractor **shall** distribute the education and enrollment materials in the format requested or approved by EBD.

F. The Contractor **shall** obtain approval of all education and enrollment materials from EBD prior to distribution.

G. The Contractor **shall** partner with EBD to publish educational and enrollment materials in monthly newsletters, EBD social media sites, and the ARBenefits Member portal.

H. Each year during the Open Enrollment period, there are approximately 20-25 Open Enrollment/HIR sessions conducted over a ninety (90) day period (August through October). The frequency of the Open Enrollment/HIR sessions typically increases as Open Enrollment approaches to approximately three (3) sessions per week from late September through October. Open Enrollment/HIR sessions are located in various regions of Arkansas at participating State agencies and school districts.

1. The Contractor **shall** attend and participate in Open Enrollment/HIR sessions in person as requested by EBD, State agencies, and/or school districts and during those sessions **shall** assist EBD and State agency/public school HIRs with the education and enrollment of Plan Participants and Members.

2. The Open Enrollment/HIR Sessions may be conducted with either a presentation style or benefit fair style format. EBD reserves the right to have the final determination of session format.

3. EBD will publish the schedule for Open Enrollment/HIR sessions approximately 30 calendar days prior to the Open Enrollment/HIR session dates and will send notifications via EBD alerts.

2.15 TRAINING

A. It is imperative EBD staff and other stakeholders understand the regulatory and administrative aspect of the Programs specified in this RFP as well as the ASE and PSE Plans. As such, the Contractor **shall** provide training to EBD staff, State agency and public school HIRs, and other designated parties if requested by EBD during the Implementation Period and throughout the Plan Year.

B. EBD anticipates no more than three (3) training sessions to occur during each contract term.

C. Utilizing a train-the-trainer style presentation, the Contractor **shall** conduct in-person training on-site at EBD offices in Little Rock, Arkansas when EBD requests in-person training.

D. The Contractor **shall** provide training webinars to EBD and other designated parties for instances when in-person training is not required.

E. EBD reserves the right to make the final determination regarding the method of training.

F. At a minimum, the Contractor **shall** include the following information in the training sessions:

1. Information about the Contractor's company.

2. A basic overview of the Programs the Contractor administers and manages under any contract resulting from this RFP with a graduation to the intricacies of the Programs.

3. Governmental guidelines pertaining to the ARCap, COBRA, and HSA Programs.

4. Best practices for providing quality customer service for the Programs.

5. Information that effectively communicates the advantages and benefits of ASE and PSE participation in the ARCap and/or HSA Programs.

6. Information that effectively communicates the administrative and regulatory aspects of the Programs.

7. Other topics as determined by EBD.

2.16 CLAIMS PROCESSING AND PAYMENTS

A. The Contractor **shall** provide claims processing and payment services for the ARCap, HSA, and COBRA Programs.

B. The Contractor **shall** complete the processing and payment of all eligible, qualified, and valid faxed claims, claims submitted on-line, and mailed claims within three (3) Business Days of receipt by the Contractor.

C. The Contractor **shall** notify the Member within three (3) Business Days of receipt of any ineligible, suspended, or pending claim that is unprocessed. The Contractor **shall** notify the Member via the Member's preferred method of communication which may include telephone, fax, mail, web portal, mobile app, or email.

1. The Contractor **shall** include the following information in the notification to the Member:

a. Claim Amount

b. Date of Service

c. Reason for Payment Denial

D. The Contractor **shall** process and correctly pay all claims in accordance with EBD's established policies, procedures, and practices as it relates to funding, check processing, payroll offsets for non-eligible debit card transactions (where funds are recouped via payroll should a Member fail to reimburse the Plan for ineligible expenses), etc.

1. EBD's policies, procedures, and practices can be accessed by visiting the ARBenefits website at http://portal.arbenefits.org/Pages/default.aspx

2. At some point during the life of the contract, EBD may determine there is a need to adjust one or more of its policies, procedures, or practices. Should EBD make any of the aforementioned adjustments, the Contractor **shall** process and pay all claims in accordance with any adjusted and/or updated policy, procedure, and/or practice as defined by EBD.

E. The Contractor **shall** correctly issue claims payments to Members via check or direct deposit as elected by the Member.

F. The Contractor **shall** process pending claims and **shall** follow-up with Members as necessary in order to obtain information applicable to the correct processing of pending claims.

G. The Contractor **shall** screen all claims to prevent payment duplication and **shall** maintain procedures that provide consistency of claims payments in accordance with the Plan and/or Program requirements.

2.17 ONGOING MEETING REQUIREMENTS

A. The Contractor and/or the Contractor's assigned account manager **shall** attend weekly meetings with EBD via teleconference for the purposes of providing general progress updates regarding the services provided, the interaction experienced with Members and Plan Participants, escalated issues, and/or other purposes as determined necessary by EBD.

1. During the term(s) of any resultant contract, should EBD determine weekly meetings are no longer necessary, the Contractor **shall** meet with EBD via teleconference as requested by EBD (e.g. biweekly instead of weekly) to provide progress updates and/or other purposes determined necessary by EBD.

2. During the term(s) of any resultant contract, should a situation arise whereby EBD determines a need for the Contractor to attend the weekly meeting in person, the Contractor **shall** attend such meeting in person at EBD offices in Little Rock, Arkansas if requested by EBD. EBD does not anticipate in person attendance at weekly meetings to be a usual occurrence.

B. Beginning during the month of the Administration Services Start Date, the Contractor **shall** attend monthly meetings in person with EBD and the Arkansas State and Public School Life and Health Insurance Board in Little Rock, Arkansas in order to provide progress updates regarding the services provided and/or other purposes as determined necessary by EBD.

C. EBD will provide the Contractor with a minimum of 72 hours advance notice regarding EBD's determined meeting place and time via email or telephone for any meeting specifics not previously published.

2.18 PAYROLL REQUIREMENTS

A. During the Implementation Period, the Contractor **shall** provide payroll interface for the transfer of information to and from the Arkansas Administrative Statewide Information System (AASIS).

B. The Contractor **shall** process various payroll files in multiple quantities to reconcile established deductions and/or elections. The Contractor **shall** have the capability to receive approximately 1-3 payroll files from the State in electronic format on a bi-weekly basis.

C. The exact guidelines regarding the process, procedure, and timeline for payroll processing may be negotiated and finalized with the Contractor during the Implementation Period or prior to award. However, EBD reserves the right to have the final determination and approval of the payroll processing guidelines.

2.19 PLAN DOCUMENT

A. The Contractor **shall** provide a compliant and comprehensive Plan Document for the ARCap and HSA Programs to EBD for approval at least thirty (30) calendar days prior to the start of each new Plan Year. The Plan Document **must** be compliant with applicable federal guidelines.

B. The Contractor **shall** provide a compliant and comprehensive Plan Document for the ARCap and HSA Programs to EBD for approval a minimum of thirty (30) calendar days prior to the date any applicable Plan or Program change necessitating a Plan Document amendment or edited restatement becomes effective.

C. At a minimum, the Contractor **shall** provide a Plan Document for the ARCap and HSA Programs that includes the following information:

1. Explanation of Program rules

2. Annual contribution and rollover limits

3. Eligible and ineligible expenses

4. Program eligibility requirements

5. How to access the benefits of coverage

6. Member responsibilities

7. Rights to appeal or continue coverage

8. Other information as determined necessary by EBD

D. Should EBD request changes or edits to any of the Plan Document(s), the Contractor **shall** make EBD's changes or edits and **shall** resubmit to EBD for approval.

2.20 REPORTING REQUIREMENTS

A. In a format approved by EBD, the Contractor **shall** provide annual and quarterly reporting that accurately reflects the activity of the Programs.

B. Should EBD request additional information and/or clarification of the information and/or data contained in any report, within one (1) Business Day and via the secure email or task system, the Contractor **shall** acknowledge receipt of EBD's request and **shall** provide a timeline for providing the additional information and/or clarification requested.

C. The Contractor **shall** provide separate monthly, quarterly, and year-end reporting for the ARCap, HSA, and COBRA Programs to EBD as determined necessary by EBD.

D. If requested by EBD, the Contractor **shall** provide ad hoc reporting during the period of the State's Fiscal Year end. Ad hoc reporting requirements **must** be established based on the needs of EBD and may vary from year to year according to the requirements placed on EBD by various State or Legislative entities.

E. On an ad hoc basis, the Contractor **shall** provide a report to EBD regarding any cumulative finding(s) and/or failure(s) of any eligibility testing or other testing required by applicable law.

F. Annual Reports

1. The Contractor **shall** provide a detailed annual report to EBD on June 1st of each year. Should June 1st fall on a day that is not a Business Day, the Contractor **shall** provide a detailed annual report to EBD on the first Business Day following June 1st.

    a. The account manager, whom the Contractor has assigned to the EBD account, **shall** present the annual report via a Power Point presentation format to EBD's management staff.

    b. The account manager **shall** make the presentation in person to EBD staff at EBD offices located in Little Rock, Arkansas. The specific details regarding location and time will be supplied to the account manager via email at least 2 weeks prior to the June 1st presentation date. It is anticipated the scheduling of the presentation will coincide with the monthly Arkansas State and Public School Life and Health Insurance Board Meetings.

    c. At a minimum, the Contractor **shall** include the following information in the annual report:

        i. Activity of the Programs.

        ii. Summary of the Contractor's operations.

        iii. Contractor's performance and administration of the Programs.

        iv. Any failure of the Contractor to comply with the Performance Standards and the applicable damages assessed.

        v. Any penalties and/or interest assessed by the IRS and/or the Arkansas Department of Finance and Administration.

G. Quarterly Reports

1. The Contractor **shall** provide detailed, quarterly reports to EBD no later than forty-five (45) calendar days after the end of each quarter.

    a. The Contractor **shall** provide a quarterly report that includes but is not limited to the following information:

        i. Summaries of the performance of the Programs.

ii. Satisfaction of the Members as determined by the total number of complaints (i.e. expressions of dissatisfaction with any service or product required by this RFP) received by the Contractor from Members such as from surveys administered during each quarter.

iii. Activity of the Programs.

iv. Other information determined relevant by EBD.

b. The account manager, whom the Contractor has assigned to the EBD account, **shall** present the quarterly report in person via a Power Point presentation to EBD's management staff.

c. The account manager **shall** make the presentation at EBD offices in Little Rock, Arkansas. It is anticipated the scheduling of the presentation will coincide with the monthly Arkansas State and Public School Life and Health Insurance Board Meetings.

d. The specific location and time of the presentation will be supplied to the account manager via email at least 2 weeks prior to the quarterly report due date.

2. The Contractor **shall** provide a quarterly report of Member accounts to EBD if requested by EBD. The Contractor **shall** appropriately separate each Member account per the applicable funding source, with each funding source having its own classification, and **shall** arrange and categorize the report by agency number as determined by EBD, or other category arrangement as requested by EBD.

3. The Contractor **shall** provide a quarterly reconciliation report organized by agency. In the report, the Contractor **shall** include the following:

a. Deductions received by the Contractor during the applicable quarter.

b. Credits to Member accounts for the applicable quarter.

4. The Contractor **shall** provide reporting for all customer service calls to EBD. At a minimum, the Contractor **shall** include the call drivers and categories of call volume in the report.

H. Monthly Reports

1. The Contractor **shall** provide a monthly pay back report for nonqualified debit card transactions.

2.21 COMPLIANCE, PRIVACY, AND SECURITY REQUIREMENTS

A. Prior to award, the Contractor and **shall** complete and sign EBD's HIPAA compliant Business Associate Agreement. EBD's sample Business Associate Agreement is posted as Attachment A to this RFP.

B. The Contractor's employees and representatives **shall** complete and sign EBD's System Confidentiality Agreement at EBD's request which may be prior to the start of the Implementation Period, prior to performing work on any contract resulting from this RFP, or prior to assessing any Member or Plan Participant information. EBD's sample System Confidentiality Agreement is posted as Attachment C to this RFP.

C. The data systems utilized by the Contractor or the Contractor's subcontractor(s) to transmit and/or warehouse any Member information **must** be SAS-70 Level II and/or SSAE-18 compliant. The Contractor **shall** provide evidence of such compliance to EBD upon request.

D. The Contractor **shall** remove or mask a Member's social security number from any printed report, letter, or other form of communication.

E. The Contractor **shall** use an alternate Member identification number, which **must not** be a social security number, for communication and reporting purposes.

1. The Contractor and EBD **shall** mutually agree on the alternate Member identification number format.

2. EBD reserves the right to have final approval of the alternate Member identification number format.

F. The Contractor **shall not** use, sell, or otherwise disclose any Member, Plan Participant, Plan, or Program information to any outside party unless specifically provided in order to comply with the requirements and operations of the Programs specified in this RFP. The Contractor **shall** obtain written approval from EBD prior to any disclosure of Member, Plan Participant, Plan, or Program information.

G. The Contractor **shall** comply with HIPAA and other federal and State laws and mandates including privacy, security, and electronic data transfer requirements.

H. The Contractor **shall** notify EBD within two (2) calendar days via secure email of any security breaches or any suspected security breaches.

I. The Contractor **shall** provide HIPAA training to all of the Contractor's current and future employees assigned to any contract resulting from this RFP prior to the employee performing work on any resultant contract and/or prior to accessing Plan, Program, Member, or Plan Participant records.

J. The Contractor **shall** provide information regarding any HIPAA, Internal Revenue Code Sections, ADA and/or other regulatory training provided to the Contractor's staff if requested by EBD. At a minimum, the Contractor **shall** provide the following information:

1. Staff's Qualifications
2. Training
3. Certifications
4. Any other information determined necessary by EBD

K. The Contractor **shall** have an emergency operations/disaster recovery plan currently in place including redundant systems in order to avoid loss of data.

2.22 DATA SHARING

A. The Contractor **shall** utilize the secure email service as defined by EBD.

B. The Contractor **shall** utilize secure file transfer protocol as defined by EBD.

C. The Contractor **shall** release all data, records, files, and other information relating the services provided by the Contractor under any resultant contract within seven (7) Business Days of contract expiration, termination, or request from EBD. The Contractor **shall** release the aforementioned data in both printed and electronic format and the Contractor **shall** consider such data the property of EBD.

2.23 TRANSPARENT ADMINISTRATION AND AUDIT REQUIREMENTS

A. The Contractor **shall** provide transparent administration of all Programs outlined in and required by this RFP.

B. The Contractor **shall** perform all services required by this RFP, including but not limited to claims processing, financial reporting, administration, and reimbursement practices and procedures in a completely open and transparent environment.

C. The Contractor **shall** provide any information or documentation pertaining to the services provided by the Contractor under the terms of any resultant contract to EBD within three (3) Business Days of request by EBD in a format acceptable to EBD.

D. The Contractor **shall** make available to EBD, EBD's chosen representatives, and/or the Arkansas Division of Legislative Audit all records applicable to the administration and management of the ARCap, HSA, and COBRA Programs such as eligibility files, account balances, deduction reports, and invoices, etc. The Contractor **shall** have the applicable records available electronically and **shall** provide applicable records via the secure email task system.

1. If the records data is too large to be sent via the secure email task system, the Contractor **shall** transport the information via a FTP site to be determined by EBD.

E. The Contractor **shall** grant EBD, their chosen representatives, and/or the Arkansas Division of Legislative Audit the right to reasonable inspection of facilities, equipment, and system support operations to ensure the Contractor's continued ability to support the Programs and/or Plan and provide the services required by this RFP.

F. The Contractor **shall** allow EBD, EBD's chosen representatives, and/or the Arkansas Division of Legislative Audit to conduct audits of all records relative to any contract resulting from this solicitation and maintained by the Contractor or the Contractor's subcontractor(s), if any.

G. The Contractor **shall** allow any EBD or State of Arkansas internal auditor and/or any designated external auditor or their authorized representatives to audit and/or inspect all aspects of the Contractor's operation as it pertains to any contract resulting from this RFP and the services provided.

H. EBD will notify the Contractor within one (1) Business Day of EBD receiving notification of an upcoming audit via secure email.

I. The Contractor **shall** be available for all audits by EBD, EBD's chosen representatives, and/or Legislative Audit personnel to take place at a time and within an audit timeline designated by EBD, on Business Days during the hours of 8 a.m. through 5 p.m. CST. The Contractor **shall** abide by the audit timeline specified by EBD.

J. The Contractor **shall** respond to any finding from an inspection and/or audit within thirty (30) calendar days of receipt of such finding.

K. On an annual basis, the Contractor **shall** conduct an IT audit of the Contractor's system used to provide the services required by this RFP.

2.24 CONFLICTS OF INTEREST AND LITIGATION DISCLOSURES

A. The Contractor **shall** adhere to the following conflict of interest and litigation disclosure requirements prior to and throughout the life of any awarded contract:

1. The Prospective Contractor **shall** disclose any actual and/or potential conflict(s) of interest pertaining to the Prospective Contractor's company. The conflict of interest disclosure requirement **shall** include but is not limited to:

   a. Any contract and/or financial arrangement between the Prospective Contractor and any entity and/or subcontractor that impacts, has the potential to impact, and/or directly conflicts with the Prospective Contractor's ability to effectively and impartially honor the terms of the contract resulting from this RFP.

   b. Throughout the term(s) of any resultant contract, the Contractor **shall** notify EBD immediately upon knowledge of any such conflict of interest.

2. The Prospective Contractor **shall** disclose all litigation (criminal or civil) and all bankruptcy petitions pertaining to the Prospective Contractor's company that impacts and/or has the potential to impact the Prospective Contractor's ability to effectively and impartially honor the terms of any contract resulting from this RFP.

   a. Throughout the term(s) of any resultant contract, the Contractor **shall** notify EBD immediately upon knowledge of any such litigation or bankruptcy petition.

B. Conflict of Interest Affidavit

1. As a Proposal Submission Requirement, the Prospective Contractor **shall** disclose any actual and/or potential conflict(s) of interest, litigation (criminal or civil), and/or bankruptcy petition(s) pertaining to the Prospective Contractor's company by completing the *Conflict of Interest Affidavit* located in the *Technical Proposal Packet* and instructed therein.

2. Should the Prospective Contractor have any actual and/or potential conflict(s) of interest, litigation (criminal or civil), and/or bankruptcy petition(s) disclosures to make, the Prospective Contractor **shall** submit an

additional document, as an attachment to the *Conflict of Interest Affidavit*, explaining the actual and/or potential conflict(s) of interest, litigation (criminal or civil), and/or bankruptcy petition(s).

a. The Prospective Contractor **shall** include all information necessary to fully communicate the nature of the actual and/or potential conflict(s) of interest, litigation (criminal or civil) and/or bankruptcy petition(s) including proposed mitigation measures and **shall** include the attachment with the *Conflict of Interest Affidavit* in the *Technical Proposal Packet* response.

3. EBD and/or EBD's legal counsel will review the disclosures submitted with *Conflict of Interest Affidavit.*

4. EBD reserves the right, in its sole discretion, to determine if any actual and/or potential conflict(s) of interest, litigation (criminal or civil), and/or bankruptcy petition(s) disclosed with the *Conflict of Interest Affidavit* will directly conflict, impact, and/or prevent the Prospective Contractor from effectively and impartially honoring the terms of the contract resulting from this RFP.

5. If EBD determines any actual and/or potential conflict(s) of interest, litigation (criminal or civil), and/or bankruptcy petition(s) disclosed with the *Conflict of Interest Affidavit* directly conflicts, impacts, and/or prevents the Prospective Contractor from effectively and impartially honoring the terms of the contract resulting from this RFP, the State reserves the right to disqualify the Prospective Contractor's proposal.

6. The *Conflict of Interest Affidavit* will not be scored as part of the RFP evaluation. However, the Prospective Contractor **shall** submit the *Conflict of Interest Affidavit* with the *Technical Proposal Packet* response. Should the Contractor fail to submit the *Conflict of Interest Affidavit* with *Technical Proposal Packet* response, the State reserves the right to disqualify the Prospective Contractor's proposal.

2.25 TRANSITION SERVICES

A. Transition Upon Contract Start

1. If the successful Contractor is one other than the current service provider, upon execution of a contract with EBD**,** the Contractor **shall** initiate, coordinate, and perform the transition of services from the current provider to the extent possible on their part.

2. Except for as specifically agreed to by the State, it is anticipated the State's main role will be supervisory in nature to ensure all of the State's needs are sufficiently and successfully met. However, the State reserves the right to have final authority regarding all actions taken to transition the services.

B. Transition Upon Termination or Expiration

1. Should any subsequent contract for the services outlined in this RFP be awarded to a Contractor other than the awardee of this RFP, then the Contractor awarded a contract from this RFP **shall,** to the greatest extent possible and reasonable, cooperate with EBD, and the new Contractor in initiating a smooth and orderly transition to the new Contractor.

2. The Contractor **shall** assist with the transition of services including data transfer to the new Contractor for no less than ninety (90) days after contract termination or expiration.

3. The Contractor **shall** provide a complete reconciliation of all Member ARCap accounts and HSAs within ninety (90) days of contract expiration or termination in an Excel spreadsheet via the task system.

2.26 PERFORMANCE STANDARDS

A. State law requires that all contracts for services include Performance Standards for measuring the overall quality of services provided that a Contractor **must** meet in order to avoid assessment of damages.

B. The State may be open to negotiations of Performance Standards prior to contract award, prior to the commencement of services, or at times throughout the contract duration. *Attachment D: Performance Standards* identifies expected deliverables, performance measures, or outcomes; and defines the acceptable standards.

C. The State has the right to modify, add, or delete Performance Standards throughout the term of the contract, should the State determine it is in its best interest to do so. Any changes or additions to performance

standards will be made in good faith following acceptable industry standards, and may include the input of the Contractor so as to establish standards that are reasonably achievable.

D. All changes made to the Performance Standards will become an official part of the contract.

E. Performance Standards will continue throughout the term of the contract.

F. Failure to meet the minimum Performance Standards as specified will result in the assessment of damages.

G. In the event a Performance Standard is not met, the Contractor will have the opportunity to defend or respond to the insufficiency. The State has the right to waive damages if it determines there were extenuating factors beyond the control of the Contractor that hindered the performance of services. In these instances, the State has final determination of the performance acceptability.

H. Should any compensation be owed to the State agency due to the assessment of damages, Contractor **shall** follow the direction of the State agency regarding the required compensation process.

SECTION 3 – CRITERIA FOR SELECTION

- ***Do not** provide responses to items in this section.*

3.1 TECHNICAL PROPOSAL SCORE

A. OSP will review each *Technical Proposal Packet* to verify submission Requirements have been met. *Technical Proposals Packets* that do not meet submission *Requirements* will be disqualified and will not be evaluated.

B. An agency-appointed Evaluation Committee will evaluate and score qualifying Technical Proposals. Evaluation will be based on Prospective Contractor's response to the *Information for Evaluation* section included in the *Technical Proposal Packet*.

1. Members of the Evaluation Committee will individually review and evaluate proposals and complete an Individual Score Worksheet for each proposal. Individual scoring for each Evaluation Criteria will be based on the following Scoring Description.

Quality Rating	Quality of Response	Description	Confidence in Proposed Approach
5	Excellent	When considered in relation to the RFP evaluation factor, the proposal squarely meets the requirement and exhibits outstanding knowledge, creativity, ability or other exceptional characteristics. Extremely good.	Very High
4	Good	When considered in the relation to the RFP evaluation factor, the proposal squarely meets the requirement and is better than merely acceptable.	High
3	Acceptable	When considered in relation to the RFP evaluation factor, the proposal is of acceptable quality.	Moderate
2	Marginal	When considered in relation to the RFP evaluation factor, the proposal's acceptability is doubtful.	Low
1	Poor	When considered in relation to the RFP evaluation factor, the proposal is inferior.	Very Low
0	Unacceptable	When considered in relation to the RFP evaluation factor, the proposal clearly does not meet the requirement, either because it was left blank or because the proposal is unresponsive.	No Confidence

2. After initial individual evaluations are complete, the Evaluation Committee members will meet to discuss their individual ratings. At this consensus scoring meeting, each member will be afforded an opportunity to discuss his or her rating for each evaluation criteria.

3. After committee members have had an opportunity to discuss their individual scores with the committee, the individual committee members will be given the opportunity to change their initial individual scores, if they feel that is appropriate.

4. The final individual scores of the evaluators will be recorded on the Consensus Score Sheets and averaged to determine the group or consensus score for each proposal.

5. Other agencies, consultants, and experts may also examine documents at the discretion of the Agency.

C. The *Information for Evaluation* section has been divided into sub-sections.

1. In each sub-section, items/questions have each been assigned a maximum point value of five (5) points. The total point value for each sub-section is reflected in the table below as the Maximum Raw Score Possible.

2. The agency has assigned Weighted Percentages to each sub-section according to its significance.

Information for Evaluation Sub-Sections	Maximum Raw Points Possible	Sub-Section's Weighted Percentage	* Maximum Weighted Score Possible
E.1 VENDOR QUALIFICATIONS AND CORPORATE STRUCTURE	40	5%	35
E.2 IMPLEMENTATION	25	10%	70
E.3 ARCAP AND HSA ADMINISTRATION	55	8%	56
E.4 COBRA ADMINISTRATION	10	2%	14
E.5 ADMINISTRATION SYSTEM	40	5%	35
E.6 CUSTOMER SERVICE	40	10%	70
E.7 EDUCATION AND ENROLLMENT SERVICES	25	7%	49
E.8 CLAIMS ADMINISTRATION	70	15%	105
E.9 KEY PERSONNEL AND STAFFING	20	5%	35
E.10 PAYROLL PROCESSING AND DCOMENTATION SUBMISSION	10	5%	35
E.11 REPORTING	20	8%	56
E.12 COMPLIANCE, PRIVACY, AND SECURITY	60	10%	70
E.13 DEBIT CARD	60	10%	70
Total Technical Score	**475**	**100%**	**700**

*Sub-Section's Percentage Weight x Total Weighted Score = Maximum Weighted Score Possible for the sub-section.

D. The proposal's weighted score for each sub-section will be determined using the following formula:

(A/B)*C =D

A = Actual Raw Points received for sub-section in evaluation
B = Maximum Raw Points possible for sub-section
C = Maximum Weighted Score possible for sub-section
D = Weighted Score received for sub-section

E. The proposal's weighted scores for sub-sections will be added to determine the Total Technical Score for the Proposal.

F. Technical Proposals that do not receive a minimum weighted score of 300 may not move forward in the solicitation process. The pricing for proposals which do not move forward will not be scored.

3.2 COST SCORE

A. When pricing is opened for scoring, the maximum amount of cost points will be given to the proposal with the lowest thirty-six (36) Month (Initial Term) Estimated Total Cost from Tab 2 on the Official Bid Price Sheet. (See *Grand Total Score* for maximum points possible for cost score.

B. The amount of cost points given to the remaining proposals will be allocated by using the following formula:

(A/B)*(C) =D

A = Lowest Total Cost
B = Second (third, fourth, etc.) Lowest Total Cost
C = Maximum Points for Lowest Total Cost
D = Total Cost Points Received

3.3 GRAND TOTAL SCORE

The Technical Score and Cost Score will be added together to determine the Grand Total Score for the proposal. The Prospective Contractor's proposal with the highest Grand Total Score will be selected as the apparent successful Contractor. (See *Award Process.)*

	Maximum Points Possible
Technical Proposal	700
Cost	300
Maximum Possible Grand Total Score	**1,000**

3.4 PROSPECTIVE CONTRACTOR ACCEPTANCE OF EVALUATION TECHNIQUE

A. Prospective Contractor **must** agree to all evaluation processes and procedures as defined in this solicitation.

B. The submission of a *Technical Proposal Packet* signifies the Prospective Contractor's understanding and agreement that subjective judgments will be made during the evaluation and scoring of the Technical Proposals.

SECTION 4 – GENERAL CONTRACTUAL ITEMS

- ***Do not** provide responses to items in this section.*

4.1 PAYMENT AND INVOICE PROVISIONS

A. Forward invoices to:

Department of Finance and Administration
Employee Benefits Division
Accounting
P.O. Box 15610
Little Rock, AR 72231-5610

B. Payment will be made in accordance with applicable State of Arkansas accounting procedures upon acceptance goods and services by the agency.

C. Do not invoice the State in advance of delivery and acceptance of any goods or services.

D. Payment will be made only after the Contractor has successfully satisfied the agency as to the reliability and effectiveness of the goods or services purchased as a whole.

E. The Contractor should invoice the agency by an itemized list of charges. The agency's Purchase Order Number and/or the Contract Number should be referenced on each invoice.

F. Other sections of this *Bid Solicitation* may contain additional Requirements for invoicing.

G. Selected Contractor **must** be registered to receive payment and future *Bid Solicitation* notifications. Prospective Contractors may register on-line at https://www.ark.org/contractor/index.html.

H. Contractor **shall** provide separate invoices for the ASE and PSE Plans on a monthly basis.

I. Contractor **shall** provide invoices on the Contractor's letterhead.

J. At a minimum, the Contractor shall include the following information on all invoices:

1. Name and contact information for the Contractor

2. Payment instructions including bank routing number and account number

3. Date of invoice billing period

4.2 GENERAL INFORMATION

A. The State will not:

1. Lease any equipment or software for a period of time which continues past the end of a fiscal year unless the contract allows for cancellation by the State Procurement Official upon a 30 day written notice to the Contractor/lessor in the event funds are not appropriated.

2. Contract with another party to indemnify and defend that party for any liability and damages.

3. Pay damages, legal expenses or other costs and expenses of any other party.

4. Continue a contract once any equipment has been repossessed.

5. Agree to any provision of a contract which violates the laws or constitution of the State of Arkansas.

6. Enter a contract which grants to another party any remedies other than the following:

a. The right to possession.

b. The right to accrued payments.

c. The right to expenses of de-installation.

d. The right to expenses of repair to return the equipment to normal working order, normal wear and tear excluded.

e. The right to recover only amounts due at the time of repossession and any unamortized nonrecurring cost as allowed by Arkansas Law.

B. Any litigation involving the State **must** take place in Pulaski County, Arkansas.

C. The laws of the State of Arkansas govern this contract.

D. A contract is not effective prior to award being made by a State Procurement Official.

E. In a contract with another party, the State will accept the risk of loss of the equipment or software and pay for any destruction, loss or damage of the equipment or software while the State has such risk, when:

1. The extent of liability for such risk is based upon the purchase price of the equipment or software at the time of any loss, and

2. The contract has required the State to carry insurance for such risk.

4.3 CONDITIONS OF CONTRACT

A. Observe and comply with federal and State of Arkansas laws, local laws, ordinances, orders, and regulations existing at the time of, or enacted subsequent to the execution of a resulting contract which in any manner affect the completion of the work.

B. Indemnify and save harmless the agency and all its officers, representatives, agents, and employees against any claim or liability arising from or based upon the violation of any such law, ordinance, regulation, order or decree by an employee, representative, or subcontractor of the Contractor.

4.4 STATEMENT OF LIABILITY

A. The State will demonstrate reasonable care but will not be liable in the event of loss, destruction or theft of Contractor-owned equipment or software and technical and business or operations literature to be delivered or to be used in the installation of deliverables and services. The Contractor will retain total liability for equipment, software and technical and business or operations literature. The State will not at any time be responsible for or accept liability for any Contractor-owned items.

B. The Contractor's liability for damages to the State will be limited to the value of the Contract or $5,000,000, whichever is higher. The foregoing limitation of liability will not apply to claims for infringement of United States patent, copyright, trademarks or trade secrets; to claims for personal injury or damage to property caused by the gross negligence or willful misconduct of the Contractor; to claims covered by other specific provisions of the Contract calling for damages; or to court costs or attorney's fees awarded by a court in addition to damages after litigation based on the Contract. The Contractor and the State will not be liable to each other, regardless of the form of action, for consequential, incidental, indirect, or special damages. This limitation of liability will not apply to claims for infringement of United States patent, copyright, trademark or trade secrets; to claims for personal injury or damage to property caused by the gross negligence or willful misconduct of the Contractor; to claims covered by other specific provisions of the Contract calling for damages; or to court costs or attorney's fees awarded by a court in addition to damages after litigation based on the Contract.

C. Language in these terms and conditions **must not** be construed or deemed as the State's waiver of its right of sovereign immunity. The Contractor agrees that any claims against the State, whether sounding in tort or in contract, will be brought before the Arkansas Claims Commission as provided by Arkansas law, and governed accordingly.

4.5 RECORD RETENTION

A. Maintain all pertinent financial and accounting records and evidence pertaining to the contract in accordance with generally accepted principles of accounting and as specified by the State of Arkansas Law. Upon request, grant access to State or Federal Government entities or any of their duly authorized representatives.

B. Make financial and accounting records available, upon request, to the State of Arkansas's designee(s) at any time during the contract period and any extension thereof, and for five (5) years from expiration date and final payment on the contract or extension thereof.

C. Other sections of this *Bid Solicitation* may contain additional Requirements regarding record retention.

4.6 PRICE ESCALATION

A. Price increases will be considered at the time of contract renewal.

B. The Contractor **must** provide to OSP a written request for the price increase. The request **must** include supporting documentation demonstrating that the increase in contract price is based on an increase in market price. OSP has the right to require additional information pertaining to the requested increase.

C. Increases will not be considered to increase profit or margins.

D. OSP has the right to approve or deny the request.

4.7 CONFIDENTIALITY

A. The Contractor, Contractor's subsidiaries, and Contractor's employees will be bound to all laws and to all Requirements set forth in this *Bid Solicitation* concerning the confidentiality and secure handling of information of which they may become aware of during the course of providing services under a resulting contract.

B. Consistent and/or uncorrected breaches of confidentiality may constitute grounds for cancellation of a resulting contract, and the State has the right to cancel the contract on these grounds.

C. Previous sections of this *Bid Solicitation* may contain additional confidentiality Requirements.

4.8 CONTRACT INTERPRETATION

Should the State and Contractor interpret specifications differently, either party may request clarification. However, if an agreement cannot be reached, the determination of the State is final and controlling.

4.9 CANCELLATION

A. For Cause. The State may cancel any contract resulting from this solicitation for cause when the Contractor fails to perform its obligations under it by giving the Contractor written notice of such cancellation at least thirty (30) days prior to the date of proposed cancellation. In any written notice of cancellation for cause, the State will advise the Contractor in writing of the reasons why the State is considering cancelling the contract and provide the Contractor with an opportunity to avoid cancellation for cause by curing any deficiencies identified in the notice of cancellation for cause prior to the date of proposed cancellation. To the extent permitted by law and at the discretion of the parties, the parties may agree to minor amendments to the contract and avoid the cancellation for cause upon mutual agreement.

B. For Convenience. The State may cancel any contract resulting from the solicitation by giving the Contractor written notice of such cancellation sixty (60) days prior to the date of cancellation.

C. If upon cancellation the Contractor has provided commodities or services which the State of Arkansas has accepted, and there are no funds legally available to pay for the commodities or services, the Contractor may file a claim with the Arkansas Claims Commission under the laws and regulations governing the filing of such claims.

4.10 SEVERABILITY

If any provision of the contract, including items incorporated by reference, is declared or found to be illegal, unenforceable, or void, then both the agency and the Contractor will be relieved of all obligations arising under such provision. If the remainder of the contract is capable of performance, it will not be affected by such declaration or finding and **must** be fully performed.

SECTION 5 – STANDARD TERMS AND CONDITIONS

1. **GENERAL**: Any special terms and conditions included in this solicitation **shall** override these Standard Terms and Conditions. The Standard Terms and Conditions and any special terms and conditions **shall** become part of any contract entered into if any or all parts of the bid are accepted by the State of Arkansas.

2. **ACCEPTANCE AND REJECTION**: The State **shall** have the right to accept or reject all or any part of a bid or any and all bids, to waive minor technicalities, and to award the bid to best serve the interest of the State.

3. **BID SUBMISSION**: Original Proposal Packets **must** be submitted to the Office of State Procurement on or before the date and time specified for bid opening. The Proposal Packet **must** contain all documents, information, and attachments as specifically and expressly required in the *Bid Solicitation*. The bid **must** be typed or printed in ink. The signature **must** be in ink. Unsigned bids **shall** be disqualified. The person signing the bid should show title or authority to bind his firm in a contract. Multiple proposals **must** be placed in separate packages and should be completely and properly identified. Late bids **shall not** be considered under any circumstances.

4. **PRICES**: Bid unit price F.O.B. destination. In case of errors in extension, unit prices **shall** govern. Prices **shall** be firm and **shall not** be subject to escalation unless otherwise specified in the *Bid Solicitation*. Unless otherwise specified, the bid **must** be firm for acceptance for thirty days from the bid opening date. "Discount from list" bids are not acceptable unless requested in the *Bid Solicitation*.

5. **QUANTITIES**: Quantities stated in a *Bid Solicitation* for term contracts are estimates only, and are not guaranteed. Contractor **must** bid unit price on the estimated quantity and unit of measure specified. The State may order more or less than the estimated quantity on term contracts. Quantities stated on firm contracts are actual Requirements of the ordering agency.

6. **BRAND NAME REFERENCES**: Unless otherwise specified in the *Bid Solicitation*, any catalog brand name or manufacturer reference used in the *Bid Solicitation* is descriptive only, not restrictive, and used to indicate the type and quality desired. Bids on brands of like nature and quality will be considered. If bidding on other than referenced specifications, the bid **must** show the manufacturer, brand or trade name, and other descriptions, and should include the manufacturer's illustrations and complete descriptions of the product offered. The State **shall** have the right to determine whether a substitute offered is equivalent to and meets the standards of the item specified, and the State may require the Contractor to supply additional descriptive material. The Contractor **shall** guarantee that the product offered will meet or exceed specifications identified in this *Bid Solicitation*. Contractors not bidding an alternate to the referenced brand name or manufacturer **shall** be required to furnish the product according to brand names, numbers, etc., as specified in the solicitation.

7. **GUARANTY**: All items bid **shall** be newly manufactured, in first-class condition, latest model and design, including, where applicable, containers suitable for shipment and storage, unless otherwise indicated in the *Bid Solicitation*. The Contractor hereby guarantees that everything furnished hereunder **shall** be free from defects in design, workmanship and material, that if sold by drawing, sample or specification, it **shall** conform thereto and **shall** serve the function for which it was furnished. The Contractor **shall** further guarantee that if the items furnished hereunder are to be installed by the Contractor, such items **shall** function properly when installed. The Contractor **shall** guarantee that all applicable laws have been complied with relating to construction, packaging, labeling and registration. The Contractor's obligations under this paragraph **shall** survive for a period of one year from the date of delivery, unless otherwise specified herein.

8. **SAMPLES**: Samples or demonstrators, when requested, **must** be furnished free of expense to the State. Each sample should be marked with the Contractor's name and address, bid or contract number and item number. If requested, samples that are not destroyed during reasonable examination will be returned at Contractor's expense. After reasonable examination, all demonstrators will be returned at Contractor’s expense.

9. **TESTING PROCEDURES FOR SPECIFICATIONS COMPLIANCE**: Tests may be performed on samples or demonstrators submitted with the bid or on samples taken from the regular shipment. In the event products tested fail to meet or exceed all conditions and Requirements of the specifications, the cost of the sample used and the reasonable cost of the testing **shall** be borne by the Contractor.

10. **AMENDMENTS**: Contractor’s proposals cannot be altered or amended after the bid opening except as permitted by regulation.

11. **TAXES AND TRADE DISCOUNTS**: Do not include State or local sales taxes in the bid price. Trade discounts should be deducted from the unit price and the net price should be shown in the bid.

12. **AWARD**: Term Contract: A contract award will be issued to the successful Contractor. It results in a binding obligation without further action by either party. This award does not authorize shipment. Shipment is authorized by the receipt of a purchase order from the ordering agency. Firm Contract: A written State purchase order authorizing shipment will be furnished to the successful Contractor.

13. **DELIVERY ON FIRM CONTRACTS**: This solicitation shows the number of days to place a commodity in the ordering agency's designated location under normal conditions. If the Contractor cannot meet the stated delivery, alternate delivery schedules may become a factor in an award. The Office of State Procurement **shall** have the right to extend delivery if reasons appear valid. If the date is not acceptable, the agency may buy elsewhere and any additional cost **shall** be borne by the Contractor.

14. **DELIVERY REQUIREMENTS**: No substitutions or cancellations are permitted without written approval of the Office of State Procurement. Delivery **shall** be made during agency work hours only 8:00 a.m. to 4:30 p.m. Central Time, unless prior approval for other delivery has been obtained from the agency. Packing memoranda **shall** be enclosed with each shipment.

15. **STORAGE**: The ordering agency is responsible for storage if the Contractor delivers within the time required and the agency cannot accept delivery.

16. **DEFAULT**: All commodities furnished **shall** be subject to inspection and acceptance of the ordering agency after delivery. Back orders, default in promised delivery, or failure to meet specifications **shall** authorize the Office of State Procurement to cancel this contract or any portion of it and reasonably purchase commodities elsewhere and charge full increase, if any, in cost and handling to the defaulting Contractor. The Contractor **must** give written notice to the Office of State Procurement and ordering agency of the reason and the expected delivery date. Consistent failure to meet delivery without a valid reason may cause removal from the Contractors list or suspension of eligibility for award.

17. **VARIATION IN QUANTITY**: The State assumes no liability for commodities produced, processed or shipped in excess of the amount specified on the agency's purchase order.

18. **INVOICING**: The Contractor **shall** be paid upon the completion of all of the following: (1) submission of an original and the specified number of copies of a properly itemized invoice showing the bid and purchase order numbers, where itemized in the *Bid Solicitation*, (2) delivery and acceptance of the commodities and (3) proper and legal processing of the invoice by all necessary State agencies. Invoices **must** be sent to the "Invoice To" point shown on the purchase order.

19. **STATE PROPERTY**: Any specifications, drawings, technical information, dies, cuts, negatives, positives, data or any other commodity furnished to the Contractor hereunder or in contemplation hereof or developed by the Contractor for use hereunder **shall** remain property of the State, **shall** be kept confidential, **shall** be used only as expressly authorized, and **shall** be returned at the Contractor's expense to the F.O.B. point provided by the agency or by OSP. Contractor **shall** properly identify items being returned.

20. **PATENTS OR COPYRIGHTS**: The Contractor **must** agree to indemnify and hold the State harmless from all claims, damages and costs including attorneys' fees, arising from infringement of patents or copyrights.

21. **ASSIGNMENT**: Any contract entered into pursuant to this solicitation **shall not** be assignable nor the duties thereunder delegable by either party without the written consent of the other party of the contract.

22. **CLAIMS**: Any claims the Contractor may assert under this Agreement **shall** be brought before the Arkansas State Claims Commission ("Commission"), which **shall** have exclusive jurisdiction over any and all claims that the Contactor may have arising from or in connection with this Agreement. Unless the Contractor's obligations to perform are terminated by the State, the Contractor **shall** continue to provide the Services under this Agreement even in the event that the Contractor has a claim pending before the Commission.

23. **CANCELLATION**: In the event, the State no longer needs the commodities or services specified for any reason, (e.g., program changes; changes in laws, rules or regulations; relocation of offices; lack of appropriated funding, etc.), the State **shall** have the right to cancel the contract or purchase order by giving the Contractor written notice of such cancellation thirty (30) days prior to the date of cancellation.

    Any delivered but unpaid for goods will be returned in normal condition to the Contractor by the State. If the State is unable to return the commodities in normal condition and there are no funds legally available to pay for the goods, the Contractor may file a claim with the Arkansas Claims Commission under the laws and regulations governing the filing of such claims. If upon cancellation the Contractor has provided services which the State has accepted, the Contractor may file a claim. **NOTHING IN THIS CONTRACT SHALL BE DEEMED A WAIVER OF THE STATE'S RIGHT TO SOVEREIGN IMMUNITY.**

24. **DISCRIMINATION**: In order to comply with the provision of Act 954 of 1977, relating to unfair employment practices, the Contractor agrees that: (a) the Contractor **shall not** discriminate against any employee or applicant for employment because of race, sex, color, age, religion, handicap, or national origin; (b) in all solicitations or advertisements for employees, the Contractor **shall** state that all qualified applicants **shall** receive consideration without regard to race, color, sex, age, religion, handicap, or national origin; (c) the Contractor will furnish such relevant information and reports as requested by the Human Resources Commission for the purpose of determining compliance with the statute; (d) failure of the Contractor to comply with the statute, the rules and regulations promulgated thereunder and this nondiscrimination clause **shall** be deemed a breach of contract and it may be cancelled, terminated or suspended in whole or in part; (e) the Contractor **shall** include the provisions of above items (a) through (d) in every subcontract so that such provisions **shall** be binding upon such subcontractor or Contractor.

25. **CONTINGENT FEE**: The Contractor guarantees that he has not retained a person to solicit or secure this contract upon an agreement or understanding for a commission, percentage, brokerage or contingent fee, except for retention of bona fide employees or bona fide established commercial selling agencies maintained by the Contractor for the purpose of securing business.

26. **ANTITRUST ASSIGNMENT**: As part of the consideration for entering into any contract pursuant to this solicitation, the Contractor named on the *Proposal Signature Page* for this solicitation, acting herein by the authorized individual or its duly authorized agent, hereby assigns, sells and transfers to the State of Arkansas all rights, title and interest in and to all causes of action it may have under the antitrust laws of the United States or this State for price fixing, which causes of action have accrued prior to the date of this assignment and which relate solely to the particular goods or services purchased or produced by this State pursuant to this contract.

27. **DISCLOSURE**: Failure to make any disclosure required by Governor's Executive Order 98-04, or any violation of any rule, regulation, or policy adopted pursuant to that order, **shall** be a material breach of the terms of this contract. Any Contractor,

whether an individual or entity, who fails to make the required disclosure or who violates any rule, regulation, or policy **shall** be subject to all legal remedies available to the agency.

ATTACHMENT A

Business Associate Agreement

I. Definitions

Catch-all definition:

The following terms used in this Agreement shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required by Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

Specific definitions:

(a) Business Associate. "Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean _____.

(b) Covered Entity. "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean **The State of Arkansas, Department of Finance and Administration, Employee Benefits Division.**

(c) HIPAA Rules. "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

II. Obligations and Activities of Business Associate

Business Associate agrees to:

(a) Not use or disclose protected health information other than as permitted or required by the Agreement or as required by law;

(b) Use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of protected health information other than as provided for by the Agreement;

(c) Report to covered entity any use or disclosure of protected health information not provided for by the Agreement of which it becomes aware, including breaches of unsecured protected health information as required at 45 CFR 164.410, and any security incident of which it becomes aware; Business Associate shall notify Covered Entity by the end of the next business day of the Business Associate or Covered Entity after Business Associate learns of such occurrence. Business Associates shall report within five business days of the notice to the Covered Entity: (a) identify the nature of the unauthorized use or disclosure/security incident; (b) Identify the PHI used or disclosed; (c) identify who made the unauthorized use or received the unauthorized disclosure; (d) identify what Business Associate has done or

shall do to mitigate any deleterious effect of the unauthorized use or disclosure (e) identify what corrective action Business Associate has taken or shall take to prevent future similar unauthorized use or disclosure; and (f) provide such other information, including a written report, as reasonably requested by Covered Entity.

i. With respect to the reporting of a security incident, as referenced above, the parties stipulate and agree that Business Associate will furnish the required report to Covered Entity in all cases involving a "Successful Security Incident," which is defined for purposes of this Business Associate Agreement as any security incident that results in unauthorized access, use, disclosure, modification or destruction of electronic protected health information of Covered Entity or interference with system operations adversely affecting the ability of Business Associate to maintain, process or safeguard electronic protected health information of Covered Entity. The parties further stipulate and agree that this paragraph constitutes notice by Business Associate to Covered Entity with respect to any Unsuccessful Security Incident, which is defined for purposes of this Business Associate Agreement as any security incident that does not result in unauthorized access, use, disclosure, modification or destruction of electronic protected health information of Covered Entity or interference with system operations adversely affecting the ability of Business Associate to maintain, process or safeguard electronic protected health information of Covered Entity. By way of example, such Unsuccessful Security Incidents may include: (i) pings on the firewall of Business Associate; or (ii) port scans; or (iii) attempts to log on to a system or enter a database with an invalid password or username; or (iv) denial-of-service attacks that do not result in a server being taken off-line; or (v) malware (worms, viruses, etc.). The parties further stipulate and agree that with respect to any such Unsuccessful Security Incident, no further or more detailed report to Covered Entity is needed or required under this Business Associate Agreement.

ii. In the event of an unauthorized disclosure or breach of a plan participant's PHI that is in the custody or control of Business Associate, Business Associate will take the following steps to assist Covered Entity in addressing applicable requirements under the HIPAA Rules, and to assist Covered Entity in fulfilling Covered Entity's HIPAA breach notice obligations. Within 5 business days, Business Associate agrees to provide:
    a. Business Associate's initial assessment and opinion regarding whether a particular unauthorized data release incident constitutes a "breach" that triggers the HIPAA breach notice requirements; and
    b. Business Associate's initial risk assessment and opinion regarding level of risk associated with breach.
    c. Business Associate agrees to provide Covered Entity with copies of all materials and information disclosed so that Covered Entity can perform independent risk assessment; and
    d. Where notifications are required, Business Associate agrees to provide assistance in drafting proposed notification(s) to the affected individuals,

HHS/OCR, or prominent media outlets, however, Covered Entity will make final determination and be responsible for notification of individuals, HHS/OCR and media if required, unless Business Associate is also considered a Covered Entity and the affected individuals are not solely covered under the State of Arkansas, ARBenefits health plans; and

e. Business Associate will provide assistance to Covered Entity in the form of supplying data in the possession of the Business Associate that is needed by Covered Entity to make the annual report to HHS/OCR of data breach incidents, as required under the HIPAA Rule. Business Associate agrees to work cooperatively with Covered Entity to help Covered Entity fulfill the annual HHS/OCR log or reporting requirement.

(d) In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of the business associate agree to the same restrictions, conditions, and requirements that apply to the business associate with respect to such information;

(e) Make available protected health information in a designated record set to the "individual or the individual's designee" as necessary to satisfy covered entity's obligations under 45 CFR 164.524;

(f) Make any amendment(s) to protected health information in a designated record set as directed or agreed to by the covered entity pursuant to 45 CFR 164.526, or take other measures as necessary to satisfy covered entity's obligations under 45 CFR 164.526;

(g) Maintain and make available the information required to provide an accounting of disclosures to the "individual" as necessary to satisfy covered entity's obligations under 45 CFR 164.528;

(h) To the extent the business associate is to carry out one or more of covered entity's obligation(s) under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to the covered entity in the performance of such obligation(s); and

(i) Make its internal practices, books, and records available to the Secretary for purposes of determining compliance with the HIPAA Rules.

III. **Permitted Uses and Disclosures by Business Associate**

(a) Business associate may only use or disclose protected health information as otherwise limited in this Agreement, Business Associate may use or disclose Protected Health Information it creates or receives to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Technical Services Agreement, provided that such use or disclosure would not violate HIPAA Rules if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity.

(b) Business associate may request additional use of Covered Entities data by specific request, which will be reviewed and approved on an individual basis and added as an addendum to this agreement and to the Technical Services Agreement.

(c) Business associate may not release Covered Entities data, even in de-identified format (45 CFR 164.514(a)-(c)) without written request and authorization from Covered Entity, unless designated in the Technical Services Agreement.

(d) Business associate may use or disclose protected health information as required by law.

(e) Business associate agrees to make uses and disclosures and requests for protected health information consistent with covered entity's minimum necessary policies and procedures.

(f) Business associate may not use or disclose protected health information in a manner that would violate Subpart E of 45 CFR Part 164 if done by covered entity, except for the specific uses and disclosures set forth below.

(g) Business associate may use protected health information for the proper management and administration of the business associate or to carry out the legal responsibilities of the business associate.

(h) Except as otherwise limited in this Agreement, business associate may provide data aggregation services relating to the health care operations of the covered entity as permitted by 45 CFR **-** 164.504(e)(2)(i)(B).

IV. **Provisions for Covered Entity to Inform Business Associate of Privacy Practices and Restrictions**

(a) Covered entity shall notify business associate of any limitation(s) in the notice of privacy practices of covered entity under 45 CFR 164.520, to the extent that such limitation may affect business associate's use or disclosure of protected health information.

(b) Covered entity shall notify business associate of any changes in, or revocation of, the permission by an individual to use or disclose his or her protected health information, to the extent that such changes may affect business associate's use or disclosure of protected health information.

(c) Covered entity shall notify business associate of any restriction on the use or disclosure of protected health information that covered entity has agreed to or is required to abide by under 45 CFR 164.522, to the extent that such restriction may affect business associate's use or disclosure of protected health information.

V. **Permissible Requests by Covered Entity**

Covered entity shall not request business associate to use or disclose protected health information in any manner that would not be permissible under Subpart E of 45 CFR Part 164

if done by covered entity. Business associate may use or disclose protected health information for data aggregation or management and legal responsibilities of the business associate.

VI. **Term and Termination**

(a) Term. This Agreement shall terminate when all of the Protected Health Information provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this Section, or on the date covered entity terminates for cause as authorized in paragraph (b) of this Section, whichever is sooner.

(b) Termination for Cause. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either:

1. Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity;
2. Immediately terminate this Agreement if Business Associate has breached a material term of this Agreement and cure is not possible; or
3. If neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

(c) Obligations of Business Associate Upon Termination.

Upon termination of this Agreement for any reason, business associate, with respect to protected health information received from covered entity, or created, maintained, or received by business associate on behalf of covered entity, shall:

1. Retain only that protected health information which is necessary for business associate to continue its proper management and administration or to carry out its legal responsibilities;
2. Return to covered entity or, destroy the remaining protected health information that the business associate still maintains in any form;
3. Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information to prevent use or disclosure of the protected health information, other than as provided for in this Section, for as long as business associate retains the protected health information;
4. Not use or disclose the protected health information retained by business associate other than for the purposes for which such protected health information was retained and subject to the same conditions set out at in section III “Permitted Uses and Disclosures By Business Associate” which applied prior to termination; and

5. Return to covered entity or, destroy the protected health information retained by business associate when it is no longer needed by business associate for its proper management and administration or to carry out its legal responsibilities.

(d) Survival. The obligations of business associate under this Section shall survive the termination of this Agreement.

VII. **Miscellaneous**

(a) Regulatory References. A reference in this Agreement to a section in the HIPAA Rules means the section as in effect or as amended.

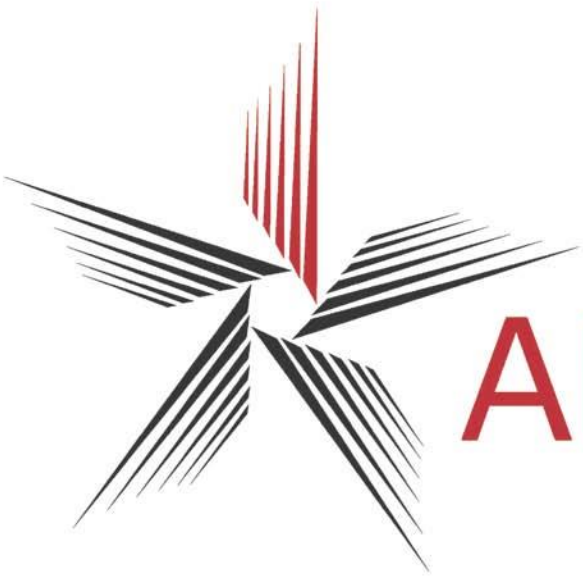
(b) Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for compliance with the requirements of the HIPAA Rules and any other applicable law.

(c) Interpretation. Any ambiguity in this Agreement shall be interpreted to permit compliance with the HIPAA Rules.

IN WITNESS WHEREOF, each of the undersigned has caused this Agreement to be duly executed in its name and on behalf effective as of _____.

COVERED ENTITY	BUSINESS ASSOCIATE
By:_____	By:_____
Print Name: Chris Howlett	Print Name:_____
Print Title: Director	Print Title:_____
Date:_____	Date: _____

ATTACHMENT B



ARBenefits

SUMMARY PLAN DESCRIPTION

For Arkansas State & Public School Employees & Retirees

Version II

Below are the Effective Dates for this ARBenefits Summary Plan Description (SPD). This SPD is designed as a “living document” and can be modified from time to time, depending on changes to covered services, pre-authorization requirements, or any number of issues. Each significant revision is noted in the Revision Dates and Sections area below. Some changes may require that we issue a Summary of Material Modification or SMM so that our members can be made aware of the change. Other changes may simply require an edit to this SPD along with a notation below.

Effective Dates:

Public School Active Employees	January 1, 2018
Public School Retirees	January 1, 2018
State Active Employees	January 1, 2018
State Retirees	January 1, 2018

Revision Dates and Sections:

January 4, 2018	PDL
January 23, 2018	Schedule of Benefits

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.

Note: Any information received by the plan from federal sources will be considered documentary evidence for enrollment changes.

Effective Notice:

This is a statement of current Plan information and is designed to replace all previously published Summary Plan Documents issued by the Plan. EBD reserves the right to interrupt the elements of this SPD and other Plan Documents as necessary for the continued administration of the plan.

Table of Contents

Plan Administration

What does this book tell me?

The Summary Plan Description (SPD) explains the benefits you may receive as a member of the Arkansas State and Public School Employee Health Insurance Plan (known as the Plan or ARBenefits throughout the rest of this book). The Plan provides coverage for participating employees, retirees and eligible dependents.

This SPD will help you understand and use your benefits. You and your covered dependents should review this SPD. It is a primary Plan Document under the Plan and it will help each member to understand the coverage provided to the membership, steps to follow to access Plan benefits, specific exclusions or limitations under the Plan, how the Plan is funded, and your rights & responsibilities as a member.

ARBenefits does have limitations and exclusions.
Not every medical expense you may incur is covered by the Plan.

This book is important! If you have any questions about the Plan, please contact Member Services at (501) 682-9656 or toll free at (877) 815-1017 and press one.

Who sponsors the Plan?

The State and Public School Life and Health Insurance Board (the Board), as established by Annotated Code §21-5-402, is the Plan Sponsor. The Board is made up of the following members designated by law:

- A state employee who is eligible to participate in the Plan appointed by the Governor
- Two Public School employees with at least one from a rural school district
- The Insurance Commissioner or his or her designee
- The Commissioner of Education or his or her designee
- The Director of the Department of Finance and Administration or his or her designee
- Three members who are engaged in employee benefits management or risk management at least one of whom is a licensed healthcare provider appointed by the Governor
- A retired Public School employee appointed by the Governor
- A retired state employee appointed by the Governor
- A public school administrator appointed by the Governor
- The Executive Director of the Arkansas State Board of Pharmacy or his or her state employee pharmacist designee
- The Director of Health Facility Services of the Department of Health or his or her designee
- A licensed member of the Arkansas Medical, Dental and Pharmaceutical Association

appointed by the Governor

The Board establishes the benefit design, sets the rates, and sets policies for the Plan. The current list of Board members can be found on the official Employee Benefits Division's DFA web site at http://www.arkansas.gov/dfa/ebd.

Who administers the Plan?

The Employee Benefits Division (EBD) for the State of Arkansas Department of Finance and Administration administers the Plan on behalf of the Board. EBD is referred to in this SPD as "we" or "us." EBD has the administrative oversight of the day-to-day operations of the Plan with such functions as determining and maintaining eligibility, managing appeals, coordination of member communication and much more. To help us with this project, EBD has contractual relationships with many outside vendors to perform such services as provider network management, claims payment, case management, and utilization review.

As the Administrator of the Plan, EBD has the full right to access all medical and claim information regarding the membership but will make every effort to protect any personal health information in accordance with applicable state and federal laws.

The Plan is not established under or subject to the Federal Employee Retirement Income Security Act of 1974 (commonly known as ERISA).

How is the Plan funded?

The Plan is considered a Self-Insured Plan, which means that all expenses incurred by the Plan are paid by contributions from your employer and your premiums. The Plan is responsible for the payment of all eligible claims and does not rely on protection from outside carriers to assume the risk. EBD maintains a cash balance held in reserve to cover catastrophic claims if they are incurred. This claims reserve and other monies collected are held in trust and are used to administer the Plan.

On an annual basis, claims information of the Plan, national inflationary factors, and other information is examined by an outside actuary/consulting team and rates are presented to the Board for review and approval. The rate that each member pays is derived from the base monthly premium for the benefit option elected by the member, less any employer contributions and/or additional subsidies.

Rates are not published in this SPD but are available on the central web site for the Plan (https://www.arbenefits.org). *

What's covered under the Plan?

ARBenefits is a comprehensive major medical health plan, with covered services including preventative care, physician services, hospital admissions & outpatient care, prescription drug coverage, behavioral/mental health services, rehabilitation, emergency care, and much more. It is important to remember that not every medical service is covered by the Plan. Certain exclusions and limitations do exist and it is your responsibility to understand the covered services under the Plan.

Some services require pre-certification before the Plan will consider the expense as a covered service. Additionally, some prescription drugs have quantity limitations, reference pricing, incorporation of Step-Therapy, or prior-authorization. This process is referred to as Utilization Management and can be a very effective plan management tool.

What is Utilization Management?

Utilization Management or UM is a process whereby services provided by a medical provider are compared against a nationally accepted set of guidelines and reimbursement rules designed by the Plan. Coverage decisions are then based on these guidelines for such areas as number of days per hospital admission, or the medical appropriateness and necessity of tests such as an MRI. Services that are provided outside of the guidelines and reimbursement rules may not be covered by the Plan, and would therefore be paid by the member.

A determination that the Plan will not cover a certain service does not mean that your provider is wrong; it only means that the service is outside the nationally accepted guidelines and will not be covered by the Plan. Your decision to continue with the service or not is entirely between you and your medical provider. See the section for Utilization Management for more information and procedures that require prior authorization.

Who are the Health Insurance Representatives?

Each state agency and school district has appointed at least one person to work as their Health Insurance Representative (HIR). These individuals often work in your payroll or personnel sections and have a variety of other duties to perform. In regards to the Plan, they will provide you with enrollment information and assist you with questions.

Who are the Benefit Coordinators?

We contract with various companies to work with the Plan to ensure that the members get the right coverage based on their election. Benefit Coordinators are contracted third-party administrators who perform many services, including but not limited to the list below:

- Provide a network of physicians, hospitals, labs, and other service providers to ensure your coverage under the Plan is appropriately managed
- Pay claims on behalf of the Plan for medical claims submitted by your health care provider
- Provide limited medical management services

Benefit Coordinators have the authority and responsibility to make decisions on behalf of the Plan when there are questions about your coverage. The decision of the Benefit Coordinator is final unless you follow the steps outlined in the Complaints and Appeals section of this SPD.

What about my Identification Card?

You will be sent a card with your Plan information, including your Benefit Coordinator and certain plan design elements such as your co-payment or deductible. Your medical care provider will use the information contained on this ID Card to submit claims, verify eligibility, receive pre-authorization for certain services, and a variety of other functions. If you change Benefit Coordinators or elect a different plan option, it is important that you alert your medical provider of the change.

These cards are for identification purposes only and do not guarantee your right to coverage under the Plan. You must meet all eligibility requirements of the Plan and ensure all premiums are paid in full to receive coverage. If you receive services for which you are not entitled, you will be responsible for paying the full cost of those services.

When you present your identification card for services, you are also giving your consent to release medical information to the Plan. The Plan has the right to refuse to reimburse for covered services if you refuse to consent to the release of any medical information relating to the covered service.

What are Plan Documents?

Plan Documents are a collective term covering any and all official documents of the Plan. They tell you important information about the Plan and how to access the benefits of coverage. Important information such as covered services, exclusions & limitations, member responsibilities, and rights to appeal or continue coverage are all explained in the various different Plan Documents. This document is the Summary Plan Description (SPD) and is one of the Plan Documents for ARBenefits.

This SPD, along with Preferred Drug List (PDL), comprise the majority of Plan Documents but other letters, memos, and official notifications may be issued. We will issue a Summary of Material Modification (SMM) to the Plan when an important element of the Plan changes. Each SMM will be posted to the central web site for the Plan, located at https://www.arbenefits.org.

Eligibility

Are you eligible for this insurance?

1. If you are a **State Employee**, you may join the Plan if you answer yes to one of the questions below:

   Are you:

   - A full-time employee of a participating agency, institution, commission, or constitutional office, and
   - In a budgeted position or a position recognized by the General Assembly, and
   - Not seasonal or temporary, and
   - Working one thousand (1,000) hours or more each year?

   Are you a member of the General Assembly?
   Are you an elected Constitutional Officer?
   Are you an appointed or elected member of a Board or Commission on a full-time salaried basis?

   Are you:

   - An extra help employee, and
   - Your agency has told you that you will be covered under the Plan, and
   - Your agency has agreed to pay the State match for your coverage.
   - A non-eligible state employee as defined under the law.
   - You are willing to be responsible for all costs for participating in the Plan (unless your agency has chosen to pay all or part of the cost).

2. If you are a **Public School Employee**, you may join the Plan if you answer yes to one of the questions below. Please note school districts determine the eligibility of their employees based on the rules below.

   Are you:

   - A certified employee, and
   - Working 30 hours or more per week each school year, and
   - Paid your salary from your district's teacher salary fund?

   Are you:

   - A non-certified employee, and
   - Working 30 hours per week or more each school year, and
   - Paid your salary from your district's local or state revenues?

3. If you are a **Retiree** – see the section entitled Coverage Continuation-Retirement.

Are your dependents eligible for this insurance?

1. If your dependent is your spouse, he / she may join the Plan as long as they are your current legal spouse. Former spouses with court orders requiring coverage are NOT ELIGIBLE to join the Plan. Spouses eligible for coverage through his/her employer are not eligible for coverage.

2. If your dependent is a child, they may join the Plan as long as they can answer yes to the following questions:

   Are they your child, adopted child, stepchild, or do you have legal guardianship for them?

   - Are they less than age twenty-six (26)

   Are they a qualified disabled dependent, and:

   - Have they been medically certified as totally disabled due to mental or physical incapacity?
   - Contact EBD to obtain an application for continuation of insurance due to incapacity. This document must be completed by the member and the dependent's physician.
   - Newly hired employees can add disabled dependents over the age of 26. Currently covered employees cannot add disabled dependents to their coverage if the dependent was not covered on the ARBenefits plan when the medical certification for the disability was determined.
   - Disabled dependents cannot leave the ARBenefits plan and be re-enrolled at a later date.

   Are they a Qualified Medical Child Support Order (QMCSO) dependent under age 26 and do you have a judgment, decree, or order issued under state law?

Notice of Dual Enrollment – Employees and / or their dependents cannot have dual coverage (for example, a state employee married to a school employee cannot be covered as the primary insured member on his plan and as a dependent on his spouse's plan).

Only eligible members and dependents can participate in the Plan. Falsification of eligibility is a serious offense and may permanently disqualify you from participation in the Plan. Financial penalties may be imposed as well.

Important Note:

Certain documents (or certified copies) such as marriage certifications, birth certificates, Medicare enrollment documentation, divorce decrees, etc. may be requested for enrollment in this Plan or as you make changes. Failure to promptly provide requested information within the designated time periods may cause you or your dependent(s) to lose certain rights under the Plan.

Qualified Changes in Coverage

Members of the Plan may make changes to their coverage during certain times of the year and after certain qualifying events. Below is a summary of the times and situations when changes will be allowed.

Initial Enrollment

When a new employee is hired or becomes eligible for coverage, each member may choose to enroll in the Plan or decline coverage. Enrollment for new employees/newly eligible individuals must be completed within 60 days of the date of employment/eligibility.

Effective date of coverage will be the first of the month following the date of hire and the date on the Election form submitted to EBD. Premiums are collected according to effective date.

Declinations for the employee and / or their dependents must be done in writing on the appropriate form. Employees who decline coverage for themselves and or their dependents cannot choose to enroll until the next Open Enrollment period or at the time of a qualifying event as described in the Special Enrollment section below.

Open Enrollment

On an annual basis, all members will enter a period called Open Enrollment where changes can be made without the need for a qualifying event. This is the only time members are allowed to change their health plan.

Non-Medicare retiree members – can make changes to plan level only (Premium, Classic or Basic).

Children's Health Insurance Program Reauthorization Act

Under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), there are new special enrollment opportunities available. Employees and dependents that are eligible for, but not enrolled in, a group health plan, can now enroll in the plan upon:

- Loss of eligibility for coverage under a state Medicaid or CHIP program, or
- Gaining eligibility for state premium assistance under Medicaid or CHIP.

The employee or dependent must request coverage within 60 days of being terminated from Medicaid or CHIP coverage or within 60 days of determination of eligibility for premium assistance.
Reauthorization of the CHIP program is pending approval from congress.

Special Enrollment / Change in Status

After certain events, a member may choose to change his / her coverage or the coverage for any eligible dependents. The effective date of coverage after an event is dependent upon the date of

application and the event itself. The effective date for additions, terminations and cancellations is the first of the month following the date of application. Changes to the member's coverage and / or the coverage of any dependent are based on a qualifying event as defined under HIPAA (Health Insurance Portability and Accountability Act) and is dependent upon the participation or lack of participation in your employer's Cafeteria Plan.

The Subscriber must submit an election form within 60 days of a qualifying event. If the Subscriber fails to submit the election form within the 60-day time frame, they must wait until the next open enrollment period or experience another qualifying event to make changes to their plan.

Note: Medicare Part D Prescription Drug Coverage does not constitute "group health coverage" as described above when Medicare Part A and/or Part B are already in effect.

Certain life changing events are considered "qualifying events" that allow employees or retirees to make changes to their plan. Active employees have 60 days from the date of the event to elect changes to their plan while retirees have 30 days from the event date.

Below is a listing of the most common qualifying events. This is not a complete list, and based on documents provided by the member, it is EBD's decision whether a valid qualifying event has occurred to allow the requested change.

Please note, unless the qualifying event results in the employee enrolling onto the plan as a new member, qualifying events do not allow for a change in plan level between the Premium, Classic or Basic plans.

Event	Action Allowed
Marriage	* Enroll legal spouse and dependents within 60 days of marriage date * Employee can only drop coverage if they have gained other group coverage through the spouse
Birth	* Enroll newborn within 60 days of the date of birth * Event also allows Employee to enroll along with spouse and any other dependents
Adoption/Guardianship	* Enroll new legal dependent
Loss of Group Coverage	* Employee can enroll within 60 days of the loss of other group coverage * Employee can add spouse and/or dependents that have lost other group coverage
Gain of Other Group Coverage	* Employee can drop coverage if they have gained other group coverage * Spouses that gain group coverage through an employer must come off of the plan * Employee can drop coverage of dependents that gain other group coverage
Divorce	* Divorce is a qualifying event for an employee to drop a spouse if decreed by the judge * Can only enroll in if other group coverage was lost on the spouse's plan.
Death	*Can drop deceased dependent by submitting a copy of the obituary or death certificate that shows the date of passing.

Turning 26	* Dependents covered by employees on the plan will automatically term off of the employee's plan at the end of the month in which they turn 26. * Employees who lose other group coverage (parent's coverage) when they turn 26 can enroll onto the plan
Loss of Medicaid/CHIP	* Allows the affected party to join the plan
Gain of Medicaid/CHIP	* Allows the employee to drop coverage for the affected party
Gain of Medicare	* Employees who gain Medicare Parts A&B coverage can elect to drop their plan coverage - The gain of Medicare Part D does not constitute group health coverage when Parts A&B are already in effect.

Birth and gain or loss of Medicaid allows a sixty (60) day window.

Birth/Adoption: coverage for a member's newborn/adopted child shall become effective as of the date of birth or adoption if the member gives EBD notice of the child by submitting an Election Form to EBD for the child within sixty (60) days of the child's date of birth or adoption. When an employee adopts a child, the employee, including his/her eligible spouse and/or dependents may enroll in the district's health insurance plan. If the member fails to submit the Election Form within the sixty (60) day timeframe provided, the member's newborn/adopted child may not be added until the next open enrollment period or experience of another qualifying event.

Retirees and COBRA participants have 30 days for qualifying event changes.

Important Note:

ASE (State) Only

No changes in coverage are allowed at the time of transfer from one state agency to another. Steps should be taken to eliminate a lapse of coverage due to a simple transfer.

PSE (School) Only

No transfers on the PSE side unless approved through summertime portability process.

ASE& PSE Retirees

Retirees have thirty (30) days to submit changes to EBD for qualified changes in coverage.

Plan Management

As the Plan Administrator, EBD handles many of the day-to-day operations of the Plan. Questions dealing with eligibility, allowed changes, publications, and customer service are coordinated through EBD. Shown below are just a few of the more common questions asked by the membership.

How do I get a service or treatment pre-certified under the Plan?

Pre-certification is an element of Utilization Management for the Plan. Review the section for Utilization Management in this SPD for more information.

How do I request a replacement ID card?

You may request a new ID card at any time by one of the following methods:

- By using the **My Benefits** page of www.ARBenefits.org to print a temporary card using your computer's printer. You may also request that a permanent card be mailed to your address from the web site.
- By contacting EBD Member Services at 877-815-1017 (Just Press One) and request a new card.

What if I'm covered under another health plan?

If you are covered under more than one health plan, Coordination of Benefits (or COB) will apply. COB allows us to make sure that the proper amount is paid in the appropriate amounts by each of your plans. Which plan will pay as the primary plan and what portion will be paid by each will be determined by your Benefit Coordinator as they work with your other plan.

It is your responsibility to provide other insurance information, including Medicare, to EBD. Any changes to the other insurance coverage must be reported promptly.

What if I have other insurance with another government program?

- **Medicaid** – If this Plan and Medicaid cover you or any covered dependent, the Plan will pay first and Medicaid will pay as secondary.
- **Tricare/CHAMPUS** – If you or any covered dependent is covered under the Plan and Tricare/ Civilian Health and Medical Program of the Uniformed Service (CHAMPUS), the program that provides health care services to dependents of active armed services personnel, the Plan pays first and Tricare/CHAMPUS pays as secondary. If you (the employee) are called to active duty for more than thirty (30) days, Tricare becomes primary and the Plan will pay as secondary.
- **Veterans Affairs Facility Services** – If you or any covered dependent receives services in a U.S. Department of Veterans Affairs Hospital or facility because of a military service-related illness or injury, benefits are not payable by the Plan. If you or a covered individual receives services in a U.S. Department of Veterans Affairs Hospital or facility related to any other condition that is not a military service-related illness or injury, benefits are payable by the Plan at the In-Network level, only to the extent those services are medically necessary and the charges are usual and customary.

- **Motor Vehicle Coverage Required by Law** – When medical payments are available under vehicle insurance, the Plan will pay excess benefits only, without reimbursement for vehicle plan deductibles. This Plan will always be considered the secondary carrier regardless of your election under PIP (Personal Injury Protection) coverage with your auto carrier.
- **Other Coverage Provided by State or Federal Law** – If you or any covered dependent is covered by both this Plan and any other coverage provided by any other state or federal law, the Plan will coordinate benefits in accordance with state and federal regulations. Please contact EBD Member Services.

Limiting age is defined in the Eligibility section of this SPD.

Contact EBD or visit www.ARBenefits.org to obtain an application for continuation of insurance due to incapacity. You and your dependent's physician must complete this document. The continuation of insurance due to incapacity will be evaluated annually and you may be required to complete another application with physician certification at that time.

I'm going on active military duty, what are my options?

School Employees:
Once you enter leave without pay status, your District should provide you with all the essential information you need to maintain coverage.

You have two options:

1. Continue your coverage: Remit your premium payments according to payroll dates provided by your district's pay cycle. Your district will collect your premium and include it with their monthly billing. EBD will not accept member checks or money orders.

2. Discontinue your coverage: If you choose this option, please fill out a change form to cancel coverage. You will be eligible to re-enroll within 120 days following your return to active employment. You must complete your application within that 120-day period and your new coverage will be effective the first day of the month following your application date. Please be aware that if you have a break in coverage, and you re-enroll you will have to start over to meet your deductible and out of pocket maximum.

Whichever option you choose; you must submit a copy of your military/deployment orders to your Health Insurance Representative.

State (NON-AASIS) Employees:

Once you enter leave without pay status, your agency should provide you with all the essential information you need to maintain coverage.

You have two options:

1. Continue your coverage: Remit your premium payments according to payroll dates provided by your agency's pay cycle. Your agency will collect your premium and include it with their monthly billing. EBD will not accept member checks or money orders.

2. Discontinue your coverage: If you choose this option, please fill out a change form to cancel coverage. You will be eligible to re-enroll within 120 days following your return to active employment. You must complete your application within that 120-day period and your new coverage will be effective the first day of the month following your application date. Please be aware that if you have a break in coverage, and you re-enroll you will have to start over to meet your deductible and out of pocket maximum.

Whichever option you choose, you must submit a copy of your military/deployment orders to your Health Insurance Representative.

State (AASIS) Employees:

Once you enter leave without pay status, EBD will send you a LWOP packet. The LWOP packet will provide you with all the essential information you need to maintain coverage. Inside the packet, there will be a Leave Without Pay Notification, LWOP Election Form, and a Table of Important Dates Schedule for LWOP.

You have two Options:

1. Continue your coverage: You must sign and return your LWOP Election Form by the election due date to continue your coverage while on Leave Without Pay. Remit your premium payments according to the Table of Important Dates schedule for LWOP. You will send your premium payments directly to EBD following this schedule.

2. Discontinue your coverage: If you choose this option, you will be eligible to re-enroll within 120 days following your return to active employment. You must complete your application within that 120-day period and your new coverage will be effective the first day of the month following your application date. Please be aware that if you have a break in coverage, and you re-enroll you will have to start over to meet your deductible and out of pocket maximum.

Whichever option you choose, you must submit a copy of your military/deployment orders to your Health Insurance Representative.

I'm going on Leave Without Pay (LWOP), Family Medical Leave, or Worker Compensation, what are my options?

School Employees:

School districts administer leave without pay policies for their employees. Employees should contact their school district for information regarding their options and instructions.

State (NON-AASIS) Employees:

Non-AASIS agencies administer leave without pay policies for their employees. Employees should contact their HR department for information regarding their options and instructions.

State (AASIS) Employees:

Once you enter leave without pay status, EBD will send you a LWOP packet. The LWOP packet will provide you with all the essential information you need to maintain coverage. Inside the packet, there will be a Leave Without Pay Notification, LWOP Election Form, and a Table of Important Dates Schedule for LWOP.

You have two Options:

1. Continue your coverage: You must sign and return your LWOP Election Form by the election due date to continue your coverage while on Leave Without Pay. Remit your premium payments according to the Table of Important Dates schedule for LWOP. You will send your premium payments directly to EBD following this schedule.
2. Discontinue your coverage: If you choose this option, you will be eligible to re-enroll within 30 days following your return to active employment. You must complete your application within that thirty (30) day period and your new coverage will be effective the first day of the month following your application date. Please be aware that if you have a break in coverage, and you re-enroll you will have to start over to meet your deductible and out of pocket maximum.

Important Note: **If you are on Leave of Absence according to A.C.A. § 21-4-210, Your agency, District, and/or Co-op must provide EBD with appropriate documentation of your LOA signed by your Agency, District, and/or Co-op's Superintendent, Director, and/or Institution head. You will need to contact us immediately for a revised premium payment amount.**

If I am terminated from employment, what are my options?

In most situations, employees that are terminated either due to a voluntary or involuntary termination are eligible to continue coverage under the Plan by electing COBRA (Consolidated Omnibus Budget Reconciliation Act). More information can be found in the Coverage Continuation – COBRA section of this SPD.

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

Can my dependents continue my health coverage if I die while an active employee (Death in Service)?

Can my covered dependents continue my health coverage if I die while an active employee (Death in Service)?

Health coverage is available for spouse/dependents covered on the employee's health plan at the date of the employee's death per the following guidelines:

Spouse with and without Dependents

- If the spouse is eligible to receive a survivor retirement annuity, the spouse and covered dependents, are eligible to continue on the health plan. If the survivor annuity benefit is available upon death of the member (first of the month following death), the surviving spouse has 30-days from the end of the month in which the active coverage ended to enroll in the retirement health plan.
- If the survivor retirement annuity is not immediately available to the spouse, but available at a later date, either the month following the date the employee would have been eligible to receive benefits had the employee survived or the date that an application for a surviving spouse's benefit is filed with the appropriate retirement system, the spouse has 30-days from the time he/she becomes eligible to draw the survivor annuity to enroll in the retirement health plan.
- If the spouse is not eligible to receive a survivor annuity, the spouse and/or dependents have the option to enroll on the COBRA health plan for a period of 36 months. A COBRA packet will automatically be sent to the surviving spouse with a 60-day enrollment period.

Dependents without Spouse on the health plan

- If a dependent child is eligible to draw a survivor retirement annuity, and the check is paid directly to the child, the child is eligible to enroll in the retirement health insurance until the retirement annuity ends, which will be until his/her death or his/her marriage or his/her attainment of age 18. Coverage will be extended past age 18 as long as the child continues uninterrupted as a full-time student at an accredited secondary school or college or university, but in no event beyond his/her attainment of age 23. The dependent child has 30-days to enroll in the retirement health plan once the annuity becomes available.
- A collateral dependent child receiving a survivor annuity may remain on the plan as long as they have been medically certified as totally disabled due to mental or physical incapacity. EBD has the right to request verification of the disability at any time.
- If a dependent child was covered on the active employee's health plan, without spousal coverage, and there is no survivor annuity paid to the dependent, the dependent child has the option to enroll on the COBRA health plan for a period of 36 months. A COBRA packet will automatically be sent to surviving dependents. There is a 60-day enrollment period for the COBRA health plan.
- If there are multiple dependents (other than the spouse) on the employee's health plan at the time of death, and COBRA is the only option available, each dependent must enroll under their own health plan.

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.

I am about to retire; what are my options?

You may choose to continue your active coverage under the Plan by electing COBRA or, you may elect to keep your current coverage on the retirement plan. More information can be found in the Coverage Continuation, Retirement (pg.), and Coverage Continuation, COBRA sections (pg.) of this SPD.

Can my coverage be canceled?

Coverage of a Subscriber or Dependent(s) may be terminated for serious intentional or unintentional acts committed against the Plan, or any member, including but not limited to concealment, misrepresentation, theft, or fraud for the purpose of obtaining coverage, filing claims, or utilizing plan services or facilities.

Coverage may also be terminated for non-payment of premiums while in a LWOP status, if a Subscriber has chosen to continue coverage while on LWOP. In addition, failure to submit a LWOP Election form to continue coverage while on LWOP may result in your coverage being terminated. Should this occur, you will be eligible for re-enrollment in the Plan. For non-military LWOP, you must enroll within 30 days following your return to active employment and payment in full of your outstanding debt. You will be reinstated in the Plan effective the 1st of the month following your application date. For reinstatement of Military LWOP, you will be eligible to re-enroll within 120 days following your return to active employment. You must complete your application within that 120-day period and your new coverage will be effective the first day of the month following your application date. You will still be responsible for your outstanding premium debt, if any.

If your coverage under LWOP is terminated due to non-payment of premiums, no COBRA coverage will be offered.

Coverage may also be terminated for late COBRA payment.

Utilization Management

It is the position of the Plan that pre-certification only applies to the items listed on this Utilization Review page. Other procedures, services, and/or equipment will be paid or denied based on the Coverage Policies in effect at the time of service delivery.

Pre-certification will be necessary for the list of procedures provided below. It will be necessary for your provider to contact the company listed below to obtain pre-certification of the services requested. The pre-certification process is the responsibility of the hospital or medical provider. If a hospital, medical provider or facility in the State of Arkansas fails to pre-certify a hospital admission or outpatient procedure, the member is not subject to any penalty for non-certification. It is the provider's responsibility to verify or make certain the procedure has been pre-certified.

Pre-notification is required for Oncology Services.

Coverages provided for transplant services are subject to medical necessity review through Case Management.

Contact Active Health Management @ 1-877-815-1017 and press option #2 for pre-certification for:

Medical Services

ABA Therapy
Residential Treatment
Intensive Outpatient Treatment
Partial Hospital /Day Treatment
Skilled Nursing Facility
Cognitive Rehabilitation
Occupational Therapy
Home Health Services
Inpatient Rehabilitation
Physical Therapy
Speech Therapy
Enteral Feeds
Long Term Acute Care Hospital (LTACH)
Intensity-Modulated Radiation Therapy (IMRT)
In Patient Admissions

Durable Medical Equipment

Spinal Cord Stimulators (implantation and device)
Continuous Glucose Monitoring Devices
Defibrillator Vests
Power Mobility Devices
Wound Vac

Medical Procedures

Septoplasty
UPPP, (Uvulopalatopharyngoplasty)
Varicose Vein Treatment
Blepharoplasty and/or Brow Lift
Gynecomastia Reduction
Mammoplasty
Panniculectomy
Rhinoplasty
Scar Revision outside doctor's office
Gastric Pacemaker (eff. 7/1/11)
Bariatric Surgery, revisions, reversals (takedown) that require surgical intervention (eff. 1/1/12)

Radiology

Computerized Tomography (CT Scan)
Computerized Tomography – Angiography (CTA Scan)
Magnetic Resonance Imaging (MRI)
Magnetic Resonance Angiography (MRA)
Positron Emission Tomography (PET Scan)

Summary of Plan Options

The Plan offers multiple options for active members and retirees, the ARBenefits Premium, Classic and Basic Plans and the ARBenefits Retiree Plan. The options are different in how your medical services are covered and how much you will pay for monthly premiums. Review each plan carefully to find the best fit for you and your family.

ARBenefits Premium - The Premium Plan is considered the "richest" of the plan options, as it contains the maximum amount of benefits with copays and coinsurance. It also has the highest monthly premium cost to the member. This plan has a deductible attached to it ($500 individual /$1,000 family deductible for ASE and $1,000 individual/$2,000 family for PSE) that must be met before the plan begins to pay for some services. The plan consists of a $3000 individual and $6000 family medical out-of-pocket maximum for ASE and $3,500 individual and $7,000 family medical out-of-pocket maximum for PSE. The copays have been lowered to $25 for a physician and $50 for a specialist. The emergency room copay is $250. There is a prescription drug plan attached to Premium, which includes $15, $40, $80 and $100 copays depending on tier. The prescription drug plan also consists of a $3100 individual and $6200 family pharmacy out-of-pocket maximum.

ARBenefits Classic - The Classic Plan is a High-Deductible PPO Plan. The ASE plan has a deductible attached to it ($2500 individual/$5000 family). The family deductible includes an embedded individual deductible of $2,700. When an individual on a Classic family plan meets the $2,700 amount, the plan will begin coinsurance for that member. The PSE plan has a deductible of $2,000 individual/$3,000 family. The PSE family deductible also includes an embedded individual deductible of $2,700. Eligible active employees are recommended to have a Health Savings Account (HSA) with this plan. There are no copays with the Classic Plan (with the exception of hearing and vision services), but prescriptions and medical services apply to the deductible and can be paid with HSA funds.

ARBenefits Basic – ASE – The Basic Plan on the state employee side is also a High-Deductible PPO Plan. It features the lowest monthly premium of any plan. The plan has a deductible attached to it ($6450 individual/$12900 family) for ASE. There is no coinsurance for the Basic Plan on the ASE side. Once the deductible is met, the plan pays at 100% for allowable services. Eligible active employees are also recommended to have a Health Savings Account (HSA) with this plan. There are no copays (with the exception of hearing and vision services) with the Basic Plan, but prescriptions and medical services apply to the deductible and can be purchased using funds in the HSA.

ARBenefits Basic – PSE – The Basic Plan on the school employee side is a High-Deductible PPO Plan. It features the lowest monthly premium of any plan. The plan has a deductible attached to it ($4,250 individual/$8,500 family). The PSE Basic Plan does have coinsurance. Once the deductible is met, the plan pays at 80% for allowable services. Eligible active employees are recommended to have a Health Savings Account (HSA) with this plan. There are no copays (with the exception of hearing and vision services) with the Basic Plan, but prescriptions and medical services apply to the deductible and can be purchased using funds in the HSA.

ARBenefits Retiree - As a Non-Medicare Retiree, a member may choose from the ARBenefits Premium, Classic or Basic Plan until the retiree or spouse reaches the age of 65, or become eligible for Medicare, in which case the only option is the Medicare Primary Plan. When this occurs, the member and dependents will automatically be move to the Medicare Primary Plan at the Premium level if they are currently enrolled in the Classic or Basic Plan. Medicare primary members will not have to use the QualChoice network of providers, however, anyone on the Medicare Primary plan

who is not eligible for Medicare, will have 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.

Medicare-Primary Retirees and/or dependent 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 benefit 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.

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 is 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.

2018 ASE Schedule of Benefits - Premium

(Active, COBRA & Non-Medicare Retiree)

	IN-NETWORK	OUT-OF-NETWORK	
Annual Deductible - Individual	$500	$2,000	
Annual Coinsurance/Copay Limit - Individual	$2,500	N/A	
*Medical Out-of-Pocket Max	$3,000	N/A	
Annual Deductible - Family	$1,000	$4,000	The plan will pay 100 percent for individuals on family coverage when they reach the individual out-of-pocket maximum amount.
Annual Coinsurance/Copay Limit - Family	$5,000	N/A	
*Medical Out-of-Pocket Max - Family	$6,000	N/A	
Paid By Plan After Satisfaction Of Deductible	80%	60%	

***Deductible, coinsurance and copays are included.**

COVERED BENEFITS AND SERVICES	IN-NETWORK COPAYMENT	IN-NETWORK	OUT-OF-NETWORK	APPLIES TO DEDUCTIBLE
ADVANCED IMAGING				
*Advanced Imaging (Radiology Services)	$0	20%	40%	Y
***Requires pre-certification**				
***Charges will not apply when provided in conjunction with Emergency Room or Inpatient Hospital Services**				
ALLERGY SERVICES				
Specialist Office Visit	$50	0%	40%	N
Testing and Serum Formulation	$0	20%	40%	Y
Injections	$0	$0	40%	N
***Formulation of allergy serum requires coinsurance**				
AMBULANCE SERVICES				
Air Ambulance Transportation		10%		N
Ground Transportation		$50 Copay		N
***Limited Benefits: $2,000 per member per trip for ground ambulance**				
BEHAVIORAL/MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT SERVICES				
Office Visit	$25	0%	40%	N
Psychological Testing	$35	0%	40%	N
In-Patient Services	$0	20%	40%	Y
Outpatient Services (Partial Hospital/Day Treatment)	$0	20%	40%	Y
Outpatient Services (Intensive Outpatient)	$0	20%	40%	Y
Residential Treatment	$0	20%	40%	Y
DENTAL SERVICES				
Repair to Non-Diseases Teeth Due to Accident/Injury	$0	20%	40%	Y

COVERED BENEFITS AND SERVICES	IN-NETWORK COPAYMENT	IN-NETWORK	OUT-OF-NETWORK	APPLIES TO DEDUCTIBLE
DIABETES MANAGEMENT SERVICE				
Insulin Pump & Supplies	$0	20%	40%	Y
Glucometers	$0	20%	40%	Y
Diabetic Self Management Training	$0	0%	40%	N
***Lancets and insulin needles for diabetics will be paid 100% by the plan for participants in the Diabetic Management Program**				
***Test strips must be purchased at Pharmacy Only.**				
***Glucometers - Provided through DME/Medical Benefit**				
DURABLE MEDICAL EQUIPMENT/ENTERAL FEEDING				
DME/Enteral Feeding	$0	20%	40%	Y
***Coverage is provided for medically necessary durable medical equipment. See exclusions. Not all services require pre-certification and may be reviewed for medical necessity by AHH. Refer to Utilization Management section.**				
HEARING SERVICES				
Hearing Screening	$50	0%	$50	N
***Limited Benefits: One screening every three years**				
Hearing Aid	$0	0%	0%	N
***Limited Benefits: $1,400 per ear every three years**				
HOME HEALTH SERVICES				
Home Health Services	$0	20%	40%	Y
HOME INTRAVENOUS DRUGS				
Home Intravenous Drugs and Solutions	$0	20%	40%	Y
HOSPICE SERVICES				
Hospice Care	$0	20%	40%	Y
HOSPITAL SERVICES				
In-Patient Services	$0	20%	40%	Y
Outpatient Services	$0	20%	40%	Y
Diagnostic Services	$0	20%	40%	Y
Emergency Room Visit and Observation Services	$250	0%	0%	N
***ER copay may be waived. See Summary Plan Description (SPD)**				
Urgent Care Center	$100	0%	0%	N
***Visits deemed non-emergency will be treated as hospital services/outpatient.**				

COVERED BENEFITS AND SERVICES	IN-NETWORK COPAYMENT	IN-NETWORK	OUT-OF-NETWORK	APPLIES TO DEDUCTIBLE
MATERNITY AND FAMILY PLANNING SERVICES				
Prenatal and Postnatal Outpatient Care	$0	20%	40%	Y
Inpatient Maternity Services	$0	20%	40%	Y
***Hospital length of stay for childbirth: This plan complies with federal law that prohibits restricting benefits for any hospital length of stay in connection with childbirth for the mother and newborn child to less than 48 hours following a normal vaginal delivery or less than 96 hours following a caesarean section delivery**				
Infertility Diagnostic Evaluation: Office Visit	$50	0%	40%	N
Infertility Testing	$0	20%	40%	Y
***Treatment for infertility is not a covered benefit under the ARBenefits Plan. Services related to infertility are covered up to diagnosis. Testing is not covered during or following treatment.**				
PHARMACY BENEFIT - REFER TO RX DRUG COVERAGE SECTION				
Prescription - Generic - Tier I	$15			
Prescription - Preferred - Tier II	$40			
Prescription - Non-Preferred - Tier III	$80			
Prescription Specialty - Tier IV	$100			
*RX Out-of-Pocket Max (Individual/Family)	$3100/$6200			
***Excluded drugs, reference price drugs and brand drugs where generic is available does not apply towards the RX Out-of-Pocket Max.**				
PHYSICIAN/SPECIALIST SERVICES				
*Primary Care Physician Office Visit	$25	$0	40%	N
*Specialist Office Visit/Specialty Care Services	$50	$0	40%	N
*Other Physician Services provided under Outpatient or In-Patient Care**	$0	20%	40%	Y
***Includes such services as debridement and/or wound dressing changes performed in an outpatient setting with or without direct physician attention**				
*Medication	$0	20%	40%	Y
***This includes injectable, oral and intravenous medications**				
Radiation Therapy	$0	20%	40%	Y
****See Professional Services under SPD - Summary of Common Services**				
PREVENTATIVE CARE SERVICES				
Physical Exams/Preventative Care	$0	0%	40%	N
Well Baby/Child Care Visits	$0	0%	40%	N
Immunizations	$0	0%	0%	N
PROSTHETIC AND ORTHOTIC DEVICES				
Prosthetic and Orthotic Devices and Services	$0	20%	40%	Y
REHABILITATION SERVICES (INPATIENT)				
Rehabilitation Services	$0	20%	40%	Y

COVERED BENEFITS AND SERVICES	IN-NETWORK COPAYMENT	IN-NETWORK	OUT-OF-NETWORK	APPLIES TO DEDUCTIBLE
REHABILITIATION SERVICES (OUTPATIENT) OR OFFICE VISIT				
Chiropractic	$25	0%	40%	N
***Limited Benefit: Fifteen (15) visits per member per plan year**				
Physical Therapy	$25	0%	40%	N
Occupational Therapy	$25	0%	40%	N
Speech Therapy	$25	0%	40%	N
***Therapy services billed by or provided by a Specialist MD will have the Specialist Copay ($50)**				
SKILLED NURSING FACILITY (SNF) SERVICES				
SNF Services	$0	20%	40%	Y
TEMPOROMANDIBULAR JOINT (TMJ)/DYSFUNCTION (TMD) SERVICES				
TMJ/TMD	$0	20%	40%	Y
***Limited Benefit: $1,000 per member per plan year**				
TRANSPLANT SERVICES				
Organ/Bone Marrow Transplant	$250	20%	Not Covered	N
***Copayment is applied to the Professional Services of the transplant provider *Limited Benefit: Two (2) organ transplants of the same organ per member per lifetime. *Limited Benefit: $10,000 lifetime limit for travel and lodging determined by EBD as reasonable and necessary in conjunction with transplant services. *Coverage is provided for transplant services subject to pre-authorization (See Utilization Management Section). Transplant services MUST be provided by approved transplant providers and facilities.**				
VISION SCREENING				
Vision Screening	$50	0%	$50	N
***Limited Benefit: One (1) exam every twenty-four (24) months**				

Certain Limitations Apply - Please check your SPD Exclusions and Limitations section for more information

2018 ASE Schedule of Benefits - Classic

(Active, COBRA & Non-Medicare Retiree)

	IN-NETWORK	OUT-OF-NETWORK	
Annual Deductible - Individual	$2,500	$4,000	
Annual Coinsurance Limit - Individual	$3,950	N/A	
*Out-of-Pocket Max	$6,450	N/A	
Annual Deductible - Family	$2,700 / $5,000	$8,000	The plan will pay 100 percent for individuals on family coverage when they reach the individual out-of-pocket maximum amount.
Annual Coinsurance Limit - Family	$7,900	N/A	
*Out-of-Pocket Max - Family	$12,900	N/A	
Paid By Plan After Satisfaction Of Deductible	80%	60%	

***Deductible, coinsurance and copays are included.**

COVERED BENEFITS AND SERVICES	IN-NETWORK COPAYMENT	IN-NETWORK	OUT-OF-NETWORK	APPLIES TO DEDUCTIBLE
ADVANCED IMAGING				
*Advanced Imaging (Radiology Services)	N/A	20%	40%	Y
***Requires pre-certification**				
***Charges will not apply when provided in conjunction with Emergency Room or Inpatient Hospital Services**				
ALLERGY SERVICES				
Services and Specialty Providers (Office Visit, Serum Formulation and Testing)	N/A	20%	40%	Y
Injections	N/A	$0	40%	Y
AMBULANCE SERVICES				
Air Ambulance Transportation	N/A	10%		N
Ground Transportation	N/A	20%		N
***Limited Benefits: $2,000 per member per trip for ground ambulance**				
BEHAVIORAL/MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT SERVICES				
Office Visit	N/A	20%	40%	Y
Psychological Testing	N/A	20%	40%	Y
In-Patient Services	N/A	20%	40%	Y
Outpatient Services (Partial Hospital/Day Treatment)	N/A	20%	40%	Y
Outpatient Services (Intensive Outpatient)	N/A	20%	40%	Y
Residential Treatment	N/A	20%	40%	Y
DENTAL SERVICES				
Repair to Non-Diseases Teeth Due to Accident/Injury	N/A	20%	40%	Y

COVERED BENEFITS AND SERVICES	IN-NETWORK COPAYMENT	IN-NETWORK	OUT-OF-NETWORK	APPLIES TO DEDUCTIBLE
DIABETES MANAGEMENT SERVICE				
Insulin Pump & Supplies	N/A	20%	40%	Y
Glucometers	N/A	20%	40%	Y
Diabetic Self Management Training	N/A	20%	40%	Y
***Lancets and insulin needles for diabetics will be paid 100% by the plan for participants in the Diabetic Management Program** ***Test strips must be purchased at Pharmacy Only.** ***Glucometers - Provided through DME/Medical Benefit**				
DURABLE MEDICAL EQUIPMENT/ENTERAL FEEDING				
DME/Enteral Feeding	N/A	20%	40%	Y
***Coverage is provided for medically necessary durable medical equipment. See exclusions. Not all services require pre-certification and may be reviewed for medical necessity by AHH. Refer to Utilization Management section.**				
HEARING SERVICES				
Hearing Screening	$50	0%	$50	N
***Limited Benefits: One screening every three years**				
Hearing Aid	$0	20%	40%	Y
***Limited Benefits: $1,400 per ear every three years**				
HOME HEALTH SERVICES				
Home Health Services	N/A	20%	40%	Y
HOME INTRAVENOUS DRUGS				
Home Intravenous Drugs and Solutions	N/A	20%	40%	Y
HOSPICE SERVICES				
Hospice Care	N/A	20%	40%	Y
HOSPITAL SERVICES				
In-Patient Services	N/A	20%	40%	Y
Outpatient Services	N/A	20%	40%	Y
Diagnostic Services	N/A	20%	40%	Y
Emergency Room Visit and Observation Services	N/A	20%	40%	Y
Urgent Care Center	N/A	20%	40%	Y
***Visits deemed non-emergency will be treated as hospital services/outpatient.**				

COVERED BENEFITS AND SERVICES	IN-NETWORK COPAYMENT	IN-NETWORK	OUT-OF-NETWORK	APPLIES TO DEDUCTIBLE
MATERNITY AND FAMILY PLANNING SERVICES				
Prenatal and Postnatal Outpatient Care	N/A	20%	40%	Y
Inpatient Maternity Services	N/A	20%	40%	Y
***Hospital length of stay for childbirth: This plan complies with federal law that prohibits restricting benefits for any hospital length of stay in connection with childbirth for the mother and newborn child to less than 48 hours following a normal vaginal delivery or less than 96 hours following a caesarean section delivery**				
Infertility Diagnostic Evaluation: Office Visit	N/A	20%	40%	Y
Infertility Testing	N/A	20%	40%	Y
***Treatment for infertility is not a covered benefit under the ARBenefits Plan. Services related to infertility are covered up to diagnosis. Testing is not covered during or following treatment.**				
PHARMACY BENEFIT - REFER TO RX DRUG COVERAGE SECTION				
Prescription - Generic - Tier I	N/A	20%	N/A	Y
Prescription - Preferred - Tier II	N/A	20%	N/A	Y
Prescription - Non-Preferred - Tier III	N/A	20%	N/A	Y
Prescription Specialty - Tier IV	N/A	20%	N/A	Y
***Excluded drugs, reference price drugs and brand drugs where generic is available does not apply towards the RX Out-of-Pocket Max.**				
PHYSICIAN/SPECIALIST SERVICES				
*Primary Care Physician Office Visit	N/A	20%	40%	Y
*Specialist Office Visit/Specialty Care Services	N/A	20%	40%	Y
*Other Physician Services provided under Outpatient or In-Patient Care**	N/A	20%	40%	Y
***Includes such services as debridement and/or wound dressing changes performed in an outpatient setting with or without direct physician attention**				
Medication	N/A	20%	40%	Y
***This includes injectable, oral and intravenous medications**				
Radiation Therapy	N/A	20%	40%	Y
****See Professional Services under SPD - Summary of Common Services**				
PREVENTATIVE CARE SERVICES				
Physical Exams/Preventative Care	N/A	0%	40%	N
Well Baby/Child Care Visits	N/A	0%	40%	N
Immunizations	N/A	0%	0%	N
PROSTHETIC AND ORTHOTIC DEVICES				
Prosthetic and Orthotic Devices and Services	N/A	20%	40%	Y
REHABILITATION SERVICES (INPATIENT)				
Rehabilitation Services	N/A	20%	40%	Y

COVERED BENEFITS AND SERVICES	IN-NETWORK COPAYMENT	IN-NETWORK	OUT-OF-NETWORK	APPLIES TO DEDUCTIBLE
REHABILITIATION SERVICES (OUTPATIENT) OR OFFICE VISIT				
Chiropractic	N/A	20%	40%	Y
***Limited Benefit: Fifteen (15) visits per member per plan year**				
Physical Therapy	N/A	20%	40%	Y
Occupational Therapy	N/A	20%	40%	Y
Speech Therapy	N/A	20%	40%	Y
SKILLED NURSING FACILITY (SNF) SERVICES				
SNF Services	N/A	20%	40%	Y
TEMPOROMANDIBULAR JOINT (TMJ)/DYSFUNCTION (TMD) SERVICES				
TMJ/TMD	N/A	20%	40%	Y
***Limited Benefit: $1,000 per member per plan year**				
TRANSPLANT SERVICES				
Organ/Bone Marrow Transplant	N/A	20%	Not Covered	Y
***Limited Benefit: Two (2) organ transplants of the same organ per member per lifetime.** ***Limited Benefit: $10,000 lifetime limit for travel and lodging determined by EBD as reasonable and necessary in conjunction with transplant services.** ***Coverage is provided for transplant services subject to pre-authorization (See Utilization Management Section). Transplant services MUST be provided by approved transplant provides and facilities.**				
VISION SCREENING				
Vision Screening	$50	0%	$50	N
***Limited Benefit: One (1) exam every twenty-four (24) months**				

Certain Limitations Apply - Please check your SPD Exclusions and Limitations section for more information

2018 ASE Schedule of Benefits - Basic

(Active, COBRA & Non-Medicare Retiree)

	IN-NETWORK	OUT-OF-NETWORK	
Annual Deductible - Individual	$6,450	**not covered**	
Annual Coinsurance Limit - Individual	N/A	**not covered**	
Out-of-Pocket Max	$6,450	**not covered**	
Annual Deductible - Family	$12,900	**not covered**	The plan will pay 100 percent for individuals on family coverage when they reach the individual out-of-pocket maximum amount.
Annual Coinsurance Limit - Family	N/A	**not covered**	
Out-of-Pocket Max - Family	$12,900	**not covered**	
Paid By Plan After Satisfaction Of Deductible	100%	**not covered**	

COVERED BENEFITS AND SERVICES	IN-NETWORK COPAYMENT	IN-NETWORK	OUT-OF-NETWORK	APPLIES TO DEDUCTIBLE
ADVANCED IMAGING				
*Advanced Imaging (Radiology Services)	N/A	0%	**not covered**	Y
***Requires pre-certification**				
***Charges will not apply when provided in conjunction with Emergency Room or Inpatient Hospital Services**				
ALLERGY SERVICES				
Services and Specialty Providers (Office Visit, Serum Formulation and Testing)	N/A	0%	**not covered**	Y
Injections	N/A	$0	**not covered**	Y
AMBULANCE SERVICES				
Air Ambulance Transportation	N/A	10%		N
Ground Transportation	N/A	20%		N
***Limited Benefits: $2,000 per member per trip for ground ambulance**				
BEHAVIORAL/MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT SERVICES				
Office Visit	N/A	0%	**not covered**	Y
Psychological Testing	N/A	0%	**not covered**	Y
In-Patient Services	N/A	0%	**not covered**	Y
Outpatient Services (Partial Hospital/Day Treatment)	N/A	0%	**not covered**	Y
Outpatient Services (Intensive Outpatient)	N/A	0%	**not covered**	Y
Residential Treatment	N/A	0%	**not covered**	Y
DENTAL SERVICES				
Repair to Non-Diseases Teeth Due to Accident/Injury	N/A	0%	**not covered**	Y

COVERED BENEFITS AND SERVICES	IN-NETWORK COPAYMENT	IN-NETWORK	OUT-OF-NETWORK	APPLIES TO DEDUCTIBLE
DIABETES MANAGEMENT SERVICE				
Insulin Pump & Supplies	N/A	0%	**not covered**	Y
Glucometers	N/A	0%	**not covered**	Y
Diabetic Self Management Training	N/A	0%	**not covered**	Y
***Lancets and insulin needles for diabetics will be paid 100% by the plan for participants in the Diabetic Management Program** ***Test strips must be purchased at Pharmacy Only.** ***Glucometers - Provided through DME/Medical Benefit**				
DURABLE MEDICAL EQUIPMENT/ENTERAL FEEDING				
DME/Enteral Feeding	N/A	0%	**not covered**	Y
***Coverage is provided for medically necessary durable medical equipment. See exclusions. Not all services require pre-certification and may be reviewed for medical necessity by AHH. Refer to Utilization Management section.**				
HEARING SERVICES				
Hearing Screening	$50	0%	**not covered**	N
***Limited Benefits: One screening every three years**				
Hearing Aid	$0	0%	**not covered**	Y
***Limited Benefits: $1,400 per ear every three years**				
HOME HEALTH SERVICES				
Home Health Services	N/A	0%	**not covered**	Y
HOME INTRAVENOUS DRUGS				
Home Intravenous Drugs and Solutions	N/A	0%	**not covered**	Y
HOSPICE SERVICES				
Hospice Care	N/A	0%	**not covered**	Y
HOSPITAL SERVICES				
In-Patient Services	N/A	0%	**not covered**	Y
Outpatient Services	N/A	0%	**not covered**	Y
Diagnostic Services	N/A	0%	**not covered**	Y
Emergency Room Visit and Observation Services	N/A	0%	**not covered**	Y
Urgent Care Center	N/A	0%	**not covered**	Y
***Visits deemed non-emergency will be treated as hospital services/outpatient.**				

COVERED BENEFITS AND SERVICES	IN-NETWORK COPAYMENT	IN-NETWORK	OUT-OF-NETWORK	APPLIES TO DEDUCTIBLE
MATERNITY AND FAMILY PLANNING SERVICES				
Prenatal and Postnatal Outpatient Care	N/A	0%	**not covered**	Y
Inpatient Maternity Services	N/A	0%	**not covered**	Y
***Hospital length of stay for childbirth: This plan complies with federal law that prohibits restricting benefits for any hospital length of stay in connection with childbirth for the mother and newborn child to less than 48 hours following a normal vaginal delivery or less than 96 hours following a caesarean section delivery**				
Infertility Diagnostic Evaluation: Office Visit	N/A	0%	**not covered**	Y
Infertility Testing	N/A	0%	**not covered**	Y
***Treatment for infertility is not a covered benefit under the ARBenefits Plan. Services related to infertility are covered up to diagnosis. Testing is not covered during or following treatment.**				
PHARMACY BENEFIT - REFER TO RX DRUG COVERAGE SECTION				
Prescription - Generic - Tier I	N/A	0%	N/A	Y
Prescription - Preferred - Tier II	N/A	0%	N/A	Y
Prescription - Non-Preferred - Tier III	N/A	0%	N/A	Y
Prescription Specialty - Tier IV	N/A	0%	N/A	Y
***Excluded drugs, reference price drugs and brand drugs where generic is available does not apply towards the RX Out-of-Pocket Max.**				
PHYSICIAN/SPECIALIST SERVICES				
*Primary Care Physician Office Visit	N/A	0%	**not covered**	Y
*Specialist Office Visit/Specialty Care Services	N/A	0%	**not covered**	Y
*Other Physician Services provided under Outpatient or In-Patient Care**	N/A	0%	**not covered**	Y
***Includes such services as debridement and/or wound dressing changes performed in an outpatient setting with or without direct physician attention**				
Medication	N/A	0%	**not covered**	Y
***This includes injectable, oral and intravenous medications**				
Radiation Therapy	N/A	0%	**not covered**	Y
****See Professional Services under SPD - Summary of Common Services**				
PREVENTATIVE CARE SERVICES				
Physical Exams/Preventative Care	N/A	0%	**not covered**	N
Well Baby/Child Care Visits	N/A	0%	**not covered**	N
Immunizations	N/A	0%	**not covered**	N
PROSTHETIC AND ORTHOTIC DEVICES				
Prosthetic and Orthotic Devices and Services	N/A	0%	**not covered**	Y
REHABILITATION SERVICES (INPATIENT)				
Rehabilitation Services	N/A	0%	**not covered**	Y

COVERED BENEFITS AND SERVICES	IN-NETWORK COPAYMENT	IN-NETWORK	OUT-OF-NETWORK	APPLIES TO DEDUCTIBLE
REHABILITIATION SERVICES (OUTPATIENT) OR OFFICE VISIT				
Chiropractic	N/A	0%	**not covered**	Y
***Limited Benefit: Fifteen (15) visits per member per plan year**				
Physical Therapy	N/A	0%	**not covered**	Y
Occupational Therapy	N/A	0%	**not covered**	Y
Speech Therapy	N/A	0%	**not covered**	Y
SKILLED NURSING FACILITY (SNF) SERVICES				
SNF Services	N/A	0%	**not covered**	Y
TEMPOROMANDIBULAR JOINT (TMJ)/DYSFUNCTION (TMD) SERVICES				
TMJ/TMD	N/A	0%	**not covered**	Y
***Limited Benefit: $1,000 per member per plan year**				
TRANSPLANT SERVICES				
Organ/Bone Marrow Transplant	N/A	0%	**not covered**	Y
***Limited Benefit: Two (2) organ transplants of the same organ per member per lifetime.** ***Limited Benefit: $10,000 lifetime limit for travel and lodging determined by EBD as reasonable and necessary in conjunction with transplant services.** ***Coverage is provided for transplant services subject to pre-authorization (See Utilization Management Section). Transplant services MUST be provided by approved transplant provides and facilities.**				
VISION SCREENING				
Vision Screening	$50	0%	**not covered**	N
***Limited Benefit: One (1) exam every twenty-four (24) months**				

Certain Limitations Apply - Please check your SPD Exclusions and Limitations section for more information

2018 PSE Schedule of Benefits - Premium

(Active, COBRA & Non-Medicare Retiree)

	IN-NETWORK	OUT-OF-NETWORK	
Annual Deductible - Individual	$1,000	$2,000	
Annual Coinsurance/Copay Limit - Individual	$2,500	N/A	
*Medical Out-of-Pocket Max	$3,500	N/A	
Annual Deductible - Family	$2,000	$4,000	The Plan will pay 100 percent for individuals on family coverage if they reach the individual out-of-pocket
Annual Coinsurance/Copay Limit - Family	$5,000	N/A	
*Medical Out-of-Pocket Max - Family	$7,000	N/A	
Paid By Plan After Satisfaction Of Deductible	80%	60%	

***Deductible, coinsurance and copays are included.**

COVERED BENEFITS AND SERVICES	IN-NETWORK COPAYMENT	IN-NETWORK	OUT-OF-NETWORK	APPLIES TO DEDUCTIBLE
ADVANCED IMAGING				
*Advanced Imaging (Radiology Services)	$0	20%	40%	Y
***Requires pre-certification**				
***Charges will not apply when provided in conjunction with Emergency Room or Inpatient Hospital Services**				
ALLERGY SERVICES				
Specialist Office Visit	$50	0%	40%	N
Testing and Serum Formulation	$0	20%	40%	Y
Injections	$0	$0	40%	N
***Formulation of allergy serum requires coinsurance**				
AMBULANCE SERVICES				
Air Ambulance Transportation		10%		N
Ground Transportation		$50 copay		N
***Limited Benefits: $2,000 per member per trip for ground ambulance**				
BEHAVIORAL/MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT SERVICES				
Office Visit	$25	0%	40%	N
Psychological Testing	$35	0%	40%	N
In-Patient Services	$0	20%	40%	Y
Outpatient Services (Partial Hospital/Day Treatment)	$0	20%	40%	Y
Outpatient Services (Intensive Outpatient)	$0	20%	40%	Y
Residential Treatment	$0	20%	40%	Y
DENTAL SERVICES				
Repair to Non-Diseases Teeth Due to Accident/Injury	$0	20%	40%	Y

COVERED BENEFITS AND SERVICES	IN-NETWORK COPAYMENT	IN-NETWORK	OUT-OF-NETWORK	APPLIES TO DEDUCTIBLE
DIABETES MANAGEMENT SERVICE				
Insulin Pump & Supplies	$0	20%	40%	Y
Glucometers	$0	20%	40%	Y
Diabetic Self Management Training	$0	0%	40%	N
***Lancets and insulin needles for diabetics will be paid 100% by the plan for participants in the Diabetic Management Program**				
***Test strips must be purchased at Pharmacy Only.**				
***Glucometers - Provided through DME/Medical Benefit**				
DURABLE MEDICAL EQUIPMENT/ENTERAL FEEDING				
DME/Enteral Feeding	$0	20%	40%	Y
***Coverage is provided for medically necessary durable medical equipment. See exclusions. Not all services require pre-certification and may be reviewed for medical necessity by AHH. Refer to Utilization Management section.**				
HEARING SERVICES				
Hearing Screening	$50	0%	$50	N
***Limited Benefits: One screening every three years**				
Hearing Aid	$0	0%	0%	N
***Limited Benefits: $1,400 per ear every three years**				
HOME HEALTH SERVICES				
Home Health Services	$0	20%	40%	Y
HOME INTRAVENOUS DRUGS				
Home Intravenous Drugs and Solutions	$0	20%	40%	Y
HOSPICE SERVICES				
Hospice Care	$0	20%	40%	Y
HOSPITAL SERVICES				
In-Patient Services	$0	20%	40%	Y
Outpatient Services	$0	20%	40%	Y
Diagnostic Services	$0	20%	40%	Y
Emergency Room Visit and Observation Services	$250	0%	0%	N
***ER copay may be waived. See Summary Plan Description (SPD)**				
Urgent Care Center	$100	0%	0%	N
***Visits deemed non-emergency will be treated as hospital services/outpatient.**				

COVERED BENEFITS AND SERVICES	IN-NETWORK COPAYMENT	IN-NETWORK	OUT-OF-NETWORK	APPLIES TO DEDUCTIBLE
MATERNITY AND FAMILY PLANNING SERVICES				
Prenatal and Postnatal Outpatient Care	$0	20%	40%	Y
Inpatient Maternity Services	$0	20%	40%	Y
***Hospital length of stay for childbirth: This plan complies with federal law that prohibits restricting benefits for any hospital length of stay in connection with childbirth for the mother and newborn child to less than 48 hours following a normal vaginal delivery or less than 96 hours following a caesarean section delivery**				
Infertility Diagnostic Evaluation: Office Visit	$50	0%	40%	N
Infertility Testing	$0	20%	40%	Y
***Treatment for infertility is not a covered benefit under the ARBenefits Plan. Services related to infertility are covered up to diagnosis. Testing is not covered during or following treatment.**				
PHARMACY BENEFIT - REFER TO RX DRUG COVERAGE SECTION				
Prescription - Generic - Tier I	$15			
Prescription - Preferred - Tier II	$40			
Prescription - Non-Preferred - Tier III	$80			
Prescription Specialty - Tier IV	$100			
*RX Out-of-Pocket Max (Individual/Family)	$3100/$6200			
***Excluded drugs, reference price drugs and brand drugs where generic is available does not apply towards the RX Out-of-Pocket Max.**				
PHYSICIAN/SPECIALIST SERVICES				
*Primary Care Physician Office Visit	$25	$0	40%	N
*Specialist Office Visit/Specialty Care Services	$50	$0	40%	N
*Other Physician Services provided under Outpatient or In-Patient Care**	$0	20%	40%	Y
***Includes such services as debridement and/or wound dressing changes performed in an outpatient setting with or without direct physician attention**				
*Medication	$0	20%	40%	Y
***This includes injectable, oral and intravenous medications**				
Radiation Therapy	$0	20%	40%	Y
****See Professional Services under SPD - Summary of Common Services**				
PREVENTATIVE CARE SERVICES				
Physical Exams/Preventative Care	$0	0%	40%	N
Well Baby/Child Care Visits	$0	0%	40%	N
Immunizations	$0	0%	0%	N
PROSTHETIC AND ORTHOTIC DEVICES				
Prosthetic and Orthotic Devices and Services	$0	20%	40%	Y
REHABILITATION SERVICES (INPATIENT)				
Rehabilitation Services	$0	20%	40%	Y

COVERED BENEFITS AND SERVICES	IN-NETWORK COPAYMENT	IN-NETWORK	OUT-OF-NETWORK	APPLIES TO DEDUCTIBLE
REHABILITIATION SERVICES (OUTPATIENT) OR OFFICE VISIT				
Chiropractic	$25	0%	40%	N
***Limited Benefit: Fifteen (15) visits per member per plan year**				
Physical Therapy	$25	0%	40%	N
Occupational Therapy	$25	0%	40%	N
Speech Therapy	$25	0%	40%	N
***Therapy services billed by or provided by a Specialist MD will have the Specialist Copay ($50)**				
SKILLED NURSING FACILITY (SNF) SERVICES				
SNF Services	$0	20%	40%	Y
TEMPOROMANDIBULAR JOINT (TMJ)/DYSFUNCTION (TMD) SERVICES				
TMJ/TMD	$0	20%	40%	Y
***Limited Benefit: $1,000 per member per plan year**				
TRANSPLANT SERVICES				
Organ/Bone Marrow Transplant	$250	20%	Not Covered	N
***Copayment is applied to the Professional Services of the transplant provider *Limited Benefit: Two (2) organ transplants of the same organ per member per lifetime. *Limited Benefit: $10,000 lifetime limit for travel and lodging determined by EBD as reasonable and necessary in conjunction with transplant services. *Coverage is provided for transplant services subject to pre-authorization (See Utilization Management Section). Transplant services MUST be provided by approved transplant providers and facilities.**				
VISION SCREENING				
Vision Screening	$50	0%	$50	N
***Limited Benefit: One (1) exam every twenty-four (24) months**				

Certain Limitations Apply - Please check your SPD Exclusions and Limitations section for more information

2018 PSE Schedule of Benefits - Classic

(Active, COBRA & Non-Medicare Retiree)

	IN-NETWORK	OUT-OF-NETWORK	
Annual Deductible - Individual	$2,000	$3,000	
Annual Coinsurance Limit - Individual	$4,450	N/A	
*Out-of-Pocket Max	$6,450	N/A	
Annual Deductible - Family	$2,700 / $3,000	$6,000	The Plan will pay 100 percent for individuals on family coverage if they reach the individual out-of-pocket maximum amount.
Annual Coinsurance Limit - Family	$6,675	N/A	
*Out-of-Pocket Max - Family	$9,675	N/A	
Paid By Plan After Satisfaction Of Deductible	80%	60%	
***Deductible, coinsurance and copays are included.**			

COVERED BENEFITS AND SERVICES	IN-NETWORK COPAYMENT	IN-NETWORK	OUT-OF-NETWORK	APPLIES TO DEDUCTIBLE
ADVANCED IMAGING				
*Advanced Imaging (Radiology Services)	N/A	20%	40%	Y
***Requires pre-certification**				
***Charges will not apply when provided in conjunction with Emergency Room or Inpatient Hospital Services**				
ALLERGY SERVICES				
Services and Specialty Providers (Office Visit, Serum Formulation and Testing)	N/A	20%	40%	Y
Injections	N/A	$0	40%	Y
AMBULANCE SERVICES				
Air Ambulance Transportation	N/A	10%		N
Ground Transportation	N/A	20%		N
***Limited Benefits: $2,000 per member per trip for ground ambulance**				
BEHAVIORAL/MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT SERVICES				
Office Visit	N/A	20%	40%	Y
Psychological Testing	N/A	20%	40%	Y
In-Patient Services	N/A	20%	40%	Y
Outpatient Services (Partial Hospital/Day Treatment)	N/A	20%	40%	Y
Outpatient Services (Intensive Outpatient)	N/A	20%	40%	Y
Residential Treatment	N/A	20%	40%	Y
DENTAL SERVICES				
Repair to Non-Diseases Teeth Due to Accident/Injury	N/A	20%	40%	Y

COVERED BENEFITS AND SERVICES	IN-NETWORK COPAYMENT	IN-NETWORK	OUT-OF-NETWORK	APPLIES TO DEDUCTIBLE
DIABETES MANAGEMENT SERVICE				
Insulin Pump & Supplies	N/A	20%	40%	Y
Glucometers	N/A	20%	40%	Y
Diabetic Self Management Training	N/A	20%	40%	Y
***Lancets and insulin needles for diabetics will be paid 100% by the plan for participants in the Diabetic Management Program** ***Test strips must be purchased at Pharmacy Only.** ***Glucometers - Provided through DME/Medical Benefit**				
DURABLE MEDICAL EQUIPMENT/ENTERAL FEEDING				
DME/Enteral Feeding	N/A	20%	40%	Y
***Coverage is provided for medically necessary durable medical equipment. See exclusions. Not all services require pre-certification and may be reviewed for medical necessity by AHH. Refer to Utilization Management section.**				
HEARING SERVICES				
Hearing Screening	$50	0%	$50	N
***Limited Benefits: One screening every three years**				
Hearing Aid	$0	20%	40%	Y
***Limited Benefits: $1,400 per ear every three years**				
HOME HEALTH SERVICES				
Home Health Services	N/A	20%	40%	Y
HOME INTRAVENOUS DRUGS				
Home Intravenous Drugs and Solutions	N/A	20%	40%	Y
HOSPICE SERVICES				
Hospice Care	N/A	20%	40%	Y
HOSPITAL SERVICES				
In-Patient Services	N/A	20%	40%	Y
Outpatient Services	N/A	20%	40%	Y
Diagnostic Services	N/A	20%	40%	Y
Emergency Room Visit and Observation Services	N/A	20%	40%	Y
Urgent Care Center	N/A	20%	40%	Y
***Visits deemed non-emergency will be treated as hospital services/outpatient.**				

COVERED BENEFITS AND SERVICES	IN-NETWORK COPAYMENT	IN-NETWORK	OUT-OF-NETWORK	APPLIES TO DEDUCTIBLE
MATERNITY AND FAMILY PLANNING SERVICES				
Prenatal and Postnatal Outpatient Care	N/A	20%	40%	Y
Inpatient Maternity Services	N/A	20%	40%	Y
***Hospital length of stay for childbirth: This plan complies with federal law that prohibits restricting benefits for any hospital length of stay in connection with childbirth for the mother and newborn child to less than 48 hours following a normal vaginal delivery or less than 96 hours following a caesarean section delivery**				
Infertility Diagnostic Evaluation: Office Visit	N/A	20%	40%	Y
Infertility Testing	N/A	20%	40%	Y
***Treatment for infertility is not a covered benefit under the ARBenefits Plan. Services related to infertility are covered up to diagnosis. Testing is not covered during or following treatment.**				
PHARMACY BENEFIT - REFER TO RX DRUG COVERAGE SECTION				
Prescription - Generic - Tier I	N/A	20%	N/A	Y
Prescription - Preferred - Tier II	N/A	20%	N/A	Y
Prescription - Non-Preferred - Tier III	N/A	20%	N/A	Y
Prescription Specialty - Tier IV	N/A	20%	N/A	Y
***Excluded drugs, reference price drugs and brand drugs where generic is available does not apply towards the RX Out-of-Pocket Max.**				
PHYSICIAN/SPECIALIST SERVICES				
*Primary Care Physician Office Visit	N/A	20%	40%	Y
*Specialist Office Visit/Specialty Care Services	N/A	20%	40%	Y
*Other Physician Services provided under Outpatient or In-Patient Care**	N/A	20%	40%	Y
***Includes such services as debridement and/or wound dressing changes performed in an outpatient setting with or without direct physician attention**				
Medication	N/A	20%	40%	Y
***This includes injectable, oral and intravenous medications**				
Radiation Therapy	N/A	20%	40%	Y
****See Professional Services under SPD - Summary of Common Services**				
PREVENTATIVE CARE SERVICES				
Physical Exams/Preventative Care	N/A	0%	40%	N
Well Baby/Child Care Visits	N/A	0%	40%	N
*Immunizations	N/A	0%	0%	N
PROSTHETIC AND ORTHOTIC DEVICES				
Prosthetic and Orthotic Devices and Services	N/A	20%	40%	Y
REHABILITATION SERVICES (INPATIENT)				
Rehabilitation Services	N/A	20%	40%	Y

COVERED BENEFITS AND SERVICES	IN-NETWORK COPAYMENT	IN-NETWORK	OUT-OF-NETWORK	APPLIES TO DEDUCTIBLE
REHABILITIATION SERVICES (OUTPATIENT) OR OFFICE VISIT				
Chiropractic	N/A	20%	40%	Y
***Limited Benefit: Fifteen (15) visits per member per plan year**				
Physical Therapy	N/A	20%	40%	Y
Occupational Therapy	N/A	20%	40%	Y
Speech Therapy	N/A	20%	40%	Y
SKILLED NURSING FACILITY (SNF) SERVICES				
SNF Services	N/A	20%	40%	Y
TEMPOROMANDIBULAR JOINT (TMJ)/DYSFUNCTION (TMD) SERVICES				
TMJ/TMD	N/A	20%	40%	Y
***Limited Benefit: $1,000 per member per plan year**				
TRANSPLANT SERVICES				
Organ/Bone Marrow Transplant	N/A	20%	Not Covered	Y
***Limited Benefit: Two (2) organ transplants of the same organ per member per lifetime.** ***Limited Benefit: $10,000 lifetime limit for travel and lodging determined by EBD as reasonable and necessary in conjunction with transplant services.** ***Coverage is provided for transplant services subject to pre-authorization (See Utilization Management Section). Transplant services MUST be provided by approved transplant provides and facilities.**				
VISION SCREENING				
Vision Screening	$50	0%	$50	N
***Limited Benefit: One (1) exam every twenty-four (24) months**				

Certain Limitations Apply - Please check your SPD Exclusions and Limitations section for more information

2018 PSE Schedule of Benefits - Basic

(Active, COBRA & Non-Medicare Retiree)

	IN-NETWORK	OUT-OF-NETWORK	
Annual Deductible - Individual	$4,250	**not covered**	
Annual Coinsurance Limit - Individual	$2,200	**not covered**	
*Out-of-Pocket Max	$6,450	**not covered**	
Annual Deductible - Family	$8,500	**not covered**	The plan will pay 100 percent for individuals on family coverage if they reach the individual out-of-pocket amount.
Annual Coinsurance Limit - Family	$4,400	**not covered**	
*Out-of-Pocket Max - Family	$12,900	**not covered**	
Paid By Plan After Satisfaction Of Deductible	80%	**not covered**	

***Deductible, coinsurance and copays are included.**

COVERED BENEFITS AND SERVICES	IN-NETWORK COPAYMENT	IN-NETWORK	OUT-OF-NETWORK	APPLIES TO DEDUCTIBLE
ADVANCED IMAGING				
*Advanced Imaging (Radiology Services)	N/A	20%	**not covered**	Y
***Requires pre-certification**				
***Charges will not apply when provided in conjunction with Emergency Room or Inpatient Hospital Services**				
ALLERGY SERVICES				
Services and Specialty Providers (Office Visit, Serum Formulation and Testing)	N/A	20%	**not covered**	Y
Injections	N/A	$0	**not covered**	Y
AMBULANCE SERVICES				
Air Ambulance Transportation	N/A	10%		N
Ground Transportation	N/A	20%		N
***Limited Benefits: $2,000 per member per trip for ground ambulance**				
BEHAVIORAL/MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT SERVICES				
Office Visit	N/A	20%	**not covered**	Y
Psychological Testing	N/A	20%	**not covered**	Y
In-Patient Services	N/A	20%	**not covered**	Y
Outpatient Services (Partial Hospital/Day Treatment)	N/A	20%	**not covered**	Y
Outpatient Services (Intensive Outpatient)	N/A	20%	**not covered**	Y
Residential Treatment	N/A	20%	**not covered**	Y
DENTAL SERVICES				
Repair to Non-Diseases Teeth Due to Accident/Injury	N/A	20%	**not covered**	Y

COVERED BENEFITS AND SERVICES	IN-NETWORK COPAYMENT	IN-NETWORK	OUT-OF-NETWORK	APPLIES TO DEDUCTIBLE
DIABETES MANAGEMENT SERVICE				
Insulin Pump & Supplies	N/A	20%	**not covered**	Y
Glucometers	N/A	20%	**not covered**	Y
Diabetic Self Management Training	N/A	20%	**not covered**	Y
***Lancets and insulin needles for diabetics will be paid 100% by the plan for participants in the Diabetic Management Program** ***Test strips must be purchased at Pharmacy Only.** ***Glucometers - Provided through DME/Medical Benefit**				
DURABLE MEDICAL EQUIPMENT/ENTERAL FEEDING				
DME/Enteral Feeding	N/A	20%	**not covered**	Y
***Coverage is provided for medically necessary durable medical equipment. See exclusions. Not all services require pre-certification and may be reviewed for medical necessity by AHH. Refer to Utilization Management section.**				
HEARING SERVICES				
Hearing Screening	$50	0%	**not covered**	N
***Limited Benefits: One screening every three years**				
Hearing Aid	$0	20%	**not covered**	Y
***Limited Benefits: $1,400 per ear every three years**				
HOME HEALTH SERVICES				
Home Health Services	N/A	20%	**not covered**	Y
HOME INTRAVENOUS DRUGS				
Home Intravenous Drugs and Solutions	N/A	20%	**not covered**	Y
HOSPICE SERVICES				
Hospice Care	N/A	20%	**not covered**	Y
HOSPITAL SERVICES				
In-Patient Services	N/A	20%	**not covered**	Y
Outpatient Services	N/A	20%	**not covered**	Y
Diagnostic Services	N/A	20%	**not covered**	Y
Emergency Room Visit and Observation Services	N/A	20%	**not covered**	Y
Urgent Care Center	N/A	20%	**not covered**	Y
***Visits deemed non-emergency will be treated as hospital services/outpatient.**				

COVERED BENEFITS AND SERVICES	IN-NETWORK COPAYMENT	IN-NETWORK	OUT-OF-NETWORK	APPLIES TO DEDUCTIBLE
MATERNITY AND FAMILY PLANNING SERVICES				
Prenatal and Postnatal Outpatient Care	N/A	20%	**not covered**	Y
Inpatient Maternity Services	N/A	20%	**not covered**	Y
***Hospital length of stay for childbirth: This plan complies with federal law that prohibits restricting benefits for any hospital length of stay in connection with childbirth for the mother and newborn child to less than 48 hours following a normal vaginal delivery or less than 96 hours following a caesarean section delivery**				
Infertility Diagnostic Evaluation: Office Visit	N/A	20%	**not covered**	Y
Infertility Testing	N/A	20%	**not covered**	Y
***Treatment for infertility is not a covered benefit under the ARBenefits Plan. Services related to infertility are covered up to diagnosis. Testing is not covered during or following treatment.**				
PHARMACY BENEFIT - REFER TO RX DRUG COVERAGE SECTION				
Prescription - Generic - Tier I	N/A	20%	N/A	Y
Prescription - Preferred - Tier II	N/A	20%	N/A	Y
Prescription - Non-Preferred - Tier III	N/A	20%	N/A	Y
Prescription Specialty - Tier IV	N/A	20%	N/A	Y
***Excluded drugs, reference price drugs and brand drugs where generic is available does not apply towards the RX Out-of-Pocket Max.**				
PHYSICIAN/SPECIALIST SERVICES				
*Primary Care Physician Office Visit	N/A	20%	**not covered**	Y
*Specialist Office Visit/Specialty Care Services	N/A	20%	**not covered**	Y
*Other Physician Services provided under Outpatient or In-Patient Care**	N/A	20%	**not covered**	Y
***Includes such services as debridement and/or wound dressing changes performed in an outpatient setting with or without direct physician attention**				
Medication	N/A	20%	**not covered**	Y
***This includes injectable, oral and intravenous medications**				
Radiation Therapy	N/A	20%	**not covered**	Y
****See Professional Services under SPD - Summary of Common Services**				
PREVENTATIVE CARE SERVICES				
Physical Exams/Preventative Care	N/A	0%	**not covered**	N
Well Baby/Child Care Visits	N/A	0%	**not covered**	N
Immunizations	N/A	0%	**not covered**	N
PROSTHETIC AND ORTHOTIC DEVICES				
Prosthetic and Orthotic Devices and Services	N/A	20%	**not covered**	Y
REHABILITATION SERVICES (INPATIENT)				
Rehabilitation Services	N/A	20%	**not covered**	Y

COVERED BENEFITS AND SERVICES	IN-NETWORK COPAYMENT	IN-NETWORK	OUT-OF-NETWORK	APPLIES TO DEDUCTIBLE
REHABILITIATION SERVICES (OUTPATIENT) OR OFFICE VISIT				
Chiropractic	N/A	20%	**not covered**	Y
***Limited Benefit: Fifteen (15) visits per member per plan year**				
Physical Therapy	N/A	20%	**not covered**	Y
Occupational Therapy	N/A	20%	**not covered**	Y
Speech Therapy	N/A	20%	**not covered**	Y
SKILLED NURSING FACILITY (SNF) SERVICES				
SNF Services	N/A	20%	**not covered**	Y
TEMPOROMANDIBULAR JOINT (TMJ)/DYSFUNCTION (TMD) SERVICES				
TMJ/TMD	N/A	20%	**not covered**	Y
***Limited Benefit: $1,000 per member per plan year**				
TRANSPLANT SERVICES				
Organ/Bone Marrow Transplant	N/A	20%	**not covered**	Y
***Limited Benefit: Two (2) organ transplants of the same organ per member per lifetime.** ***Limited Benefit: $10,000 lifetime limit for travel and lodging determined by EBD as reasonable and necessary in conjunction with transplant services.** ***Coverage is provided for transplant services subject to pre-authorization (See Utilization Management Section). Transplant services MUST be provided by approved transplant provides and facilities.**				
VISION SCREENING				
Vision Screening	$50	0%	**not covered**	N
***Limited Benefit: One (1) exam every twenty-four (24) months**				

Certain Limitations Apply - Please check your SPD Exclusions and Limitations section for more information

Prescription Drug Coverage

A Prescription Drug Program covers most members of the Plan with the exception being the Public School Medicare-Primary Retirees. Coverage under the Prescription Drug Program is not available without participation in the medical plan, meaning that a member cannot elect to have coverage for his/her prescription drugs as a stand-alone plan.

The Prescription Drug Program covers a wide selection of medications, but not all prescription drugs available in the United States are covered. The Plan uses an established Formulary of covered drugs and, in most cases, has the drugs classified into one of six tiers. Medications that are not on the formulary are not covered by the Plan and any cost associated with the drug would be the responsibility of the member.

- Tier I Generic
- Tier II Formulary Brand (Preferred)
- Tier III Non-Formulary Brand (Non-Preferred)
- Tier IV Specialty
- Reference Pricing
- Brand to Generic Incentive

Note: See section, “How much will my prescription cost?”

Who coordinates the prescription drug program?

EBD has a contract with an outside third-party company who serves as the PBM (Pharmacy Benefit Manager) for the Plan. The PBM has the responsibility to contract with pharmacies, negotiate discounts, and work with EBD to create a quality benefit program for the membership.

What types of prescription drugs and supplies are covered?

- Drugs prescribed by a physician that require a prescription under federal law, and are purchased in the United States at an in-network pharmacy, unless otherwise excluded from the plan
- Diabetic supplies such as lancets and test strips when prescribed by a physician.

Are there any limitations on the covered drugs?

Benefits for any one prescription may be limited to:

- Quantity limits established by the Plan
- Refills only up to the time specified by a physician
- Refills up to one year from the date of order by a physician
- Reference based pricing on certain medications instead of a flat co-pay (indicated as RP on the PDL)
- Prior authorization review on certain medications
- Step therapy guidelines established by the plan

How much will my prescription drugs cost?

The cost of a prescription at an in-network pharmacy will depend on a variety of issues, such as your plan option, the tier of the medication, and how much of your deductible has been met, if applicable.

If you are a member of the ARBenefits or ARBenefits Retiree plans (excluding the Public School Medicare-Primary Retirees), the cost of most covered prescription drugs will be tied to a co-payment based on the tier to which the drug has been assigned. The co-pay amounts are shown in the Schedule of Benefits. The co-pay is the maximum cost that a member will pay for a drug in a particular tier although the member will pay less if the drug price is lower than the fixed co-pay. Some medications are not assigned to a co-payment tier, but are priced at a fixed rate per pill. Your cost for a prescription with this pricing method varies greatly depending on the prescription and pharmacy. Prescriptions that are priced at a fixed rate per pill are indicated on the Preferred Drug List (PDL) with an (RP) for reference pricing.

If you are a member of the ARBenefits HD Classic or Basic plans, you will be responsible for the total cost of the prescription (after any applicable network discount) until you have satisfied your deductible. After the deductible has been met, you will be responsible for a portion of the cost as a co-insurance up to the point when your maximum out-of-pocket annual co-insurance limit has been reached. When the annual co-insurance limit has been reached, the Plan will cover 100% of the cost of all covered medications. Medications listed as reference priced are considered non-covered on the Classic and Basic plans and will not apply to the deductible, annual coinsurance, or out of pocket limits. In addition, medications listed as reference priced will not apply to the annual out-of-pocket limits for members enrolled in the Premium or Primary plans. Please note: the ASE Basic plan does not have an annual coinsurance limit. The deductible is equal to the out-of-pocket amount. The plan will pay 100% once this amount has been reached.

What is the Brand Generic Program?

Currently, brand-name medications that are available in the generic form are covered with a brand copayment. Choosing to fill a brand-name drug that is available in an equivalent generic form will require a tiered copayment **PLUS** the difference in the cost between the generic and equivalent brand-name drug. (Please note brand name drugs with equivalent generics available will be non-covered on the Classic and Basic plans, and will not apply to the annual out-of-pocket limits on the Premium and Primary plans.)

If there is a clinically based reason your physician will not prescribe a generic medication for you, he/she can contact EBRx at (866) 564-8258 to inquire about an override.

Example: Drug B is a brand drug and cost $150. Drug B has a generic drug available and it cost $30. For a one-month supply, the cost would be as follows.

Benefit example prior to 9/1/2012

Generic Drug Cost	$30	Non-Preferred Brand Drug Cost	$ 150
Member Copay	-$10	Member Copay	-$ 60

Plan Cost	$20	Plan Cost	$ 90

Effective 9/1/2012

Generic Drug Cost	$30	Non-Preferred Brand Drug Cost	$150
Member Copay	-$10	Plan Cost	-$ 20
Plan Cost	$20	Member Cost	$ 130

If there is a clinically based reason your physician will not prescribe a generic medication for you, he/she can contact EBRx at (866) 564-8258 to inquire about an override.

How is a prescription filled at an Out-of-Network pharmacy?

If a prescription is filled at an out-of-network pharmacy, the member will be responsible for 100% of the cost of the drug when the medication is dispensed. The plan does not allow coverage for out-of-network pharmacies. Confirmation of participating pharmacies may be obtained by calling the number on your ARBenefits card and pressing 1 for assistance.

How are prescription drugs assigned to a Tier?

As new medications receive FDA approval and are released to the open market, they are excluded from coverage until the Arkansas State and Public School's Drug Utilization Evaluation Committee (DUEC) and the Prescription Benefit Consultant (University of Arkansas for Medical Sciences, College of Pharmacy) reviews them. Their recommendations are then taken to the State and Public School Life & Health Insurance Board (the Board) for a determination, which is in the best interest of our group as a whole.

When a covered, formulary preferred brand name drug becomes available in a generic alternative, the new generic will be placed at the same Tier as the brand and the brand will be subject to the brand/generic pricing incentive.

How do I find out, which drugs are in which Tier?

We publish a Preferred Drug List (PDL) that contains many of the more commonly prescribed medications and classifies the drugs into co-payment tiers. (See heading "Does the Plan have any special programs, limitations, or restrictions?" for additional information.) The PDL is available on the central web site of the Plan at www.ARBenefits.org, and is updated as needed.

If your medication is not listed on the PDL, you can obtain coverage information by calling the number on your ARBenefits card and pressing "1" for assistance. Alternatively, you may log in to the ARBenefits member portal (www.ARBenefits.org), click on "Member Links", then "Personal Pharmacy Records" under the heading "Internal Links". The prescription drug benefit member portal will open. Coverage for medications can be found by clicking on "Drug Price Check" and then typing in the name of the drug.

What are my options for purchasing medication under the Plan?

The Prescription Drug Program offers two convenient and cost effective ways to purchase prescription medications. The combined medical/prescription drug card may be used to obtain

prescription medications at a discounted cost from a participating retail pharmacy. The Mail Order Prescription Drug Program does not offer additional cost savings on medications; however, does provide a member with the convenience of receiving up to a 3-month supply of medications at their doorstep, paying one (1) co-pay for each month's supply. The Mail Order Program is limited to medications that are required on a long term or maintenance basis. Contact ARBenefits for information regarding prescriptions that can be filled through the Mail Order Program. Please note specialty medications are limited to a one month supply through all distribution services.

How do I use the Retail Prescription Drug Card Program?

Drugs that are prescribed for short-term use should be filled from a network pharmacy using your combined medical and pharmacy identification card. The network includes most pharmacies in Arkansas and pharmacies nationwide. Most chain stores participate in this network, as well as many independent pharmacies across the nation. Confirmation of participating pharmacies may be obtained by calling ARBenefits.

Most retail prescriptions are limited to a 31-day supply. Prescriptions are dispensed according to the instructions of the prescribing physician. If the medical condition is such that the prescription drug is to be taken over a prolonged period of time, (months or even years), you may be able to receive up to a 93-day supply. Contact ARBenefits to verify if your medication will be covered for a 93-day supply at a retail pharmacy or the mail order prescription drug program. (Examples of medications not covered for more than a 31-day supply include antidepressants, proton pump inhibitors, stimulants including those for ADHD, sleep aides, and non-steroidal anti-inflammatory agents.)

How do I use the Pharmacy Mail Order Program?

The mail order prescription program is designed to assist individuals who take the same medication for a long period of time for conditions such as diabetes, high blood pressure, heart, or thyroid conditions. You will need to obtain two (2) 31-day supplies of medication or two fills at a network retail pharmacy before the mail order program can be utilized. This helps to ensure that prescriptions are appropriate for the duration of therapy. If medication is still required after the two (2) 31-day supplies or two (2) fills, you may ask your physician for a prescription for up to a 93-day supply, if appropriate. The mail order program allows you to obtain a 93-day supply of certain medications at one time for three (3) months co-payments.

You may use the mail order option by calling the PBM's mail order provider at 1-855-873-8739.

Each mail order prescription is limited to a maximum quantity limit of a 93-day supply. Pharmacies are required by law to dispense the prescription in the exact quantity specified by the physician. Therefore, if the quantity prescribed is for less than 93 days per refill, the mail order pharmacy will fill the exact quantity written by the physician. **Please be aware that not all medications are available through the mail order program. Contact ARBenefits to verify that your prescription is covered through mail order.**

Why does the Plan encourage generic drugs?

A generic drug is identical in chemical composition to its brand name counterpart, has been approved by the Food and Drug Administration (FDA) to be therapeutically equivalent, and is as effective as the brand name product. The use of generics performs a vital role in controlling the cost of prescription drugs for both the participant and the Plan.

Who do I contact for drug information?

If your physician or pharmacist is unable to answer your drug information questions, you can call the Arkansas Drug Information Center, a service provided by the UAMS College of Pharmacy at 1-888-228-1233.

What about prescriptions for weight loss or smoking cessation?

If participating in the Tobacco Cessation Program, you can receive nicotine replacement patches, the medications bupropion (generic for Zyban), or Chantix at no cost if enrolled and approved by the smoking cessation program. Coverage for bupropion and Chantix is available to members who do not wish to participate in the program; however, standard tier co-payments will apply. To enroll in the program, you may call EBD Member Services at 1-877-815-1017. The PDL reflects which tier each medication falls under. Weight loss medications are not a covered benefit.

Does the Plan have any special programs, limitations, or restrictions?

The Pharmacy Benefits Manager for the Plan has several cost saving initiatives in place designed to assist our prescription drug program in delivering the best possible healthcare at the most reasonable cost. The programs described below are Prior Authorization, Quantity Limits, Daily Dose Edits, Step Therapy, Reference Pricing, and New Generics. Medications listed on the PDL are marked with the abbreviations PA, QL, ST, RP, or NG when applicable.

Prior Authorization (PA)

The Prior Authorization program helps to ensure the appropriate usage of certain medications by applying FDA approved indications and the manufacturer's guidelines to the utilization of certain medications. The DUEC, Pharmacy Benefits Manager, and pharmacy benefits consultant, (University of Arkansas for Medical Sciences College of Pharmacy), have identified the medications that have a high potential for serious side effects, high costs, or high abuse potential.

The following steps should be taken in order to obtain a Prior Authorization:

- Your **physician** may contact EBRx (Evidence Based Prescription drug call center at the UAMS College of Pharmacy) by calling 1-866-564-8258 to discuss prescription drugs that require prior authorization.
- A team of pharmacists is available to evaluate the information provided by your physician. Forms are not faxed to your physician's office, as all reviews are handled over the phone.

- Once the prior authorization clinical guidelines are met, your prior authorization will be approved and entered into the system.
- If the clinical guidelines are not met, your physician will be notified during the phone call.
- If the prior authorization is denied, you can still obtain your medication; however, you will be financially responsible for the full cost of the prescription.

- Your **physician** may appeal the denial by sending documentation to:

EBRx Medical Director
Attn: AR EBD APPEAL
4301 W. Markham, Slot 522-9
Little Rock, AR 72205

Quantity Limits (QL)

The QL program is intended to clarify the usual quantity that constitutes a 31-day supply for particular medications. The quantities allowed per each fill are based upon the dosing recommendations made by the manufacturer. To get access to this list of medications, you can call ARBenefits. In addition, these items are indicated on the Preferred Drug List with a (QL). (Note: Some medications, such as opioids for pain control, may have limits in place that allow for smaller quantities to be filled for a shorter time period than 31 days.)

Daily Dosing Edits

Daily Dose Edits are designed to notify members when they are taking lower strength medications multiple times a day when higher strengths are available.

Step Therapy (ST)

Step therapy is a program designed for people who take prescription drugs used to treat certain ongoing medical conditions. The step therapy program is designed with safety, cost, and most importantly, your health in mind. It allows you and your family to receive the affordable treatment you need and helps the Plan contain the rising cost of prescription drug coverage.

Prescription drugs that are placed under the step therapy program generally require you to have failed therapy with one drug before coverage for another drug will be given, unless your physician has a compelling reason you should not first try one of the other drugs.

To find out which medications are included in the Step Therapy program, contact ARBenefits. These products are also indicated on the Preferred Drug List with (ST).

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.

ATTACHMENT C

Employee Benefits Division

System Confidentiality Agreement

I, the undersigned, reviewed and understand the following statements:

- All groups, employee, member, and any other protected health information (PHI) are considered confidential and should not be used for purposes other than its intended use.
- I have an ethical and legal obligation to protect confidential and PHI information used or obtained in the course of performing duties and understand that all the policies on confidentiality apply equally to data stored on the computer and on paper records.
- Authorization to disclose information is made only by managers and only on a need to know basis as part of an Employee Benefits Division (EBD) deliverable.
- Media contacts concerning any EBD software or other projects must be referred to the EBD Communications office or the Executive Director.
- Vendors and Contractors are responsible for and are held accountable for communicating EBD's confidentiality policy to their staff.
- Unauthorized use of or access to, confidential information or PHI may result in discipline up to and including termination of contracts. Violation of confidentiality or PHI may also create civil or criminal liability.

Computer Access Confidentiality Agreement

I, the undersigned, acknowledge that in the course of my work at EBD or with personnel located at EBD, I will be privileged to information confidential to EBD or to an individual employee or Group. I acknowledge receipt of my User ID to the EBD Network and Systems and understand the following:

- My User ID and password (s) (network and application systems) will be used as personal identification for purposes of data access in the same manner as my signature is used for identification.
- I will not disclose my User ID or password to anyone.
- I will never attempt to learn another person's User ID or password.
- I will not attempt to access information on the EBD network except to meet needs specific t my job/position.
- I will not divulge any knowledge that I gain, with regards to EBD computer or network security.
- If I discover any breach of confidentiality, or unauthorized access I will notify my manager, who will notify EBD immediately.
- I understand that my social security number and date of birth are required fields for system access and will be held to the highest levels of confidentiality/security per Public Law 104-191.

Monitoring Access to Confidential Data

Department of Finance and Administration departments, which support computer information systems, will monitor use of the systems and will report access or confidentiality violations immediately to the Technical Operations Manager, Privacy Security Officer, and to the Executive Director of EBD. All staff and employees are responsible for immediately reporting any apparent violations of this confidentiality policy to their Managers for action.

I, the undersigned, further understand and agree that the consequences of a violation of the above statements may result in disciplinary action up to and including termination of the relationship as well as possible civil or criminal liability.

Print Name: _____ SSN#:_____

Signature: _____ Date of Birth: _____

Organization/Coop Affiliation: _____Group #: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Manager's Signature: _____ Date: _____

EBD Use Only

EBD Privacy/Security Signature: _____ Date: _____

Attachment D – Performance Standards

Criteria	Standard	Damages
Enrollment	Contractor correctly processes enrollment additions, changes, and deletions within three (3) Business Days of receipt.	$50 per day for each day past three (3) Business Days of receipt by the Contractor when any enrollment addition, change, or deletion is not correctly made. Contractor will credit damages payment to monthly invoice to which the damages applied.
	Contractor coordinates with and receives EBD approval for all Member communications and education/enrollment material.	5% of monthly invoice fee for each instance during the respective month that the Contractor fails to coordinate with and receive approval from EBD for Member communications and education/enrollment material. Contractor will credit the damages payment to the monthly invoice for which the damages apply.
Administration	The Contractor correctly credits Member's ARCap and HSA Accounts.	5% of monthly invoice amount for any month whereby greater than 5% of Member accounts are incorrectly credited. Contractor will credit damages payment to the monthly invoice for which the damages apply.
	Contractor processes and submits payment to Member for all valid faxed, mailed, and online submitted claims within three (3) Business Days of receipt of claim by the Contractor.	$100 per occurrence for each valid claim the Contractor fails to process and remit payment for within three (3) Business Days of receipt of claim by the Contractor. Contractor will credit damages payment to the monthly invoice for which the damages apply.
	The Contractor submits a comprehensive and compliant Plan Document to EBD for approval at the following times during the life of the contract: • 30 calendar days prior to the start of each new Plan Year • 30 calendar days prior to the date of any Plan or Program change that necessitates a Plan Document amendment or edited restatement becomes effective	$100 per day for each day past the deadline to submit Plan Document to EBD. Contractor will credit the damages payment to the first monthly invoice submitted after the submission of the Plan Document to EBD.

	• During the Implementation Period if the Implementation Period occurs at a time that is not in line with the new Plan Year.	
	Contractor correctly pays 98% of Program claims and screens all Program claims to prevent payment duplication.	5% of the aggregated quarterly invoice total applicable to the quarter during which less than 98% of claims payments were correctly paid. Contractor will credit the damages payment to the applicable quarterly invoice.
Compliance, Privacy, and Security	Contractor maintains compliance of all Programs with applicable State and Federal laws during each quarter during the life of the contract.	5% of the aggregated quarterly invoice total applicable to the quarter during which compliance was not maintained
	Contractor masks Member's SSN from any printed report, letter, and other communication.	1% of monthly invoice total for any instance during the respective month when a Member's SSN is not masked from any printed report, letter, and other communication.
	Contractor notifies EBD within two (2) calendar days via secure email of any security breaches or suspected security breaches.	$1000 per occurrence for Contractor's failure to notify EBD within two (2) calendar days via secure email of any security breach or suspected security breach.
Implementation	All implementation activities are successfully completed by the Contractor and approved by EBD on or before the Administrative Services Start Date as stated in the RFP or other Administrative Services Start Date as determined by EBD	1% of total Implementation Fee for each day past the Administrative Services Start Date (as stated in the RFP or other Administrative Services Start Date as determined by EBD) when all Implementation activities are not completed by the Contractor and approved by EBD.
Customer Service	Contractor provides uninterrupted toll-free customer service during the hours of 8:00 a.m. – 5:00 p.m. CST Monday through Friday excluding State Holidays	$100 for each day during the month when the Contractor fails to provide uninterrupted toll-free customer service access during the hours of 8:00 a.m – 5:00 p.m. CST Monday through Friday excluding State Holidays.
	Contractor records and archives 100% of customer service calls and retains archived calls for a minimum of 18 months after the end of the Plan Year. Contractor retrieves calls and provides them to EBD	1% of monthly invoice for the respective month during which the Contractor fails to record and archive 100% of customer service calls, and/or fails to retrieve and submit calls to EBD within seven (7) Business Days of request by EBD.

	within seven (7) Business Days from request by EBD	
Audits	Contractor is available for audits by EBD, EBD's chosen representatives, and/or Legislative Audit on Business Days during the hours of 8 a.m. through 5 p.m. CST and within an audit timeline designated by EBD.	$100 for each occurrence whereby the Contractor is unavailable for an audit on Business Days during the hours of 8 a.m. through 5 p.m. CST. $100 per occurrence whereby the Contractor fails to abide by the audit timeline designated by EBD.
	Contractor responds to findings from an inspection or audit within thirty (30) calendar days of receipt of notification of any finding by Contractor	$100 per day for each day passed thirty (30) calendar days that the Contractor fails to respond to any finding from and inspection or audit.
Meetings	Contractor attends the initial 1-3 day meeting(s) during the Implementation Period in person and as required in the RFP. Contractor attends all weekly meetings occurring during the Implementation Period either in person or via telephone/video conferencing as requested by EBD.	1% of Implementation Fee for each required meeting not attended as required in the RFP or requested by EBD.
	Contractor attends all Open Enrollment Meetings in person as requested by EBD and/or required in the RFP during the sixty (60) day Open Enrollment Period.	5% of monthly invoice fee for each Open Enrollment meeting during the respective month that the Contractor fails to attend as requested by EBD and/or required in the RFP
Reports	Contractor submits annual reports to EBD in the manner required in the RFP by June 1st of each year.	$100 per day for each day past the June 1st deadline for any annual report the Contractor fails to submit to EBD.
	Contractor submits quarterly reports in the manner required in the RFP within forty-five (45) calendar days after the end of each quarter.	$100 per day for each day after the forty-fifth (45th) calendar day after the end of the respective quarter for any quarterly report the Contractor fails to submit to EBD.

TECHNICAL PROPOSAL PACKET
SP-18-0099

PROPOSAL SIGNATURE PAGE

Type or Print the following information.

PROSPECTIVE CONTRACTOR'S INFORMATION					
Company:					
Address:					
City:		State:		Zip Code:	
Business Designation:	☐ Individual ☐ Partnership	☐ Sole Proprietorship ☐ Corporation		☐ Public Service Corp ☐ Nonprofit	
Minority Designation: *See Minority Business Policy*	☐ Not Applicable AR Minority Certification #: _____	☐ African American ☐ American Indian	☐ Hispanic American ☐ Asian American Service Disabled Veteran Certification #: _____	☐ Pacific Islander American ☐ Service Disabled Veteran	

PROSPECTIVE CONTRACTOR CONTACT INFORMATION *Provide contact information to be used for bid solicitation related matters.*			
Contact Person:		Title:	
Phone:		Alternate Phone:	
Email:			

CONFIRMATION OF REDACTED COPY

☐ YES, a redacted copy of submission documents is enclosed.

☐ NO, a redacted copy of submission documents is not enclosed. I understand a full copy of non-redacted submission documents will be released if requested.

Note: If a redacted copy of the submission documents is not provided with Prospective Contractor's response packet, and neither box is checked, a copy of the non-redacted documents, with the exception of financial data (other than pricing), will be released in response to any request made under the Arkansas Freedom of Information Act (FOIA). See Bid Solicitation for additional information.

ILLEGAL IMMIGRANT CONFIRMATION

By signing and submitting a response to this *Bid Solicitation*, a Prospective Contractor agrees and certifies that they do not employ illegal immigrants. If selected, the Prospective Contractor certifies that they will not employ illegal immigrants during the aggregate term of a contract.

ISRAEL BOYCOTT RESTRICTION CONFIRMATION

By checking the box below, a Prospective Contractor agrees and certifies that they do not boycott Israel, and if selected, will not boycott Israel during the aggregate term of the contract.

☐ Prospective Contractor does not and will not boycott Israel.

An official authorized to bind the Prospective Contractor to a resultant contract shall sign below.

The signature below signifies agreement that any exception that conflicts with a Requirement of this *Bid Solicitation* **will cause the Prospective Contractor's proposal to be disqualified.**

Authorized Signature: _____ **Title:** _____
Use Ink Only.

Printed/Typed Name: _____ **Date:** _____

CONFLICT OF INTEREST AFFIDAVIT

- This *Conflict of Interest Affidavit* is for the Prospective Contractor's disclosure of any actual and/or potential conflict(s) of interest, litigation (criminal or civil), and/or bankruptcy petition(s) as described and required in the RFP, Section 2.24.

- Per Section 2.24 of the RFP, this *Conflict of Interest Affidavit* will not be scored as part of the RFP evaluation. However, submission of this signed *Conflict of Interest Affidavit* along with the required disclosures if any, as stated in the RFP Section 2.24 is a Proposal Submission Requirement.

- Do not include additional information if not pertinent to the itemized request.

- Should the Prospective Contractor have any actual and/or potential conflict(s) of interest, litigation (criminal or civil), and/or bankruptcy petition(s) disclosures to make, the Prospective Contractor **shall** submit an additional document, as an attachment to this *Conflict of Interest Affidavit*, explaining the actual and/or potential conflict(s) of interest, litigation (criminal or civil), and/or bankruptcy petition(s).

- The Prospective Contractor **shall** include all information necessary to fully communicate the nature of the actual and/or potential conflict(s) of interest, litigation (criminal or civil), and/or bankruptcy petition(s) including proposed mitigation measures.

Check the appropriate box below:

☐ Per Section 2.24 of the RFP, my company does not have any actual and/or potential conflict(s) of interest, litigation (criminal or civil), and/or bankruptcy petition(s) to disclose at this time.

☐ See the attachment to this *Conflict of Interest Affidavit* disclosing my company's actual and/or potential conflict(s) of interest, litigation (criminal or civil), and/or bankruptcy petition(s).

By signature below, the Prospective Contractor certifies that it meets the disclosure requirements as stated in Section 2.24 of the RFP to the best of its knowledge, and **shall** continue to meet disclosure requirements as stated in Section 2.24 of the RFP throughout the life of the contract.

Authorized Signature: _____
Use Ink Only.

Printed/Typed Name: _____ **Date:** _____

PROPOSED SUBCONTRACTORS FORM

- ***Do not*** *include additional information relating to subcontractors on this form or as an attachment to this form.*

PROSPECTIVE CONTRACTOR PROPOSES TO USE THE FOLLOWING SUBCONTRACTOR(S) TO PROVIDE SERVICES.
Type or Print the following information

Subcontractor's Company Name	Street Address	City, State, ZIP

☐ **PROSPECTIVE CONTRACTOR DOES NOT PROPOSE TO USE SUBCONTRACTORS TO PERFORM SERVICES.**

INFORMATION FOR EVALUATION

- *Provide a response to each item/question in this section. Prospective Contractor may expand the space under each item/question to provide a complete response.*
- ***Do not** include additional information if not pertinent to the itemized request.*

	Maximum RAW Score Available
E.1 VENDOR QUALIFICATIONS AND CORPORATE STRUCTURE	
A. Provide a statement of differentiation that distinguishes the products and services your company provides from other companies providing the same or similar services and provide the following information: 1. Corporate Structure and Ownership including an organizational chart 2. Number of years your company has been providing services required in the RFP 3. Location of Corporate Office 4. Locations of all Sales/Support Offices specifying which office will be responsible for working with EBD 5. Information regarding professional/industry association memberships 6. A statement expressing the percentage of your company's revenue that is derived from providing services similar to those required by the RFP 7. Total dollar amount of all GPFSA, DCAP, LPFSA and HSA claims processed by your company in calendar year 2016 8. Audited financial statements for the past three (3) years or other financial documentation that accurately reflects your company's financial condition. Submit in electronic format only.	5 points
B. Provide an executive summary containing no more than three (3) pages detailing your company's understanding of the following: 1. The services to be provided under any resultant contract 2. The Contractor's responsibilities under any resultant contract 3. Other information relevant to the services described in the RFP and necessary to fully communicate your company's understanding of the services to be provided and the responsibilities of the Contractor	5 points
C. List and describe your company's past experience with projects of similar scope. Specifically list and describe all projects administered and managed by your company that meet the five (5) year experience requirement.	5 points

D. List and describe the State, Federal, and/or local public entities that your company has provided services for in the past. Include the services provided, the dates your company provided the services, and how this experience provided your company with the capability to work with a geographically diverse population.	5 points
E. Detail the contract(s) and/or interest(s) held by your company with any operation located outside of the continental United States including a description of the relationship. Detail entities owned by your company or entities your company has a financial interest in (inside or outside the continental United States) that would receive compensation if your company were to be awarded a contract as a result of this RFP and describe the relationship.	5 points
F. Describe your company's overall client retention rate over the previous two (2) years for your company's complete book of business.	5 points
G. Detail your company's philosophy, policies, and processes for providing transparent administration to its clients.	5 points
H. Describe your company's experience coordinating the development, implementation, and management of Program(s) similar in size and scope to those required in this RFP.	5 points
E.2 IMPLEMENTATION	
A. Describe your company's proposed implementation process that will provide for a successful implementation by the proposed Administration Services Start Date as stated in the RFP.	5 points
B. Provide a detailed Implementation schedule/timeline. Include all activities required for successful implementation and the timeframes for completing those activities including the following: 1. Data transfer requirements 2. Suggested methods for timely data migration 3. Member/Plan Participant education and outreach 4. Training 5. Member account transfers 6. Debit card distribution	5 points
B. Detail your company's implementation team members that will attend the initial 1-3 day(s) Implementation meeting(s) in Little Rock, Arkansas. Provide the following for each member of the implementation team: 1. Name 2. Title 3. Experience and credentials Describe what practices your company has found effective in similar meetings.	5 points

C. Describe your company's experience with the implementation of projects in similar size and scope. Include timelines, goals, results, pitfalls, risk mitigation, and any other element necessary to fully communicate your company's implementation experience. Detail the specific information generally requested of clients during these types of implementations.	5 points
D. Describe the risks your company anticipates EBD, the Plan, Programs, Members, and Plan Participants may face during the Implementation Period and your company's plan to mitigate those risks.	5 points
E.3 ARCAP AND HSA ADMINISTRATION	
A. Provide a detailed description of the contractual relationship with your Custodian/Trustee.	5 points
B. Provide a sample of the following documents in electronic format only (CD or Flash Drive): 1. Member Account Application(s) 2. Beneficiary Designation Form 3. Marketing/Education Material(s) 4. Summary Plan Description, Plan Document, or similar document 5. All other documents/information currently provided to prospective Members for other clients of your company	5 points
C. Describe your company's processes and capabilities for sending alerts for any rejected, unexpected, and/or unintended funding to a Member's account and the process for notifying clients upon each occurrence.	5 points
D. Describe your company's accounting and business processes that provides for the correct crediting of Member accounts. Describe issues your company has faced in the past that caused the incorrect crediting of Member accounts and how your company provided for correction and the measures/processes instituted to prevent reoccurrence.	5 points
E. Describe the procedures your company currently has in place for the submission of Member/Plan Participant documentation and information.	5 points
F. Describe how the Affordable Care Act has affected the language in your company's Summary Plan Description, Plan Document, or similar document and include how often your company reviews/ updates such documents.	5 points
G. Describe how the interest rate is determined for HSAs administered by your company, such as by a specific mutual fund or money market account, or by the custodian/trustee. Provide the current interest rate paid on your company's HSAs and your Members' average account balance over an annual period.	5 points
H. Detail the different fund investments offered by your company for HSAs. Include information regarding the following: 1. Investment Options	5 points

2. Limitations 3. Restrictions 4. Communication material(s) 5. Custom investment options, pre-established investment models, or other options	
I. Describe your company's options for allowing the Member to select multiple custodians and how the services your company provides for comprehensive HSA administration is affected by the Member's selection of multiple custodians.	5 points
J. Detail how many actively managed accounts your company currently supports. Do not include any account totals for the custodian or other administrators using the same administration system.	5 points
K. Describe your company's method of handling liability to an HSA Member for miscommunication or erroneous information from your company regarding the Member's HSA.	5 points
E.4 COBRA ADMINISTRATION	
A. Provide a detailed statement expressing your company's understanding of what it means to provide COBRA administrative services as required in the RFP.	5 points
B. Describe your company's most noteworthy qualifications for providing COBRA administrative services. Specifically highlight your company's qualifications that distinguish you from your competitors.	5 points
E.5 ADMINISTRATION SYSTEM	
A. Describe your company's system used to provide the services specified in the RFP and include the following: 1. The length of time the system has been in full operation 2. The capabilities the system has for providing a single sign-on / Trusted Link between necessary applications 3. The capabilities for accepting electronic transfer of eligibility	5 points
B. Provide a sample login or detailed color printed screenshots with a description of layout and purpose of single secure website/portal.	5 points
C. Describe the major system conversions occurring within your company within the past two (2) years and any major system conversions planned to occur in the future.	5 points
D. Describe your company's process for clients to request enhancements to your company's administration system and website based on non-standard benefit design and provide the average turnaround time for system and website changes or enhancements.	5 points
E. Describe the method your company uses to gather data necessary for non-discrimination testing including a sample of the forms provided for public sector use and the frequency of reporting. Detail any other testing available.	5 points

F. Describe the process by which your company educates and disseminates information to clients regarding legislative and regulatory changes to its clients and how your company incorporates these changes into its administration system. Include samples of such client communications.	5 points
G. Provide a copy of your company's most recent IT Audit including an auditor opinion, auditor testing, and the results.	5 points
H. Describe how your company ensures that all payments are in accordance with the approved benefit design.	5 points
E.6 CUSTOMER SERVICE	
A. Describe your company's capabilities, to track, record, archive, retrieve, and report on customer services calls. Include information regarding the following: 1. Average Hold Times 2. Average Abandonment Rates 3. Average time for call to be answered 4. Initial Call Resolution Rate	5 points
B. Describe your customer service call escalation procedure.	5 points
C. Detail the average tenure and turnover rate of your customer service staff.	5 points
D. Describe the following as they pertain to your company's customer service staff: 1. Types of Pre-employment screenings administered 2. Criminal Background Checks required 3. Types and frequency of all training administered	5 points
E. Provide information pertaining to how your company staffs its customer service department. At a minimum include information on the following: 1. Number of employees per shift 2. Number of shifts 3. Staff available during 11:00 a.m.-1:00 p.m. CST 4. The number of Spanish speaking customer service staff 5. Office location 6. Ratio of customer service staff per 1000 Members	5 points

F. Provide detailed information regarding the customer service team that will have direct contact with Members/Plan Participants. Describe the customer service assistance and the year-end tax filing forms that will be provided to Members including: 1. Tax Form 8889 2. 1099-SA 3. 5498-SA	5points
G. Describe your company's abilities in and experience with providing comprehensive customer service to clients.	5 points
H. Describe your company's phone system's automated functionality including what information is accessible to Members.	5 points
E.7 EDUCATION AND ENROLLMENT SERVICES	
A. Describe the procedures your company uses to increase employee participation levels for programs similar to the ARCap and HSA Programs. At a minimum, provide the following information: 1. Your company's use of mass mailings, targeted marketing, and individual meetings with employees to increase participation 2. In electronic format (such as a CD or flash drive) provide samples of your company's Member communication pieces used to communicate the advantages and benefits of participation in a Health Savings Account and Flexible Spending Account.	5 points
B. Provide details regarding the increase in participation levels other clients of your company have experienced for similar Programs and how those increases were realized. Provide the projected increases in participation over the next three (3) years for the ARCap and HSA Programs using similar strategies.	5 points
C. Describe your company's education and enrollment process in detail. At a minimum include the following in your response: 1. Staff responsible for processing and completing enrollments including their experience and qualifications 2. Brochures, benefit election and other forms, and/or other information used in the enrollment process. Provide the information in electronic format only such as a CD or flash drive. 3. Education and training materials designed and produced by your company and used in the past to educate your company's clients, Members, Plan Participants, and other applicable designated parties. Provide this information in electronic format only such as on a CD or flash drive.	5 points
D. Describe the meeting styles previously used by your company during Open Enrollment sessions. Describe the advantages and disadvantages of both the presentation style and benefit fair style formats.	5 points

E. Describe the Member self-service capabilities offered by your company including any internet based / online methods of enrollment.	5 points
E.8 CLAIMS ADMINISTRATION	
A. Provide a detailed description of your company's claims submission process and claims adjudication software systems. Include information regarding automated and manual checks for non-eligible expenses.	5 points
B. Provide a flowchart to demonstrate the processing of each type of account based claim (HSA, GPFSA, LPFSA, DCAP, COBRA). Indicate each manual or computer system interface from the time a claim is received until it is paid, rejected, or denied. Describe each step on the flowchart including the following: 1. Any sorting or batching conventions 2. Method of establishing inventory 3. Assignment of claim numbers 4. Initial inspection for completeness	5 points
C. Provide the location of the facility where claims are processed and paid. Describe your company's system for monitoring claims administration performance.	5 points
D. Provide a detailed description of the ways Members can electronically store receipts and supporting documentation on-line to support distributions from their HSA. At a minimum, include the following information: 1. The length of time images are stored in your company's system 2. A description of how and when images are archived 3. A description of how Members would access the archived documentation	5 points
E. Detail the percentage of claims related Member complaints received by your company during 2016. At a minimum include the following information: 1. Average length of time between receipt of complaint and response 2. Top three (3) types of complaints 3. Steps taken for resolution	5 points
F. Provide a detailed description of how Members may view claim detail information and an accurate, real-time account balance using the following methods: 1. Member website/online 2. Automated phone system/IVR 3. Customer Service	5 points

G. Provide the percentage of claims suspended for any reason in 2016. Provide the top three (3) reasons for suspension.	5 points
H. Provide a detailed description of the different ways a Member can submit a claim. At a minimum, include information regarding the following methods: 1. Mobile Application (i.e. iPhone, iPad, or Android applications) 2. Website 3. Fax and/or paper	5 points
I. Provide a detailed description of the methods used to process pending claims, including the following: 1. Follow-up with Members in order to obtain information applicable to claims 2. Screening of claims to avoid payment duplication 3. Procedures to assure consistency of claims payment in accordance with the Plan	5 points
J. Based on your company's experience, describe the best method to facilitate the collection of funds from a large employer in order for your company to pay claims. Describe your company's process for issuing claims payments to Members and the turnaround time for claims to be processed and paid.	5 points
K. Describe how your company manages deductions for Members who are utilizing the Family and Medical Leave Act (FMLA) and/or Leave Without Pay (LWOP).	5 points
L. Describe your company's capabilities of processing a large number of claims and the turnaround time typically experienced. Include a description of any time-saving technological approaches used by your company and the number of claims processed by your company in 2016.	5 points
M. Describe how your company administers a claims grace period.	5 points
N. Describe your company's preferred approach of requesting supporting documentation from a Member. Include suggestions for final collection from employee payroll with the understanding that EBD considers payroll adjustment/deduction the collection method of last resort.	5 points
E.9 KEY PERSONELL AND STAFFING	
A. Provide the credentials including a resume of the dedicated account manager your company will assign to the EBD account. Detail the authorizations, job description, and responsibilities the dedicated account manager will have while managing the EBD account. If the dedicated account manager is not currently known, detail the credentials your company will require of a dedicated account manager and the authorizations, job description, and responsibilities your company will assign to a dedicated account manager for the EBD account if your company is awarded a contract.	5 points
B. Describe the types and levels of other support staff, such as in the areas of eligibility/Membership, cash disbursement, etc. Provide the location of the support staff by function to be assigned to the EBD account.	5 points

C. Detail the staff your company has available to administer and manage the EBD account. Detail the years of experience your company's senior staff has in administering and managing projects similar to this RFP.	5 points
D. Describe the staff member(s) responsible for operations, claims, accounting, and privacy/security information. Include the following for the staff member(s) responsible for each department. 1. Name 2. Title 3. Experience and credentials	5 points
E.10 PAYROLL PROCESSING AND DOCUMENTATION SUBMISSION	
A. Provide a detailed description of your company's procedures used to process various and multiple payroll files to reconcile established deductions/elections in a timely manner. Include the processes used for files received electronically and in paper format.	5 points
B. Provide a detailed description of your company's proposed procedures to provide payroll interface for the transfer of information to and from the Arkansas Administrative Statewide Information System (AASIS).	5 points
E.11 REPORTING	
A. Provide a specific list, description, and a sample package of your company's standard reports including the frequency of report generation. Provide sample reports in electronic format only such as a CD or flash drive.	5 points
B. Provide a detailed description of the process for clients to request reports not currently available and the estimated time until receipt by the client.	5 points
C. Describe your company's process for handling a client's request for ad hoc reports. Include the turnaround time for receipt of report by the client.	5 points
D. Describe the process clients use to request additional information or clarification of the data contained in a report. Include the turnaround time for providing the requested information to clients.	5 points
E.12 COMPLIANCE, PRIVACY, AND SECURITY	
A. In electronic format (CD or flash drive) provide a copy of your company's emergency operations plan. At a minimum include the following: 1. A detailed disaster recovery plan 2. A detailed business continuity plan	5 points
B. In electronic format only (CD or flash drive), provide copies of your company's privacy, security, and breach notification policies and procedures.	5 points
C. Provide a detailed explanation of insurance, bonding, and guarantees offered by your company in the event of issues caused by loss of operations due to an emergency or disaster.	5 points

D. Provide a detailed description of any breaches, complaints, or grievances regarding protected health information (e.g., security or privacy) for your company's complete book of business. At a minimum include the following: 1. Event date and description 2. Resolution or ongoing details	5 points
E. Provide a detailed description of any event where your company's employee(s) willfully committed acts that compromised Member information including any that did not involve personal health information.	5 points
F. Provide information regarding the Cyber Liability Insurance carried by your company.	5 points
G. Provide a detailed description of your company's HIPAA policies and procedures.	5 points
H. Provide a detailed description of your company's internal security policies, procedures, practices, and the system utilities used to protect Member social security numbers and other elements of personal information from your company's employees who do not have a valid "need to know".	5 points
I. Provide a detailed description of training provided to your company's employees/staff including Internal Revenue Code Sections, ADA, HIPAA and other regulatory issues/laws.	5 points
J. Describe the method your company uses to remove or mask a Member's social security number from any printed report, letter, or other form of communication.	5 points
K. Explain how your company will monitor and control unauthorized attempts to access EBD files.	5 points
L. Describe the intrusion detection and monitoring tools your company utilizes. Include information regarding the frequency your company conducts penetration testing and vulnerability scans.	5 points
E.13 DEBIT CARD	
A. Provide a detailed description of the connection between your company's card administration platform and claims administration software.	5 points
B. Provide a detailed description of any connection with any merchant who currently supports an IIAS.	5 points
C. Provide a detailed description of how your debit card administration system utilizes email for efficient and cost effective Member communication.	5 points
D. Provide a detailed description how email notifications are provided to the Members regarding the following: 1. Status of debit card transactions 2. With specific identification dealing with auto-substantiation 3. Claims submission requirements 4. Debit card status	5 points
E. Describe in detail your company's method of communicating the following to Members:	5 points

1. Process of using the debit card 2. Receiving and understanding email notifications 3. How to contact customer service	
F. Describe in detail the process (including contact information) Members would follow for questions regarding the following: 1. Charge-backs 2. Stolen Cards 3. Unauthorized transactions 4. Other non-typical debit card customer service issues	5 points
G. Provide information on how the debit card may be customized for your company's clients, including Plan branding.	5 points
H. Provide a sample (front and back) of your standard debit card. An actual plastic card is preferred but printed images are also acceptable.	5 points
I. Provide a detailed description of all auto-substantiation parameters available to the Plan.	5 points
J. Describe your company's process for taking an electronic claims import for medical or pharmacy claims to substantiate debit card transactions or for automatic reimbursement of non-debit card transactions. Include the following information: 1. Data file specifications 2. Timing issues 3. Eligibility concerns 4. Other relevant information	5 points
K. Describe your company's recommended process to facilitate claims offset for non-substantiated debit card transactions and the options available within your company's administration system to deviate from the recommended process.	5 points
L. Provide details regarding the reasons your company's debit cards have been offline at any time within the past two (2) years. Include the length of time the debit cards were offline for each occurrence.	5 points