ARKANSAS STATE POLICE HEALTH BENEFIT PLAN
SCHEDULE OF BENEFITS
Effective January 1, 2024

SERVICES REQUIRING PRIOR APPROVAL

Inpatient admissions, including emergency admissions and concurrent care extension, at a Hospital and similar facilities, such as:

Acute Care Facility
Inpatient Rehabilitation (Physical)
Skilled Nursing Facility
Long Term Acute Care (LTACH)

Inpatient stay in a Hospital or Birthing Center that is longer than 48 hours following a normal vaginal delivery or 96 hours following a Cesarean section

Organ transplants (except Cornea transplants)

Prosthetics
Osseointegrated implantable hearing aids

Specific Outpatient Medical Services

Home Health Services
Hospice Care
Occupational Therapy*
Cognitive Rehabilitation
Intensity-Modulated Radiation Therapy (IMRT)
Physical Therapy*
Prosthodontics
Speech Therapy*
Enteral Formulae and Supplies
Craniofacial Anomaly Services

* Prior Approval for occupational, speech, and physical rehabilitative therapies applies after the 15th visit.

Specific Outpatient Medical Procedures

Uvulopalatopharyngoplasty (UPPP)
Blepharoplasty and/or Brow Lift
Mammoplasty
Rhinoplasty
Gastric Pacemaker
Varicose Vein Treatment
Gynecomastia Reduction
Panniculectomy
Scar Revision outside doctor's office

Specific Durable Medical Equipment

Spinal Cord Stimulators (implantation and device)
Defibrillator Vests
Wound Vacuum Therapy / Device
Continuous Glucose Monitoring Devices
Power Mobility Devices

Behavioral Health Services

Behavioral Health Facility Admissions
Intensive Outpatient Treatment
Applied Behavioral Analysis Services
Residential Treatment Facility Admissions
Partial Hospital/Day Treatment
Repetitive Transcranial Magnetic Stimulation (rTMS)

Advanced Imaging and Radiology Services

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

MEDICAL BENEFITS		
	In-Network	**Out-of-Network**
Calendar Year Deductible	$1,000 per person $2,000 per Family Unit	$2,000 per person $4,000 per Family Unit

Deductibles Payable by Plan Participants, per Calendar Year
A deductible is an amount of money that is paid once a Calendar Year per Covered Person or Family Unit. On the first day of each Calendar Year, a new deductible amount is required.

Deductible Three Month Carryover. Covered Charges incurred in, and applied toward the deductible in the last three months of the Calendar Year will be applied toward the deductible in the next Calendar Year.

Deductible Accumulation
The In-Network and Out-of-Network deductibles are totally separate and do not contribute toward or offset each other.

This Plan has an embedded individual deductible, meaning that an individual enrolled in family coverage will never have to pay more than the individual deductible amount before the Plan begins to pay coinsurance for the individual.

The Calendar Year deductible is waived for the following Covered Charges:
- In-Network Preventive Care
- In-Network PCP Office and Outpatient Services
- In-Network Urgent Care Services
- In-Network allergy serum and injections
- In-Network routine eye exam, hearing screening and hearing aids
- In-Network organ transplant surgery and surgeon charges
- Ambulance Services
- Multiple births
- Emergency room surgical and related services

	In-Network	**Out-of-Network**
Annual Out-of-Pocket Limits	$4,000 per person $8,000 per Family Unit	Unlimited

Annual Out-of-Pocket Limits
Unless stated otherwise in this document, the Plan will pay 80% of In-Network Covered Charges until the annual Out-of-Pocket Limit is satisfied, at which time the Plan will pay 100% of the remainder of In-Network Covered Charges for the rest of the Calendar Year.

Generally speaking, the Plan will never pay more than 60% of Out-of-Network Covered Charges. Any exceptions to that rule are noted within this Schedule of Benefits.

Out-of-Pocket Accumulation
The In-Network and Out-of-Network Out-of-Pocket amounts are totally separate and do not contribute toward or offset each other.
This Plan has an embedded individual out-of-pocket limit, meaning than an individual enrolled in family coverage will never have to pay more than the individual out-of-pocket limit before the Plan begins to pay Covered Charges at 100% for the individual.

The charges for the following do not apply to the annual Out-of-Pocket Limit:
- Out-of-Network Charges
- Pharmacy Benefit Charges
- Penalties for failure to obtain Prior Approval
- Amounts in excess of the Allowable Charge
- Non-covered services

HOSPITAL BENEFITS		
	In-Network	**Out-of-Network**
Inpatient facility services	80%, after deductible	$200 copay 60%, after deductible
Outpatient facility services *Outpatient Surgery (includes all related charges two weeks prior and two weeks after for outpatient hospital charges).*	100%, deductible waived	60%, after deductible
Other outpatient services	80%, after deductible	60%, after deductible
Emergency room when services are considered a Medical Emergency as defined by the Plan.		
Emergency room services excluding surgery and treatment.	80%, after deductible	80%, after deductible
Emergency room services for surgery and related services.	100%, deductible waived	100%, after deductible
Emergency room when services are not related to a Medical Emergency as defined by the Plan.		
Emergency room services excluding surgery and treatment.	80%, after deductible	60%, after deductible
Emergency room services for surgery and related services.	100%, deductible waived	60%, after deductible

Prior Approval. Prior Approval is required for all inpatient admissions (except for a Hospital admission following a Medical Emergency) and many surgical services. See Cost Management Section for more information.

NOTE: For inpatient admissions related to treatment of a Medical Emergency, the Covered Person or the treating Provider should notify the Plan of the admission within 48 hours of the admission.

Room and Board Allowances. Covered Charges for room and board during an inpatient admission shall be limited to the lesser of the billed charge or the Allowable Charge established by the Plan.

PHYSICIAN BENEFITS			
	In-Network PCPs*	**In-Network Specialist**	**All Out-of-Network Physicians**
Office visit	$30 copay, then 100%, deductible waived	80%, after deductible	60%, after deductible
Lab, x-rays, and high-tech radiology ordered by PCP and rendered at a hospital, outside lab or radiology facility billed within three days of the office visit.	100%, deductible waived	80%, after deductible	60%, after deductible
Standard Preventive Care: *At all times, the Plan will comply with the Patient Protection Affordable Care Act (ACA). The list of services included as Standard Preventive Care may change from time to time depending upon government guidelines. A current listing of required preventive care can be accessed at* www.HealthCare.gov/center/regulations/prevention.html and www.cdc.gov/vaccines/.	100%, deductible waived	100%, deductible waived	not covered
Breast Cancer, Diagnostic Exams	100%, deductible waived	100%, deductible waived	60%, after deductible
Colorectal Cancer Screenings, Follow-Up Colonoscopy	100%, deductible waived	100%, deductible waived	60%, after deductible
Routine Preventive Care: *In addition to the preventive services mandated by the ACA, the Plan also provides more generous coverage for the following services:* • *Pap smears, x-rays, and labs billed as annual or preventive GYN visit.*	100%, deductible waived	100%, deductible waived	not covered

PHYSICIAN BENEFITS, continued			
	In-Network PCPs*	**In-Network Specialist**	**All Out-of-Network Physicians**
Outpatient Services			
Outpatient Surgery (includes all related charges two weeks prior and two weeks after for the physician's office or outpatient hospital charges, including the emergency room location.)	100%, deductible waived	100%, deductible waived	60%, after deductible
Outpatient Therapy (includes Physical, Occupational, and Speech Therapy) • *Prior Approval is required after the 15th visit.*	$30 copay, then 100%, deductible waived	$30 copay, then 100%, deductible waived	60%, after deductible
Other Outpatient Services	80%, after deductible	80%, after deductible	60%, after deductible
Lab, x-rays, and high-tech radiology ordered by PCP and rendered at a hospital, outside lab or radiology facility billed within three days of the office visit.	100%, deductible waived	80%, after deductible	60%, after deductible
Inpatient services	80%, after deductible	80%, after deductible	60%, after deductible
Emergency room when services are considered a Medical Emergency as defined by the Plan.			
Emergency room services excluding surgery and treatment	80%, after deductible	80%, after deductible	80%, after deductible
Emergency room services for surgery and related services.	100%, deductible waived	100%, deductible waived	100%, deductible waived
Emergency room when services are not related to a Medical Emergency as defined by the Plan.			
Emergency room services excluding surgery and treatment	80%, after deductible	80%, after deductible	60%, after deductible
Emergency room services for surgery and related services.	100%, deductible waived	100%, deductible waived	60%, after deductible

***Primary Care Physicians i**nclude general practitioners, family practitioners, doctors of internal medicine, pediatricians, and geriatricians.

Covered Charges billed by physician assistants, registered nurse practitioners, certified nurse practitioners, and clinical nurse specialists that work under the direction of a Primary Care Physician will also be paid at the Primary Care Physician reimbursement rate.

OTHER BENEFIT LIMITS AND MAXIMUMS		
	In-Network	**Out-of-Network**
Allergy services *Testing and treatment* *Serum and Injections*	PCP: 100%, deductible waived Specialist: 80%, after deductible PCP: 100%, deductible waived Specialist: 100%, deductible waived	60%, after deductible 60%, after deductible
Ambulance Services *Ground and Air transport* • . • . *Water transport*	80%, deductible waived Not covered	80%, deductible waived Not covered
Behavioral Health Treatment *Office services* *Outpatient, professional* *Outpatient, facility* *Inpatient, professional* *Inpatient, facility*	 80%, after deductible 80%, after deductible 80%. after deductible 80%, after deductible 80%, after deductible	 60%, after deductible 60%, after deductible 60%, after deductible 60%, after deductible $200 copay 60%, after deductible
Cardiac Rehabilitation	80%, after deductible	60%, after deductible
Chiropractic services • *Limited to 30 visits per year.*	80%, after deductible	60%, after deductible
Diabetes Management *Services include insulin pumps and pump supplies, eye exams to screen for diabetic retinopathy, diabetic shoes and inserts.* *Routine foot care for prevention of complications associated with diabetes mellitus*	80%, after deductible PCP: 100%, deductible waived Specialist: 80%, after deductible	60%, after deductible 60%, after deductible
Durable Medical Equipment	80%, after deductible	60%, after deductible
Hearing Aids/Implantable Hearing Devices *Hearing aids* • *Limited to $1,400 per ear every three years.* *Cochlear implants* • *Limited to one per ear per Lifetime.* *Auditory Brain Stem Implant* • *Limited to one per Lifetime.* *Hearing Aids/Implantable Hearing Devices* • *Osseointegrated implantable hearing aids require Prior Approval.*	 100%, deductible waived 80%, after deductible 80%, after deductible 80%, after deductible	 60%, after deductible 60%, after deductible 60%, after deductible 60%, after deductible

OTHER BENEFIT LIMITS AND MAXIMUMS, continued		
	In-Network	**Out-of-Network**
Hearing Exams *Routine hearing screenings* *Diagnostic hearing test* **Advanced Diagnostic Imaging** • *Requires Prior Approval.*	 100%, deductible waived 80%, after deductible 80%, after deductible	 not covered 60%, after deductible 60%, after deductible
Hospice Care • *Limited to $5,000 per Lifetime.*	80%, after deductible	60%, after deductible
Independent Laboratory **Independent laboratory charges when ordered by a PCP and is billed within three days of a PCP visit.**	80%, after deductible 100%, deductible waived	80%, after deductible 100%, deductible waived
Mastectomy Prosthetics Bras following mastectomy • *Limited to six bras per calendar year.* Replacement for the following is available when necessitated by the device's useful life: • *Silicon breast prosthesis after two years.* • *Fabric, foam or fiber filled breast prosthesis after six months.* • *Nipple prosthesis is after three months.*	 80%, after deductible 80%, after deductible	 60%, after deductible 60%, after deductible
Maternity services *Office visits* *Childbirth/delivery, physician services* *Childbirth/delivery, facility services* *Routine obstetrical ultrasound* • *Limited to one per Pregnancy.* *Electric and manual breast pumps*	 80%, after deductible 80%, after deductible 80%, after deductible 80%, after deductible 100%, deductible waived	 60%, after deductible 60%, after deductible $200 copay 60%, after deductible 60%, after deductible 100%, deductible waived
Neurologic Rehabilitation Facilities • *Requires Prior Approval.* *Outpatient services* *Inpatient services*	 80%, after deductible 80%, after deductible	 80%, after deductible $200 copay, 80%, after deductible
Organ Transplants *Prior Approval is required with the exception of cornea transplants.* *Transplant, facility charges* *Surgery/Surgeon Charges (including all related charges two weeks prior and two weeks after for the Physician's Office or Outpatient Hospital Charges.* *Travel and Lodging* • *Limited to $10,000 per transplant.*	80%, after deductible 100%, deductible waived 80%, after deductible	60%, after deductible 60%, after deductible 60%, after deductible

OTHER BENEFIT LIMITS AND MAXIMUMS, continued		
	In-Network	**Out-of-Network**
Orthotic Appliances • *Limited to once per three-year period except when necessitated by normal growth or when the age of the orthotic device exceeds the useful life.*	80%, after deductible	60%, after deductible
Prosthetic Devices • *Requires Prior Approval.* • *Limited to once per three-year period except when necessitated by normal growth or when the age of the prosthetic device exceeds the useful life. For specific limits on breast prosthesis after mastectomy see Mastectomy Prosthetics located earlier in this section.*	80%, after deductible	60%, after deductible
Telehealth Benefits *Including Telemedicine services and Telephone-based services.* *Including Telemedicine services and Telephone-based services.*	PCP: $30 copay, then 100%, deductible waived Specialist: 80%, after deductible	60%, after deductible 60%, deductible waived
Temporomandibular Joint (TMJ) Disorder • *Limited to $2,000 per Calendar Year.*	80%, after deductible	60%, after deductible
Therapy Services • *Includes Outpatient Occupational, Physical, and Speech Therapies.* • *Services require Prior Approval from the Claims Administrator after the 15th visit.*	$30 copay, then 100%, deductible waived	60%, after deductible
Urgent Care Clinic	$30 copay, then 100%, deductible waived	60%, after deductible
Vision Exam *Routine eye exams* • *Limited to one routine exam every two years.* *Eye exams following Illness/Injury* *Eyeglasses* • *Limited to initial pair following cataract surgery.*	100%, deductible waived 80%, after deductible 80%, after deductible	60%, after deductible 60%, after deductible 60%, after deductible

PRESCRIPTION DRUG BENEFITS		
Annual Limit on Pharmacy Out-of-Pocket	**In-Network**	**Out-of-Network**
Individual	$2,850	unlimited
Family	$5,700	unlimited
Covered Benefits and Services	**In-Network Coinsurance**	**Out-of-Network Coinsurance**
Retail Pharmacy (Drug Store) - *Standard Formulary with Step Therapy*		
ASP Retirees who retired under the ASP Contributory System before January 1, 1978.	$10/30/50	Not covered
Active and COBRA participants, as well as Retirees who retired under the ASP Contributory System after January 1, 1978.	$15/40/65	Not covered