ARKANSAS HIGHER EDUCATION CONSORTIUM BENEFITS TRUST
SCHEDULE OF BENEFITS
CORE Plan - Effective 7/1/2017

For both In-Network and Out-of-Network Benefits, some services may require pre-authorization by QualChoice. For details and to access the most current listing of services requiring pre-authorization, visit www.qualchoice.com.

All benefit payments are subject to the Maximum Allowable Charge. Use of an Out-of-Network provider may result in you being balanced billed and having higher out-of-pocket costs. Amounts in excess of the Maximum Allowable Charge do not count toward Deductible or Coinsurance limits.

Note: Calendar Year maximums listed are combined between In-Network and Out-of-Network. For example, if "30 Visits per Calendar Year" are listed under both In-Network and Out-of-Network Providers, you are only allowed a combined maximum of 30 visits.

Note: There are two (2) separate deductible and out-of-pocket maximums that must be met for In-Network and Out-of-Network providers. Once two (2) family members have met their deductible and out-of-pocket maximums, then they will be considered satisfied for the remaining family members on the plan for that calendar year.

BENEFITS	**IN-NETWORK PROVIDERS YOU PAY**	**OUT-OF-NETWORK PROVIDERS YOU PAY**
ESSENTIAL HEALTH BENEFITS	Unlimited	
DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person	$2,500	$5,000
Per Family Unit	$5,000	$10,000
Coinsurance	20%	40%
MAXIMUM OUT-OF-POCKET, PER CALENDAR YEAR		
Per Covered Person	$7,100	No Limit
Per Family Unit	$14,200	No Limit
The following charges apply towards the maximum out-of-pocket. Once this amount is reached, the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise: • Deductible(s) • Coinsurance • Medical and Pharmacy Copayments		
COVERED CHARGES *Refer to the QualChoice medical policies for specific procedures covered under each category. These policies can be viewed online at www.qualchoice.com.*		
Inpatient Services	$200 Copayment + 20% after deductible	$200 Copayment + 40% after deductible
Outpatient Surgery/Ambulatory Surgical Center	$100 Copayment + 20% after deductible	$100 Copayment + 40% after deductible
Emergency Room Services	$200 Copayment + 20% after deductible	
Urgent Care Services	$60 Copayment	40% after deductible
Ambulance Service Per Trip Maximum: $5,000 for Ground Ambulance and $10,000 for Air Ambulance	20%; deductible waived	
Skilled Nursing/Rehabilitation Facility 60 days Calendar Year Maximum	20% after deductible	40% after deductible

COVERED CHARGES	IN-NETWORK PROVIDERS YOU PAY	OUT-OF-NETWORK PROVIDERS YOU PAY
Physician Services		
Inpatient visits	20% after deductible	40% after deductible
Primary Care Physician Office Visits (PCP) Evaluation & Management	$30 Copayment	40% after deductible
Specialists Office Visits (SCP) Evaluation & Management	$60 Copayment	40% after deductible
Routine Procedures such as Routine X-rays & Lab in a physician's office	0% after Copayment	40% after deductible
Complex Procedures such as Minor Surgeries and Specialized Lab performed in a physician's office	20% after Copayment	40% after deductible
Advanced Diagnostic services, such as advanced imaging (CT, MRI, PET, MRA), Nuclear Medicine, Pharmaceutical Products, Scopic Procedures; Therapeutic Treatments and Genetic Testing. As well as advanced surgical services performed in a physician's office.	20% after deductible	40% after deductible
Preventative Care Services		
Preventive health benefits are intended for the early detection of diseases by screening for their presence in an individual who has neither symptoms nor findings suggestive of those diseases. Some tests are not covered as part of the preventive health screening benefit because they are not recommended by the United States Preventive Services Task Force (USPSTF) or approved medical polices. Those services that will be considered to be a preventive health service are subject to change at any time in order to align with and be consistent with the USPSTF guidelines and medical policies.		
Routine Well Baby Care & Immunizations	No Cost to You	Not Covered
Routine Well Child/Adult Care & Immunizations	No Cost to You	Not Covered
Routine vision exam (limit 1 every 24 months)	No Cost to You	Not Covered
Maternity Services		
Physician Services Initial Office Visit	$30 Copayment	40% after deductible
All other Services	20% after deductible	40% after deductible
Facility Services	$200 Copayment + 20% after deductible	$200 Copayment + 40% after deductible
Allery Services		
Office Visit	$60 Copayment	40% after deductible
Allergy Testing & Serums	20% after Copayment	40% after deductible
Allergy Shots	No Cost to You	40% after deductible
Home Health Care 100 days per Calendar Year Maximum	20% after deductible	40% after deductible
Hospice Care 6 months per Calendar Year Maximum	20% after deductible	40% after deductible
Therapy Services Limited to 30 visits per Calendar Year for all therapies combined		
Occupational Therapy Physical Therapy Speech & Audiology Spinal Manipulation/Chiropractic	$60 Copayment	40% after deductible
Durable Medical Equipment	20% after deductible	40% after deductible

COVERED CHARGES	IN-NETWORK PROVIDERS YOU PAY	OUT-OF-NETWORK PROVIDERS YOU PAY
Mental Disorders/Substance Abuse		
Inpatient Hospital Services	$200 Copayment + 20% after deductible	$200 Copayment + 40% after deductible
Professional Services (Office/Outpatient Visits)	$30 Copayment	40% after deductible
Professional Services (Inpatient/Outpatient Facility)	20% after deductible	40% after deductible
Prosthetic and Orthotic Services and Devices	20% after deductible	40% after deductible
Organ Transplants Lifetime maximum of 2 transplants	$200 Copayment + 20% after deductible	$200 Copayment + 40% after deductible
Temporomandibular Joint Disorders (TMJ)	20% after deductible	40% after deductible
Hearing Aid Device Covered up to $1,400 per ear, once every 3 years	No Cost to You	
Hearing Exam Covered once every 3 years	No Cost to You	
Infertility Coverage		
Infertility Diagnostic Services Only	20% after deductible	Not Covered
Infertility Treatment	Not Covered	Not Covered
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 results 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 deductible and coinsurance.		
Bariatric Services Lifetime Maximum of $10,000	20% after deductible	40% after deductible

PRESCRIPTION DRUG BENEFITS	30 Day Supply Retail (You Pay)	90 Day Supply Retail or Mail Order (You Pay)
▪ Tier 1 – Generic ▪ Tier 2 – Preferred ▪ Tier 3 – Nonpreferred ▪ Specialty Pharmacy	$15 Copayment $55 Copayment $75 Copayment 50% Coinsurance	$30 Copayment $110 Copayment $150 Copayment Not Covered
If dispensed in your physician's office or at a facility see your medical benefits.		

Limitations

- All new prescriptions are limited to a 30 day supply.
- Refills are limited to a 90 day supply at certain contracted pharmacies and through retail or mail order.

Step Therapy

Certain medications may be required to be used before another medication is covered. Step Therpay is the process of beginning drug therapy for a medical condition with the most cost-effective and safest drug therapy, and progessing to other and more costly therpay if the first line medication fails.

Examples of step therapy drugs under this plan include anti-hypertensive and Attention Deficit Disorder (ADD) medications. Contact Customer Service at 1-800-235-7111 for more details.

Benefit Details

- Benefits are subject to all benefit terms, conditions, limitation and exclusions.
- Benefits are provided for formulary prescription drugs when prescribed by a physician or by a licensed healthcare provider within the scope of their license.
- Benefits are available through a network pharmacy, a network mail order pharmacy or an out of network pharmacy, provided that the drug is a Covered Prescription Drug.

For information about specific medications, visit our website at www.qualchoice.com. Some medications may require pre-authorization by QualChoice. For details and to access the most current listing of services requiring pre-authorization, visit www.qualchoice.com.