






ARHealth Schedule of Benefits


2008 Plan Year Summary of Common Services

Covered Benefits and Services*	ARHealth			ARHealth HD PPO	
	In-Network Copayment	In-Network Coinsurance	Out-of-Network Coinsurance	In-Network Coinsurance	Out-of-Network Coinsurance
Deductible - Individual	-	\$0	\$1,000	\$1,250	\$3,000
Deductible - Family	-	\$0	\$2,000	\$2,500	\$6,000
Annual Coinsurance Limit - Individual (after deductible)	-	\$1,000	\$5,000	\$2,500	\$5,000
Annual Coinsurance Limit - Family (after deductible)	-	\$2,000	\$10,000	\$5,000	\$10,000
Lifetime Maximum	-	-	\$1,000,000	-	\$1,000,000
Physician / Specialist Services					
Primary Care Physician Office Visit	\$20	0%	40%	20%	40%
Specialist Office Visit / Specialty Care Services	\$30	0%	40%	20%	40%
Other Physician Services (including lab and X-ray)	\$0	10%	40%	20%	40%
Pharmacy Benefit					
Prescription - Generic	\$10	0%	0%	20%	20%
Prescription - Preferred	\$30	0%	0%	20%	20%
Prescription - Non-Preferred	\$60	0%	0%	20%	20%
Prilosec OTC	\$5	0%	0%	20%	20%
Hospital Services					
In-Patient Services	\$250	10%	40%	20%	40%
Out-Patient Services	\$100	10%	40%	20%	40%
Diagnostic Services (including lab and X-ray)	\$0	10%	40%	20%	40%
Emergency Care Services					
ER Visit, Urgent Care Center, Observation	\$100	0%	0%	20%	20%
Preventive Care / Wellness Services					
 Physical Exams / Preventive Care Services	\$0	0%	Not Covered	0%	Not Covered
 Well Baby / Child Care Visits	\$0	0%	Not Covered	0%	Not Covered
 Immunizations (see page 18)	\$0	0%	Not Covered	0%	Not Covered
 Dental Screening - one (1) every six (6) months	\$30	0%	25%	20%	40%
 Vision Screening - one (1) every twenty-four (24) months	\$30	0%	Not Covered	20%	Not Covered

* Above is a summary of common services - Please refer to the Schedule of Benefits for full details, limitations and exclusions

Additional services may require pre-approval by the Benefit Coordinator

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Covered Benefits and Services*	ARHealth			ARHealth HD PPO	
	In-Network Copayment	In-Network Coinsurance	Out-of-Network Coinsurance	In-Network Coinsurance	Out-of-Network Coinsurance
Allergy Services					
Injection with no office visit	\$0	10%	40%	20%	40%
Services by Specialty Providers (office visit & testing)	\$30	10%	40%	20%	40%
Ambulance Services					
Ground or Air Ambulance Transportation	\$0	0%	40%	20%	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 for detailed information					
Dental Care Services					
 Dental Screening - one (1) every six (6) months	\$30	0%	25%	20%	40%
Repair to non-diseased teeth due to accident / injury	\$30	10%	35%	20%	40%
Coverage is provided for the following dental services in an outpatient setting:					
* 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	20%	0%	40%	20%	40%
Glucometers & Supplies	20%	0%	40%	20%	40%
Diabetic Self Management Training	\$25 per Program	0%	40%	20%	40%
* 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					
Durable Medical Equipment					
DME & Medical Supplies	\$0	20%	40%	20%	40%
* Coverage is provided only when medically necessary and pre-approved by your Benefit Coordinator					
* The Plan does not provide benefits for DME that is for patient convenience					
* Limited to \$10,000 annual maximum benefit from the Plan					
Emergency Care Services					
ER Visit, Urgent Care Center, Observation Services	\$100	0%	0%	20%	20%
* 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 contact the toll free number listed on your health identification card for participating facility or physician in the event of an emergency outside of the service area					

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Employee Assistance Program (EAP) Services

Star EAP Services	\$0	0%	Not Covered	0%	Not Covered
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- * 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	10%	40%	20%	40%
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- * Coverage is provided only when medically necessary and pre-approved by your Benefit Coordinator
- * Limited to 30 visits per member per Plan Year. Pre-certification required for additional visits

Home Intravenous Drugs

Home IV Drugs and Solutions	\$0	10%	40%	20%	40%
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- * Coverage is provided for home intravenous (IV) drugs and solutions when ordered by an in-network physician
- * Some medications may require prior authorization for coverage by the Benefit Coordinator
- * You may contact your Benefit Coordinator's customer service department to verify if a medication requires prior authorization for coverage. You are responsible for the appropriate coinsurance

Hospice Services

Hospice Care	\$0	10%	40%	20%	40%
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- * Coverage is provided only when medically necessary and pre-approved by your Benefit Coordinator
- * Coverage is provided only when medically necessary and pre-approved by your Benefit Coordinator

Hospital Services - Inpatient

In-Patient Services	\$250	10%	40%	20%	40%
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- * Copayment charged per admission for the POS Plan except in cases of direct transfer to another facility
- * Maximum of 3 Copayments per Member per Plan Year
- * Coverage is provided only when medically necessary and pre-approved by your Benefit Coordinator
- * If you select a private room, member is responsible for the difference in charges for private room and semi-private room

Hospital Services - Outpatient

Out-Patient Surgical Services	\$100	10%	40%	20%	40%
Diagnostic Services (including lab and X-ray)	\$0	10%	40%	20%	40%

- * Diagnostic Services and procedures are performed outside the PCP office
- * Coverage is provided only when medically necessary and pre-approved by your Benefit Coordinator

Injectable Medications

Injectable Medication	Office Copay	10%	40%	20%	40%
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- * Subject to Plan Exclusions and Limitations as defined in the Summary Plan Description (SPD)
- * Coverage is provided for home intravenous (IV) drugs and solutions when ordered by an in-network physician
- * Some medications may require prior authorization for coverage by the Benefit Coordinator
- * You may contact your Benefit Coordinator's customer service department to verify if a medication requires prior authorization for coverage. You are responsible for the appropriate coinsurance



Immunizations (see page 18)	\$0	0%	Not Covered	0%	Not Covered
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Maternity and Family Planning Services

Prenatal and Postnatal Out-Patient Care	\$20	10%	40%	20%	40%
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- * Prenatal and Postnatal outpatient care Copayment required on first visit only

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Maternity and Family Planning Services - Cont.

In-Patient Maternity Services	\$250	10%	40%	20%	40%
* 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 & Testing	\$25	10%	40%	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.					
Infertility Testing	\$200	10%	40%	20%	40%

Organ Transplant Services (Pre-Authorization Required)

Organ Transplant	\$250	10%	Not Covered	20%	Not Covered
* 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 in-network providers and facilities					
* In order to be eligible for coverage, you MUST notify your Benefit Coordinator prior to receiving any transplant services, including transplant evaluation. The Benefit Coordinator MUST coordinate all transplant services, including transplant evaluation. Questions about your transplant benefits, contact your Benefit Coordinator					

Ostomy Supplies

Ostomy Supplies	\$0	10%	40%	20%	40%
* 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					

Pharmacy Benefit

Prescription - Generic	\$10	0%	0%	20%	20%
Prescription - Preferred	\$30	0%	0%	20%	20%
Prescription - Non-Preferred	\$60	0%	0%	20%	20%
Prilosec OTC	\$5	0%	0%	20%	20%
* Drugs not covered by the Plan are paid at 100% member responsibility					
* ARHealth HD PPO members may receive a negotiated discount for their prescription. Cost of prescription will count toward applicable deductible and Coinsurance Annual Limit					

Preventive Care Services

* See Preventive Care Services for detailed information

Professional Services

Primary Care Physician (PCP) Office Visit	\$20	0%	40%	20%	40%
* ARHealth members must select a PCP that is contracted with the Benefit Coordinator to receive in-network benefits					
Specialist Office Visit / Specialty Care Services	\$30	0%	40%	20%	40%
* No Referral Necessary from PCP for Specialist Office Visit / Specialty Care Services provided by a specialist physician M.D. (medical doctor) or D.O. (doctor of osteopathy)					
* Certain specialist physicians may require your PCP to call and schedule your appointment.					
Other Physician Services (including lab and X-ray)	\$0	10%	40%	20%	40%

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2008 Plan Year Schedule of Benefits

Prosthetic and Orthotic Devices

Prosthetic and Orthotic Devices	\$0	20%	40%	20%	40%
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- * Benefit Limited to One (1) prosthetic device that aid in bodily functioning or replace a limb after an accident or surgical loss and Two (2) orthotic devices used for correction or prevention of skeletal deformities
- * Coverage is provided only when medically necessary and pre-approved by your Benefit Coordinator
- * Appliance provider of the appliance must be contracted with your 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	10%	40%	20%	40%
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- * Coverage is provided only when medically necessary and pre-approved by your Benefit Coordinator
- * Charges apply when services are not provided in conjunction with PCP or Specialist visit

Reconstructive Surgery

Correction of Defects due to Accident or Covered Surgery	Hospital Copay	10%	40%	20%	40%
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- * 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 when medically necessary and pre-approved by your Benefit Coordinator. Contact your Benefit Coordinator confirmation of covered services. The circumstances for coverage are very limited

Rehabilitation Services (In-Patient)

Rehabilitation Services	\$250	10%	40%	20%	40%
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- * 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 your Benefit Coordinator

Rehabilitation Services (Out-Patient)

Physical Therapy	\$0	10%	40%	20%	40%
Occupational Therapy	\$0	10%	40%	20%	40%
Speech Therapy	\$0	10%	40%	20%	40%
Chiropractic Services	\$30	10%	40%	20%	40%

- * Benefit limited to Fifteen (15) visits per therapy per member per Plan Year
- * Cardiac Rehabilitation benefits will be applied based on medical necessity and utilization management criteria
- * Coverage is provided only when medically necessary and pre-approved by your Benefit Coordinator
- * 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	10%	40%	20%	40%
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- * Benefit limited to Sixty (60) days per member per Plan Year
- * Coverage is provided only when medically necessary and pre-approved by your Benefit Coordinator

Temporomandibular Joint (TMJ) Dysfunction Services (Pre-Authorization Required)

TMJ Services	Office Copay	10%	40%	20%	40%
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- * PCP or Specialist Copayment will apply as applicable
- * Coverage is provided only when medically necessary and pre-approved by your Benefit Coordinator

Vision Care Services

Vision Screening - one (1) every twenty-four (24) months	\$30	0%	Not Covered	20%	Not Covered
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Additional services may require pre-approval by the Benefit Coordinator

