# 2015 Schedule of Benefits - Gold

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| Annual Deductible - Individual | $1,000 | $1,000 |
| Annual Coinsurance Limit - Individual | $2,500 | $5,000 |
| True Out-of-Pocket Max - Individual | *$3,500 | *$6000 |
| Annual Deductible - Family | $2,000 | $2,000 |
| Annual Coinsurance Limit - Family | $5,000 | $10,000 |
| True Out-of-Pocket Max - Family | *$7,000 | *$12,000 |
| Paid By Plan After Satisfaction Of Deductil | 80% | 60% |
| *Does not include copays | | |


| COVERED BENEFITS AND SERVICES | IN-NETWORK COPAYMENT | IN-NETWORK | OUT-OF-NETWORK | APPLIES TO DEDUCTIBLE |
|---|---|---|---|---|
| **ADVANCED IMAGING** | | | | |
| Advanced Imaging | $0 | 20% | 40% | Y |
| ***Charges will apply for such services as MRI, MRA, CTA AND PET Scans**<br>***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) | $70 | 20% | 40% | N |
| Injections | $0 | $0 | 0% | N |
| ***Formulation of allergy serum requires coinsurance** | | | | |
| **AMBULANCE SERVICES** | | | | |
| Air Ambulance Transportation | $0 | 10% | 10% | N |
| Ground Transportation | $50 | 0% | 40% | N |
| ***Limited Benefits** | | | | |
| **BEHAVIORAL/MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT** | | | | |
| Office Visit | $35 | 0% | 40% | N |
| Psychological Testing | $35 | 0% | 40% | N |
| In-Patient Services | $250 | 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 |

| COVERED BENEFITS AND SERVICES | IN-NETWORK COPAYMENT | IN-NETWORK | OUT-OF-NETWORK | APPLIES TO DEDUCTIBLE |
|---|---|---|---|---|
| **DIABETES MANAGEMENT SERVICE** | | | | |
| Insulin Pump & Supplies | $0 | 20% | 40% | Y |
| Glucometers | $0 | 20% | 40% | N |
| Diabetic Self Management Training | $0 | 0% | 40% | N |
| ***Lancets and insulin needles for diabetics will be paid 100% by the plan for participants in the Diabetic Management Program<br>*Glucometers - Provided through DME/Medical Benefit** | | | | |
| **DURABLE MEDICAL EQUIPMENT/ ENTERAL FEEDING** | | | | |
| DME/Enteral Feeding | $0 | 20% | 40% | 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.** | | | | |
| **HEARING SERVICES** | | | | |
| Hearing Screening<br>(Does not apply to out-of- pocket max) | $70 | 0% | $70 copay | N |
| ***Limited Benefit: One screening every three years** | | | | |
| Hearing Aid<br>(Does not apply to out-of-pocket max) | $0 | 0% | 0% | N |
| ***Limited Benefit: $1,400 per ear every three (3) 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 |
| Urgent Care Center | $70 | 0% | 0% | N |
| ***Visits deemed non-emergency charged as hospital services/outpatient, the coinsurance/copayment will apply.** | | | | |

| 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% | N |
| ***Prenatal and postnatal outpatient care copayment required on first visit only** | | | | |
| Inpatient Maternity Services | $0 | 20% | 40% | Y |
| ***Copayment applicable per admission<br>*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 | 20% | 40% | N |
| Infertility Testing | $0 | 20% | 40% | Y |
| ***Treatment for infertility is not a covered benefit under the ARBenefits Bronze 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 | 0% | N/A | N |
| Prescription - Preferred - Tier II | $40 | 0% | N/A | N |
| Prescription - Non-Preferred - Tier III | $80 | 0% | N/A | N |
| Prescription Specialty - Tier IV | $100 | 0% | N/A | N |
| **PHYSICIAN/SPECIALIST SERVICES** | | | | |
| *Primary Care Physician Office Visit | $35 | $0 | 40% | N |
| *Specialist Office Visit/Specialty Care Services | $70 | $0 | 40% | N |
| *Other Physician Services provided under Outpatient or In-Patient Care** | $0 | 20% | 40% | N |
| ***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 |
| ***Co-pay applies to consultation ONLY. Co-insurance will be applied to office services.<br><br>**See Professional Services under SPD - Summary of Common Services** | | | | |
| **PREVENTATIVE CARE SERVICES** | | | | |
| Physical Exams/Preventative Care | $0 | 0% | 40% | N |
| Well Baby/Child Care Visits | $0 | 0% | 40% | N |
| Immunizations *Vaccinations for the Flu, HPV and Herpes Zoster (Shingles) are covered 100% by the plan under the pharmacy benefit | $0 | 0% | 0% | N |

| COVERED BENEFITS AND SERVICES | IN-NETWORK COPAYMENT | IN-NETWORK | OUT-OF-NETWORK | APPLIES TO DEDUCTIBLE |
|---|---|---|---|---|
| **PROSTHETIC AND ORTHOTIC DEVICES** | | | | |
| Prosthetic and Orthotic Devices and Services | $0 | 20% | 40% | Y |
| **REHABILITATION SERVICES (INPATIENT)** | | | | |
| Rehabilitation Services | $0 | 20% | 40% | Y |
| ***The limitation for no more than three impatient admission copays does not apply to rehab services** | | | | |
| **REHABILITIATION SERVICES (OUTPATIENT) OR OFFICE VISIT** | | | | |
| Chiropractic | $35 | 0% | 40% | N |
| ***Limited Benefit: Fifteen (15) visits per member per plan year** | | | | |
| Physical Therapy | $35 | 0% | 40% | N |
| Occupational Therapy | $35 | 0% | 40% | N |
| Speech Therapy | $35 | 0% | 40% | N |
| ***There may be coinsurance applied depending on the extent of services.**<br>****Therapy services billed by or provided by a Specialist MD will have the Specialist Copay ($70)** | | | | |
| **SKILLED NURSING FACILITY (SNF) SERVICE** | | | | |
| SNF Services | $0 | 20% | 40% | Y |
| **TEMPOROMANDIBULAR JOINT (TMJ)/ DYSFUNCTION (TMD) SERVICES** | | | | |
| TMJ/TMD | $0 | 20% | 40% | Y |
| ***Limited Benefit: $1,000 per member per plan year** | | | | |
| **TRANSPLANT SERVICES** | | | | |
| Organ/Bone Marrow Transplant | $250 | 20% | 40% | N |
| ***Copayment applicable per admission.**<br>***Limited Benefit: Two (2) organ transplants of the same organ per member per lifetime.**<br>***Limited Benefit: $10,000 lifetime limit for travel and lodging determined by EBD as reasonable and necessary in conjunction with transplant services.**<br>***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 | $70 | 0% | $70 copay | N |
| ***Limited Benefit: One (1) exam every twenty-four (24) months** | | | | |