ASE Basic Plan – 2020

(Active employees, non-Medicare Retirees & COBRA)

Benefits listed below apply to the 2020 plan year (January 1 – December 31, 2020). ARBenefits follows primary coverage criteria of Health Advantage. Nationwide in-network coverage is available when using a PPO participating provider with the local Blue Cross Blue Shield plan. Certain limitations and exclusions apply to certain services. Consult the Limitations and Exclusions section of the ARBenefits Summary Plan Description (SPD) for more information. ***The Basic plan does not include coverage for out-of-network services except for medical emergencies***.

	In-Network Benefits Only
Annual Deductible Individual Family	 $6,450 $12,900
Paid by Plan after satisfaction of deducitble	100%
- Deductible does not apply to eligible preventive care. *- Plan copays do not count towards the satisfaction of the deductible.*	
Coinsurance / Copay limits Individual Family	 N/A N/A
Medical Out-of-Pocket Maximum Individual Family	 $6,450 $12,900
- Out-of-pocket maximum includes member deductible, copay and coinsurance contributions. *- Plan pays 100 percent for individuals on family coverage if they reach the individual out-of-pocket maximum*.	

Covered Services and Benefits

Office Visits/Urgent Care	In-Network Benefits
Eligible preventive care	Plan pays 100% No deducitble
Doctor visits/urgent care Primary care physician (PCP) office visit Specialist office visit Urgent Care visit Emergency Room visit & observation	 Plan pays 100% after deductible Plan pays 100% after deductible Plan pays 100% after deductible Plan pays 100% after deductible
Diagnostic tests & services All covered non-preventive tests and services	Plan pays 100% after deductible
Telemedicine	Telemedicine claims are processed as office visits and are subject to the applicable office visit copay and or deductible/coinsurance.

Pharmacy Benefits	In-Network Benefits
Prescription - Generic - Tier I	Plan pays 100% after deductible
Prescription - Preferred - Tier II	Plan pays 100% after deductible
Prescription - Non-Preferred - Tier III	Plan pays 100% after deductible
Prescription Specialty - Tier IV	Plan pays 100% after deductible

Advanced Imaging	In-Network Benefits
*****Advanced Imaging (high-tech radiology services)	Plan pays 100% after deductible
**Services require prior approval.*	

Allergy Services	In-Network Benefits
Specialist office visit	Plan pays 100% after deductible
Testing & serum formulation	Plan pays 100% after deductible
Allergy injections	$0

Ambulance Services	In-Network Benefits
Air ambulance transportation	Plan pays 100% after deductible
*Ground transportation	Plan pays 100% after deductible
**Limited benefit of $2,000 per trip for ground ambulance.* **International air evacuation is not covered.*	

Behavioral/Mental Health & Substance Abuse Services	In-Network Benefits
Office visit	Plan pays 100% after deductible
Psychological testing	Plan pays 100% after deductible
*Inpatient services	Plan pays 100% after deductible
Outpatient services (intensive outpatient)	Plan pays 100% after deductible
Residential Treatment	Plan pays 100% after deductible
**Inpatient services include partial hospital/day treatment.*	

Dental Services	In-Network Benefits
Repair to natural non-diseased teeth due to accidental trauma/injury	Plan pays 100% after deductible

Diabetes Management	In-Network Benefits
Insulin pump and supplies	Plan pays 100% after deductible
Glucometer	Plan pays 100% after deductible
Diabetic self-management training	Plan pays 100% after deductible
Diabetic testing supplies paid 100% by the Plan if member is in the ARBenefits sponsored Diabetes Management Program. *If member is not in the plan sponsored program, test strips must be purchased through Pharmacy only.* *Glucometers provided through DME/Medical benefit.*	

Durable Medical Equipment	In-Network Benefits
DME/Enteral feeding	Plan pays 100% after deductible
**Coverage is provided for medically necessary durable medical equipment (DME). See exclusions in SPD. Not all services require pre-certification and may be reviewed for medical necessity by Health Advantage. Refer to Utilization Management section of plan SPD.*	

Hearing Services	In-Network Benefits
*Hearing Screening	$50 copay
**Hearing Aids	$0 (see benefit below)
**Limited Benefit: One (1) screening covered every thirty-six (36) months.* ***Limited Benefit: $1,400 per ear every (3) three years towards the cost of hearing aids.*	

Home Health Services/Hospice Care	In-Network Benefits
Home health services	Plan pays 100% after deductible
Home intravenous drugs and solutions	Plan pays 100% after deductible
Hospice care	Plan pays 100% after deductible

Hospital Services	In-Network Benefits
Inpatient services	Plan pays 100% after deductible
Outpatient services	Plan pays 100% after deductible
Diagnostic services	Plan pays 100% after deductible
Visits deemed non-emergency will be treated as outpatient.	

Maternity & Family Planning	In-Network Benefits
Prenatal & postnatal outpatient care	Plan pays 100% after deductible
Inpatient maternity services	Plan pays 100% after deductible
**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	Plan pays 100% after deductible
Infertility testing	Plan pays 100% after deductible
**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.*	

Prosthetic and Orthotic Devices	In-Network Benefits
Prosthetic and orthotic devices & services	Plan pays 100% after deductible
** Limit of one (1) prosthetic device per lifetime. Limit of two (2) orthotic devices per lifetime. Limit of six (6) bras per calendar year following mastectomy.*	

Rehabilitation Services	In-Network Benefits
Inpatient services	Plan pays 100% after deductible
Outpatient services	
Chiropractic	Plan pays 100% after deductible
**Limited Benefit: Fifteen (15) visits per member per plan year. Diagnostic services such as lab or x-ray subject to plan deductible and coinsurance.*	
Physical therapy	Plan pays 100% after deductible
Occupational therapy	Plan pays 100% after deductible
Speech therapy	Plan pays 100% after deductible
**Prior approval required for outpatient therapy.*	

Skilled Nursing Facility (SNF)	In-Network Benefits
SNF services	Plan pays 100% after deductible

Temporomandibular Joint (TMJ)/Dysfunction Services	In-Network Benefits
TMJ/TMD services	Plan pays 100% after deductible
**Limited benefit: $1,000 per member per plan year*	

Transplant Services	In-Network Benefits
Organ/Bone marrow transplant	Plan pays 100% after deductible
**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. Claim subject to deductible and coinsurance.* **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 Services	In-Network Benefits
*Vision screening	$50 copay
**Limited Benefit: One (1) exam covered every twenty-four (24) months.*	