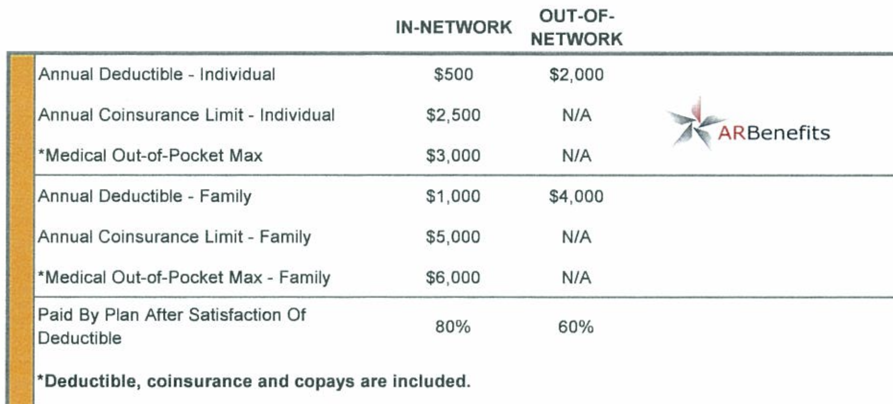
2015 Schedule of Benefits - Premium

(Active, Cobra & Non-Medicare Retiree)



	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible - Individual	$500	$2,000
Annual Coinsurance Limit - Individual	$2,500	N/A
*Medical Out-of-Pocket Max	$3,000	N/A
Annual Deductible - Family	$1,000	$4,000
Annual Coinsurance Limit - Family	$5,000	N/A
*Medical Out-of-Pocket Max - Family	$6,000	N/A
Paid By Plan After Satisfaction Of Deductible	80%	60%

***Deductible, coinsurance and copays are included.**

COVERED BENEFITS AND SERVICES	IN-NETWORK COPAYMENT	IN-NETWORK	OUT-OF-NETWORK	APPLIES TO DEDUCTIBLE
ADVANCED IMAGING				
*Advanced Imaging (Radiology Services)	$0	20%	40%	Y
ALLERGY SERVICES				
Services and Specialty Providers (Office Visit and Testing)	$50	20%	40%	N
Injections	$0	$0	0%	N
AMBULANCE SERVICES				
Air Ambulance Transportation	$0	10%	10%	N
Ground Transportation	$50	0%	40%	N

Advanced Imaging notes:

***Requires pre-certification**

***Charges will apply for such services as MRI, MRA, CTA AND PET Scans**

***Charges will not apply when provided in conjunction with Emergency Room or Inpatient Hospital Services**

Allergy Services note:

***Formulation of allergy serum requires coinsurance**

Ambulance Services note:

***Limited Benefits**

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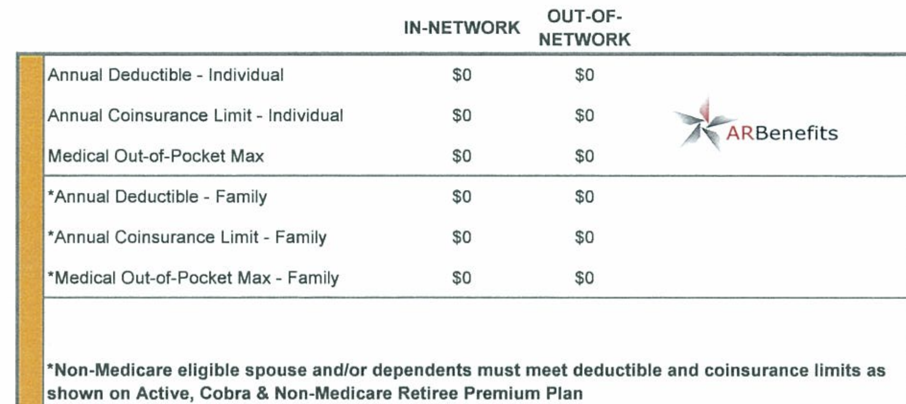
2015 Schedule of Benefits - Premium Retiree

(Medicare Primary Retirees)



	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible - Individual	$0	$0
Annual Coinsurance Limit - Individual	$0	$0
Medical Out-of-Pocket Max	$0	$0
*Annual Deductible - Family	$0	$0
*Annual Coinsurance Limit - Family	$0	$0
*Medical Out-of-Pocket Max - Family	$0	$0

***Non-Medicare eligible spouse and/or dependents must meet deductible and coinsurance limits as shown on Active, Cobra & Non-Medicare Retiree Premium Plan**

COVERED BENEFITS AND SERVICES	IN-NETWORK COPAYMENT	IN-NETWORK	OUT-OF-NETWORK	APPLIES TO DEDUCTIBLE
ADVANCED IMAGING				
*Advanced Imaging (Radiology Services)	$0	20%	40%	N/A
ALLERGY SERVICES				
Services and Specialty Providers (Office Visit and Testing)	$50	20%	40%	N/A
Injections	$0	$0	0%	N/A
AMBULANCE SERVICES				
Air Ambulance Transportation	$0	10%	10%	N/A
Ground Transportation	$50	0%	40%	N/A

Advanced Imaging notes:

***Requires pre-certification**

***Charges will apply for such services as MRI, MRA, CTA AND PET Scans**

***Charges will not apply when provided in conjunction with Emergency Room or Inpatient Hospital Services**

Allergy Services note:

***Formulation of allergy serum requires coinsurance**

Ambulance Services note:

***Limited Benefits**

COVERED BENEFITS AND SERVICES	IN-NETWORK COPAYMENT	IN-NETWORK	OUT-OF-NETWORK	APPLIES TO DEDUCTIBLE
BEHAVIORAL/MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT SERVICES				
Office Visit	$25	0%	40%	N
Psychological Testing	$35	0%	40%	N
In-Patient Services	$0	20%	40%	Y
Outpatient Services (Partial Hospital/Day Treatment)	$0	20%	40%	Y
Outpatient Services (Intensive Outpatient)	$0	20%	40%	Y
Residential Treatment	$0	20%	40%	Y
DENTAL SERVICES				
Repair to Non-Diseases Teeth Due to Accident/Injury	$0	20%	35%	Y
DIABETES MANAGEMENT SERVICE				
Insulin Pump & Supplies	$0	20%	40%	Y
Glucometers	$0	20%	40%	N
Diabetic Self Management Training	$0	0%	40%	N
DURABLE MEDICAL EQUIPMENT/ ENTERAL FEEDING				
DME/Enteral Feeding	$0	20%	40%	Y

***Lancets and insulin needles for diabetics will be paid 100% by the plan for participants in the Diabetic Management Program**

***Test strips must be purchased at Pharmacy Only.**

***Glucometers - Provided through DME/Medical Benefit**

***Coverage is provided for medically necessary durable medical equipment. See exclusions. Not all services require pre-certification and may be reviewed for medical necessity by AHH. Refer to Utilization Management section.**

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COVERED BENEFITS AND SERVICES	IN-NETWORK COPAYMENT	IN-NETWORK	OUT-OF-NETWORK	APPLIES TO DEDUCTIBLE
HEARING SERVICES				
Hearing Screening	$50	0%	$50	N
***Limited Benefits: One screening every three years**				
Hearing Aid	$0	20%	40%	Y
***Limited Benefits: $1,400 per ear every three years**				
HOME HEALTH SERVICES				
Home Health Services	$0	20%	40%	Y
HOME INTRAVENOUS DRUGS				
Home Intravenous Drugs and Solutions	$0	20%	40%	Y
HOSPICE SERVICES				
Hospice Care	$0	20%	40%	Y
HOSPITAL SERVICES				
In-Patient Services	$0	20%	40%	Y
Outpatient Services	$0	20%	40%	Y
Diagnostic Services	$0	20%	40%	Y
Emergency Room Visit and Observation Services	$250	0%	0%	N
***ER copay will be waived if admitted in the hospital.**				
Urgent Care Center	$100	0%	0%	N
***Visits deemed non-emergency charged as hospital services/outpatient, the coinsurance/copayment will apply.**				

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COVERED BENEFITS AND SERVICES	IN-NETWORK COPAYMENT	IN-NETWORK	OUT-OF-NETWORK	APPLIES TO DEDUCTIBLE
MATERNITY AND FAMILY PLANNING SERVICES				
Prenatal and Postnatal Outpatient Care	$0	20%	40%	Y
Inpatient Maternity Services	$0	20%	40%	Y
***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: Office Visit	$70	0%	40%	N
Infertility Testing	$0	20%	40%	Y
***Treatment for infertility is not a covered benefit under the ARBenefits Plan. Services related to infertility are covered up to diagnosis. Testing is not covered during or following treatment.**				
PHARMACY BENEFIT - REFER TO RX DRUG COVERAGE SECTION				
Prescription - Generic - Tier I	$15			
Prescription - Preferred - Tier II	$40			
Prescription - Non-Preferred - Tier III	$80			
Prescription Specialty - Tier IV	$100			
*RX Out-of-Pocket Max (Individual/Family)	$3100/$6200			
***Excluded drugs, reference price drugs and brand drugs where generic is available does not apply towards the RX Out-of-Pocket Max.**				
PHYSICIAN/SPECIALIST SERVICES				
*Primary Care Physician Office Visit	$25	$0	40%	N
*Specialist Office Visit/Specialty Care Services	$50	$0	40%	N
***Co-pay applies to consultation ONLY. Co-insurance will be applied to other office services.**				
*Other Physician Services provided under Outpatient or In-Patient Care**	$0	20%	40%	Y
***Includes such services as debridement and/or wound dressing changes performed in an outpatient setting with or without direct physician attention**				
Medication	$0	20%	40%	Y
***This includes injectable, oral and intravenous medications**				
Radiation Therapy	$0	20%	40%	Y

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**See Professional Services under SPD - Summary of Common Services

COVERED BENEFITS AND SERVICES	IN-NETWORK COPAYMENT	IN-NETWORK	OUT-OF-NETWORK	APPLIES TO DEDUCTIBLE
PREVENTATIVE CARE SERVICES				
Physical Exams/Preventative Care	$0	0%	40%	N
Well Baby/Child Care Visits	$0	0%	40%	N
*Immunizations	$0	0%	0%	N
***Vaccinations for the Flu, HPV and Herpes Zoster (Shingles) are covered 100% by the plan under the pharmacy benefit.**				
PROSTHETIC AND ORTHOTIC DEVICES				
Prosthetic and Orthotic Devices and Services	$0	20%	40%	Y
REHABILITATION SERVICES (INPATIENT)				
Rehabilitation Services	$0	20%	40%	Y
REHABILITIATION SERVICES (OUTPATIENT) OR OFFICE VISIT				
Chiropractic	$25	0%	40%	N
***Limited Benefit: Fifteen (15) visits per member per plan year**				
Physical Therapy	$25	0%	40%	N
Occupational Therapy	$25	0%	40%	N
Speech Therapy	$25	0%	40%	N
***Therapy services billed by or provided by a Specialist MD will have the Specialist Copay ($50)**				
SKILLED NURSING FACILITY (SNF) SERVICES				
SNF Services	$0	20%	40%	Y
TEMPOROMANDIBULAR JOINT (TMJ)/ DYSFUNCTION (TMD) SERVICES				
TMJ/TMD	$0	20%	40%	Y

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COVERED BENEFITS AND SERVICES	IN-NETWORK COPAYMENT	IN-NETWORK	OUT-OF-NETWORK	APPLIES TO DEDUCTIBLE
TRANSPLANT SERVICES				
Organ/Bone Marrow Transplant	$250	20%	40%	N

***Copayment applicable per admission.**
***Limited Benefit: Two (2) organ transplants of the same organ per member per lifetime.**
***Limited Benefit: $10,000 lifetime limit for travel and lodging determined by EBD as reasonable and necessary in conjunction with transplant services.**
***Coverage is provided for transplant services subject to pre-authorization (See Utilization Management Section). Transplant services MUST be provided by approved transplant provides and facilities.**

COVERED BENEFITS AND SERVICES	IN-NETWORK COPAYMENT	IN-NETWORK	OUT-OF-NETWORK	APPLIES TO DEDUCTIBLE
VISION SCREENING				
Vision Screening	$50	0%	$50	N

***Limited Benefit: One (1) exam every twenty-four (24) months**

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Certain Limitations Apply - Please check your SPD Exclusions and Limitations section for more information