2018 PSE Schedule of Benefits - Premium

	IN-NETWORK	OUT-OF-NETWORK	
Annual Deductible - Individual	$1,000	$2,000	
Annual Coinsurance/Copay Limit - Individual	$2,500	N/A	
*Medical Out-of-Pocket Max	$3,500	N/A	
Annual Deductible - Family	$2,000	$4,000	The Plan will pay 100 percent for individuals on family coverage if they reach the individual out-of-pocket
Annual Coinsurance/Copay Limit - Family	$5,000	N/A	
*Medical Out-of-Pocket Max - Family	$7,000	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
***Requires pre-certification**				
***Charges will not apply when provided in conjunction with Emergency Room or Inpatient Hospital Services**				
ALLERGY SERVICES				
Specialist Office Visit	$50	0%	40%	N
Testing and Serum Formulation	$0	20%	40%	Y
Injections	$0	$0	40%	N
***Formulation of allergy serum requires coinsurance**				
AMBULANCE SERVICES				
Air Ambulance Transportation		10%		N
Ground Transportation		$50 copay		N
***Limited Benefits: $2,000 per member per trip for ground ambulance**				
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%	40%	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%	Y
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**				
***Test strips must be purchased at Pharmacy Only.**				
***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	$50	0%	$50	N
Hearing Aid	$0	0%	0%	N
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 may be waived. See Summary Plan Description (SPD)**				
Urgent Care Center	$100	0%	0%	N
***Visits deemed non-emergency will be treated as hospital services/outpatient.**				

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	$50	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
*Other Physician Services provided under Outpatient or In-Patient Care**	$0	20%	40%	Y
*Medication	$0	20%	40%	Y
Radiation Therapy	$0	20%	40%	Y
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
PROSTHETIC AND ORTHOTIC DEVICES				
Prosthetic and Orthotic Devices and Services	$0	20%	40%	Y
REHABILITATION SERVICES (INPATIENT)				
Rehabilitation Services	$0	20%	40%	Y

COVERED BENEFITS AND SERVICES	IN-NETWORK COPAYMENT	IN-NETWORK	OUT-OF-NETWORK	APPLIES TO DEDUCTIBLE
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
***Limited Benefit: $1,000 per member per plan year**				
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 providers and facilities.**				
VISION SCREENING				
Vision Screening	$50	0%	$50	N
***Limited Benefit: One (1) exam every twenty-four (24) months**				

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

2018 PSE Schedule of Benefits - Classic

	IN-NETWORK	OUT-OF-NETWORK	
Annual Deductible - Individual	$2,000	$3,000	
Annual Coinsurance Limit - Individual	$4,450	N/A	
*Out-of-Pocket Max	$6,450	N/A	
Annual Deductible - Family	$3,000	$6,000	The Plan will pay 100 percent for individuals on family coverage if they reach the individual out-of-pocket maximum amount.
Annual Coinsurance Limit - Family	$6,675	N/A	
*Out-of-Pocket Max - Family	$9,675	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)	N/A	20%	40%	Y
***Requires pre-certification**				
***Charges will not apply when provided in conjunction with Emergency Room or Inpatient Hospital Services**				
ALLERGY SERVICES				
Services and Specialty Providers (Office Visit, Serum Formulation and Testing)	N/A	20%	40%	Y
Injections	N/A	$0	40%	Y
AMBULANCE SERVICES				
Air Ambulance Transportation	N/A	10%		N
Ground Transportation	N/A	20%		N
***Limited Benefits: $2,000 per member per trip for ground ambulance**				
BEHAVIORAL/MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT SERVICES				
Office Visit	N/A	20%	40%	Y
Psychological Testing	N/A	20%	40%	Y
In-Patient Services	N/A	20%	40%	Y
Outpatient Services (Partial Hospital/Day Treatment)	N/A	20%	40%	Y
Outpatient Services (Intensive Outpatient)	N/A	20%	40%	Y
Residential Treatment	N/A	20%	40%	Y
DENTAL SERVICES				
Repair to Non-Diseases Teeth Due to Accident/Injury	N/A	20%	40%	Y

COVERED BENEFITS AND SERVICES	IN-NETWORK COPAYMENT	IN-NETWORK	OUT-OF-NETWORK	APPLIES TO DEDUCTIBLE

DIABETES MANAGEMENT SERVICE				
Insulin Pump & Supplies	N/A	20%	40%	Y
Glucometers	N/A	20%	40%	Y
Diabetic Self Management Training	N/A	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**				

DURABLE MEDICAL EQUIPMENT/ENTERAL FEEDING				
DME/Enteral Feeding	N/A	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	$50	0%	$50	N
Hearing Aid	$0	20%	40%	Y

HOME HEALTH SERVICES				
Home Health Services	N/A	20%	40%	Y

HOME INTRAVENOUS DRUGS				
Home Intravenous Drugs and Solutions	N/A	20%	40%	Y

HOSPICE SERVICES				
Hospice Care	N/A	20%	40%	Y

HOSPITAL SERVICES				
In-Patient Services	N/A	20%	40%	Y
Outpatient Services	N/A	20%	40%	Y
Diagnostic Services	N/A	20%	40%	Y
Emergency Room Visit and Observation Services	N/A	20%	40%	Y
Urgent Care Center	N/A	20%	40%	Y
***Visits deemed non-emergency will be treated as hospital services/outpatient.**				

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	N/A	20%	40%	Y
Inpatient Maternity Services	N/A	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	N/A	20%	40%	Y
Infertility Testing	N/A	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	N/A	20%	N/A	Y
Prescription - Preferred - Tier II	N/A	20%	N/A	Y
Prescription - Non-Preferred - Tier III	N/A	20%	N/A	Y
Prescription Specialty - Tier IV	N/A	20%	N/A	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	N/A	20%	40%	Y
*Specialist Office Visit/Specialty Care Services	N/A	20%	40%	Y
*Other Physician Services provided under Outpatient or In-Patient Care**	N/A	20%	40%	Y
Medication	N/A	20%	40%	Y
Radiation Therapy	N/A	20%	40%	Y
PREVENTATIVE CARE SERVICES				
Physical Exams/Preventative Care	N/A	0%	40%	N
Well Baby/Child Care Visits	N/A	0%	40%	N
*Immunizations	N/A	0%	0%	N
PROSTHETIC AND ORTHOTIC DEVICES				
Prosthetic and Orthotic Devices and Services	N/A	20%	40%	Y
REHABILITATION SERVICES (INPATIENT)				
Rehabilitation Services	N/A	20%	40%	Y

COVERED BENEFITS AND SERVICES	IN-NETWORK COPAYMENT	IN-NETWORK	OUT-OF-NETWORK	APPLIES TO DEDUCTIBLE
REHABILITIATION SERVICES (OUTPATIENT) OR OFFICE VISIT				
Chiropractic	N/A	20%	40%	Y
***Limited Benefit: Fifteen (15) visits per member per plan year**				
Physical Therapy	N/A	20%	40%	Y
Occupational Therapy	N/A	20%	40%	Y
Speech Therapy	N/A	20%	40%	Y
SKILLED NURSING FACILITY (SNF) SERVICES				
SNF Services	N/A	20%	40%	Y
TEMPOROMANDIBULAR JOINT (TMJ)/DYSFUNCTION (TMD) SERVICES				
TMJ/TMD	N/A	20%	40%	Y
***Limited Benefit: $1,000 per member per plan year**				
TRANSPLANT SERVICES				
Organ/Bone Marrow Transplant	N/A	20%	40%	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%	$50	N
***Limited Benefit: One (1) exam every twenty-four (24) months**				

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

2018 PSE Schedule of Benefits - Basic

	IN-NETWORK	OUT-OF-NETWORK	
Annual Deductible - Individual	$4,250	not covered	
Annual Coinsurance Limit - Individual	$2,200	not covered	
*Out-of-Pocket Max	$6,450	not covered	
Annual Deductible - Family	$8,500	not covered	The plan will pay 100 percent for individuals on family coverage if they reach the individual out-of-pocket amount.
Annual Coinsurance Limit - Family	$4,400	not covered	
*Out-of-Pocket Max - Family	$12,900	not covered	
Paid By Plan After Satisfaction Of Deductible	80%	not covered	

***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)	N/A	20%	not covered	Y
***Requires pre-certification**				
***Charges will not apply when provided in conjunction with Emergency Room or Inpatient Hospital Services**				
ALLERGY SERVICES				
Services and Specialty Providers (Office Visit, Serum Formulation and Testing)	N/A	20%	not covered	Y
Injections	N/A	$0	not covered	Y
AMBULANCE SERVICES				
Air Ambulance Transportation	N/A	10%		N
Ground Transportation	N/A	20%		N
***Limited Benefits: $2,000 per member per trip for ground ambulance**				
BEHAVIORAL/MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT SERVICES				
Office Visit	N/A	20%	not covered	Y
Psychological Testing	N/A	20%	not covered	Y
In-Patient Services	N/A	20%	not covered	Y
Outpatient Services (Partial Hospital/Day Treatment)	N/A	20%	not covered	Y
Outpatient Services (Intensive Outpatient)	N/A	20%	not covered	Y
Residential Treatment	N/A	20%	not covered	Y
DENTAL SERVICES				
Repair to Non-Diseases Teeth Due to Accident/Injury	N/A	20%	not covered	Y

COVERED BENEFITS AND SERVICES	IN-NETWORK COPAYMENT	IN-NETWORK	OUT-OF-NETWORK	APPLIES TO DEDUCTIBLE
DIABETES MANAGEMENT SERVICE				

Insulin Pump & Supplies	N/A	20%	not covered	Y
Glucometers	N/A	20%	not covered	Y
Diabetic Self Management Training	N/A	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	N/A	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.**				

HEARING SERVICES				
Hearing Screening	$50	0%	not covered	N
Hearing Aid	$0	20%	not covered	Y

HOME HEALTH SERVICES				
Home Health Services	N/A	20%	not covered	Y

HOME INTRAVENOUS DRUGS				
Home Intravenous Drugs and Solutions	N/A	20%	not covered	Y

HOSPICE SERVICES				
Hospice Care	N/A	20%	not covered	Y

HOSPITAL SERVICES				
In-Patient Services	N/A	20%	not covered	Y
Outpatient Services	N/A	20%	not covered	Y
Diagnostic Services	N/A	20%	not covered	Y
Emergency Room Visit and Observation Services	N/A	20%	not covered	Y
Urgent Care Center	N/A	20%	not covered	Y
***Visits deemed non-emergency will be treated as hospital services/outpatient.**				

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	N/A	20%	**not covered**	Y
Inpatient Maternity Services	N/A	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	N/A	20%	**not covered**	Y
Infertility Testing	N/A	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	N/A	20%	N/A	Y
Prescription - Preferred - Tier II	N/A	20%	N/A	Y
Prescription - Non-Preferred - Tier III	N/A	20%	N/A	Y
Prescription Specialty - Tier IV	N/A	20%	N/A	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	N/A	20%	**not covered**	Y
*Specialist Office Visit/Specialty Care Services	N/A	20%	**not covered**	Y
*Other Physician Services provided under Outpatient or In-Patient Care**	N/A	20%	**not covered**	Y
Medication	N/A	20%	**not covered**	Y
Radiation Therapy	N/A	20%	**not covered**	Y
PREVENTATIVE CARE SERVICES				
Physical Exams/Preventative Care	N/A	0%	**not covered**	N
Well Baby/Child Care Visits	N/A	0%	**not covered**	N
Immunizations	N/A	0%	**not covered**	N
PROSTHETIC AND ORTHOTIC DEVICES				
Prosthetic and Orthotic Devices and Services	N/A	20%	**not covered**	Y
REHABILITATION SERVICES (INPATIENT)				
Rehabilitation Services	N/A	20%	**not covered**	Y

COVERED BENEFITS AND SERVICES	IN-NETWORK COPAYMENT	IN-NETWORK	OUT-OF-NETWORK	APPLIES TO DEDUCTIBLE
REHABILITIATION SERVICES (OUTPATIENT) OR OFFICE VISIT				
Chiropractic	N/A	20%	**not covered**	Y
***Limited Benefit: Fifteen (15) visits per member per plan year**				
Physical Therapy	N/A	20%	**not covered**	Y
Occupational Therapy	N/A	20%	**not covered**	Y
Speech Therapy	N/A	20%	**not covered**	Y
SKILLED NURSING FACILITY (SNF) SERVICES				
SNF Services	N/A	20%	**not covered**	Y
TEMPOROMANDIBULAR JOINT (TMJ)/DYSFUNCTION (TMD) SERVICES				
TMJ/TMD	N/A	20%	**not covered**	Y
***Limited Benefit: $1,000 per member per plan year**				
TRANSPLANT SERVICES				
Organ/Bone Marrow Transplant	N/A	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**				

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