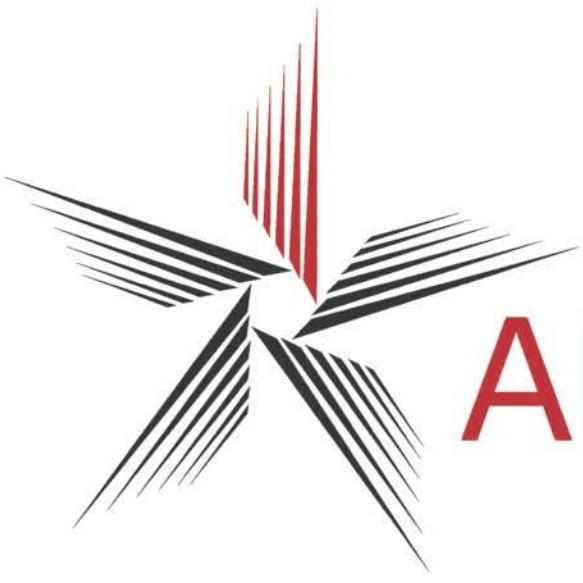
ATTACHMENT B



ARBenefits

SUMMARY PLAN DESCRIPTION

For Arkansas State & Public School Employees & Retirees

Version II

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

Effective Dates:

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

Revision Dates and Sections:

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

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

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

Effective Notice:

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

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Plan Administration

What does this book tell me?

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

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

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

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

Who sponsors the Plan?

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

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

appointed by the Governor

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

Who administers the Plan?

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

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

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

How is the Plan funded?

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

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

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

What's covered under the Plan?

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

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

What is Utilization Management?

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

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

Who are the Health Insurance Representatives?

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

Who are the Benefit Coordinators?

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

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

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

What about my Identification Card?

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

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

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

What are Plan Documents?

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

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

Eligibility

Are you eligible for this insurance?

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

   Are you:

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

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

   Are you:

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

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

   Are you:

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

   Are you:

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

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

Are your dependents eligible for this insurance?

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

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

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

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

   Are they a qualified disabled dependent, and:

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

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

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

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

Important Note:

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

Qualified Changes in Coverage

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

Initial Enrollment

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

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

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

Open Enrollment

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

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

Children's Health Insurance Program Reauthorization Act

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

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

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

Special Enrollment / Change in Status

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

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

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

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

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

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

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

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

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

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

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

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

Important Note:

ASE (State) Only

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

PSE (School) Only

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

ASE& PSE Retirees

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

Plan Management

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

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

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

How do I request a replacement ID card?

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

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

What if I'm covered under another health plan?

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

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

What if I have other insurance with another government program?

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

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

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

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

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

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

You have two options:

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

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

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

State (NON-AASIS) Employees:

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

You have two options:

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

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

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

State (AASIS) Employees:

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

You have two Options:

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

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

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

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

School Employees:

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

State (NON-AASIS) Employees:

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

State (AASIS) Employees:

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

You have two Options:

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

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

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

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

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

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

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

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

Spouse with and without Dependents

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

Dependents without Spouse on the health plan

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

NOTE:
If the spouse and/or dependents do not enroll in the retirement health plan or COBRA within their respective enrollment periods, all privileges under the plan are terminated.

I am about to retire; what are my options?

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

Can my coverage be canceled?

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

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

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

Coverage may also be terminated for late COBRA payment.

Utilization Management

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

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

Pre-notification is required for Oncology Services.

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

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

Medical Services

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

Durable Medical Equipment

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

Medical Procedures

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

Radiology

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

Summary of Plan Options

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

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

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

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

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

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

who is not eligible for Medicare, will have to use the QualChoice network to receive in-network benefits.

You have the option to terminate coverage on your spouse when he/she becomes Medicare eligible and not be moved to the Medicare Primary Plan, if you wish to remain on the Classic or Basic Plan. You must submit an Election Form, to EBD, requesting termination of the spouse 60 days prior to the eligibility date of the Medicare for the spouse so that the plan change will not automatically occur. If you wait until after the plan change has been made, you cannot change back to your original plan until Open Enrollment for the next January effective date.

Medicare-Primary Retirees and/or dependent will have the Medicare Primary Plan for insurance coverage through QualChoice, with the flexibility to visit any physician or hospital as long as they accept Medicare assignment. The Medicare Primary Plan will coordinate your benefit coverage with Medicare Parts A & B and the Plan will pay secondary to Medicare. Coverage for all other non-Medicare members on the policy will be on the QualChoice network at the Premium level. The Public School Medicare-Primary Retirees do not have prescription drug coverage and are encouraged to examine Medicare Part D for additional coverage.

Note: The ARBenefits Medicare Premium Plan for Retirees will coordinate as if Medicare Part A and Part B are both in force at the time of service. If the member does not have Part B, the Plan will pay as though the member does have Medicare Part B and the member will have full financial responsibility for incurred claims.

Approximately 60-days prior to you and/or your spouse becoming age 65, EBD will send you a letter requesting your Medicare information and a copy of your Medicare card. Please identify if your coverage is due to age, disability or End State Renal Disease.

EBD is able to identify members/spouses who are age 65, but is unable to identify members who become Medicare eligible due to disability or End Stage Renal Disease (ESRD), please notify EBD so that we can make certain your claims are paid according to Medicare rules. We also will need a copy of your Medicare card.

2018 ASE Schedule of Benefits - Premium

(Active, COBRA & Non-Medicare Retiree)

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

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

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

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

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

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

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

2018 ASE Schedule of Benefits - Classic

(Active, COBRA & Non-Medicare Retiree)

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

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

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

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

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

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

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

2018 ASE Schedule of Benefits - Basic

(Active, COBRA & Non-Medicare Retiree)

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

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

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

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

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

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

2018 PSE Schedule of Benefits - Premium

(Active, COBRA & Non-Medicare Retiree)

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

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

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

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

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

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

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

2018 PSE Schedule of Benefits - Classic

(Active, COBRA & Non-Medicare Retiree)

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

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

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

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

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

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

2018 PSE Schedule of Benefits - Basic

(Active, COBRA & Non-Medicare Retiree)

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

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

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

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

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

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

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

Prescription Drug Coverage

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

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

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

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

Who coordinates the prescription drug program?

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

What types of prescription drugs and supplies are covered?

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

Are there any limitations on the covered drugs?

Benefits for any one prescription may be limited to:

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

How much will my prescription drugs cost?

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

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

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

What is the Brand Generic Program?

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

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

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

Benefit example prior to 9/1/2012

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

Plan Cost	$20	Plan Cost	$ 90

Effective 9/1/2012

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

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

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

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

How are prescription drugs assigned to a Tier?

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

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

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

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

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

What are my options for purchasing medication under the Plan?

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

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

How do I use the Retail Prescription Drug Card Program?

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

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

How do I use the Pharmacy Mail Order Program?

The mail order prescription program is designed to assist individuals who take the same medication for a long period of time for conditions such as diabetes, high blood pressure, heart, or thyroid conditions. You will need to obtain two (2) 31-day supplies of medication or two fills at a network retail pharmacy before the mail order program can be utilized. This helps to ensure that prescriptions are appropriate for the duration of therapy. If medication is still required after the two (2) 31-day supplies or two (2) fills, you may ask your physician for a prescription for up to a 93-day supply, if appropriate. The mail order program allows you to obtain a 93-day supply of certain medications at one time for three (3) months co-payments.

You may use the mail order option by calling the PBM's mail order provider at 1-855-873-8739.

Each mail order prescription is limited to a maximum quantity limit of a 93-day supply. Pharmacies are required by law to dispense the prescription in the exact quantity specified by the physician. Therefore, if the quantity prescribed is for less than 93 days per refill, the mail order pharmacy will fill the exact quantity written by the physician. **Please be aware that not all medications are available through the mail order program. Contact ARBenefits to verify that your prescription is covered through mail order.**

Why does the Plan encourage generic drugs?

A generic drug is identical in chemical composition to its brand name counterpart, has been approved by the Food and Drug Administration (FDA) to be therapeutically equivalent, and is as effective as the brand name product. The use of generics performs a vital role in controlling the cost of prescription drugs for both the participant and the Plan.

Who do I contact for drug information?

If your physician or pharmacist is unable to answer your drug information questions, you can call the Arkansas Drug Information Center, a service provided by the UAMS College of Pharmacy at 1-888-228-1233.

What about prescriptions for weight loss or smoking cessation?

If participating in the Tobacco Cessation Program, you can receive nicotine replacement patches, the medications bupropion (generic for Zyban), or Chantix at no cost if enrolled and approved by the smoking cessation program. Coverage for bupropion and Chantix is available to members who do not wish to participate in the program; however, standard tier co-payments will apply. To enroll in the program, you may call EBD Member Services at 1-877-815-1017. The PDL reflects which tier each medication falls under. Weight loss medications are not a covered benefit.

Does the Plan have any special programs, limitations, or restrictions?

The Pharmacy Benefits Manager for the Plan has several cost saving initiatives in place designed to assist our prescription drug program in delivering the best possible healthcare at the most reasonable cost. The programs described below are Prior Authorization, Quantity Limits, Daily Dose Edits, Step Therapy, Reference Pricing, and New Generics. Medications listed on the PDL are marked with the abbreviations PA, QL, ST, RP, or NG when applicable.

Prior Authorization (PA)

The Prior Authorization program helps to ensure the appropriate usage of certain medications by applying FDA approved indications and the manufacturer's guidelines to the utilization of certain medications. The DUEC, Pharmacy Benefits Manager, and pharmacy benefits consultant, (University of Arkansas for Medical Sciences College of Pharmacy), have identified the medications that have a high potential for serious side effects, high costs, or high abuse potential.

The following steps should be taken in order to obtain a Prior Authorization:

- Your **physician** may contact EBRx (Evidence Based Prescription drug call center at the UAMS College of Pharmacy) by calling 1-866-564-8258 to discuss prescription drugs that require prior authorization.
- A team of pharmacists is available to evaluate the information provided by your physician. Forms are not faxed to your physician's office, as all reviews are handled over the phone.

- Once the prior authorization clinical guidelines are met, your prior authorization will be approved and entered into the system.
- If the clinical guidelines are not met, your physician will be notified during the phone call.
- If the prior authorization is denied, you can still obtain your medication; however, you will be financially responsible for the full cost of the prescription.

- Your **physician** may appeal the denial by sending documentation to:

EBRx Medical Director
Attn: AR EBD APPEAL
4301 W. Markham, Slot 522-9
Little Rock, AR 72205

Quantity Limits (QL)

The QL program is intended to clarify the usual quantity that constitutes a 31-day supply for particular medications. The quantities allowed per each fill are based upon the dosing recommendations made by the manufacturer. To get access to this list of medications, you can call ARBenefits. In addition, these items are indicated on the Preferred Drug List with a (QL). (Note: Some medications, such as opioids for pain control, may have limits in place that allow for smaller quantities to be filled for a shorter time period than 31 days.)

Daily Dosing Edits

Daily Dose Edits are designed to notify members when they are taking lower strength medications multiple times a day when higher strengths are available.

Step Therapy (ST)

Step therapy is a program designed for people who take prescription drugs used to treat certain ongoing medical conditions. The step therapy program is designed with safety, cost, and most importantly, your health in mind. It allows you and your family to receive the affordable treatment you need and helps the Plan contain the rising cost of prescription drug coverage.

Prescription drugs that are placed under the step therapy program generally require you to have failed therapy with one drug before coverage for another drug will be given, unless your physician has a compelling reason you should not first try one of the other drugs.

To find out which medications are included in the Step Therapy program, contact ARBenefits. These products are also indicated on the Preferred Drug List with (ST).