2015 Schedule of Benefits - Classic

(Active, Cobra & Non-Medicare Retiree)

	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible - Individual	$2,500	not covered
Annual Coinsurance Limit - Individual	$4,100	not covered
*Medical Out-of-Pocket Max	$6,600	not covered
Annual Deductible - Family	$5,000	not covered
Annual Coinsurance Limit - Family	$8,200	not covered
*Medical Out-of-Pocket Max - Family	$13,200	not covered
Paid By Plan After Satisfaction Of Deductible	80%	not covered
***Deductible, coinsurance and copays are included.**		

COVERED BENEFITS AND SERVICES	IN-NETWORK	OUT-OF-NETWORK	APPLIES TO DEDUCTIBLE
ADVANCED IMAGING (RADIOLOGY SERVICES)			
Advanced Imaging (Radiology Services)	20%	not covered	Y
***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			
Services and Specialty Providers (Office Visit and Testing)	20%	not covered	Y
Injections	$0	not covered	N
AMBULANCE SERVICES			
Air Ambulance Transportation	10%		N
Ground Transportation	20%		N
***Limited Benefits**			

2015 Schedule of Benefits - Basic

(Active, Cobra & Non-Medicare Retiree)

	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible - Individual	$6,600	not covered
Annual Coinsurance Limit - Individual	N/A	not covered
*Medical Out-of-Pocket Max	$6,600	not covered
Annual Deductible - Family	$13,200	not covered
Annual Coinsurance Limit - Family	N/A	not covered
*Medical Out-of-Pocket Max - Family	$13,200	not covered
Paid By Plan After Satisfaction Of Deductible	100%	not covered
***Deductible, coinsurance and copays are included.**		

COVERED BENEFITS AND SERVICES	IN-NETWORK	OUT-OF-NETWORK	APPLIES TO DEDUCTIBLE
ADVANCED IMAGING			
Advanced Imaging (Radiology Services)	0%	not covered	Y
***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			
Services and Specialty Providers (Office Visit and Testing)	0%	not covered	Y
Injections	$0	not covered	N
AMBULANCE SERVICES			
Air Ambulance Transportation	0%		Y
Ground Transportation	0%		Y
***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	20%	**not covered**	Y	
Psychological Testing	20%	**not covered**	Y	
In-Patient Services	20%	**not covered**	Y	
Outpatient Services (Partial Hospital/Day Treatment)	20%	**not covered**	Y	
Outpatient Services (Intensive Outpatient)	20%	**not covered**	Y	
Residential Treatment	20%	**not covered**	Y	
DENTAL SERVICES				
Repair to Non-Diseases Teeth Due to Accident/Injury	20%	**not covered**	Y	
DIABETES MANAGEMENT SERVICE				
Insulin Pump & Supplies	20%	**not covered**	Y	
Glucometers	20%	**not covered**	Y	
Diabetic Self Management Training	20%	**not covered**	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**				
DURABLE MEDICAL EQUIPMENT/ ENTERAL FEEDING				
DME/Enteral Feeding	20%	**not covered**	Y	
***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.**				

COVERED BENEFITS AND SERVICES	IN-NETWORK COPAYMENT	IN-NETWORK	OUT-OF-NETWORK	APPLIES TO DEDUCTIBLE
BEHAVIORAL/MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT SERVICES				
Office Visit	0%	**not covered**	Y	
Psychological Testing	0%	**not covered**	Y	
In-Patient Services	0%	**not covered**	Y	
Outpatient Services (Partial Hospital/Day Treatment)	0%	**not covered**	Y	
Outpatient Services (Intensive Outpatient)	0%	**not covered**	Y	
Residential Treatment	0%	**not covered**	Y	
DENTAL SERVICES				
Repair to Non-Diseases Teeth Due to Accident/Injury	0%	**not covered**	Y	
DIABETES MANAGEMENT SERVICE				
Insulin Pump & Supplies	0%	**not covered**	Y	
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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%	not covered	N
***Limited Benefits: One screening every three years**				
Hearing Aids	$0	20%	not covered	Y
***Limited Benefits: $1,400 per ear every three years**				
HOME HEALTH SERVICES				
Home Health Services		20%	not covered	Y
HOME INTRAVENOUS DRUGS				
Home Intravenous Drugs and Solutions		20%	not covered	Y
HOSPICE SERVICES				
Hospice Care		20%	not covered	Y
HOSPITAL SERVICES				
In-Patient Services		20%	not covered	Y
Outpatient Services		20%	not covered	Y
Diagnostic Services		20%	not covered	Y
Emergency Room Visit and Observation Services		20%	not covered	Y
Urgent Care Center		20%	not covered	Y

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Outpatient Services		0%	not covered	Y
Diagnostic Services		0%	not covered	Y
Emergency Room Visit and Observation Services		0%	not covered	Y
Urgent Care Center		0%	not covered	Y

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	20%		not covered	Y
Inpatient Maternity Services	20%		not covered	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	20%		not covered	Y
Infertility Testing	20%		not covered	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	Included with Medical			Y
Prescription - Preferred - Tier II	Included with Medical			Y
Prescription - Non-Preferred - Tier III	Included with Medical			N/A
Prescription Specialty - Tier IV	Included with Medical			Y
***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	20%		not covered	Y
Specialist Office Visit/Specialty Care Services	20%		not covered	Y
*Other Physician Services provided under Outpatient or In-Patient Care**	20%		not covered	Y
***Includes such services as debridement and/or wound dressing changes performed in an outpatient setting with or without direct physician attention.**				
Medication	20%		not covered	Y
***This includes injectable, oral and intravenous medications**				
Radiation Therapy	20%		not covered	Y
****See Professional Services under SPD - Summary of Common Services**				

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COVERED BENEFITS AND SERVICES	IN-NETWORK COPAYMENT	IN-NETWORK	OUT-OF-NETWORK	APPLIES TO DEDUCTIBLE
PREVENTATIVE CARE SERVICES				
Physical Exams/Preventative Care		0%	not covered	N
Well Baby/Child Care Visits		0%	not covered	N
*Immunizations		0%	not covered	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		20%	not covered	Y
REHABILITATION SERVICES (INPATIENT)				
Rehabilitation Services		20%	not covered	Y
REHABILITIATION SERVICES (OUTPATIENT) OR OFFICE VISIT				
Chiropractic		20%	not covered	Y
***Limited Benefit: Fifteen (15) visits per member per plan year**				
Physical Therapy		20%	not covered	Y
Occupational Therapy		20%	not covered	Y
Speech Therapy		20%	not covered	Y
SKILLED NURSING FACILITY (SNF) SERVICES				
SNF Services		20%	not covered	Y
TEMPOROMANDIBULAR JOINT (TMJ)/ DYSFUNCTION (TMD) SERVICES				
TMJ/TMD		20%	not covered	Y
***Limited Benefit: $1,000 per member per plan year**				

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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		20%	not covered	Y
*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.				
VISION SCREENING				
Vision Screening	$50	0%	not covered	N
*Limited Benefit: One (1) exam every twenty-four (24) months				

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