

Annual Benefits Guide 2009 Plan Year

for Public School
Retirees

Provided By



Employee Benefits Division

Department of Finance & Administration
State of Arkansas



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What's New for 2009?

October is the month for your Annual Enrollment, a time to review your ARHealth coverage and make certain changes without the need for specific qualified life events. It is also a time to review the plan changes that will have a direct impact on the cost of covered services. Last but not least, it is an opportunity to review the premiums for the upcoming plan year which begins January 1, 2009.

A summary of this year's changes are listed below:

- ARHealth In-Network Co-Insurance raised from 10% to 20%.
- ARHealth In-Network Co-Insurance Annual Limit raised from \$1,000 individual/\$2,000 family to \$1,500 individual/\$3,000 family.

All covered benefits and services, co-pays, restrictions, pre-authorization requirements, and other plan features will remain the same.

Please take a few minutes to review the schedule of benefits carefully to see how the new changes may impact how you access and pay for certain medical services.

What Changes Can I Make During Annual Enrollment?

What's Annual Enrollment?

During October, you may make changes to your health care coverage. You must do so by completing the necessary forms, either by paper form or on-line, before the deadline. Otherwise, you may have to wait until next year to make the change.

- ✓ *If you and your spouse are both either a Public School Retiree or a State Retiree and you are on separate plans, you can make the change to be added to your spouse's plan. One time change allowed.*
- ✓ *If you are drawing a retirement annuity from both Public School Retirement and State Retirement, you can make a switch to the other plan at this time. One time change allowed.*
- ✓ *During the plan year if you are a Public School Retiree and you lose your pharmacy benefit due to Medicare entitlement, you can change to the State Retiree plan if you are drawing a state annuity in addition to your public school annuity.*
- ✓ *You cannot add dependents at Open Enrollment. In order to add a dependent to your coverage, they must have experienced a qualifying event and Employee Benefits Division must have a Waiver on file as to why you did not cover them on your insurance at the time of retirement.*

Forms must be completed and returned to EBD by October 31st for processing.

Who Can Help With Questions?

Contact Numbers for the ARHealth Plans

Self Funded



Health Advantage (ARHealth)

P.O. Box 8069
Little Rock, AR 72203
Phone: (800) 482-8416
E-mail: customerserviceASE@arkbluecross.com
Web: www.healthadvantage-hmo.com

NMHC Mail (Mail Order Pharmacy)

P.O. Box 407096
Fort Lauderdale, FL 33340-7096
Phone: (800) 881-1966
Web: www.nmhcmail.com

NMHC (Prescription Coverage: ARHealth & ARHealth HD PPO)

320 Executive Court Dr., Suite 201
Little Rock, AR 72205
Phone: (800) 880-1188
Web: www.nmhc.com

American Health Holding, Inc. (AHH) (Medical Utilization Review)

100 W. Old Wilson Bridge Road, Third Floor
Worthington, OH 43085
Phone: (800) 592-0358
Fax: (866) 317-0166
Web: www.americanhealthholding.com

EBRx* (Pharmacy Prior Authorization and Appeals)

UAMS College of Pharmacy: AR EBD Appeal
4301 W. Markham, Slot 522-9
Little Rock, AR 72205
Phone: (866) 564-8258
*Requires physician contact

Corphealth / Star EAP (Behavioral/Mental Health & Substance Abuse)

10816 Executive Center Drive, Suite 206
Little Rock, AR 72211
Phone: (866) 378-1645
E-mail: customerservice@corphealth.com
Web: www.corphealth.com

USable Life (Life Insurance)

320 West Capital, Suite 700
P.O. Box 1650
Little Rock, AR 72203
Phone: (800) 370-5854 (Customer Service)
Phone: (800) 648-0271 (Claims)
Phone: (501) 375-7200
Web: www.usablelife.com

PDB Enterprises Inc. (Case Management)

P.O. box 30220
Little Rock, AR 72260-0005
Phone: (501) 455-0950 (Office)
Phone: (877) 455-5361 (Toll Free)
Fax: (501) 455-4065
Web: www.pdbenterprises.com

Employee Benefits Division (EBD) General Benefit Information & Assistance

Mailing Address:

P.O. Box 15610
Little Rock, AR 72231-5610

Physical Address:

501 Woodlane Street, Suite 500
Little Rock, AR 72201
Phone: (877) 815-1017
Phone: (501) 682-9656
E-mail: AskEBD@ARBenefits.org
Web: www.ARBenefits.org


What Does ARHealth Cover for Medicare Primary Retirees?

Public School Retirees with Medicare Primary




Medicare Does Not Pay	ARHealth Covers
Part A Hospital Services	
Inpatient hospital deductible each benefit period	ARHealth pays the deductible
Copayment per day for days 61-90 in a hospital	ARHealth pays the copayment per day
Copayment per day for days 91-150 (Lifetime Reserve)	ARHealth pays the copayment per day
100% of Medicare - Allowable expenses for additional 365 days after Medicare hospital benefits stop completely	ARHealth pays
Calendar year blood deductible (First 3 Pints of Blood) if deductible is not met by the replacement of blood	ARHealth pays
Copayment per day for days 21-100 in a Skilled Nursing Facility	ARHealth pays the copayment per day
Part B Physician and Medical Services	
Part B deductible	ARHealth pays the deductible
Normally 20% of Medicare-approved amount (Part B Coinsurance) and 20% of Medicare-approved charges for Durable Medical Equipment (After Part B Deductible Is Met)	ARHealth pays 20% of the Medicare-approved amount
Medicare Part B excess charges 100% <i>(This benefit would apply when you receive services from a physician that does not accept Medicare assignment.)</i>	ARHealth pays 100% of the Part B excess charges when you receive services from a physician that does not accept Medicare.
Additional Benefits Not Covered by Medicare	
Basic outpatient prescription drug benefits	Not covered (Option of taking Medicare Part D)

What Does ARHealth Cover for Non-Medicare Retirees?


The following services are available to the ARHealth retiree members without Medicare-Primary coverage.

 Apple Icon indicates Wellness Benefit

2009 Plan Year - Summary of Common Services

Covered Benefits and Services*	ARHealth		
	In-Network Copayment	In-Network Coinsurance	Out-of-Network Coinsurance
Deductible - Individual	-	\$0	\$1,000
Deductible - Family	-	\$0	\$2,000
Annual Coinsurance Limit - Individual (after deductible)	-	\$1,500	\$5,000
Annual Coinsurance Limit - Family (after deductible)	-	\$3,000	\$10,000
Lifetime Maximum	-	-	\$1,000,000
Physician / Specialist Services			
Primary Care Physician Office Visit	\$25	0%	40%
Specialist Office Visit / Specialty Care Services	\$35	0%	40%
Other Physician Services provided under Out-Patient or In-Patient Care	\$0	20%	40%
Pharmacy Benefit			
Prescription - Generic - Tier I	\$10	0%	0%
Prescription - Preferred - Tier II	\$30	0%	0%
Prescription - Non-Preferred - Tier III	\$60	0%	0%
Prilosec OTC	\$5	0%	0%
Hospital Services			
In-Patient Services	\$250	20%	40%
Out-Patient Surgical Services	\$100	20%	40%
Diagnostic Services	\$0	20%	40%
Emergency Care Services			
ER Visit, Urgent Care Center, Observation	\$100	0%	0%
Preventive Care Services			
 Physical Exams / Preventive Care	\$0	0%	Not Covered
 Well Baby / Child Care Visits	\$0	0%	Not Covered
 Immunizations	\$0	0%	Not Covered

ARHealth Coverage for Non-Medicare Retirees continued...

 Apple Icon indicates Wellness Benefit

2009 Plan Year - Schedule of Benefits

Covered Benefits and Services*	ARHealth		
	In-Network Copayment	In-Network Coinsurance	Out-of-Network Coinsurance
Allergy Services			
Injection with no office visit	\$0	20%	40%
Services by Specialty Providers (office visit & testing)	\$35	20%	40%
Ambulance Services			
Ground or Air Ambulance Transportation	\$0	0%	40%
* Limited Benefit: \$1,000 per member per plan year but does not include charges for emergency medications administered during transport			
Behavioral / Mental Health & Substance Abuse Treatment Services			
* See Behavioral / Mental Health and Substance Abuse Treatment Care Services section of this Annual Benefits Guide or in your Summary Plan Description (SPD)			
Dental Care Services			
Repair to non-diseased teeth due to accident/injury	\$35	20%	35%
Coverage is provided for the following dental services in an outpatient setting:			
<ul style="list-style-type: none"> * Treatment and x-rays necessary to correct damage to non-diseased teeth or surrounding tissue caused by an accident or Sjogren's Syndrome occurring on or after effective date * Treatment or correction of a non-dental physiological condition caused by Sjogren's syndrome * Injury that has resulted in severe functional impairment * Treatment for tumors or cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth * Removal of impacted or partially impacted wisdom teeth * Pre-treatment dental services in connection with treatment of cancer of the head or neck 			
Diabetes Management Service			
Insulin Pump & Supplies	\$0	20%	40%
Glucometers & Supplies	\$0	20%	40%
Diabetic Self Management Training	\$25 per Program	0%	40%
<ul style="list-style-type: none"> * Diabetic Supplies, Insulin, Insulin Syringes and Lancets (if purchased together) available through prescription drug card at your Pharmacy. Applicable charges may apply such as copayments, deductible charges, or coinsurance charges * Not subject to DME annual benefit limit of \$10,000 * Glucometers must be purchased through DME provider and is not subject to annual maximum DME benefit 			
Durable Medical Equipment / Enteral Feeding			
DME/Enteral Feeding	\$0	20%	40%
<ul style="list-style-type: none"> * Coverage is provided for medically necessary durable medical equipment, see exclusions * Enteral Feeding requires Pre-Certification by American Health Holding * Durable Medical repairs must be pre-approved by American Health Holding for items over \$1,000 * Durable Medical purchases must be pre-approved by American Health Holding for items over \$1,000 * The Plan does not provide benefits for DME that is for patient convenience * In-network DME providers should be used to maximize plan benefits * Limited to \$10,000 annual maximum benefit from the Plan 			

Not all providers participate in every network. Please consult your Benefit Coordinator's Online Provider Directory for an up-to-date list of participating network physicians, hospitals, and other service providers. Out-of-Network providers have the authority to Balance Bill you for all services. See inside back cover for an example of In-Network versus Out-of-Network charges.


ARHealth Coverage for Non-Medicare Retirees continued...

 Apple Icon indicates Wellness Benefit

2009 Plan Year - Schedule of Benefits			
Covered Benefits and Services*	ARHealth		
	In-Network Copayment	In-Network Coinsurance	Out-of-Network Coinsurance
Emergency Care Services			
ER Visit, Urgent Care Center, Observation Services	\$100	0%	0%
<ul style="list-style-type: none"> * Medical emergency means the sudden onset of a medical condition with symptoms enough to cause a prudent person to believe that lack of immediate medical attention could result in serious jeopardy to his / her health, the health of an unborn child, impairment of a bodily function or dysfunction of any bodily organ or part * Copayment waived if admitted directly to the hospital or transferred directly to another facility from that emergency admission * You may contact the toll free number listed on your health identification card for a participating facility or physician in the event of an emergency outside of the service area 			
Employee Assistance Program (EAP) Services			
Star EAP Services	\$0	0%	Not Covered
<ul style="list-style-type: none"> * Employee Assistance Program (Star EAP) Telephonic Consultation and Face-to-Face Short Term / Brief Resolution Counseling is provided for all active insured employees and covered dependents * Limited to eight (8) EAP sessions per episode with no copayment * Must contact Arkansas Help Line at 1-866-378-1645 			
Home Health Services			
Home Health Services	\$0	20%	40%
<ul style="list-style-type: none"> * Coverage is provided for home health visit services when your medical condition supports the need for in-home services and is approved by American Health Holding and such care is prescribed, authorized, or ordered by an in-network physician and provided by an in-network home health agency, for in-network benefits to be applied * Coverage is provided only when medically necessary and pre-approved by American Health Holding * Benefit limited to thirty (30) visits per member per Plan Year 			
Home Intravenous Drugs			
Home IV Drugs and Solutions	\$0	20%	40%
<ul style="list-style-type: none"> * Some medications may require prior authorization for coverage by American Health Holding * Contact American Health Holding to verify if a medication requires prior authorization for coverage. You are responsible for the appropriate coinsurance 			
Hospice Services			
Hospice Care	\$0	20%	40%
<ul style="list-style-type: none"> * Coverage is provided only when medically necessary and services reviewed by American Health Holding 			
Hospital Services - Inpatient			
In-Patient Services	\$250	20%	40%
<ul style="list-style-type: none"> * Copayment charged per admission except in cases of direct transfer to another facility * Maximum of 3 copayments per member per Plan Year * Coverage is provided for inpatient services when medically necessary and pre-approved by American Health Holdings * If you select a private room, you are responsible for the difference in charges for private room and semi-private room 			

Not all providers participate in every network. Please consult your Benefit Coordinator's Online Provider Directory for an up-to-date list of participating network physicians, hospitals, and other service providers. Out-of-Network providers have the authority to Balance Bill you for all services. See inside back cover for an example of In-Network versus Out-of-Network charges.

ARHealth Coverage for Non-Medicare Retirees continued...

 Apple Icon indicates Wellness Benefit

2009 Plan Year - Schedule of Benefits

Covered Benefits and Services*	ARHealth		
	In-Network Copayment	In-Network Coinsurance	Out-of-Network Coinsurance
Hospital Services - Outpatient			
Out-Patient Surgical Services	\$100	20%	40%
<ul style="list-style-type: none"> * Diagnostic Services and procedures that are performed outside the PCP office * Coverage is provided for outpatient services when medically necessary and pre-approved by American Health Holding * Refer to list of services requiring pre-determination or pre-certification by American Health Holding 			
Diagnostic Services	\$0	20%	40%
* For Out-patient Radiological services, see section for Radiology Services			
Injectable Medication	\$0	20%	40%
<ul style="list-style-type: none"> * Subject to Plan Exclusions and Limitations as defined in the Summary Plan Description (SPD) * Some medications may require prior authorization for coverage by American Health Holding * Contact American Health Holding to verify if a medication requires prior authorization for coverage. You are responsible for the appropriate coinsurance 			
Immunizations			
Immunizations	\$0	0%	Not Covered
* Flu vaccinations and immunizations are considered In-Network when provided at Arkansas Health Department			
Maternity and Family Planning Services			
Prenatal and Postnatal Out-Patient Care	\$25	20%	40%
<ul style="list-style-type: none"> * Prenatal and Postnatal outpatient care Copayment required on first visit only * Pregnancy pre-notification required by American Health Holding 			
In-Patient Maternity Services	\$250	20%	40%
<ul style="list-style-type: none"> * Copayment applicable per admission * Hospital Length of Stay for Childbirth: 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 			
Infertility Diagnostic Evaluation	\$35	20%	40%
* Treatment for infertility is not a covered benefit under the ARHealth or ARHealth HD PPO plan. Services related to infertility are covered up to diagnosis. Testing is not covered during or following treatment.			
Infertility Testing	\$200	20%	40%
Ostomy Supplies			
Ostomy Supplies	\$0	20%	40%
<ul style="list-style-type: none"> * Benefit limited to a three (3) month supply * For maximum benefits, ostomy supplies should be obtained through a DME provider that is contracted with your Benefit Coordinator * Contact your Benefit Coordinator for a list of participating DME providers 			

Not all providers participate in every network. Please consult your Benefit Coordinator's Online Provider Directory for an up-to-date list of participating network physicians, hospitals, and other service providers. Out-of-Network providers have the authority to Balance Bill you for all services. See inside back cover for an example of In-Network verses Out-of-Network charges.

ARHealth Coverage for Non-Medicare Retirees continued...

 Apple Icon indicates Wellness Benefits

2009 Plan Year - Schedule of Benefits

Covered Benefits and Services*	ARHealth		
	In-Network Copayment	In-Network Coinsurance	Out-of-Network Coinsurance
Pharmacy Benefit			
Prescription - Generic - Tier I	\$10	0%	0%
Prescription - Preferred - Tier II	\$30	0%	0%
Prescription - Non-Preferred - Tier III	\$60	0%	0%
Prilosec OTC	\$5	0%	0%
<ul style="list-style-type: none"> * Member is responsible for paying 100% of prescription cost for drugs not covered by the plan. * ARHealth HD PPO members may receive a negotiated discount for their prescription. Cost of prescription will count toward applicable deductible and Coinsurance Annual Limit 			
Preventative Care Services			
* See Preventative Care Services in this Annual Benefits Guide or in your Summary Plan Description (SPD)			
Professional Services			
Chiropractic Services	\$35	20%	40%
* Benefit limited to Fifteen (15) visits per member per Plan Year			
Physician Office Visits	\$25	0%	40%
* ARHealth and ARHealth HD PPO plans do not require you to select a Primary Care Physician (PCP), but it is highly recommended. By coordinating your personal health care through a single physician, you can help maintain a consistent level of service with a provider that understands your medical needs and situation			
Specialist Office Visit / Specialty Care Services	\$35	0%	40%
Other Physician Services provided under Out-Patient or In-Patient Care	\$0	20%	40%
Injectable Medication	Office Copay	0%	40%
<ul style="list-style-type: none"> * Office copay will vary depending on provider classification (physician or specialist) * Subject to Plan Exclusions and Limitations as defined in the Summary Plan Description (SPD) * Some medications may require prior authorization for coverage by American Health Holding * Contact American Health Holding to verify if a medication requires prior authorization for coverage. 			
Prosthetic and Orthotic Devices			
Prosthetic and Orthotic Devices	\$0	20%	40%
<ul style="list-style-type: none"> * Benefit limited to one (1) prosthetic device that aids in bodily functioning or replaces a limb after an accident or surgical loss and two (2) orthotic devices used for correction or prevention of skeletal deformities * Prosthetic or Orthotic Devices must be deemed medically necessary. Pre-approval by American Health Holding for items over \$1,000 * Appliance provider must be contracted with benefit coordinator * In order for the device to be covered, it must be an appliance that is defined by the Medicare DME Manual * Repair or replacement of devices due to normal growth or wear is a covered benefit * Maintenance and repairs resulting from misuse or abuse is not covered and is the responsibility of the member * Benefit limited to \$15,000 in Prosthetic / Orthotic Plan benefits per Plan Year 			
Radiology Services			
Radiology Services	\$250	20%	40%
<ul style="list-style-type: none"> * Charges will apply for such services as MRI, MRA, CT, and PET Scans * Maximum of one (1) copayment per member per Plan Year * Coverage is provided only when medically necessary and pre-approved by American Health Holding * Charges will not apply when provided in conjunction with Emergency Room or In-Patient Hospital Services 			

Not all providers participate in every network. Please consult your Benefit Coordinator's Online Provider Directory for an up-to-date list of participating network physicians, hospitals, and other service providers. Out-of-Network providers have the authority to Balance Bill you for all services.

See inside back cover for an example of In-Network versus Out-of-Network charges.

ARHealth Coverage for Non-Medicare Retirees continued...

 Apple Icon indicates Wellness Benefits

2009 Plan Year - Schedule of Benefits

Covered Benefits and Services*	ARHealth		
	In-Network Copayment	In-Network Coinsurance	Out-of-Network Coinsurance
Reconstructive Surgery			
Correction of defects due to accident or covered surgery	Hospital Copay	20%	40%
<ul style="list-style-type: none"> * Out-Patient or In-Patient copayment will apply as applicable * Children 18 years and under for specific conditions for congenital deformity or accident/injury repair * Coverage is provided only when medically necessary and pre-approved by American Health Holding. Contact American Health Holding for confirmation of covered services. The circumstances for coverage are very limited. 			
Rehabilitation Services (In-Patient)			
Rehabilitation Services	\$250	20%	40%
<ul style="list-style-type: none"> * Benefit limited to sixty (60) days per member per Plan Year * Copayment applicable per admission * Coverage is provided only when medically necessary and pre-approved by American Health Holding 			
Rehabilitation Services (Out-Patient)			
Physical Therapy	\$0	20%	40%
Occupational Therapy	\$0	20%	40%
Speech Therapy	\$0	20%	40%
<ul style="list-style-type: none"> * Coverage is provided for these services based on medical necessity, determined by American Health Holding, and when arranged, authorized, and provided by an in-network physician and in-network facility * The Plan does not provide benefits for maintenance therapy. Maintenance Therapy refers to therapy in which you actively participate that is provided to you after no continued significant and measurable improvement is reasonably or medically anticipated 			
Skilled Nursing Facility (SNF) Services			
SNF Services	\$250	20%	40%
<ul style="list-style-type: none"> * Benefit limited to Sixty (60) days per member per Plan Year and require pre-authorization by American Health Holding * Coverage is provided for SNF services based on medical necessity, determined by American Health Holding, and when arranged, authorized, and provided by an in-network physician and in-network facility 			
Temporomandibular Joint (TMJ) / Dysfunction (TMD) Services			
TMJ / TMD Services	Office Copay	20%	40%
<ul style="list-style-type: none"> * Pre-Authorization by American Health Holding and participation with case management services required * Physician or Specialist copayment will apply as applicable * Coverage is provided for TMJ / TMD services based on medical necessity. 			
Transplant Services			
Organ / Bone Marrow Transplant	\$250	20%	Not Covered
<ul style="list-style-type: none"> * Copayment applicable per admission * Benefit Limited to two (2) organ transplants per Member per Lifetime * Benefit Limited to \$10,000 lifetime limit for travel and lodging in conjunction with transplant services * Coverage is provided for transplant services subject to the benefit maximums and requirements. Transplant services MUST be provided by approved transplant providers and facilities * In order to be eligible for coverage, you MUST notify American Health Holding prior to receiving any transplant services, including transplant evaluation. You MUST coordinate all transplant services, including transplant evaluation. For questions about your transplant benefits, contact American Health Holding 			

Not all providers participate in every network. Please consult your Benefit Coordinator's Online Provider Directory for an up-to-date list of participating network physicians, hospitals, and other service providers. Out-of-Network providers have the authority to Balance Bill you for all services. See inside back cover for an example of In-Network versus Out-of-Network charges.

What Else Comes With ARHealth for Non-Medicare Retirees?

ARHealth is more than just health insurance, it's a comprehensive health program dedicated to the overall health of the membership. In addition to the covered services for physician visits and hospital admissions, ARHealth provides the Non-Medicare primary members with access to a variety of other services such as:

- *Behavioral/Mental Health & Substance Abuse Services*
- *ARWellness programs for weight loss, tobacco cessation, and more*
- *Utilization Management and Case Management*
- *Preventative Care/Wellness Benefit*

Behavioral / Mental Health & Substance Abuse Services

Behavioral / Mental Health Services and Substance Abuse Services are coordinated through Corphealth. Contact Corphealth for a list of participating providers and instructions on accessing these services.

Covered Benefits and Services*	ARHealth		
	In-Network Copayment	In-Network Coinsurance	Out-of-Network Coinsurance
Deductible - Individual	-	\$0	\$1,000
Deductible - Family	-	\$0	\$2,000
* Subject to same deductible as medical plan			
Annual Coinsurance Limit - Individual (after deductible)	-	\$1,000	\$1,250
Annual Coinsurance Limit - Family (after deductible)	-	\$2,000	\$1,875
Initial Behavioral Health Benefit			
Initial Behavioral Health Benefit	\$0	0%	Not Covered
* Must contact Arkansas Help Line at 1-866-378-1645			
Traditional Out-Patient Services	\$25	0%	\$25 copay + 25% coins.
In-Patient Services	\$250	10%	\$300 copay + 35% coins.
* Copayment charged per admission for the ARHealth Plan			
Out-Patient Services (partial hospital / day treatment)	\$0	25%	\$0 copay + 25% coins.
Out-Patient Services (Intensive Out-patient)	\$0	0%	\$125 copay + 45% coins.
* Out-of-Network copayment applies to first visits only			
Residential Treatment	\$0	10%	35% coins.

ARWellness

Each year, millions of us make a decision to get in shape, stop smoking, or just take better care of ourselves. Unfortunately, many people fail to meet their goals, not from a lack of dedication but from a lack of education. We all know that getting in shape and eating better are the right things to do, but not everyone knows how to make those dreams become a reality. That is how ARWellness can help.

As a member of the ARHealth Plan, you are eligible to participate in the wellness initiative called ARWellness. As with all wellness programs, the goal of ARWellness is to provide our members with education and assistance to help them make better decisions about their personal well-being. ARWellness is actually a combination of 5 separate programs with different areas of focus. Coordinated through Corphealth; these 5 programs are Balance[®], Nourish[®], Breathe[®], Relax[®], and Care[®] For Your Back, and are the product of HealthMedia[®], Corphealth's strategic partner.

Utilization Management

EBD has contracted with American Health Holding (AHH) to provide utilization management. The utilization management services will include precertification, predetermination, and concurrent review.

Predetermination is necessary to verify if you are active with the plan and if the service being requested is a covered benefit on the plan. AHH will maintain contact with the hospital providers to approve additional days for your hospitalization when your medical status changes and additional days are warranted for concurrent review.

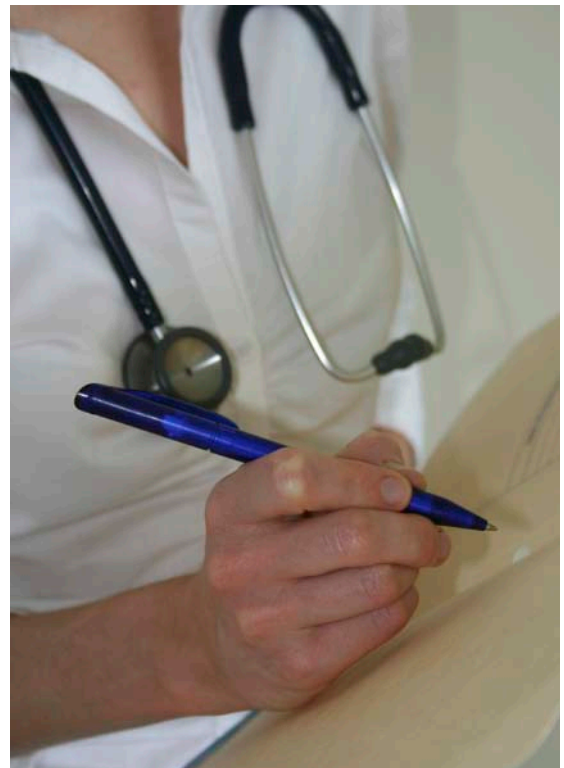
Precertification and predetermination will be **necessary** for the list of procedures provided in the SPD. It will be necessary for your provider to contact AHH at 1-800-592-0358 to obtain authorization of the services being requested. This number is also printed on your insurance card. It is your responsibility to verify or make certain the procedure has been approved to avoid problems with the payment for the services.

Case Management

The Case Management (CM) program at EBD is provided by seasoned expert nurses. These case managers bridge the gap between the health care provider, health care system, and any member receiving health care services. Even though CMs are specialized in a variety of areas (maternity, mental health, wellness, cardiac, oncology, catastrophic injury and illness, etc.), they work with physicians and the rest of your health care team to discuss, coordinate and follow-up on the best options available to you before, during, and following your health care experience.

The goal of CM is to empower members to maintain quality health and explore healthcare options available within the Summary Plan Description guidelines and our communities at large. Please feel free to contact an EBD CM by calling our local 501-683-5779 or toll free 866-451-8194.

Case Management services are provided by both EBD Health Services and an outside contractor called PDB Enterprises.



Preventative Care / Wellness Benefits

The following preventive/wellness services are covered at 100% under the ARHealth plan for non-Medicare retirees and their covered dependents. Services are covered at In-Network providers ONLY. Services may be obtained from more than one physician. Services that are not for screening or preventive in nature, but rather due to illness or specific condition, are subject to the standard Schedule of Benefits and will be subject to co-payments, co-insurance, and deductibles when applicable. For questions, contact your Benefit Coordinator.

Wellness Services	
Immunizations	
Well Baby Care - under 2 years of age	
Well Child Care - 2 years or older	
Physical Exams - Adults (limit 1 per Plan Year at no cost)	
Routine Mammogram (limit 1 per Plan Year at no cost)	
Annual Routine Gynecological visit (limit 1 per Plan Year at no cost)	
New Baby/Well Baby Visits	
Under 1 year	Initial comprehensive preventive medicine evaluation and management of an individual. Including an age and gender appropriate history, examination, counseling, or anticipatory guidance/risk factor reduction interventions, and ordering of appropriate immunizations laboratory/diagnostic, new patient; infant (age under 1 year)
Under 1 year	Periodic comprehensive preventive medicine reevaluation and management of an individual. Including an age and gender appropriate history, examination, counseling or anticipatory guidance/risk factor reduction interventions, and ordering of appropriate immunizations, laboratory/diagnostic, established patient; infant (age under 1 year)
Newborn Care	Normal newborn care in other than hospital or birthing room setting, including physical examination of baby and conference with parents.
Preventive Care Services - Child (under age 18)	
• Birth to Age 1 = Six Visits	• Age 12 to 17 = Annual Visits
• Age 1 to 2 = Three Visits	• Lead Level = Age 9 months to 24 months
• Age 3 to 4 = Annual Visits	• Vision Screening = 3-6, 8, 10, 12 & 15 months
• Age 5 to 11 = Annual Visits	• Hearing Screenings = 4-6, 8, 10, 12 & 15 months
Preventive Care Services - Adults (age 18 and over)	
• Annual Physical Office Visit	• Fecal occult blood test annually and one of the following: * Flexible sigmoidoscopy every 5 years * Colonoscopy once every 10 years * Double contrast barium enema once every 5 years
• Colorectal Cancer Screening beginning at age 50	
• Pap Smear	• Cholesterol and HDL - Once every 5 years for males age 35 and older and once every 5 years for females 45 and older
• Prostate Specific Antigen (PSA) age 40 and over	

*Flu vaccinations and immunizations considered In-Network when received at Arkansas Health Department

Preventative Care / Wellness Benefits continued...

Immunizations - Child (under age 18)

Diphtheria

Diphtheria and Tetanus toxoid and acellular pertussis (DTaP)

Diphtheria and Tetanus toxoid and whole cell pertussis (DTP)

Diphtheria and Tetanus toxoid and whole cell pertussis and Hemophilus Influenza b (DTP-Hib)

Diphtheria and Tetanus toxoid and whole cell pertussis, Hemophilus Influenza b, and Inactivated Poliovirus (DTap-Hib-IPV)

Diphtheria and Tetanus toxoid for ages over 7 (Td)

Gardasil ages 9 to 18

Hemophilus Influenza b (hib)

Hepatitis B (HEP B)

Hepatitis B (HEP B) and Hemophilus Influenza b (hib) combo

Influenza (flu) ages 6 months and older

Measles, live for subq use (IPV)

Measles, Mumps, Rubella (MMR)

Measles, Mumps, Rubella and Varicella (MMRV)

Measles, Rubella

Menactra Vaccine ages 11 to 18

Mumps

Pneumococcal Vaccine

Polio, live , oral use (OPV)

Rota Teq Vaccine administered orally in 3 doses for the prevention of Rotavirus, ages 2, 4, and 6 months

Rubella

Tetanus

Varicella

Immunizations - Adults (age 18 and over)

Diphtheria, every 10 years

Diphtheria and Tetanus toxoid for ages over 7 (Td), every 10 years

Gardasil ages 18 to 26

Hepatitis B (HEP B) - once per lifetime

Influenza (flu), annually

Menactra Vaccine ages 18 to 27

Pneumococcal Vaccine

Zostavax Vaccine for adults 60 and over

*Flu vaccinations and immunizations considered In-Network when received at Arkansas Health Department

How Much Will It Cost Me?

Monthly Premiums for Public School Retirees 2009 Plan Year Rates - Effective January 1, 2009 - December 31, 2009

ARHealth Retirees	Base Monthly Premium	Subsidy	Plan Contribution	Total Monthly Retiree Cost
Retiree Only (Not Medicare Eligible)	\$654.85	\$76.59	\$106.04	\$472.22
Retiree (Not Medicare Eligible) & Spouse (Not Medicare Eligible)	\$1,309.66	\$76.59	\$106.04	\$1,127.03
Retiree (Not Medicare Eligible) & Child(ren)	\$1,047.74	\$76.59	\$106.04	\$865.11
Retiree (Not Medicare Eligible) & Spouse (Not Medicare Eligible) & Child(ren)	\$1,965.45	\$76.59	\$106.04	\$1,782.82
Retiree (Not Medicare Eligible & Spouse (Medicare Eligible)	\$792.34	\$76.59	\$106.04	\$609.71
Retiree (Not Medicare Eligible) & Spouse (Medicare Eligible) & Child(ren)	\$1,186.65	\$76.59	\$106.04	\$1,004.02
Retiree Only (Medicare Eligible)	\$144.16	\$76.59	\$26.13	\$41.44
Retiree (Medicare Eligible) & Spouse (Not Medicare Eligible)	\$777.06	\$76.59	\$26.13	\$674.34
Retiree (Medicare Eligible) & Child(ren)	\$523.90	\$76.59	\$26.13	\$421.18
Retiree (Medicare Eligible) & Spouse (Not Medicare Eligible) & Child(ren)	\$1,156.80	\$76.59	\$26.13	\$1,054.08
Retiree (Medicare Eligible) & Spouse (Medicare Eligible)	\$273.32	\$76.59	\$26.13	\$170.60
Retiree (Medicare Eligible) & Spouse (Medicare Eligible) & Child(ren)	\$653.05	\$76.59	\$26.13	\$550.33

Monthly Premiums for Public School COBRA Participants

2009 Plan Year Rates - Effective October 1, 2008 - September 30, 2009

One of the options available to members of ARHealth as an active employee is to continue their coverage under COBRA. The Consolidated Omnibus Reconciliation Act of 1985 (COBRA) allows for continuation of health benefits after termination or retirement. Rates for members electing to continue their coverage through COBRA is listed below.

		HRA DISCOUNT				
	Total Monthly Premium	One Healthy Discount Level I	One Healthy Discount Level II	Two Healthy Discounts Level I	One Healthy Discount Level I and One Level II	Two Healthy Discounts Level II
		\$10 monthly savings	\$20 monthly savings	\$20 monthly savings	\$30 monthly savings	\$40 monthly savings
ARHealth Employee Only						
Health Advantage	\$394.75	\$384.75	\$374.75	-	-	-
ARHealth - NovaSys	\$399.79	\$389.79	\$379.79	-	-	-
HD PPO - NovaSys	\$312.62	\$302.62	\$292.62	-	-	-
ARHealth Employee & Spouse						
Health Advantage	\$1,056.85	\$1,046.85	\$1,036.85	\$1,036.85	\$1,026.85	\$1,016.85
NovaSys	\$1,070.93	\$1,060.93	\$1,050.93	\$1,050.93	\$1,040.93	\$1,030.93
HD PPO - NovaSys	\$827.72	\$817.72	\$807.72	\$807.72	\$797.72	\$787.72
ARHealth Employee & Child(ren)						
Health Advantage	\$682.00	\$672.00	\$662.00	-	-	-
NovaSys	\$691.08	\$681.08	\$671.08	-	-	-
HD PPO - NovaSys	\$534.18	\$524.18	\$514.18	-	-	-
ARHealth Employee & Family						
Health Advantage	\$1,064.46	\$1,054.46	\$1,044.46	\$1,044.46	\$1,034.46	\$1,024.46
NovaSys	\$1,078.58	\$1,068.58	\$1,058.58	\$1,058.58	\$1,048.58	\$1,038.58
HD PPO - NovaSys	\$834.51	\$824.51	\$814.51	\$814.51	\$804.51	\$794.51

But I Have A Question!

Is the network provider remaining the same as 2008?

Yes. The ARHealth Retiree plan is still administered by Health Advantage who has the largest network in and outside of the state.

How is the Arkansas State and Public School ARHealth plan different from the other plans?

- You have open access, which means that you may self-refer to a physician that is in-network and still receive in-network benefits. Out-of-Network benefits are only applied if you receive services from a non-participating provider.
- You will pay a \$25 copayment (PCP) for services provided by one of the following in-network doctors in their office, with no deductible.
 - General Practitioners
 - Family Practitioners
 - Internal Medicine
 - Pediatricians
- You will pay a \$35 copayment (Specialist) for services provided by an in-network specialist in their office, with no deductible.
- ARHealth Retiree members will be able to utilize the Health Advantage network of physicians and facilities.
- If you use an out of state participating Blue Cross provider, you will not be charged the difference between the amount billed by the provider and the Blue Cross-allowed amount. You will be responsible for the deductible, coinsurance or copayment amounts.

Do I have prescription drug coverage through the ARHealth Retiree plan if I am Medicare Primary?

As a Public School Retiree, you will lose prescription drug coverage once you become Medicare-Primary. You may want to consider enrolling in Medicare Part D or another prescription drug program.

Retirement

What are the retirement insurance eligibility rules?

- Are you participating in one of the five (5) retirement plans – APERS, ATRS, Highway, Judicial or Alternate? If yes,
- To be eligible you must have been participating in the group health insurance coverage on the last day as an active employee. If yes,
- You must apply within 31 days of becoming an active retiree to participate in the group health insurance program. If the retiree does not want to participate in the group health insurance program, they must sign a Waiver of Enrollment form indicating their wish to not participate within 31 days of becoming an active retiree.
- If the retiree declines to participate in the group health insurance program, that decision is final.
- EXCEPTION-LOSS OF ELIGIBILITY. If the retiree is an active retiree and declined coverage from the group health insurance program within thirty-one (31) days of retirement and specified in writing that the reason for the declination of coverage was because he/she (the active retiree) had coverage through another employer group health plan, and later his insurance coverage is terminated because of loss of eligibility, then the retiree and any dependents shall qualify for coverage in the State sponsored program provided the active retiree applies for coverage within thirty-one (31) days of the loss of eligibility. Examples of when loss of eligibility may occur is termination of employment, decrease in the number of hours worked, marriage, divorce or adoption of a child. An example of when loss of eligibility is not applicable is non-payment of premium and termination for cause. A person may not always lose eligibility for insurance coverage through one of the above-cited circumstances, but frequently they do.

- EBD advises retirees to seriously consider participating in the group health insurance offered to them as an active retiree of one of the five retirement programs. If the retiree declines to participate in group health insurance coverage within 31 days of becoming an active retiree, he must qualify for a loss of eligibility as cited above to become active in the group health insurance program.
- If the retiree is currently employed and the employer offers group health insurance coverage, the retiree may enroll in his current employer plan and drop insurance coverage with the Arkansas State and Public School Employees Group Health Insurance. The retiree may then reinstate insurance coverage with the Arkansas State and Public School Employees Group Health Insurance in the future if he/she experiences the loss of eligibility.

What are my insurance options upon retirement?

Upon retirement from your agency or district, you and your dependents are eligible to continue health coverage through several options which are outlined in detail below. *The necessary forms must be submitted to Employee Benefits Division within 31 days of your retirement date.*

OPTION A – Health and Life Insurance Continuation under Retirement System

If you are eligible for a retirement benefit from one of the participating retirement systems*, you may continue your current health coverage in the retirement group by having the insurance premium deducted from your retirement check. Complete the form titled “Retiree Payroll Deduction Authorization.” This is the form that notifies us of your intention to continue your health insurance. Mail completed form to the Employee Benefits Division at the mailing address listed on the top. If your retirement benefit amount is inadequate to cover the insurance premiums, you will also be asked to set up a bank draft by completing the “Authorization Agreement for Pre-Authorization Payments.”

OPTION B – COBRA Continuation ONLY

The Consolidated Omnibus Reconciliation Act of 1985 (COBRA) allows for continuation of health benefits after termination or retirement. If you are not eligible for retirement benefits from one of the participating retirement systems* and would like to retain your current health benefits, you may continue your health insurance for a period of 18 months as a COBRA Continuant. If you have not received a COBRA Election Form in the mail within 14 days of your last date of employment, please contact the Employee Benefits Division at (877) 815-1017.

OPTION C – COBRA until retirement benefits begin

If you are eligible for retirement (i.e. have enough years of service) but will not immediately receive a retirement benefit, you may choose health insurance coverage under COBRA for a maximum of 18 months (or until you are eligible to receive a retirement check if within the 18 month period). To enroll under COBRA, please read and complete the COBRA Election form that will be mailed to your home. When your retirement benefit begins, you may change to the retirement group by contacting the Employee Benefits Division.

NOTE: *It is the responsibility of the retiree to notify the Employee Benefits Division at least two (2) months before COBRA expires in order to make arrangements to change to the regular retiree group health insurance program.*

OPTION D – COBRA when retirement benefits are available

If you are eligible for retirement benefits from one of the participating retirement systems* when you retire, you may continue your health insurance through COBRA if you so choose. COBRA payments are made by bank draft. A bank draft payment is established by completing the “Authorization Agreement for Pre-Authorization Payments.” At the end of your COBRA benefit eligibility period (18 months) you will need to change to the retiree insurance group in order to continue your health insurance. It is very important to remember that you must remain on COBRA and make timely payments for the entire eligibility period to be eligible to begin insurance through the retirement system when COBRA coverage ends.

NOTE: It is the responsibility of the retiree to notify the Employee Benefits Division at least two (2) months before COBRA expires in order to make arrangements to change to the regular retiree group health insurance program.

OPTION E – Waiver of Enrollment

If you do not wish to continue the Health Insurance coverage at all, please complete a “Waiver Form” and then sign and date. Once completed, that form should be sent directly to Employee Benefits Division.

**Participating Retirement Systems are: Arkansas Public Employees Retirement System, Arkansas Teacher Retirement System, Judicial Retirement System, Arkansas Highway and Transportation Department Retirement System, and Alternative Retirement System.*

What if I take early retirement and do not qualify for retirement benefits?

- You are only eligible to continue the health insurance coverage as a COBRA participant. Once your COBRA has ended (18 months) and you are eligible to participate in one of the retirement plans, you may enroll at that time.

How do I enroll in the retirement health insurance program?

- You must complete a Retirement Deduction Authorization Form and send it to EBD within the 31 day election period. (See enclosed rates for Medicare, Non-Medicare and COBRA.)
- If you are declining coverage at this time, you must complete a Waiver Form. This form must be sent to EBD within the 31 day election period.

What continued health coverage benefits will my covered dependents have should I die?

Surviving covered dependents (excluding children ages 19 and up) of an insured retiree may continue the group health insurance coverage regardless of their option for survivor’s benefits. The premiums for this coverage may be deducted from the survivor’s benefits if applicable. If no survivor’s check is due, the surviving covered dependents will pay premiums directly to EBD on a monthly basis by bank draft only.

Who should be notified of the death of a retiree or dependent?

- EBD should be notified immediately upon the death of a retiree or covered dependent so that we can terminate coverage on that member and notify all benefit coordinators. At this time we would initiate the paperwork if there is to be a reduction in premiums.
- Upon notification of the death of a retiree, EBD will send out a Surviving Dependent letter to any covered dependents on the retiree’s plan extending the opportunity for them to continue to be covered under the State and Public School Retirement Health Program.

If I am eligible for Medicare, do I have to carry both Part A and Part B as a retiree?

YES. Retirees who are eligible for Medicare must carry Part B (physician). The benefit coordinator will coordinate benefits as if Part B is in force. This means that coverage under government programs, including Medicare, required or provided by any statute unless coordination of benefits with any such program is forbidden by law. Subscribers and Dependents who are eligible for Medicare must have both Part A and B. If a member eligible for Medicare does not have Medicare Part B, the plan will pay as though the member does have Medicare Part B and the member will have full financial responsibility for claims incurred.

NOTE: The general Medicare Open Enrollment period is from January through March each year for a July 1st effective date. Retirees without Medicare Part B should contact the Social Security Administration (at 1-800-772-1213) about obtaining Part B coverage. Medicare Part B premiums are monthly and may increase up to 10% for each 12 month period that you could have had Part B but did not sign up for it (there are some special exceptions).

If I am not eligible for Medicare at the time of retirement, but become eligible at a later date, how do I get the reduced premiums?

You need to send EBD a copy of your Medicare card as soon as you receive it so that we can make the proper adjustments to your account. If you are a Public School Retiree you will lose prescription drug coverage and may want to consider enrolling in Medicare Part D or another prescription drug program.

NOTE: Certificate of Creditable Coverage (COCC) statement included in this publication.

What are the participating retirement systems?

- Arkansas Public Employees Retirement System (APERS)
- Arkansas Teacher Retirement System (ATRS)
- Judicial Retirement System
- Arkansas Highway Retirement System
- Alternative Retirement System

What if my annuity check is not large enough for my insurance premiums?

EBD will set you up as a Cash Retiree and your premiums can only be made by bank draft.

When can I make plan changes?

The only opportunity for a Retiree to add dependents (other than newly acquired) is if there is a loss of coverage (qualifying or family status change event).

Will I still be covered by life insurance when I retire?

If you have questions about retaining Life Insurance after you retire, contact USABLE Life at 1-800-370-5856.

Who do I contact to file a life insurance claim if a retiree or dependent dies?

USABLE Life needs to be contacted directly at 1-800-370-5856.

If you need to change a beneficiary, please send that information directly to USABLE Life.

How Do I Access My SPD?

The SPD, which contains your General Rights Notice under COBRA, can be accessed online at www.ARBenefits.org. You may also write a letter to EBD at the address listed in the front of this book if you are unable to access the online SPD.

How do I access forms for ARHealth?

Forms can be downloaded from the Publications and Forms Library of ARBenefits.org or can be mailed to you when requested by calling EBD at the numbers provided in this Guide.

For other questions or concerns, please refer to page 3, "Who Can Help With Questions?" Contact the companies listed there, or the Employee Benefits Division, for assistance.



Manage your Claims with In-Network Providers

In the following example, a simple 3-day stay at an In-Network hospital is compared to the same stay at an Out-of-Network facility. Network discounts and Balance Billing makes a significant difference to your pocketbook.

The following example assumes a 3-day in-patient hospital stay with billed charges of \$12,000 for a member on the ARHealth Plan with Employee-Only coverage.

	In-Network Hospital	Out-of-Network Hospital
Billed Charges	\$12,000	\$12,000
Allowed Charges	\$3,600	\$3,600
Less Member Deductible	(\$0)	(\$1,000)
Less Member Co-payment	(\$250)	(\$0)
Less Member Co-Insurance	(\$670)	(\$1,040)
ARHealth Plan's Payment	\$2,680	\$1,560
Total Member's Responsibility	\$920 including co-payment and co-insurance	\$10,440 including deductible, co- insurance, and balance of billed charges

In the above example, an ARHealth Member is responsible for only \$585 for the stay at an In-Network hospital but \$9,440 for the same stay at an Out-of-Network hospital.

Understanding Your EOB

Every member will receive an EOB (Explanation of Benefit) after a medical service such as an office visit or hospital stay. It is very important that you understand your EOB and review it for accuracy. Your EOB will list the provider, dates, description and charges associated with your service. If you have questions or you have not received services from the provider listed on the date of service, please contact your Benefit Coordinator.

Explanation of Benefits

This is not a bill

SUBSCRIBER NAME NUMBER	PATIENT'S NAME	RELATIONSHIP	I.D. NUMBER	GROUP NAME	GROUP
John Doe	Jane Doe	Spouse	0075622002	AR State Emp/Act	001001

CLAIM DETAIL INFORMATION

Date Received: June 29, 2007	Date Processed: July 11, 2007	Provider of Service: C Dale Johnson, MD	Provider Number: 51998-8887
Claim Number: 050820T110086			

Date of Service From/Thru	Type of Service	Billed Amount	Allowed Amount	Non-covered Amount	Deductible Amount	Copayment Amount	Coinsurance Amount	Primary Payer Amount	Provider Adjustment Amount	Provider Payment
6/18/07-6/18/07	Physician Visit - Office or Other (1)	30.00	23.09	0.00	0.00	0.00	0.00	0.00	11.53	18.47
6/18/07-6/18/07	Pathology (1)	30.00	15.30	0.00	0.00	0.00	0.00	0.00	14.70	15.30
Claim Totals		60.00	38.39	0.00	0.00	0.00	0.00	0.00	26.23	33.77

Did you visit the doctor or have any services done that day?

Did you see this provider?

Did they do what they indicate?

*Above example is not indicative of costs/discounts and is for illustration purposes only.

Creditable Coverage Disclosure Notice

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage after May 15, 2006, you may need to give a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Date: Plan Year 2009

Name of Entity/Sender: Arkansas State and Public School Life
and Health Insurance Board

Contact-Office: State of Arkansas, Department of
Finance and Administration,
Employee Benefits Division

Address: Post Office Box 15610
Little Rock, AR 72231-5610

Phone Number: (501)682-9656