



## Health Maintenance Organization (HMO)

- Health Care Reform compliant
- In-network preventive care covered 100%
- Participant annual maximum: \$2,000,000

Summary of Services	Participating Providers (In-Network)	Non-Participating Providers (Out-of-Network)
<b>Individual Deductible Options</b> • The family deductible is 3 times the single • In-network and out-of-network deductible and coinsurance amounts must be satisfied separately	0 250 500 1,000 1,500 2,500 3,500 5,000 7,500	Not Applicable
<b>Coinsurance Options</b> The percentage Arise Health Plan will pay for covered services	100% 90% 80%	Not Applicable
<b>Annual Coinsurance Limits</b>	\$5,000 \$10,000 \$20,000	Not Applicable
<b>Wellness Care and Routine Physicals</b> Preventive services rated A or B by the U.S. Preventive Services Task Force (USPSTF) are covered at 100%, including recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women. Please see policy for a complete listing of services rated A or B.	100% Coverage + Waiver of Deductible	Not Covered
• Routine Mammograms (40+)	100% Coverage + Waiver of Deductible	Not Covered
<b>Hospital Services</b> • Room and Board, Miscellaneous Hospital Expenses, and Intensive Care Unit (prior approval required*) • Outpatient Facility Fees • Outpatient Radiology, Pathology, and Lab Services • Outpatient Practitioner Fees	Deductible & Coinsurance	Not Covered
<b>Emergency and Urgent Care Services</b> • Emergency Room Facility Fees • Emergency Room Care (including physician charges & miscellaneous expenses)	\$150 Copay (Waived if admitted to hospital within 24 hours)	
• Ambulance (prior approval required for non-emergency transport*)	Participating Provider Deductible & Coinsurance	
<b>Transplants</b> Covered expenses include, but are not limited to, hospital charges, practitioner charges, organ and tissue acquisition, tissue typing, and ancillary services at a Designated Transplant Facility that are Medically Necessary.	100% Coverage After Deductible	Not Covered
<b>Professional Services</b> • Office Visits (including chiropractic care and occupational, physical, speech, and respiratory therapy) • X-ray and Lab Services (applies to all related services for that physician on the same date of service and billed in conjunction with the office visit)	\$20 Copay \$30 Copay \$40 Copay	Not Covered
• Maternity Services** Global Physician Charges Facility	100% Coverage Deductible & Coinsurance	Not Covered
• Medical and Surgical Services	Deductible & Coinsurance	Not Covered

Summary of Services (Continued)	Participating Providers (In-Network)	Non-Participating Providers (Out-of-Network)
<b>Home Health Care</b> <ul style="list-style-type: none"> <li>• Home Health Services (up to 40 visits per year; prior approval required*)</li> <li>• Home IV Therapy and Supplies (prior approval required*)</li> </ul>	Deductible & Coinsurance	Not Covered
<b>Hearing Aids &amp; Cochlear Implants</b> <ul style="list-style-type: none"> <li>• Covered expenses include the cost of hearing aids and cochlear implants that are prescribed by a physician or audiologist for a Dependent under the age of 18 who is certified as deaf or hearing impaired by a physician or audiologist</li> <li>• Coverage for hearing aids will be limited to the cost of one hearing aid every three years per ear per Dependent under 18 years of age</li> </ul>	Deductible & Coinsurance	Not Covered
<b>Autism Spectrum Disorders</b> <ul style="list-style-type: none"> <li>• Includes autism disorder, Asperger's syndrome, or any other pervasive development disorder</li> <li>• Covered expenses will be provided for services rendered that have a primary diagnosis code of Autism Spectrum Disorders</li> <li>• Covered expenses are payable for evidence-based behavioral intensive-level services up to a maximum benefit of \$50,000 per calendar year with a maximum of 35 hours of care per week for a maximum of 48 months</li> <li>• Covered expenses are payable for evidence-based nonintensive-level services up to a maximum benefit of \$25,000 per calendar year</li> </ul>	Deductible & Coinsurance	Not Covered
<b>Other Health Care Services</b> <ul style="list-style-type: none"> <li>• Breast Reconstruction (following a mastectomy)</li> <li>• Durable Medical Equipment (DME costing more than \$500 requires prior approval)</li> <li>• Diabetic Equipment and Self-Management Education Programs</li> <li>• Temporomandibular Joint (TMJ) Disorders (diagnosis and non-surgical treatment up to \$1,250 per year)</li> <li>• Skilled Nursing Care Facility (up to 30 days per confinement)</li> <li>• Contraceptive devices, implants, or injections</li> </ul>	Deductible & Coinsurance	Not Covered
<b>Nervous and Mental Disorders, Alcoholism, and Drug Abuse</b> <p>All services for nervous and mental disorders, alcoholism, and drug abuse will be subject to the same deductible and coinsurance amounts as any other illness. However, outpatient therapy services billed as an office visit will be subject to the office visit copayment.</p>	Deductible & Coinsurance	Not Covered
<b>Prescription Drugs</b> (including insulin, disposable diabetic supplies, and oral contraceptives; prior approval required for certain drugs*) <ul style="list-style-type: none"> <li>• Three-tier benefit options</li> <li>• First tier is for generic drugs on our drug formulary; second tier is for brand-name drugs on our drug formulary; third tier is for drugs not on our drug formulary</li> <li>• Retail: 30-day supply</li> <li>• Mail order: 90-day supply subject to 2 times the retail copay</li> </ul>	\$10/\$25/\$50 \$20/\$40/\$60	Prescriptions covered only when provided by Express Scripts affiliated pharmacies
<p>*Prior approval required when receiving certain benefits; without prior approval, benefits may be denied or substantially limited. Note: All benefits are subject to the applicable limitations and exclusions as defined in the policy. Annual benefit limitations apply per calendar year.</p> <p>**Other maternity services billed in addition to global services, including labs, may be subject to a copay, deductible, and/or coinsurance based on where the services were rendered.</p> <p><b>IMPORTANT:</b> This plan summary provides only a general description of benefits and limitations. You can find a detailed description of coverage in the applicable group certificate. Coverage is subject to all the terms and conditions of the certificate and any endorsements. If there is ever a disagreement between the certificate and this brochure, the certificate has final authority. This plan summary must be used in conjunction with the Additional Plan Information inserts which includes plan limitations and exclusions. In-network and out-of-network deductibles track separately.</p>		