**ARKANSAS STATE POLICE HEALTH BENEFIT PLAN**
**SCHEDULE OF BENEFITS**
**Effective January 1, 2023**

## SERVICES REQUIRING PRIOR APPROVAL

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

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|---|---|
| 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 Outpatient Medical Services**

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

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

**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 | |

**New Directions Behavioral Health**

| | |
|---|---|
| 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 Radiology**

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

**Ambulance Services**
Non-Emergent air and land transportation

| MEDICAL BENEFITS | | |
|---|---|---|
| | **In-Network** | **Out-of-Network** |
| **Calendar Year Deductible** | $1,000 per person<br>$2,000 per Family Unit | $2,000 per person<br>$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<br>$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<br>60%, after deductible |
| **Outpatient facility services** | 80%, after deductible | 60%, after deductible |
| **Emergency room when services are considered a Medical Emergency as defined by the Plan.**<br>*Emergency room services excluding surgery and treatment.*<br>*Emergency room services for surgery and related services.* | 80%, after deductible<br>100%, deductible waived | 80%, after deductible<br>100%, after deductible |
| **Emergency room when services are not related to a Medical Emergency as defined by the Plan.**<br>*Emergency room services excluding surgery and treatment.*<br>*Emergency room services for surgery and related services.* | 80%, after deductible<br>100%, deductible waived | 60%, after deductible<br>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:*<br>• *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)*<br>• *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**<br>*Testing and treatment* | PCP: 100%, deductible waived<br>Specialist: 80%, after deductible | 60%, after deductible |
| *Serum and Injections* | PCP: 100%, deductible waived<br>Specialist: 100%, deductible waived | 60%, after deductible |
| **Ambulance Services**<br>*Ground transport*<br>• *Prior Approval is required for non-emergent transportation services.* | 80%, deductible waived | 80%, deductible waived |
| *Air transport*<br>• *Prior Approval is required for non-emergent transportation services.* | 80%, deductible waived | 80%, deductible waived |
| *Water transport* | Not covered | Not covered |
| **Behavioral Health Treatment**<br>*Office services*<br>*Outpatient, professional*<br>*Outpatient, facility*<br>*Inpatient, professional*<br>*Inpatient, facility* | <br>80%, after deductible<br>80%, after deductible<br>80%. after deductible<br>80%, after deductible<br>80%, after deductible | <br>60%, after deductible<br>60%, after deductible<br>60%, after deductible<br>60%, after deductible<br>$200 copay<br>60%, after deductible |
| **Cardiac Rehabilitation** | 80%, after deductible | 60%, after deductible |
| **Chiropractic services**<br>• *Limited to 30 visits per year.* | 80%, after deductible | 60%, after deductible |
| **Diabetes Management**<br>*Services include insulin pumps and pump supplies, eye exams to screen for diabetic retinopathy, diabetic shoes and inserts.* | 80%, after deductible | 60%, after deductible |
| *Routine foot care for prevention of complications associated with diabetes mellitus* | PCP: 100%, deductible waived<br>Specialist: 80%, after deductible | 60%, after deductible |
| **Durable Medical Equipment** | 80%, after deductible | 60%, after deductible |
| **Hearing Aids/Implantable Hearing Devices**<br>*Hearing aids*<br>• *Limited to $1,400 per ear every three years.* | 100%, deductible waived | 60%, after deductible |
| *Cochlear implants*<br>• *Limited to one per ear per Lifetime.* | 80%, after deductible | 60%, after deductible |
| *Auditory Brain Stem Implant*<br>• *Limited to one per Lifetime.* | 80%, after deductible | 60%, after deductible |
| *Hearing Aids/Implantable Hearing Devices*<br>• *Osseointegrated implantable hearing aids require Prior Approval.* | 80%, after deductible | 60%, after deductible |

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

| OTHER BENEFIT LIMITS AND MAXIMUMS, continued | | |
|---|---|---|
| | **In-Network** | **Out-of-Network** |
| **Orthotic Appliances**<br>• *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**<br>• *Requires Prior Approval.*<br>• *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**<br>*Including Telemedicine services and Telephone-based services.*<br><br>*Including Telemedicine services and Telephone-based services.* | PCP:<br>$30 copay, then 100%, deductible waived<br><br>Specialist: 80%, after deductible | 60%, after deductible<br><br>60%, deductible waived |
| **Temporomandibular Joint (TMJ) Disorder**<br>• *Limited to $2,000 per Calendar Year.* | 80%, after deductible | 60%, after deductible |
| **Therapy Services**<br>• *Includes Outpatient Occupational, Physical, and Speech Therapies.*<br>• *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**<br>*Routine eye exams*<br>• *Limited to one routine exam every two years.*<br><br>*Eye exams following Illness/Injury*<br>*Eyeglasses*<br>• *Limited to initial pair following cataract surgery.* | 100%, deductible waived<br><br>80%, after deductible<br><br>80%, after deductible | 60%, after deductible<br><br>60%, after deductible<br><br>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 |