Arise HEALTH PLAN

Berlin Area School District

Outline of Benefits - HMO Embedded HDHP
Effective July 1, 2017

PROVISION/BENEFIT	PARTICIPATING PROVIDER What you pay	NON-PARTICIPATING PROVIDER What you pay
Deductible - Embedded HDHP		
Per Covered Person	$3,000	Not Applicable
Per Family	$6,000	Not Applicable
Coinsurance		
Coinsurance	10%	Not Applicable
Annual Out-of Pocket Limit (includes deductible & coinsurance) Embedded HDHP		
Per Covered Person	$4,500	Not Applicable
Per Family	$9,000	Not Applicable
Covered Expenses – Excluding Prescription Legend Drugs Dispensed by a Pharmacy		
Ambulance services**	Deductible and Coinsurance	Participating Deductible and Coinsurance
Behavioral health		
Therapy visits	Deductible and Coinsurance	Not Covered
Outpatient/Transitional services	Deductible and Coinsurance	Not Covered
Inpatient services**	Deductible and Coinsurance	Not Covered
Contraceptives	0%	Not Covered
Diagnostic x-ray and laboratory services – outpatient**	Deductible and Coinsurance	Not Covered
Durable medical equipment**	Deductible and Coinsurance	Not Covered
Emergency room – visit charge only	Deductible and Coinsurance	Participating Deductible and Coinsurance
Emergency room services	Deductible and Coinsurance	Participating Deductible and Coinsurance
Home care – limited to 50 visits per year	Deductible and Coinsurance	Not Covered
Home and office visits – visit charge only	Deductible and Coinsurance	Not Covered
Hospital inpatient services**	Deductible and Coinsurance	Not Covered
Immunizations	0%	Not Covered
Injections - outpatient	Deductible and Coinsurance	Not Covered
Kidney disease treatment	Deductible and Coinsurance	Not Covered
Maternity services	Deductible and Coinsurance	Not Covered
Medical supplies	Deductible and Coinsurance	Not Covered
Nutritional counseling	0%	Not Covered
Preventive care services*	0%	Not Covered

PROVISION/BENEFIT	PARTICIPATING PROVIDER What you pay	NON-PARTICIPATING PROVIDER What you pay
Surgical services	Deductible and Coinsurance	Not Covered
Telehealth visits (through Teladoc)	Deductible and Coinsurance	Not Covered
Therapy visits Office setting Home or outpatient hospital setting	 Deductible and Coinsurance Deductible and Coinsurance	 Not Covered Not Covered
Transplants services**	Deductible then 0%	Not Covered
All other health care services – unless otherwise stated in your plan	Deductible and Coinsurance	Not Covered
Prescription Drugs and Diabetic Supplies Dispensed by a Participating Pharmacy ***(Drugs and covered supplies dispensed by a non-participating pharmacy are not covered.)***		
Prescription drugs and diabetic supplies: excludes preventive drugs	Participating Deductible and Coinsurance	
Preventive drugs – as required by the Affordable Care Act and defined in the policy	0% (deductible waived)	
Limitations *Maintenance medications must be purchased through home delivery, unless the member has elected to opt out of that program prior to the fourth purchase*	Retail: 30-day supply Home Delivery: 90-day supply Specialty drugs and Chemotherapy drugs: 30-day supply Smoking Cessation – Limited to 180 day supply	
Mandatory generic & Step therapy	Applicable	
Specialty drugs**	Specialty drugs are prescription legend drugs that we determine to be: (a) associated with a high level of clinical management and/or patient monitoring; (b) associated with special handling or distribution requirements; or (c) generally high cost.	

This is a partial summary of the benefits created from a brief sales quote presentation. Finalized benefits will take precedence over any benefit information presented in this outline.

* Includes preventive screenings as required by the United States Preventive Services Task Force (USPSTF)

** Some services may require prior authorization. Please refer to the Member Home tab for further information at www.arisehealthplan.com.

Arise HEALTH PLAN

Berlin Area School District

Outline of Benefits – POS Copay Plan
Effective July 1, 2017

PROVISION/BENEFIT	PARTICIPATING PROVIDERS What you pay	NON-PARTICIPATING PROVIDERS What you pay
Deductible		
Per Covered Person	$3,000	$6,000
Per Family	$6,000	$12,000
Copayments		
Primary care physician (PCP) - includes a chiropractor	$25	Not Applicable
Specialty physician	$50	Not Applicable
Convenient care clinic	$25	Not Applicable
Telehealth visits (through Teladoc)	$0	Not Applicable
Emergency room	$500	$500
Prescription drug and certain diabetic supplies	Dispensed by a Retail Pharmacy: Value Drugs- $0 Generic - $10 Participating Brand-Name - $25 Brand-Name – $60 Specialty – Subject to applicable copayment listed above Home Delivery is [2.5X] the retail pharmacy copayment	
Coinsurance		
Coinsurance	20%	40%
Maximum Annual Out-of Pocket Limit (includes deductible, coinsurance & all copayments)		
Per Covered Person	$4,500	$9,000
Per Family	$9,000	$18,000
Covered Expenses – Excluding Prescription Legend Drugs Dispensed by a Pharmacy		
Ambulance services**	Deductible and Coinsurance	Participating Provider Deductible and Coinsurance
Behavioral health Outpatient services Inpatient services** Transitional services	 PCP copayment, then 0% Deductible and Coinsurance Deductible and Coinsurance	 Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance
Contraceptives	0%	Deductible and Coinsurance
Diagnostic x-ray and laboratory services – outpatient**	Deductible and Coinsurance	Deductible and Coinsurance
Durable medical equipment**	Deductible and Coinsurance	Deductible and Coinsurance

PROVISION/BENEFIT	PARTICIPATING PROVIDERS What you pay	NON-PARTICIPATING PROVIDERS What you pay
Emergency room – visit charge only	Copayment, then 0%	Copayment, then 0%
Emergency room services	0%	0%
Home care – limited to 50 visits per year	Deductible and Coinsurance	Deductible and Coinsurance
Home and office visits – visit charge only	Copayment, then 0%	Deductible and Coinsurance
Hospital inpatient services**	Deductible and Coinsurance	Deductible and Coinsurance
Immunizations	0%	0%
Injections - outpatient	Coinsurance	Deductible and Coinsurance
Kidney disease treatment	Deductible and Coinsurance	Deductible and Coinsurance
Maternity services	Deductible and Coinsurance	Deductible and Coinsurance
Medical supplies	Deductible and Coinsurance	Deductible and Coinsurance
Nutritional counseling	0%	Deductible and Coinsurance
Preventive care services*	0%	Deductible and Coinsurance
Surgical services	Deductible and Coinsurance	Deductible and Coinsurance
Telehealth visits (through Teladoc)	Copayment, then 0%	Not Covered
Therapy visits Office setting Outpatient hospital setting	 Deductible and Coinsurance Deductible and Coinsurance	 Deductible and Coinsurance Deductible and Coinsurance
Transplants services**	Deductible, then 0%	Not Covered
All other health care services – unless otherwise stated in your plan	Deductible and Coinsurance	Deductible and Coinsurance
Prescription Drugs and Diabetic Supplies from a Participating Pharmacy ***(Drugs and covered supplies dispensed by a non-participating pharmacy are not covered.)***		
Prescription drugs and diabetic supplies: excludes preventive drugs	Copayment, then 0%	
Preventive drugs – as required by the Affordable Care Act and defined in the policy	0% (copayment waived)	
Limitations *Maintenance medications must be purchased through home delivery, unless the member has elected to opt out of that program prior to the fourth purchase*	Retail: 30-day supply Home Delivery: 90-day supply Specialty drugs and Chemotherapy drugs: 30-day supply Smoking Cessation – Limited to 180 day supply	
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