AR BENEFITS

Below is a snapshot of benefits covered by the ARBenefits plan for each of our 2027 Public School Employee plan levels. A full schedule of benefits for each plan level is available HERE. If you have any questions, please contact EBD at 877-815-1017 or email Ask.EBD@arkansas.gov.

	PREMIUM		CLASSIC		BASIC
	IN-NETWORK	OUT OF NETWORK	IN-NETWORK	OUT OF NETWORK	IN-NETWORK
INDIVIDUAL DEDUCTIBLE	$750	$2,000	$2,000	$3,000	$4,000
FAMILY DEDUCTIBLE	$1,500	$4,000	$5,000	$6,000	$8,000
INDIVIDUAL OUT-OF-POCKET MAX (MEDICAL)	$3,250	N/A	$6,450	N/A	$6,450
FAMILY OUT-OF-POCKET MAX (MEDICAL)	$6,500	N/A	$9,675	N/A	$12,900
	YOU PAY		YOU PAY		YOU PAY
COVERED SERVICES	IN-NETWORK	OUT OF NETWORK	IN-NETWORK	OUT OF NETWORK	IN-NETWORK
PHYSICIAN'S OFFICE VISIT	$25 COPAY	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE
SPECIALIST'S OFFICE VISIT	$50 COPAY	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE
OTHER PHYSICIAN SERVICES	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE
ADVANCED IMAGING (RADIOLOGY)	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE
ER VIST AND OBSERVATION	$250 COPAY	$250 COPAY	20% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE
IN-PATIENT HOSPITAL SERVICES	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE
OUTPATIENT HOSPITAL SERVICES	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE
DIAGNOSTIC SERVICES	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE
URGENT CARE CENTER	$100 COPAY	$100 COPAY	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE
PHYSICAL EXAMS/PREVENTATIVE CARE	0%	40% AFTER DEDUCTIBLE	0%	40% AFTER DEDUCTIBLE	0%
IMMUNIZATIONS	0%	40% AFTER DEDUCTIBLE	0%	40% AFTER DEDUCTIBLE	0%
WELL BABY/CHILD CARE VISITS	0%	40% AFTER DEDUCTIBLE	0%	40% AFTER DEDUCTIBLE	0%
VISION SCREENING	$50 COPAY	$50 COPAY	$50 COPAY	$50 COPAY	$50 COPAY
HEARING SCREENING	$50 COPAY	$50 COPAY	$50 COPAY	$50 COPAY	$50 COPAY
INSULIN PUMP	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE
GLUCOMETERS	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE

- Members must meet their plan's deductible amount before coinsurance begins for covered services.
- The family deductible is the deductible amount for any tier above Employee Only coverage (Employee + Spouse, Employee + Children, Family).
- Copays do not count towards the deductible amount. The out-of-pocket maximum includes the deductible, copays, and coinsurance amounts you have paid toward covered in-network services.
- Employees on the *Premium Plan* can have the $250 ER copay waived if they are referred to the ER by the Nurse24 hotline (1-866-458-0408). The Nurse24 hotline is not intended for use during medical emergencies.
- The plan will pay 100% for individuals on family coverage when they reach the individual out-of-pocket maximum amount.
- There is no out-of-network coverage for the Basic Plan.

PRESCRIPTION DRUGS	PREMIUM	CLASSIC	BASIC
TIER 1 - GENERIC	$15 COPAY	20% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE
TIER 2 - PREFERRED	$40 COPAY	20% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE
TIER 3 - NON-PREFERRED	$80 COPAY	20% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE
TIER 4 - SPECIALTY	$100 COPAY	20% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE
REFERENCED PRICE DRUGS	PLAN PAYS CERTAIN AMOUNTS PER UNIT; MEMBER RESPONSIBLE FOR REMAINING COST	NOT COVERED	NOT COVERED
INDIVIDUAL RX OUT-OF-POCKET MAX	$3,100	N/A	N/A
FAMILY RX OUT-OF-POCKET MAX	$6,200	N/A	N/A

Employees on the Classic or Basic plans must meet their plan medial deductible amounts prior to starting the 20% coinsurance for covered medications.

2027 Rates (per month)

Premium

Employee Only: $211.78
Employee & Spouse: $741.30
Employee & Child(ren): $479.52
Employee & Family: $817.60

Classic

Employee Only: $92.68
Employee & Spouse: $364.66
Employee & Child(ren): $219.48
Employee & Family: $410.94

Basic

Employee Only: $45.34
Employee & Spouse: $253.32
Employee & Child(ren): $146.82
Employee & Family: $274.86

2027 Open Enrollment

Open Enrollment for the 2027 plan year is October 1-31, 2026. You can enroll online through the ARBenefits Member Portal at my.ARBenefits.org. Changes elected during Open Enrollment are effective 1/1/2027. If you do not want to make any changes to your ARBenefits medical health plan, you do NOT need to re-enroll. Your current coverage will stay as is for 2027.

If you have an FSA, you MUST re-enroll each year.

Visit our website at www.sas.arkansas.gov for more information.

Things you can do during Open Enrollment

- Enroll in an ARBenefits Plan
- Change plans between Premium, Classic, Basic
- Drop/add dependents
- Cancel your coverage for the next year