2026
EMPLOYEE BENEFIT GUIDE

Benton
THE HEART OF ARKANSAS SINCE 1836

JTS
INTENTIONALLY DIFFERENT

Scan this code to access the digital version of your guide.

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JTS
INTENTIONALLY DIFFERENT

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WHAT YOU NEED TO KNOW

Full-time employees who are actively at work are eligible to enroll into benefits. Qualified dependents can also be added to eligible benefits.

Checklist of what to bring for open enrollment for each dependent that you are enrolling in eligible benefits:

1. Social Security Number
2. Address
3. Date of Birth

Having these items will expedite the completion of all enrollment forms, beneficiary cards, etc.

If you are a current employee (not a new hire), please keep the following information in mind:

- You cannot make any changes until the annual "open enrollment period", which allows employees, who may have previously declined to enroll, the opportunity to enroll in new coverage. (Certain restrictions and limitations may apply to employees who initially declined coverage when they first became eligible to enroll.)
  - o However, there are certain qualifying events that allow current employees to make benefit changes. These include, but are not limited to:
    - » marriage, divorce, adoption or birth of child, death of a spouse or other eligible dependent.

WHAT YOU NEED TO KNOW

WORKERS COMPENSATION

1. When a work-related injury occurs, please notify Human Resources as soon as possible. If the injury occurs during the weekend, please notify Human Resources on Monday morning.
2. Human Resources will schedule you an appointment with the city's medical provider.
3. Please make sure that all workers compensation reporting forms are completed and submitted to Human Resources within 24-48 hours.

MUNICIPAL HEALTH BENEFITS PROGRAM

Medical Precertification Phone Number:
Ph: (888) 295-3591 (toll free)

PO Box 188
North Little Rock AR 72115
501-978-6137
501-537-7252 (Fax)
www.arml.org

New Hire Benefits begin:

- Anyone hired on the 1st-14th benefits are effective the 1st of the next month. *Municipal Health Benefits Program Only*
- Anyone hired the 15th – end of month benefits will be effective the 1st of the following month. Municipal Health Benefits Program Only
- All other products are effective 1st of the month following 30 days.

HEALTH, DENTAL, AND VISION RATES

MUNICIPAL HEALTH HDHP PLAN				
Per Pay Period Rates (24)				
Tier	EE Cost	ER Cost	HSA ER	Total
Employee	$0.00	$177.36	$71.18	$248.54
Employee + Family	$138.00	$260.54	$153.56	$552.10
Annual Employer Cost Employee Only		$4,256.64	$1,708.32	$5,964.96
Annual Employer Cost Employee + Family		$6,252.96	$3,685.44	$9,938.40

MUNICIPAL HEALTH COPAY PLAN			
Per Pay Period Rates (24)			
Tier	EE Cost	ER Cost	Total
Employee	$28.84	$273.39	$302.23
Employee + Family	$227.28	$455.51	$682.79
Annual Employer Cost Employee Only			$6561.36
Annual Employer Cost Employee + Family			$10932.24

Arkansas Municipal League is our health insurance provider. Arkansas Municipal League provides health insurance plan benefits for office visits, preventive care, prescription drugs, and hospital services.

TRADITIONAL COPY PLAN	IN-NETWORK	OUT-OF-NETWORK
CALENDAR YEAR DEDUCTIBLE		
Individual	$500	
Family	$6,000	
OUT-OF-POCKET MAXIMUM		
Individual	$4,500	N/A
Family	$8,000	N/A
Coinsurance	80%	50%
COVERED SERVICES AND BENEFITS		
OFFICE VISITS		
Virtual Care	$0 Copay	
Primary Care Physician	$20*	$20*
Specialist	$20*	$20*
EMERGENCY MEDICAL CARE		
Emergency Room	$250 copay + Deductible + 20% coinsurance	
Urgent Care Center	$20*	
Ground Ambulance ($1,000/trip)	Limited to two trips per year	
Air Ambulance ($10,000/trip)		
HOSPITAL SERVICES		
Inpatient Services	Deductible + Coinsurance	Deductible + Coinsurance
Outpatient Services	Deductible + Coinsurance	Deductible + Coinsurance
PRESCRIPTIONS		
Generic Brand	$10	N/A
Preferred Brand	$30	N/A
Non Preferred Brand	$50	N/A

*copay amounts cover all charges billed under CPT Codes 99201 through 99215. Any charges outside these ranges will be subject to deductible and co-insurance.

Arkansas Municipal League is our health insurance provider. Arkansas Municipal League provides health insurance plan benefits for office visits, preventive care, prescription drugs, and hospital services.

HDHP PLAN	IN-NETWORK	OUT-OF-NETWORK
CALENDAR YEAR DEDUCTIBLE		
Individual	$2,500	
Family	$7,500	
OUT-OF-POCKET MAXIMUM		
Individual	$5,000	N/A
Family	$10,000	N/A
Coinsurance	80%	50%
Lifetime Benefit Maximum	Unlimited	Unlimited
COVERED SERVICES AND BENEFITS		
OFFICE VISITS		
Primary Care Physician	Deductible	Deductible + Coinsurance
Specialist	Deductible	Deductible+ Coinsurance
Virtual Care	Deductible + Coinsurance	Deductible + Coinsurance
EMERGENCY MEDICAL CARE		
Emergency Room	$250 + Deductible + 20% Coinsurance	
Urgent Care Center	Deductible + Coinsurance	Deductible + Coinsurance
Ground Ambulance ($1,000/trip)	Limited to two trips per year	
Air Ambulance ($10,000/trip)		
HOSPITAL SERVICES		
Inpatient Services	Deductible + Coinsurance	Deductible + Coinsurance
Outpatient Services	Deductible + Coinsurance	Deductible + Coinsurance
PRESCRIPTIONS		
Generic Brand	Deductible	N/A
Preferred Brand	Deductible	N/A
Non-preferred Brand	Deductible	N/A

Arkansas Municipal League provides dental coverage through the Delta Dental Network. Having dental insurance contributes to your total well-being. With this plan, you have comprehensive dental coverage at affordable rates.

INDIVIDUAL COINSURANCE	
IN-NETWORK	**OUT-OF-NETWORK**
80% of MHBP's Allowable Amount for Covered Dental Charges; 100% of MHBP's Allowable Amount for Preventive Dental Services	50% of MHBP's Out-of-Network Allowable Amount for Covered Dental Charges
DENTAL SERVICES	
PREVENTIVE SERVICES *100% Covered*	• Cleanings (Two examinations & cleanings/year) • X-rays • Fluoride Treatment • Sealants
COVERED DENTAL CHARGES	
• Fillings, extractions, space maintainers, and oral surgery • Anesthetics administered in connection with covered dental services • Injection of antibiotic drugs by the attending dentist • Treatment of periodontal and other diseases of the gums and tissues of the mouth • Endodontic treatment (root canal therapy) • Repair or re-cementing of crowns, inlays, bridgework or relining or repair of dentures • Initial installation of partial or full removable dentures to replace one or more natural teeth extracted while covered under these provisions • New dentures or bridgework (after two years from effective date with MHBP)** • Inlays, gold fillings, crowns, and initial installation of fixed bridgework to replace one or more natural teeth extracted while covered under these provisions • Orthodontic treatment, including correction of malocclusion • Temporomandibular Joint Dysfunctions (TMJ)	

DENTAL COVERAGE MAXIMUMS & DEDUCTIBLE	
Deductible	$50 per person
Benefit Year Maximum	$1,200 per person
Orthodontic Lifetime Maximum	$1,000 per person
TMJ Annual Maximum	$1,200 per person

Arkansas Municipal League is our vision insurance provider. Vision insurance provides enhanced benefits for materials, frames, lenses and contacts.

VISION CARE SERVICES	IN-NETWORK	OUT-OF-NETWORK COST REIMBURSEMENT
COPAYS		
Exams	$25 Copay	Up to $40
Frames Any available frame at provider location.	$0 copay; 20% off balance over $120 allowance	Up to $60
CONTACT LENSES: Contact Lens allowance includes materials only.		
Conventional	$0 copay; 15% off balance over $120 allowance	Up to $96
Disposable	$0 copay; 100% of balance over $120 allowance	Up to $96
Medically Necessary	$0 Copay	Up to $210
STANDARD PLASTIC LENSES		
Single Vision	$25 Copay	Up to $40
Bifocal	$25 Copay	Up to $60
Trifocals	$25 Copay	Up to $80
Lenticular	$25 Copay	Up to $100
Standard Progressive	$80 Copay	Up to $60
Premium Progressive	$110 - $200 Copay	Up to $60

SERVICES	FREQUENCY
Exam	12 months
Lenses	12 months
Frames	12 months
Contacts	12 months

A Health Savings Account, HSA, is a savings account that works alongside your High Deductible Health Plan. Using an HSA helps you reduce qualified out-of-pocket healthcare expenses up to 35%, including the deductible part.

BENEFITS OF A HEALTH SAVINGS ACCOUNT

You can save up to 35% on out-of-pocket health care expenses with tax free dollars. That's like having $100 to spend rather than $65. Qualified expenses include your health plan deductible (doctors, labs, prescriptions, hospitalization). Plus vision, dental, chiropractic, and mental health services.

HSA's are particularly helpful because they can roll over from year to year and never expire (even lasting into retirement years), so you can use the funds you've saved even if you change health plans or employers.

City of Benton will pay $142.36/Month for those enrolled in Employee Only HSA account and $307.12/Month for those enrolled in the Family HSA account.

CONTRIBUTION LIMITS	
Individual	$4,400
Family	$8,750
*** Employees 55+ can contribute an additional $1,000**	

KEY HSA FEATURES
• Account Management
• Track HSA Spending
• Automated Contributions
• Monitor HSA Investments
• Easy Reimbursement
• Access HSA Marketplace

HSA ELIGIBLE ITEMS	
• X-Rays	• Prescriptions
• Contact Lenses	• Dentist
• Chiropractor	• MRIs
• Lab Work	• Physical Therapy

* You can use your HSA money on all qualified medical expenses as defined by the IRS. The IRS Publication 502 has the full list of things that are qualified, are not qualified, and could potentially be qualified based on certain circumstances. *

The "Lively HSA & FSA" mobile app brings the simplicity, ease-of-use, and modern experience of the Lively platform to the palm of your hand, making it easy to manage your accounts on the go

FEATURES OF AN FSA	
Why an FSA?	Using a Flexible Spending Account (FSA) is great way to stretch your benefit dollars. You use before-tax dollars in your FSA to reimburse yourself for eligible out-of-pocket medical expenses. That means you can enjoy tax savings and increased take-home pay—all with the convenience of a prepaid debit card.
Employee Benefits	• Reduces your income taxes (Federal, state, and FICA) because setting aside pre-tax FSA dollars results in a lower taxable salary. • Using pre-tax dollars to pay for eligible medical expenses translates into savings of as much as 30%. • Offers immediate access to elected healthcare FSA funds via an FSA debit card. • Most common expenses such as medical, dental, orthodontic, vision, and prescription drug are eligible for reimbursement with supporting documentation.
How it Works	• Decide how much you will contribute to your FSA each year, up to the maximum allowed by your employer's FSA plan. This election amount (divided equally by the number of payroll periods) is automatically deducted from your paycheck by your employer. From a tax perspective, the more you elect to put into your FSA, the more you save! • You can choose to be reimbursed for eligible medical expenses up to the amount of your annual election by submitting a request to JTS via your online FSA portal, by email/fax, or on your JTS FSA phone app. Or you may choose to use your convenient FSA debit card to pay for the eligible expense at the point of purchase, eliminating the need to request reimbursement (per IRS requirements, note that additional substantiating documentation may be requested by JTS for debit card purchases).

MAXIMUM CONTRIBUTION AMOUNTS

- $3,400 - Medical Reimbursement
- $680 Rollover Amount

FOR EMPLOYEES/PARTICIPANTS

- Convenient JTS Mobile Technology (mobile app and text messaging)
- Multiple account management tools (web, phone, and fax)
- Fast reimbursements
- Toll-free Customer Care Center
- Easy online enrollment or re-enrollment
- Tax Savings Calculator

A section 125 Cafeteria Plan (FlexSystem FSA) allows for the inclusion of Dependent Care (Section 129 of the Internal Revenue Code) benefits. Eligibility for the dependent care benefit requires that certain criteria be met with respect to the expense, the provider, etc.

A. *The dependent care expenses must be work related. The care must be necessary for the employee and the employee's spouse to work, to look for work, to attend school full-time or are physically unable to care for their children.*

B. *The dependent care expenses provided during a calendar year cannot exceed $7,500. In the case of a separate return by a married individual, the limit is $3,750.*

The dependent care expenses must be for the care of one or more qualifying persons. A qualifying person is one of the following:

A. *A dependent who was under age 13 when the care was provided and for whom an exemption can be claimed.*

B. *A spouse who was physically or mentally not able to care for himself or herself, and lived with you for more than half the year.*

C. *A dependent who was physically or mentally not able to care for himself or herself and for whom an exemption can be claimed, and lived with you for more than half the year.*

ELIGIBLE EXPENSES FOR FSA DEPENDENT CARE (PARTIAL LIST):
• FICA/FUTA taxes of dependent care provider
• Nanny expenses attributed to dependent care
• Nursery school (pre-school)
• Late pick up fees
• Day Camp—primary purpose must be custodial care and not educational in nature
• Day care when one parent is working and the other is sleeping during daytime hours
INELIGIBLE EXPENSES:
• Kindergarten
• Activity fees/supplies
• Late payment/charges
• Overnight camp
• Transportation
• Fees paid to a provider not reporting the income of the IRS

This coverage provides financial protection for you and your loved ones. Your needs vary greatly upon age, number of dependents, dependents ages and your financial situation. Basic Life is designed to provide benefits to your designated beneficiary for loss of life. AD&D coverage provides payment for the loss of life or limbs sustained as a result of accidental bodily injury.

BASIC LIFE & AD&D	BENEFIT AMOUNTS
Guaranteed Issue Amount	$50,000
Benefit Reduction	Reduces by 35% at age 65 and 50% at age 70.
Employee benefit paid by employer.	

Symetra is our group term life and accidental death and dismemberment provider. Term life coverage provides benefits to your designated beneficiary for loss of life. AD&D coverage provides payment for the loss of life or limbs sustained as a result of accidental bodily injury.

LIFE BENEFIT	EMPLOYEE	SPOUSE	DEPENDENT
Amount	5x annual salary, not to exceed $500,000	100% of the approved employee benefit amount, not to exceed $100,000	$10,000
Guaranteed Issue (for Newly Eligible Employees)	$150,000	$25,000	$10,000
Accelerated Death Benefit	Included- up to 75%		
Included	Waiver of Premium, Portability, Suicide Limitation - *Two Years, Seat Belt Benefit		
Reduction	Benefits reduce by 50% at Age 70		

Universal Life insurance provides permanent life insurance protection with a premium that never increases due to age or a specified term. Life Insurance is a promise to your family to help protect their future. The death benefit can be used any way you or your family sees fit.

ELIGIBILITY	
EMPLOYEE **$150,000 (Guaranteed Issue)** **$500,000 (Simplified Issue)**	To be eligible for insurance, an employee must satisfy all of the following requirements: - be age 16 through 80. - be on active service, performing in the usual manner all of the regular duties of his or her occupation at one of the places of business where he or she normally works or at some location directed by the employer; and - be continuously employed for the amount of time and working the minimum number of hours per week as you require to be eligible for benefits. These requirements will be defined on the Life and Health Group Application and Agreement.
SPOUSE **$25,000 (Guaranteed Issue)** **$100,000 (Simplified Issue)**	To be eligible for insurance, a spouse (or equivalent as defined by state law or otherwise agreed upon between you and us) must satisfy all of the following requirements: - must be age 16 through 65. - must be legally married to the employee as determined by the laws of the state in which the employee resides or meet the eligibility requirements required by the group to be benefit eligible. - must not be disabled. - must not be eligible as an employee under the group policy.
CHILD UL **$25,000 (Guaranteed Issue)**	To be eligible for universal life insurance, a child must satisfy all of the following requirements: - must be under the age of 26. - must be an employee's natural child, stepchild, grandchild, legally adopted child or child for whom adoption proceedings have begun, or a child for whom the employee has been appointed legal guardian. - must not be disabled. - must not be eligible as an employee under the group policy.
CHILD TERM **$10,000 (Guaranteed Issue)**	To be eligible for insurance under this rider, a child must satisfy all of the following requirements: - must be 15 days through age 25. - must be an employee's natural child or stepchild, legally adopted child or child for whom - adoption proceedings have begun, or a child for whom the employee has been appointed legal guardian. - must not be eligible as an employee under the group policy.

Disability income protection insurance provides a benefit for "long-term" disability resulting from a covered injury or sickness. Benefits begin at the end of the elimination period and continue while you are disabled up to the maximum benefit duration.

LONG-TERM DISABILITY BENEFITS	
Monthly Benefit Amount	66.67% of salary up to $7,500 per month will be covered
Minimum Benefit	Greater of 10% or $100
Elimination Period	180 days
Maximum Benefit Duration	Social Security normal retirement age
Evidence of Insurability	(EOI) Medical questions required for all late entrants. During your new hire enrollment, medical questions will not be required.
Pre-Existing Conditions	Benefits will not be paid if your disability begins in the first 12 months following the effective date of your coverage if you have received treatment 3 months prior to effective date.

Symetra is our short-term disability provider. Disability insurance provides income protection in the event that you miss work due to an accident or illness.

SHORT-TERM DISABILITY BENEFITS	
Benefit Amount	66.67% of salary
Maximum Weekly Benefit	$2,000
Minimum Weekly Benefit	$25
Accident Elimination Period	7 Days
Sickness Elimination Period	7 Days
Maximum Payment Duration	25 Weeks
Pre-Existing Condition	Benefits will not be paid if your disability begins in the first 12 months following the effective date of your coverage if you have received treatment 3 months prior to effective date.

With Cancer insurance, you can rest a little easier. The coverage pays you a cash benefit to help with costs associated with treatments, to pay for daily living expenses and more importantly, to empower you to seek the care you need.

RADIATION & CHEMOTHERAPY		BENEFIT DETAILS
Radiation & Chemotherapy	$20,000	maximum benefit per 12-month period
Blood, Plasma, & Platelets	$20,000	maximum benefit per 12-month period
WELLNESS & NON-MEDICAL BENEFITS		**BENEFIT DETAILS**
Wellness	$100	per calendar year for cancer screening tests
Initial Diagnosis	$5,000	pays a one-time, lump sum benefit when a covered person is initially diagnosed with cancer for the first time ever.
Lodging Benefit	$100	per day, 50 day maximum per 12 month period
Guarantee Issue	The first time an employee is eligible to apply	
Pre-existing Period	You may not be eligible for benefits if you have received treatment for cancer within the past 12 months until you have been covered under the plan for 12 months.	
HOSPITAL BENEFITS		**BENEFIT DETAILS**
Anesthesia	25%	of covered surgery benefit
Prosthesis	$2,500	actual charges
Surgery	Inpatient: $5,000 Outpatient: $7,500	actual benefit is determined by the surgery schedule in the contract
Hospital Confinement	$100	per day of covered confinement

PER PAY PERIOD RATES (24)	
Individual	$17.66
Employee and Children	$19.96
Family	$31.81

Critical Illness insurance pays a lump sum benefit directly to you (unless otherwise assigned) and your covered dependents upon diagnosis of a covered critical illness.

BENEFIT DETAILS			
	EMPLOYEE	SPOUSE	CHILD
GUARANTEE ISSUE Not Subject to Pre-Ex!	Up to $35,000	Up to $17,500	N/A

BASE BENEFITS	COVERAGE
Heart Attack	100%
Sudden Cardiac Arrest	100%
Coronary Artery Bypass Surgery	25%
Major Organ Transplant (25% of this benefit is payable for insureds placed on a transplant list for a major organ transplant)	100%
Bone Marrow Transplant (Stem Cell Transplant)	100%
Kidney Failure (End Stage Renal Failure)	100%
Stroke (Ischemic or Hemorrhagic)	100%

ADDITIONAL BENEFITS	COVERAGE
Coma	100%
Severe Burns	100%
Paralysis	100%
Loss of Sight, Speech, or Hearing	100%
Advanced Alzheimer's Disease	100%
Advance Parkinson's Disease	100%
Benign Brain Tumor	100%
Amyotraphic Lateral Sclerosis (ALS)	100%
Multiple Sclerosis (MS)	100%
Health Screening Benefit *(payable for employee & spouse only)*	**$100 per calendar year**

CHILDHOOD CONDITION BENEFITS	
Cystic Fibrosis, Cerebral Palsy, Cleft Lip or Cleft Palate, Down Syndrome, Phenylalanine Hydroxylase Deficiency Disease (PKU), Spina Bifida, Type 1 Diabetes: 50% of Employee Benefit	
Autism Spectrum Disorder	$3,000

CANCER BENEFITS (if you choose to include the cancer rider, you will also have the following benefits.)	COVERAGE
Cancer (Internal or Invasive)	100%
Non-Invasive Cancer	25%
Skin Cancer	$250 per calendar year

Accident coverage pays cash benefits for expenses associated with an accidental injury and can help protect hard-earned savings should an on- or off-the-job accidental injury occur.

BENEFITS	AMOUNTS
Initial Treatment *(once per accident, within 7 days after the accident, not payable for telemedicine services)*	
ER/Urgent Care	$200
ER/Urgent Care with X-ray	$250
Doctor's Office	$100
Doctor's Office with X-ray	$150
Accident Follow-Up Treatment *(maximum of 6 per accident, within 6 months after the accident provided initial treatment is within 7 days of the accident)*	$50
Major Diagnostic Testing *(once per accident, within 6 months after the accident)*	$200
Ambulance *(within 90 days after the accident)*	
Ground	$400
Air	$1,200
Emergency Room Observation *(within 7 days after the accident)*	
Short Observation Period (4-24 hrs)	$50
Long Observation Period (24+ hrs)	$100
Dismemberment *(once per accident, within 6 months after the accident)*	$62.50 - $12,500
Burns *(once per accident, within 6 months after the accident)*	$100 - $20,000
Lacerations *(once per accident, within 7 days after the accident)*	$100 - $800
Outpatient Surgery and Anesthesia *(per day / within one year after the accident)*	
Performed in a Hospital or Surgical Center	$400
Performed in a Doctor's Office, Urgent Care Facility, or Emergency Room *(per day / maximum of two procedures per accident)*	$50
Dislocations	
Open Reduction	Up to $6,000
Closed Reduction	Up to $3,000
Fractures	
Open Reduction	Up to $8,000
Closed Reduction	Up to $4,000
Hospital Admission *(once per accident, within 6 months after the accident)*	$1,250
Hospital Confinement *(maximum of 365 days per accident, within 6 months after the accident)*	$300
Wellness	$100

PER PAY PERIOD RATES	
Employee	$10.25
Employee & Spouse	$17.87
Employee & Child(ren)	$24.43
Family	$32.05

The hospital care policy helps offer you financial protection in the event that you or your dependents are admitted to the hospital. Benefits provide you with assistance in paying your deductible and co-payments associated with inpatient expenses.

BENEFITS	BENEFIT AMOUNTS
Hospital Admission (per confinement) *Once per covered sickness or accident per calendar year*	$1,500
Hospital Confinement (per day) *Maximum confinement period: 31 days per covered sickness or covered accident*	$300
Hospital Intensive Care (per day) *Maximum confinement period: 10 days per covered sickness or covered accident*	$150
Health Screening Benefit *Payable once per calendar year per insured*	$50
Portability/Continuation	Included
Pre-Existing Condition Exclusion	12/12
Waiting Period	None
Reductions and Terminations	None
Guaranteed Issue	Guaranteed issue coverage is offered to all eligible applicants during the initial enrollment and for new hires thereafter. At LPSS's first anniversary, late enrollees are eligible to enroll on a guaranteed issue basis.

COVERAGE TIER	PER PAY PERIOD RATES
Employee	$15.76
Employee + Spouse	$31.69
Employee + Child(ren)	$25.15
Family	$41.08

Prescription Discount Card

JTS

Make sure you're always getting the best deal on your prescriptions with deep discounts through New Benefits Rx. Save 10% to 85% on most prescriptions at 60,000 retail pharmacies nationwide and through home delivery.

Download My Benefits Work

Search for "My Benefits Work" in either the Apple or Google Play Store and download the mobile app

Even if you have insurance, you can still use this card to save on prescriptions.

Simply present both cards at the pharmacy to receive the lowest price.

How to Register

Open the My Benefits Work app, tap "Register" and "Click here to register your free pharmacy card"

Add Group ID JTS002 and Member ID 142407524 and complete the form

Search for Savings

Tap the New Benefits Rx icon then "Check Prices & Pharmacies" to search for the best medication prices

Card for You

Prescription Discount Card

Group # JTS002
Member # 142407524

Questions? **800.800.7616** or **RxPrice.NewBenefits.com**
Pharmacists Help Desk: 866.520.5985

This is NOT insurance.
Payment must be made at the time of service.

nbRx
BIN: 610225
PNC: 05591000

Card for Family or Friend

Prescription Discount Card

Group # JTS002
Member # 142407524

Questions? **800.800.7616** or **RxPrice.NewBenefits.com**
Pharmacists Help Desk: 866.520.5985

This is NOT insurance.
Payment must be made at the time of service.

nbRx
BIN: 610225
PNC: 05591000

Pharmacy discounts are not insurance, not intended as a substitute for insurance, and only available at participating pharmacies. Administrator: New Benefits, Dallas, TX.

lyric

Virtual Urgent Care **How to Use**

24/7/365 access to care. Fast, Convenient & Affordable.

Doctors can be hard to reach, illness can occur in the middle of the night, and sometimes you just have a question. In all of those circumstances – and many more – Lyric Health is a convenient and affordable solution.

Simple as 1, 2, 3

1 Call | Tap | or Click

Call 1.866.223.8831, download the **Lyric Health App** , or visit **www.getlyric.com** to log into your member portal to schedule a consultation with state licensed physician.

2 Triage

Member speaks to a Care Coordinator who will triage and update the patient's Electronic Health Record (EHR).

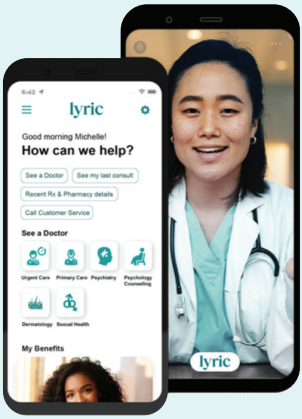
3 Consult

Member consults with Physician who recommends a treatment plan, and if medication(s) is prescribed, it's sent electronically.

When to use

Our goal is to provide you with convenient, affordable healthcare, when you need it most – 24/7/365.

- When you need care now
- If you have a health related questions, and just need professional guidance
- If you're considering the ER or urgent care center for a non-emergency issue
- On vacation, a business trip, or away from home



70% of low acuity illness can be taken care of **virtually**

Common Conditions:

- Cold & Flu Symptoms
- Sinus Problems
- Ear Infection
- Allergies
- Urinary Tract Infection
- Nausea
- Pink Eye
- Stomach Viruses
- Infections
- Rashes
- Sore Throat
- Acne
- Recommendations
- Second Opinions and more

1.866.223.8831 | www.getlyric.com

Licensed healthcare providers provide clinical services through medical practices affiliated with Lyric and other network providers. Additional or different telehealth requirements may be applicable in certain states; see www.getlyric.com for full terms and conditions.

Scan to download the Lyric Health App

Municipal Health Benefit Program Member Portal

YOUR ONLINE BENEFITS CENTER

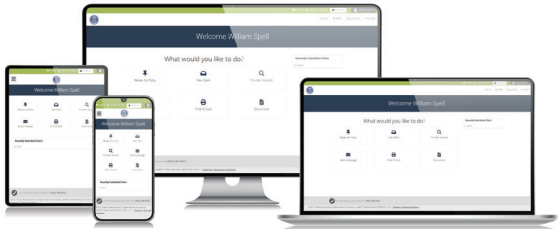
With the new MHBP member portal, you can easily manage your healthcare and plan benefits online.

- Mobile Access: No app needed! Just log in from the browser on your mobile device and the portal will resize to fit your screen. Scan the QR code below to get started.
- User-Friendly Design: The engaging design makes it easier to navigate our portal and find claims, benefits and other important plan information.
- Print ID Card: Whether it's printing or showing your ID card from your phone, this feature will save you time and space in your wallet.
- Email Us: Save yourself a phone call and send us a message in our secure, HIPAA-compliant portal.

The MHBP member portal is your go-to for important benefit-related tasks and information, including:

- Claims
- Benefit Plan Details
- Prescription Info
- Explanations of Benefits
- Search for a Doctor

https://mhbp.arml.org



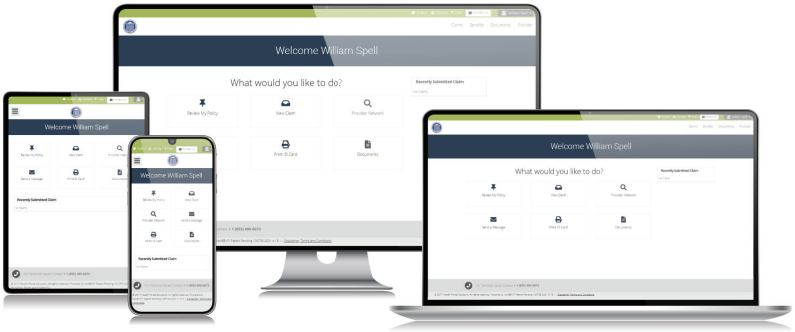
CREATE YOUR ACCOUNT TODAY!

1. Go to *https://mhbp.arml.org*, or scan the QR code below with your phone to get started. Click "Create New Account" and select the "Member" option.
2. On the registration form, fill out your personal details as they appear on your ID card. The email address you use will also be your portal username.
3. Next, set your security questions, time zone and location settings.
4. Agree to the web confidentiality agreement for our portal.
5. At this point, you'll see a confirmation page and get a confirmation email with a link. Click the link to confirm and complete your registration. If you can't find this email, check your Junk folder.
6. Verify your username and answer your security questions.
7. Then, create your password using the password guidelines. Your registration is complete!

Use your phone's camera app to scan the QR code to get started!

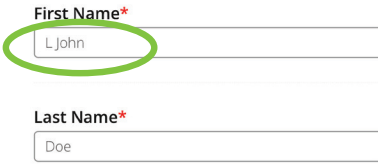
Portal Registration FAQ

Got a question about creating your member portal account? Below are answers to the most frequently asked questions about portal registration.



Q: Do I need to use my middle name when I register?

A: No, unless your ID card shows an initial in your first name. If that's the case, use the initial and your first name as shown in the example.

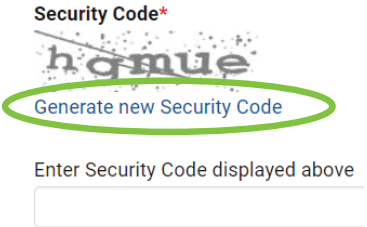


Q: If my employee ID has a dash, do I need to put the dash in the registration form?

A: No, just enter the ID number without the dash.

Q: What do I do if I can't read the security code?

A: Click the button that says "Generate new Security Code" and you'll get a different one.



Q: What is the best browser to access the portal?

A: The portal can be used on any browser but works best on Google Chrome and Microsoft Edge.

Q: How do I log in once I've created my account?

A: Simply go to https://mhbp.arml.org to log in to your account

Need additional assistance? Call 1-855-490-6673

HIPAA Special Enrollment Rights

Initial Notice of Your HIPAA Special Enrollment Rights

Loss of Other Coverage - If you are declining enrollment for yourself and/or your dependents (including your spouse) because of other health insurance coverage or group health plan coverage, you may be able to enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage or if the employer stops contributing towards your or your dependent's coverage. You may be asked to submit a signed statement that this other coverage was the reason for waiving enrollment originally. To be eligible for this special enrollment opportunity you must request enrollment within 30 days after your other coverage ends or after the employer stops contributing towards the other coverage.
New Dependent as a Result of Marriage, Birth, Adoption or Placement for Adoption - If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and/or your dependent(s). To be eligible for this special enrollment opportunity you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Medicaid Coverage - The health plan will allow an employee or dependent who is eligible, but not enrolled for coverage, to enroll for coverage if either of the following events occur:

1. **TERMINATION OF MEDICAID OR CHIP COVERAGE** - If the employee or dependent is covered under a Medicaid plan or under a State child health plan (SCHIP) and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility.
2. **ELIGIBILITY FOR PREMIUM ASSISTANCE UNDER MEDICAID OR CHIP** - If the employee or dependent becomes eligible for premium assistance under Medicaid or SCHIP, including under any waiver or demonstration project conducted under or in relation to such a plan. This is usually a program where the state assists employed individuals with premium payment assistance for their employer's group health plan rather than provide direct enrollment in a state Medicaid program.

To be eligible for this special enrollment opportunity you must request coverage under the group health plan within 60 days after the date the employee or dependent becomes eligible for premium assistance under Medicaid or SCHIP or the date you or your dependent's Medicaid or state-sponsored CHIP coverage ends.
To request special enrollment or obtain more information, please contact Human Resources.

HIPAA Privacy Notice

Notice Of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY THE EMPLOYER AND ITS AFFILIATES, IF ANY, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION AS MANDATED FOR HEALTH PLANS THAT ARE SUBJECT TO HIPAA. PLEASE REVIEW IT CAREFULLY.
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires certain health plans to notify plan participants and beneficiaries about its policies and practices to protect the confidentiality of their health information (45 Code of Federal Regulations parts 160 and 164). Where HIPAA applies to a health plan sponsored by the Employer, this document is intended to satisfy HIPAA's notice requirement for all health information created, received, or maintained by the Employer-sponsored health plan (the Plan). The regulations will supersede any discrepancy between the information in this notice and the regulations.
The Plan needs to create, receive, and maintain records that contain health information about you to administer the Plan and provide you with health care benefits. This notice describes the Plan's health information privacy policy for your health care, dental, personal spending account and flexible reimbursement account benefits. The notice tells you the ways the Plan may use and disclose health information about you, describes your rights, and the obligations the Plan has regarding the use and disclosure of your health information. It does not address the health information policies or practices of your health care providers.

Our Commitment Regarding Health Information Privacy

The privacy policy and practices of the Plan protect confidential health information that identifies you or could be used to identify you and relates to a physical or mental health condition or the payment of your health care expenses. This individually identifiable health information is known as "protected health information" (PHI). Your PHI will not be used or disclosed without a written authorization from you, except as described in this notice or as otherwise permitted by Federal and State health information privacy laws.

Privacy Obligations of the Plan

The Plan is required by law to: (a) make sure that health information that identifies you is kept private; (b) give you this notice of the Plan's legal duties and privacy practices for health information about you; and (c) follow the terms of the notice that is currently in effect.

How the Plan May Use and Disclose Health Information About You
The following are the different ways the Plan may use and disclose your PHI without your written authorization:

For Treatment. The Plan may disclose your PHI to a health care provider who renders treatment on your behalf. For example, if you are unable to provide your medical history as the result of an accident, the Plan may advise an emergency room physician about the types of prescription drugs you currently take.

For Payment. The Plan may use and disclose your PHI so claims for health care treatment, services, and supplies you receive from health care providers may be paid according to the terms of the Plan. For example, the Plan may receive and maintain information about surgery you received to enable the Plan to process a hospital's claim for reimbursement of surgical expenses incurred on your behalf.

For Health Care Operations. The Plan may use and disclose your PHI to enable it to operate or operate more efficiently or make certain all of the Plan's participants receive their health benefits. For example, the Plan may use your PHI for case management or to perform population-based studies designed to reduce health care costs. In addition, the Plan may use or disclose your PHI to conduct compliance reviews, audits, actuarial studies, and/or for fraud and abuse detection. The Plan may also combine health information about many plan participants and disclose it to the Employer and its affiliates, if any, in summary fashion so it can decide what coverages the Plan should provide. The Plan may remove information that identifies you from health information disclosed so it may be used without the Employer's learning who the specific participants are.

To the Employer. The Plan may disclose your PHI to designated Employer personnel so they can carry out their plan-related administrative functions, including the uses and disclosures described in this notice. Such disclosures will be made only to the Employer's Privacy Officer and personnel under the Privacy Officer's supervision. These individuals will protect the privacy of your health information and ensure it is used only as described in this notice or as permitted by law. Unless authorized by you in writing, your health information: 1) may not be disclosed by the Plan to any other employee and 2) will not be used by the Employer for any employment-related actions and decisions or in connection with any other employee benefit plan sponsored by the Employer.

To a Business Associate. Certain services are provided to the Plan by third-party administrators known as "business associates." For example, the Plan may input information about your health care treatment into an electronic claim processing system maintained by the business associate so your claim may be paid. In so doing, the Plan will disclose your PHI to its business associate so it can perform its claims payment function. However, the Plan will require its business associates, through contract, to appropriately safeguard your health information.

Treatment Alternatives. The Plan may use and disclose your PHI to tell you about possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. The Plan may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.

Individual Involved in Your Care or Payment of Your Care. The Plan may disclose PHI to a close friend or family member involved in or who helps pay for your health care. The Plan may also advise a family member or close friend about your condition, your location (for example, that you are in the hospital), or death.

As Required by Law. The Plan will disclose your PHI when required to do so by Federal, State or Local law, including those that require the reporting of certain types of wounds or physical injuries.

To the Secretary of the Department of Health and Human Services (HHS). The Plan may disclose your PHI to HHS for the investigation or determination of compliance with privacy regulations.

Special Use and Disclosure Situations
The Plan may also use or disclose your PHI under the following circumstances:

Lawsuits and Disputes. If you become involved in a lawsuit or other legal action, the Plan may disclose your PHI in response to a court or administrative order, a subpoena, warrant, discovery request, or other lawful due process.

Law Enforcement. The Plan may release your PHI if asked to do so by a law enforcement official, for example, to identify or locate a suspect, material witness, or missing person or to report a crime, the crime's location or victims, or the identity, description, or location of the person who committed the crime.

Worker's Compensation. The Plan may disclose your PHI to the extent authorized by and to the extent necessary to comply with worker's compensation laws and other similar programs.

Military and Veterans. If you are or become a member of the U.S. armed forces, the Plan may release medical information about you as deemed necessary by military command authorities.

To Avert Serious Threat to Health or Safety. The Plan may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person.

Public Health Risks. The Plan may disclose health information about you for public health activities. These activities include preventing or controlling disease, injury or disability; reporting births and deaths; reporting child abuse or neglect; or reporting reactions to medication or problems with medical products or to notify people of recalls of products they have been using.

Health Oversight Activities. The Plan may disclose your PHI to a health oversight agency for audits, investigations, inspections, and licensure necessary for the government to monitor the health care system and government programs.

Research. Under certain circumstances, the Plan may use and disclose your PHI for medical research purposes.

National Security, Intelligence Activities, and Protective Services. The Plan may release your PHI to authorized Federal officials: 1) for intelligence, counterintelligence, and other national security activities authorized by law and 2) to enable them to provide protection to the members of the U. S. government or foreign heads of state, or to conduct special investigations.

Organ and Tissue Donation. If you are an organ donor, the Plan may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank to facilitate organ or tissue donation and transplantation.

Coroners, Medical Examiners, and Funeral Directors. The Plan may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. The Plan may also release your PHI to a funeral director, as necessary, to carry out his or her duty.

Your Rights Regarding Health Information About You
Your rights regarding the health information the Plan maintain about you are as follows:

Right to Inspect and Copy. You have the right to inspect and copy your PHI. This includes information about your plan eligibility, claim and appeal records, and billing records, but does not include psychotherapy notes. To inspect and copy health information maintained by the Plan, submit your request in writing to the Privacy Officer. The Plan may charge a fee for the cost of copying and/or mailing your request. In limited circumstances, the Plan may deny your request to inspect and copy your PHI. Generally, if you are denied access to health information, you may request a review of the denial.

Right to Amend. If you feel that health information the Plan have about you is incorrect or incomplete, you may ask to amend it. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, send a detailed request in writing to the Privacy Officer. You must provide the reason(s) to support your request. The Plan may deny your request if you ask to amend health information that was: accurate and complete, not created by the Plan; not part of the health information kept by or for the Plan; or not information that you would be permitted to inspect and copy.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of disclosures of your PHI that the Plan have made to others, except for those necessary to carry out health care treatment, payment, or operations; disclosures made to you; disclosures made prior to this effective date at the end of this notice; or in certain other situations. To request an accounting of disclosures, submit your request in writing to the Privacy Officer. Your request must state a time period, which may not be longer than six years prior to the date the accounting was requested.

Right to Request Restrictions. You have the right to request a restriction on the health information the Plan use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information the Plan disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that the Plan not use or disclose information about a surgery you had. To request restrictions, make your request in writing to the Privacy Officer. You must advise us: 1) what information you want to limit; 2) whether you want to limit the Plan's use, disclosure, or both; and 3) to whom you want the limit(s) to apply. Note: The Plan is not required to agree to your request.

Right to Request Confidential Communications.
You have the right to request that the Plan communicate with you about health matters in a certain way or at a certain location. For example, you can ask that the Plan send you explanation of benefits (EOB) forms about your benefit claims to a specified address. To request confidential communications, make your request in writing to the Privacy Officer. The Plan will make every attempt to accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to Opt-Out of Fundraising Communications. While the plan has no intention of being involved in fundraising activities, if the plan intends to contact you to raise funds for the plan, you have the right to opt-out of receiving such communications.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may write to the Privacy Officer to request a written copy of this notice at any time.

A Note About Personal Representatives
You may exercise your rights through a personal authorized representative. Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public;
- A court order of appointment of the person as the conservator or guardian of the individual; or

» An individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Changes to this Notice

The Plan reserves the right to change this notice at any time and to make the revised or changed notice effective for health information the Plan already has about you, as well as any information the Plan receives in the future. The Plan will post a copy of the current notice in the Employer's office. All individuals covered under the Plan will receive a revised notice within 60 days of a material revision to the notice.

Notice of Breach of PHI

You have a right to receive a notice when there is a breach of your unsecured PHI.

Complaints

If you believe your privacy rights under this policy have been violated, you may file a written complaint with the Privacy Officer at the address listed below. Alternatively, you may file a complaint with the Secretary of the U.S. Department of Health and Human Services (Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington D.C. 20201), generally, within 180 days of when the act or omission complained of occurred. Note: The Plan, the Employer, and any of its affiliates will not retaliate against you for filing a complaint.

Other Uses and Disclosures of Health Information

A plan must obtain your written authorization to use or disclose psychotherapy notes, to use PHI for marketing purposes, or to sell PHI. An authorization for a use or disclosure of psychotherapy notes may only be combined with another authorization for a use and disclosure of psychotherapy notes.

Plans (excluding long-term care plans) are prohibited from using or disclosing PHI that is genetic information for underwriting purposes.

Other uses and disclosures of health information not covered by this notice or by the laws that apply to the Plan will be made only with your written authorization. If you authorize the Plan to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you revoke your authorization, the Plan will no longer use or disclose your PHI for the reasons covered by your written authorization; however, the Plan will not reverse any uses or disclosures already made.

Contact Information: If you have any questions about this notice, please contact the Privacy Officer.

Maternity Coverage

For maternity stays, in accordance with federal law, the plan does not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal delivery, or less than 96 hours following a cesarean delivery. However, federal law generally does not prevent the mother's or newborn's attending care provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). The plan cannot require a provider to prescribe a length of stay any shorter than 48 hours (or 96 hours following a cesarean delivery).

Women's Health and Cancer Rights

On October 21, 1998, Congress passed a bill called the Women's Health and Cancer Rights Act. This law requires group health plans that provide coverage for mastectomy to provide coverage for certain reconstructive services. These services include:

» Reconstruction of the breast upon which the mastectomy has been performed,
» Surgery/reconstruction of the other breast to produce a symmetrical appearance,
» Prostheses, and
» Physical complications during all stages of mastectomy, including lymphedemas

In addition, the plan may not:

» Interfere with a woman's rights under the plan to avoid these requirements, or
» Offer inducements to the health provider, or assess penalties against the health provider, in an attempt to interfere with the requirements of the law.

However, the plan may apply deductibles and copays consistent with other coverage provided by the plan. If you have questions about the current plan coverage, please contact your HR Department.

Important Notice from City of Benton About Your Prescription Drug Coverage and Medicare Part D

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with City of Benton 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. City of Benton has determined that the prescription drug coverage offered by the City of Benton Welfare Benefit 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 from October 15th to December 7th. 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?

If you decide to join a Medicare drug plan, your current City of Benton coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current City of Benton coverage, be aware that you and your dependents will 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 City of Benton and don't 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…
Contact a JTS representative for more information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through City of Benton.

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).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

JTS

INTENTIONALLY DIFFERENT

QUESTIONS ABOUT YOUR BENEFITS?

501.476.5839.

arteam@jtsfs.com