

**ARKANSAS STATE POLICE HEALTH BENEFIT PLAN
SCHEDULE OF BENEFITS
Effective January 1, 2026**

SERVICES REQUIRING PRIOR APPROVAL	
Inpatient admissions, including emergency admissions and concurrent care extension, at a Hospital and similar facilities, such as:	
Acute Care Facility	Skilled Nursing Facility
Inpatient Rehabilitation (Physical)	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 Durable Medical Equipment	
Power Mobility Devices	
Specific Outpatient Medical Services	
Home Health Services	Physical Therapy
Hospice Care	Prosthodontics
Occupational Therapy	Speech Therapy
Cognitive Rehabilitation	Enteral Formulæ and Supplies
Intensity-Modulated Radiation Therapy (IMRT)	Craniofacial Anomaly Services
Specific Outpatient Medical Procedures	
Uvulopalatopharyngoplasty (UPPP)	Varicose Vein Treatment
Blepharoplasty and/or Brow Lift	Gynecomastia Reduction
Mammoplasty	Panniculectomy
Rhinoplasty	Scar Revision outside doctor's office
Gastric Pacemaker	
Specific Durable Medical Equipment	
Spinal Cord Stimulators (implantation and device)	Continuous Glucose Monitoring Devices
Defibrillator Vests	Power Mobility Devices
Wound Vacuum Therapy / Device	
Behavioral Health Services	
Behavioral Health Facility Admissions	Residential Treatment Facility Admissions
Intensive Outpatient Treatment	Partial Hospital/Day Treatment
Applied Behavioral Analysis Services	Repetitive Transcranial Magnetic Stimulation (rTMS)
Advanced Imaging and Radiology Services	
Computerized Tomography (CT)	Computerized Tomography Angiography (CTA)
Magnetic Resonance Imaging (MRI)	Magnetic Resonance Angiography (MRA)
Positron Emission Toography (PET)	

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
<p>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.</p> <p>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.</p> <p>Deductible Accumulation The In-Network and Out-of-Network deductibles are totally separate and do not contribute toward or offset each other.</p> <p>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.</p> <p>The Calendar Year deductible is waived for the following Covered Charges:</p> <ul style="list-style-type: none"> • 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
<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>The charges for the following do not apply to the annual Out-of-Pocket Limit:</p> <ul style="list-style-type: none"> • 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% of Covered Charges, after deductible	\$200 Copay, then 60% of Covered Charges, after deductible
Outpatient facility services	80% of Covered Charges, after deductible	60% of Covered Charges, after deductible
Emergency room when services are considered a Medical Emergency as defined by the Plan. <i>Emergency room services excluding surgery and treatment.</i> <i>Emergency room services for surgery and related services.</i>	80% of Covered Charges, after deductible 100% of Covered Charges, deductible waived	80% of Covered Charges, after deductible 100% of Covered Charges, after deductible
Emergency room when services are not related to a Medical Emergency as defined by the Plan. <i>Emergency room services excluding surgery and treatment.</i> <i>Emergency room services for surgery and related services.</i>	80% of Covered Charges, after deductible 100% of Covered Charges, deductible waived	60% of Covered Charges, after deductible 60% of Covered Charges, after deductible
<p>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.</p> <p>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.</p> <p>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.</p>		

PHYSICIAN BENEFITS			
	In-Network PCPs*	In-Network Specialist	All Out-of-Network Physicians
Office visit <i>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.</i>	\$30 Copay, then 100% of Covered Charges, deductible waived 100% of Covered Charges, deductible waived	80% of Covered Charges, after deductible 80% of Covered Charges, after deductible	60% of Covered Charges, after deductible 60% of Covered Charges, after deductible
Standard Preventive Care: <i>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/.</i>	100% of Covered Charges, deductible waived	100% of Covered Charges, deductible waived	not covered
Breast Cancer, Diagnostic Exams	100% of Covered Charges, deductible waived	100% of Covered Charges, deductible waived	60% of Covered Charges after deductible
Colorectal Cancer Screenings, Follow-Up Colonoscopy	100% of Covered Charges, deductible waived	100% of Covered Charges, deductible waived	60% of Covered Charges, after deductible
Routine Preventive Care: <i>In addition to the preventive services mandated by the ACA, the Plan also provides more generous coverage for the following services:</i> <ul style="list-style-type: none"> <i>Pap smears, x-rays, and labs billed as annual or preventive GYN visit.</i> 	100% of Covered Charges, deductible waived	100% of Covered Charges, deductible waived	not covered

PHYSICIAN BENEFITS, continued

	In-Network PCPs*	In-Network Specialist	All Out-of- Network Physicians
Outpatient Services			
<i>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.)</i>	100% of Covered Charges, deductible waived	100% of Covered Charges, deductible waived	60% of Covered Charges, after deductible
<i>Outpatient Therapy (includes Physical, Occupational, and Speech Therapy)</i> <ul style="list-style-type: none"> • Prior Approval is required.. 	\$30 Copay, then 100% of Covered Charges, deductible waived	\$30 Copay, then 100% of Covered Charges, deductible waived	60% of Covered Charges, after deductible
<i>Other Outpatient Services</i>	80% of Covered Charges, after deductible	80% of Covered Charges, after deductible	60% of Covered Charges, after deductible
<i>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.</i>	100% of Covered Charges, deductible waived	80% of Covered Charges, after deductible	60% of Covered Charges, after deductible
Inpatient services	80% of Covered Charges, after deductible	80% of Covered Charges, after deductible	60% of Covered Charges, after deductible
Emergency room when services are considered a Medical Emergency as defined by the Plan.			
<i>Emergency room services excluding surgery and treatment</i>	80% of Covered Charges, after deductible	80% of Covered Charges, after deductible	80% of Covered Charges, after deductible
<i>Emergency room services for surgery and related services.</i>	100% of Covered Charges, deductible waived	100% of Covered Charges, deductible waived	100% of Covered Charges, deductible waived
Emergency room when services are not related to a Medical Emergency as defined by the Plan.			
<i>Emergency room services excluding surgery and treatment</i>	80% of Covered Charges, after deductible	80% of Covered Charges, after deductible	60% of Covered Charges, after deductible
<i>Emergency room services for surgery and related services.</i>	100% of Covered Charges, deductible waived	100% of Covered Charges, deductible waived	60% of Covered Charges, after deductible

***Primary Care Physicians** include 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 No benefits will be paid in excess of any listed limit.		
	In-Network	Out-of-Network
Advanced Diagnostic Imaging • <i>Requires Prior Approval.</i>	80% of Covered Charges, after deductible	60% of Covered Charges, after deductible
Allergy services <i>Testing and treatment</i>	PCP: 100% of Covered Charges, deductible waived Specialist: 80% of Covered Charges, after deductible	60% of Covered Charges, after deductible
<i>Serum and Injections</i>	PCP: 100% of Covered Charges, deductible waived Specialist: 100% of Covered Charges, deductible waived	60% of Covered Charges, after deductible
Ambulance Services <i>Air and Ground Ambulance Services</i>	80% of Covered Charges, deductible waived	80% of Covered Charges, deductible waived
<i>Water transport</i>	Not covered	Not covered
Behavioral Health Treatment <i>Office services</i>	80% of Covered Charges, after deductible	60% of Covered Charges, after deductible
<i>Outpatient, professional</i>	80% of Covered Charges, after deductible	60% of Covered Charges, after deductible
<i>Outpatient, facility</i>	80% of Covered Charges, after deductible	60% of Covered Charges, after deductible
<i>Inpatient, professional</i>	80% of Covered Charges, after deductible	60% of Covered Charges, after deductible
<i>Inpatient, facility</i>	80% of Covered Charges, after deductible	\$200 Copay, then 60% of Covered Charges, after deductible
Cardiac Rehabilitation	80% of Covered Charges, after deductible	60% of Covered Charges, after deductible
Chiropractic services • <i>Limited to 30 visits per year.</i>	80% of Covered Charges, after deductible	60% of Covered Charges, after deductible
Diabetes Management <i>Services include insulin pumps and pump supplies, eye exams to screen for diabetic retinopathy, diabetic shoes and inserts.</i>	80% of Covered Charges, after deductible	60% of Covered Charges, after deductible
<i>Routine foot care for prevention of complications associated with diabetes mellitus</i>	PCP: 100% of Covered Charges, deductible waived Specialist: 80% of Covered Charges, deductible waived	60% of Covered Charges, after deductible
Durable Medical Equipment	80% of Covered Charges, after deductible	60% of Covered Charges, after deductible

OTHER BENEFIT LIMITS AND MAXIMUMS, continued

No benefits will be paid in excess of any listed limit.

	In-Network	Out-of-Network
<p>Hearing Aids/Implantable Hearing Devices</p> <p><i>Hearing aids</i></p> <ul style="list-style-type: none"> Limited to \$1,400 per ear every three years. <p><i>Cochlear implants</i></p> <ul style="list-style-type: none"> Limited to one per ear per Lifetime. <p><i>Auditory brain stem implant</i></p> <ul style="list-style-type: none"> Limited to one per Lifetime 	<p>100% of Covered Charges, deductible waived</p> <p>80% of Covered Charges, after deductible</p> <p>80% of Covered Charges, after deductible</p>	<p>60% of Covered Charges, after deductible</p> <p>60% of Covered Charges, after deductible</p> <p>60% of Covered Charges, after deductible</p>
<p>Hearing Exams</p> <p><i>Routine hearing screenings</i></p> <p><i>Diagnostic hearing test</i></p>	<p>100% of Covered Charges, deductible waived</p> <p>80% of Covered Charges, after deductible</p> <p>80% of Covered Charges, after deductible</p>	<p>not covered</p> <p>60% of Covered Charges, after deductible</p> <p>60% of Covered Charges, after deductible</p>
<p>Hospice Care</p> <ul style="list-style-type: none"> Limited to \$5,000 per Lifetime. 	<p>80% of Covered Charges, after deductible</p>	<p>60% of Covered Charges, after deductible</p>
<p>Independent Laboratory</p> <p>Independent laboratory charges when ordered by a PCP and is billed within three days of a PCP visit.</p>	<p>80% of Covered Charges, after deductible</p> <p>100% of Covered Charges, deductible waived</p>	<p>80% of Covered Charges, after deductible</p> <p>100% of Covered Charges, deductible waived</p>
<p>Mastectomy Prosthetics</p> <p>Bras following mastectomy</p> <ul style="list-style-type: none"> Limited to six bras per calendar year <p>Replacement for the following is available when necessitated by the device's useful life:</p> <ul style="list-style-type: none"> Silicon breast prosthesis after two years. Fabric, foam or fiber filled breast prosthesis after six months. Nipple prosthesis is after three months. 	<p>80% of Covered Charges, after deductible</p> <p>80% of Covered Charges, after deductible</p>	<p>60% of Covered Charges, after deductible</p> <p>60% of Covered Charges, after deductible</p>

OTHER BENEFIT LIMITS AND MAXIMUMS, continued
No benefits will be paid in excess of any listed limit.

	In-Network	Out-of-Network
Maternity services <i>Office visits</i> <i>Childbirth/delivery, physician services</i> <i>Childbirth/delivery, facility services</i> <i>Routine obstetrical ultrasound</i> <ul style="list-style-type: none"> Limited to one per Pregnancy. <i>Electric and manual breast pumps</i> <ul style="list-style-type: none"> Limited to one manual breast pump; and/or one electric breast pump, up to \$160 maximum, per Pregnancy when purchased. <i>There is no coverage of Pregnancy for a Dependent other than a Covered Spouse.</i>	<p align="center">80% of Covered Charges, after deductible</p> <p align="center">80% of Covered Charges, after deductible</p> <p align="center">80% of Covered Charges, after deductible</p> <p align="center">80% of Covered Charges, after deductible</p> <p align="center">100% of Covered Charges, deductible waived</p>	<p align="center">60% of Covered Charges, after deductible</p> <p align="center">60% of Covered Charges, after deductible</p> <p align="center">\$200 Copay, then 60% of Covered Charges, after deductible</p> <p align="center">60% of Covered Charges, after deductible</p> <p align="center">100% of Covered Charges, deductible waived</p>
Neurologic Rehabilitation Facilities <ul style="list-style-type: none"> Requires Prior Approval. <i>Outpatient services</i> <i>Inpatient services</i>	<p align="center">80% of Covered Charges, after deductible</p> <p align="center">80% of Covered Charges, after deductible</p>	<p align="center">80% of Covered Charges, after deductible</p> <p align="center">\$200 Copay, then 80% of Covered Charges, after deductible</p>
Organ Transplants <ul style="list-style-type: none"> Prior Approval is required with the exception of cornea transplants. <i>Transplant, facility charges</i> <i>Surgery/Surgeon Charges (including all related charges two weeks prior and two weeks after for the Physician's Office or Outpatient Hospital Charges.</i> <i>Travel and Lodging</i> <ul style="list-style-type: none"> Limited to \$10,000 per transplant 	<p align="center">80% of Covered Charges, after deductible</p> <p align="center">100% of Covered Charges, deductible waived</p> <p align="center">80% of Covered Charges, after deductible</p>	<p align="center">60% of Covered Charges, after deductible</p> <p align="center">60% of Covered Charges, after deductible</p> <p align="center">60% of Covered Charges, after deductible</p>
Orthotic Appliances <ul style="list-style-type: none"> 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. 	<p align="center">80% of Covered Charges, after deductible</p>	<p align="center">60% of Covered Charges, after deductible</p>

OTHER BENEFIT LIMITS AND MAXIMUMS, continued

No benefits will be paid in excess of any listed limit.

	In-Network	Out-of-Network
<p>Prosthetic Devices</p> <ul style="list-style-type: none"> • <i>Requires Prior Approval.</i> • <i>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.</i> 	80% of Covered Charges, after deductible	60% of Covered Charges, after deductible
<p>Telehealth Benefits Includes both Telemedicine services and telephone-based services.</p>	PCP: \$30 Copay, then 100% of Covered Charges, deductible waived Specialist: 80% of Covered Charges, after deductible	60% of Covered Charges, after deductible
<p>Temporomandibular Joint (TMJ) Disorder</p> <ul style="list-style-type: none"> • <i>Limited to \$2,000 per Calendar Year.</i> 	80% of Covered Charges, after deductible	60% of Covered Charges, after deductible
<p>Therapy Services</p> <ul style="list-style-type: none"> • <i>Includes Outpatient Occupational, Physical, and Speech Therapies.</i> • <i>Requires Prior Approval.</i> 	\$30 Copay, then 100% of Covered Charges, deductible waived	60% of Covered Charges, after deductible
<p>Urgent Care Clinic</p>	\$30 Copay, then 100% of Covered Charges deductible waived	60% of Covered Charges, after deductible
<p>Vision Exam <i>Routine eye exams</i></p> <ul style="list-style-type: none"> • <i>Limited to one routine exam every two years.</i> <p><i>Eye exams following Illness/Injury</i> <i>Eyeglasses</i></p> <ul style="list-style-type: none"> • <i>Limited to initial pair following cataract surgery.</i> 	100% of Covered Charges, deductible waived 80% of Covered Charges, after deductible 80% of Covered Charges, after deductible	60% of Covered Charges, after deductible 60% of Covered Charges, after deductible 60% of Covered Charges, after deductible

PRESCRIPTION DRUG BENEFITS SCHEDULE OF 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) - <i>Standard Formulary with Step Therapy</i>		
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