ARBenefits Classic - PSE

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 1/1/2024 – 12/31/2024
Coverage for: All Tiers| **Plan Type:** HSA

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.transform.ar.gov/employee-benefits or by calling 1-877-815-1017.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Individual **$1,750** Family **$3,200 / $3,300** Does not apply to preventative care.	You must pay all costs up to the deductible amount before this plan begins to pay for covered services you use. Check your Summary Plan Description to see when the **deductible** starts over (usually, but not always, January 1). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes **$6,450** Individual **$9,675** Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. The plan will pay 100% for individuals on family coverage when they reach the individual out-of-pocket maximum amount.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the **out-of-pocket** limit
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware that your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 3. See your Summary Plan Description for additional information about **excluded services**.

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- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	None
	Specialist visit	20% coinsurance	40% coinsurance	None
	Other practitioner office visit	20% coinsurance	40% coinsurance	None
	Preventive care/screening/immunization	$0	$0	None
	Telemedicine is covered by the ARBenefits Plan. Telemedicine claims are processed as office visits and are subject to the applicable office visit copay and or deductibles/coinsurance.			
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or condition. More information available at www.transform.ar.gov	Generic drugs	20% coinsurance	n/a	None
	Preferred brand drugs	20% coinsurance	n/a	None
	Non-preferred brand drugs	20% coinsurance	n/a	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	40% coinsurance	Limited benefit of $2000 per member per trip for ground ambulance.
	Urgent care	20% coinsurance	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	If you select a private room, you are responsible for the difference in charges for a private room and semi- private room.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	40% coinsurance	None
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	None
	Substance use disorder outpatient services	20% coinsurance	40% coinsurance	None
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	None
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance	None
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	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.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	None
	Rehabilitation services (outpatient)	20% coinsurance	40% coinsurance	None
	Skilled nursing care	20% coinsurance	40% coinsurance	None
	Durable medical equipment	20% coinsurance	40% coinsurance	None
	Hospice service	20% coinsurance	40% coinsurance	None
If your child needs dental or eye care	Eye exam	$50 copay	$50 copay	Limited benefit of one exam every twenty-four (24) months
	Glasses	n/a	n/a	None
	Dental check-up	n/a	n/a	None

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Cosmetic Surgery
- Dental Care
- Infertility Treatment
- Long-Term Care
- Private-Duty Nursing

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Chiropractic Care
- Hearing Aids
- Eye Exams

Questions: Call 1-877-815-1017 or visit us at www.transform.ar.gov/employee-benefits.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.transform.ar.gov/employee-benefits or call 1-877-815-1017 to request a copy.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at 1-877-815-1017. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: ARBenefits, P.O. Box 15610, Little Rock, AR 72231-5610. Phone: 1-877-815-1017. E-mail: ask.ebd@arkansas.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-815-1017.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,640
- **Patient pays** $2,900

Sample care costs:

Hospital charges (mother)	$3,600
Routine obstetric care	$2,100
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,750
Copays	$0
Coinsurance	$1,150
Limits or exclusions	$0
Total	**$2,900**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,940
- **Patient pays** $2,460

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,750
Copays	$0
Coinsurance	$710
Limits or exclusions	$0
Total	**$2,460**

Note: These numbers assume the patient is participating in our maternity and diabetes wellness programs. If you do not participate in the wellness programs, your costs may be higher. For more information about these programs, please contact: 1-877-815-1017.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.