PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION
Arkansas State Police Employee Health Benefit Plan

SCHEDULE OF BENEFITS

Note: A referral is not required for specialist services received from participating providers in the Health Advantage Open Access Network

Health Advantage is the Claims Administrator for the Arkansas State Police Employee Health Benefit Plan.
"Refer to SPD for specific benefit guidelines"

Lifetime Maximum – per Member (All Services)	Unlimited	
Dependent Age	26	
OUT OF POCKET LIMITS	**In-Network**	**Out-of-Network**
Annual Deductible – Individual Coverage	$1,000	$2,000
Annual Deductible – Family Coverage	$2,000	$4,000
Annual Limit on Medical Out of Pocket – Individual *	$4,000	Unlimited
Annual Limit on Medical Out of Pocket – Family *	$8,000	Unlimited
Annual Limit on Pharmacy Out of Pocket – Individual	$2,850	Not Covered
Annual Limit on Pharmacy Out of Pocket – Family	$5,700	Not Covered
**The Annual Limit on Medical Out of Pocket can be met by payments of Coinsurance, Copayments and Deductible amounts for In-Network Provider services. It cannot be met by non-covered expenses, or any Coinsurance or Deductible amounts for Out-of-Network Provider services, or Prescription Drug Copayments.*		
COVERED BENEFITS AND SERVICES	**In-Network Coinsurance**	**Out-of-Network Coinsurance**
Professional Services		
Primary Care Physician (PCP) visit	$30 Copayment	40% after Ded
Specialist Office Visit (consultation/evaluation only)	20% after Ded	40% after Ded
Services and procedures provided in the Specialist office other than consultation and evaluation	20% after Ded	40% after Ded
Preventive Health Services		
Immunizations (by PCP)	0%	Not Covered
Routine Well Baby Care - (by PCP)	0%	Not Covered
Routine Physical Exams - Adults (by PCP)	0%	Not Covered
Routine Gynecological visit (PCP or GYN)	0%	Not Covered
Mammogram/Pap Smear/Prostate-specific antigen test	0%	Not Covered
Routine Vision Exam (Specialist) (One visit per Member every 2 Years)	0%	Not Covered
Bone Density	0%	Not Covered
Preventive Care Services in compliance with Patient Protection and Affordable Care Act (PPACA) and the recommendations from the US Preventive Services Task Force	0%	Not Covered
Allergy Services		
Services provided by the PCP	0%	40% after Ded
Services provided by the Specialist	20% after Ded	40% after Ded
Hospital Services		
Inpatient Services -Semi-private room **(Prior Approval Required)**	20% after Ded	$200 Copayment 40% after Ded
Outpatient Hospital Services	20% after Ded	40% after Ded
Outpatient Surgical Services **(Some Surgeries Require Prior Approval)** (Including all related charges 2 weeks prior and 2 weeks after for the physician's office or outpatient hospital charges)	0%	40% after Ded
Emergency Care Services		
Urgent Care Center	$30 Copayment	40% after Ded
Services and procedures provided in the Urgent Care Center other than consultation and evaluation	0%	40% after Ded
Emergency Room	20% after In-Network Deductible (Coverage is the same for In-Network and Out-of-Network)	
Observation Services		

COVERED BENEFITS AND SERVICES	In-Network Coinsurance	Out-of-Network Coinsurance
Ambulance Services (Ground - limited to $5000 / trip; Air – limited to $10,000 / trip)	20%; deductible waived	
Ambulatory Surgery Center Services (Including all related charges 2 weeks prior and 2 weeks after for the physician's office or outpatient hospital charges.)	0%	40% after Ded
Outpatient Diagnostic Services		
Diagnostic Services - Lab and X-ray.	20% after Ded	40% after Ded
Diagnostic Services for Surgical Procedures (Performed within 2 weeks prior and 2 weeks after for the physician's office or outpatient hospital charges)	0%	40% after Ded
Advanced Diagnostic Imaging Services Must be Prior Approved by AIM		
Advanced Diagnostic Imaging – CT Scan, PET Scan, MRI/MRA, Nuclear Cardiology	20% after Ded	40% after Ded
Maternity and Family Planning Services (Member & Spouse Only)	20% after Ded	40% after Ded
Prenatal and Postnatal outpatient care	20% after Ded	40% after Ded
Inpatient Maternity Services **(Prior Approval Required)**	20% after Ded	**$200 Copayment** 40% after Ded
Infertility Counseling or Infertility Testing (refer to SPD)	20% after Ded	40% after Ded
Infertility Treatment not covered		
Therapy Services		
Inpatient Therapy Services (Prior Approval Required)	20% after Ded	$200 Copayment 40% after Ded
Outpatient Rehabilitation Services: Physical, Occupational, and Speech Therapy (**Prior Approval Required)**	$30 Copayment	40% after Ded
Chiropractic Services (Limited to 30 aggregate visits per Member per Contract Year)	20% after Ded	40% after Ded
Cardiac Rehabilitation (Limited to 36 visits per Member per Calendar Year)	20% after Ded	40% after Ded
Mental Illness and Substance Use Disorder Services Must be Prior Approved by New Directions Behavioral Health		
Inpatient Hospital Semi-private room	20% after Ded	40% after Ded
Partial Hospitalization	20% after Ded	40% after Ded
Residential Treatment Centers	20% after Ded	40% after Ded
Outpatient (consultation/evaluation only)	20% after Ded	40% after Ded
Outpatient Services and procedures provided in the Specialist office other than consultation and evaluation	20% after Ded	40% after Ded
Durable Medical Equipment (DME) and Medical Supplies (Prior Approval Required)	20% after Ded	40% after Ded
Prosthetic and Orthotic Devices and Services	20% after Ded	40% after Ded
Neurologic Rehabilitation Facility Services – (Prior Approval Required) – Limited to 60 days per lifetime	20% after Ded	40% after Ded
Diabetes Management Services		
Diabetic Supplies, shoes (per Medicare guidelines) and equipment	20% after Ded	40% after Ded
Diabetic Self Management Training Single or Multiple visits	0%	40% after Ded
Skilled Nursing Facility – (Prior Approval Required)	20% after Ded	40% after Ded
Home Health Services (Prior Approval Required)	20% after Ded	40% after Ded
Hospice Care (Limited to $5000 per member per lifetime)	20% after Ded	40% after Ded
Oral Surgery	0%	40% after Ded
Dental Care Services Damage to non-diseased teeth due to accident	20% after Ded	40% after Ded
Reconstructive Surgery Correct defects due to Accident or Surgery. (Refer to SPD)	20% after Ded	40% after Ded
Reduction Mammoplasty (Prior Approved by Health Advantage)	20% after Ded	40% after Ded

COVERED BENEFITS AND SERVICES	In-Network Coinsurance	Out-of-Network Coinsurance
Medications (Prior Approval required for Specialty Medications contact EBRx) Hospital or Ambulatory Surgical Center	20% after Ded	40% after Ded
Medications (Prior Approval required for Specialty Medications contact EBRx) Physician's Office	20% after Ded	40% after Ded
Retail Pharmacy (Drug Store) *Standard Formulary with Step Therapy* ***ASP Retirees who retired under the ASP Contributory System before January 1, 1978**	$10/30/50	Not Covered
Retail Pharmacy (Drug Store) *Standard Formulary with Step Therapy* ***Active and COBRA participants, as well as Retirees who retired under the ASP Contributory system after January 1, 1978**	$15/40/65	Not Covered
Home Infusion Therapy Pharmacy - Injectable Medications	(Contact Customer Service)	(Contact Customer Service)
Organ Transplant Services (Prior Approval Required)	20% after Ded	Not Covered

All Covered Services are subject to the Health Advantage Allowance or Allowable Charge