ARBENEFITS

Below is a snapshot of benefits covered by the ARBenefits plan for each of our 2024 Arkansas 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 1-877-815-1017 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	$1,750	$3,000	$4,000
FAMILY DEDUCTIBLE	$1,500	$4,000	$3,200/$3,300	$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	0%	20% AFTER DEDUCTIBLE	40% 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	0%	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE
PHYSICAL EXAMS/PREVENTATIVE CARE	0%	40% AFTER DEDUCTIBLE	0%	40% AFTER DEDUCTIBLE	0%
IMMUNIZATIONS	0%	0%	0%	0%	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 satisfaction of your 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 24/7 Nurse Hotline (1-866-458-0408). The 24/7 Nurse Hotline is not intended for use during a medical emergency.
- The plan will pay 100 percent for individuals on family coverage when they reach the individual out-of-pocket maximum amount.
- No out-of-network coverage for Basic Coverage.

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 medical deductible amounts prior to starting 20% coinsurance for covered drugs.

2024 Rates

Premium

Employee Only: $201.96
Employee and Spouse: $706.92
Employee and Children: $457.28
Employee and Family: $779.68

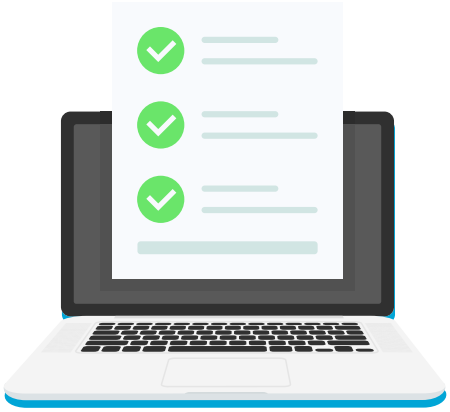
Classic

Employee Only: $88.38
Employee and Spouse: $347.76
Employee and Children: $209.30
Employee and Family: $391.88

Basic

Employee Only: $43.24
Employee and Spouse: $241.58
Employee and Children: $140.02
Employee and Family: $262.12

2025 Open Enrollment



Open enrollment for the 2025 plan year is October 1-31, 2024. You can enroll online through the ARBenefits Member Portal at my.ARBenefits.org. Changes elected during Open Enrollment are effective 1/1/2025. If you do not want to make any changes to your ARBenefits health plan, you do not need to re-enroll with the exception of an FSA. If you have an FSA, you must re-enroll each year. Your current coverage will stay as is for 2025. Visit our website at www.transform.ar.gov for more information.

Changes that can be made during Open Enrollment include:

- Enroll in the plan
- Change plan level (Basic, Classic, Premium)
- Cancel Coverage
- Add/drop a spouse and/or dependents from your plan