ARKANSAS HIGHER EDUCATION CONSORTIUM BENEFITS TRUST
SCHEDULE OF BENEFITS – PPO PLAN

BENEFITS	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Note: If the calendar year maximums are listed under both In-Network and Out-of-Network Providers the calendar year maximum is combined between the In-Network and Out-of-Network Providers. For Example, if "40 Visits per Calendar Year" are listed under both In-Network and Out-of-Network Providers, you are only allowed a combined maximum of 40 visits.		
CALENDAR YEAR MAXIMUM	$2,500,000	
DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person	$500	$500
Per Family Unit	$1,000	$1,000
Note: There are two (2) separate deductibles that must be met for In-Network and Out-of-Network providers. Deductible amounts accrue toward the maximum out of pocket payment for both In and Out of Network. The Deductible applies to all Covered Services received by a Covered Person during the Calendar Year except as noted. *Once two (2) family members have met their deductible then the deductible will be considered satisfied for the remaining family members on the plan for that calendar year.*		
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR		
Per Covered Person	$2,000	$4,000
Per Family Unit	No Limit	No Limit
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%. • Deductible(s) • Amounts over UCR • Copayments • Out of Network Services		
COVERED CHARGES		
Hospital Services		
Room and Board	80% after deductible	60% after deductible
Intensive Care Unit	80% after deductible	60% after deductible
Inpatient Prescription Drugs	80% after deductible	60% after deductible
Outpatient Surgery/Ambulatory Surgical Center	80% after deductible	60% after deductible
Emergency Room Services	80% after deductible	
Skilled Nursing Facility/Rehabilitation 60 days Calendar Year Maximum	80% after deductible	60% after deductible
Physician Services		
Inpatient visits	80% after deductible	60% after deductible
Primary Care Physician Office Visits (PCP)	80% after deductible	60% after deductible
Specialists Office Visits	80% after deductible	60% after deductible
Routine Diagnostic x-rays & lab in a *Physician's office*	80% after deductible	60% after deductible
Other surgical services performed in a physician's office	80% after deductible	60% after deductible
Complex diagnostic services, such as advanced imaging (CT, MRI, MRA, Nuclear Medicine), DEXA, Treadmill tests	80% after deductible	60% after deductible

BENEFITS	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Other procedures – chemotherapy, radiation therapy and infusion therapy	80% after deductible	60% after deductible
Preventative Care Services		
Routine Well Baby Care & Immunizations	100%; deductible waived	60% after deductible
Routine Well Child Care & Immunizations	100%; deductible waived	60% after deductible
Routine Well Adult Care ▪ Annual physical ▪ Pap smear ▪ Immunizations ▪ Screening mammogram age 40 and over ▪ Prostate screenings for men age 40 and over ▪ Bone Density screening tests, age 65+ ▪ Fecal occult blood test annually ▪ Flexible sigmoidoscopy once every 5 years ▪ Double contrast barium enema once every 5 years ▪ Preventative colonoscopy age 50 and older, once every 10 years.	100%; deductible waived	60% after deductible
Routine vision exam (limit one (1) every 24 months	100%; deductible waived	60% after deductible
Maternity Services **Physician Services** Routine Prenatal Lab	80% after deductible	60% after deductible
Initial Office Visit	80% after deductible	60% after deductible
All other Services	80% after deductible	60% after deductible
Facility Services	80% after deductible	80% after deductible
Allergy Services Office Visit, Allergy Shots and Allergy Testing	80% after deductible	60% after deductible
Home Health Care 100 days per Calendar Year Maximum $10,000 Lifetime Maximum	80% after deductible	60% after deductible
Hospice Care 6 months or $10,000 Calendar Year Maximum Bereavement Counseling limited to two (2) visits	80% after deductible	60% after deductible
Ambulance Service Calendar Year Maximum $5,000 for Ground Ambulance and $10,000 for Air Ambulance	80% deductible waived	
Therapy Services – Limited to 30 visits per Calendar Year for all therapy services.		
Occupational Therapy Physical Therapy Speech & Audiology Spinal Manipulation/Chiropractic	80% after deductible	60% after deductible
Durable Medical Equipment Calendar Year Maximum $10,000	80% after deductible	60% after deductible
Mental Disorders/Substance Abuse		
Inpatient Hospital Services	80% after deductible	60% after deductible
Professional Services (Office/Outpatient Visits)	80% after deductible	60% after deductible
Professional Services (Inpatient/Outpatient Facility)	80% after deductible	60% after deductible

BENEFITS	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Prosethetic and Orthotic Services and Devices	80% after deductible	60% after deductible
Organ Transplants Lifetime maximum of two transplants	80% after deductible	60% after deductible
Jaw Joint/TMJ	80% after deductible	60% after deductible
Wig After Chemotherapy	80% after deductible	60% after deductible
Hearing Aid Device Covered up to $1,400 per ear every three years	100%	100%
Hearing Exam Covered once every three years	100%	100%
Lap Band Procedure for Morbid Obesity Lifetime Maximum $10,000	80% after deductible	60% after deductible
Supplemental Accident Benefit - Payable at 100% for first $500 of covered charges. Injury/Accident Expense Benefits are paid at 100% for Covered Services incurred as a result of an injury. The Covered Services must be incurred within 60 days of the injury. Covered Services that exceed the Injury/Accident Maximum will be subject to the deductible and coinsurance.		

PRESCRIPTION DRUG BENEFITS	
Retail Pharmacy Option – *Limited to ~~30~~ 30 day supply*	100% after Copayment
▪ Tier 1 – Generic	$10 Copayment
▪ Tier 2 – Preferred	$25 Copayment
▪ Tier 3 – Nonpreferred	$55 Copayment
Mail Order Option – *Limited to 90 day supply*	100% after Copayment
▪ Tier 1 – Generic	$20 Copayment
▪ Tier 2 – Preferred	$50 Copayment
▪ Tier 3 – Nonpreferred	$110 Copayment
Diabetic Supplies Excludes meter and pump supplies	Paid at 100%

Specialty Pharmaceuticals	IN-NETWORK	OUT-OF-NETWORK
Infusables, Injectables and RX over $500 per month or $500 per dose.	$200 Copayment Pre-Authorized is Required	Not Covered

ARKANSAS HIGHER EDUCATION CONSORTIUM BENEFITS TRUST
SCHEDULE OF BENEFITS – IDEMNITY PLAN

BENEFITS	**IDEMNITY PLAN**
Note: If the calendar year maximums are listed under both In-Network and Out-of-Network Providers the calendar year maximum is combined between the In-Network and Out-of-Network Providers. For Example, if "40 Visits per Calendar Year" are listed under both In-Network and Out-of-Network Providers, you are only allowed a combined maximum of 40 visits.	
CALENDAR YEAR MAXIMUM	$2,500,000
DEDUCTIBLE, PER CALENDAR YEAR	
Per Covered Person	$500
Per Family Unit	$1,000
Note: There are two (2) separate deductibles that must be met for In-Network and Out-of-Network providers. Deductible amounts accrue toward the maximum out of pocket payment for both In and Out of Network. The Deductible applies to all Covered Services received by a Covered Person during the Calendar Year except as noted. *Once two (2) family members have met their deductible then the deductible will be considered satisfied for the remaining family members on the plan for that calendar year.*	
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR	
Per Covered Person	$2,000
Per Family Unit	No Limit
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.	
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Hospital Services	
Room and Board	80% after deductible
Intensive Care Unit	80% after deductible
Inpatient Prescription Drugs	80% after deductible
Outpatient Surgery/Ambulatory Surgical Center	80% after deductible
Emergency Room Services	80% after deductible
Skilled Nursing Facility/Rehabilitation **60 days Calendar Year Maximum**	80% after deductible
Physician Services	
Inpatient visits	80% after deductible
Primary Care Physician Office Visits (PCP)	80% after deductible
Specialists Office Visits	80% after deductible
Routine Diagnostic x-rays & lab in a *Physician's office*	80% after deductible
Other surgical services performed in a physician's office	80% after deductible
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BENEFITS	IDEMNITY PLAN
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▪ Tier 3 – Nonpreferred	$55 Copayment
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