

ASE Premium 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 nationwide 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.

	In-Network	Out-of-Network
Annual Deductible		
Individual	\$500	\$2,000
Family	\$1,000	\$4,000
Paid by Plan after satisfaction of deductible	80%	60%
<i>- Plan copays do not count towards the satisfaction of the deductible.</i>		
Coinsurance / Copay limits		
Individual	\$2,500	N/A
Family	\$5,000	N/A
Medical Out-of-Pocket Maximum		
Individual	\$3,000	N/A
Family	\$6,000	N/A
<i>- Out-of-pocket Maximum includes member deductible, copay and coinsurance contributions.</i>		
<i>- Plan pays 100 percent for individuals on family coverage if they reach the individual out-of-pocket maximum.</i>		
Pharmacy Out-of-Pocket Maximum		
Individual	\$3,100	N/A
Family	\$6,200	N/A
<i>- Excluded drugs, reference priced drugs and brand drugs where generic is available do not apply towards the pharmacy out-of-pocket maximum.</i>		

Covered Services and Benefits

Office Visits/Urgent Care	In-Network Benefits	Out-of-Network Benefits
Eligible preventive care	Plan pays 100% No deductible	Plan pays 60% after deductible
Office visits/urgent care		
Primary care physician (PCP) office visit	\$25 copay	Plan pays 60% after deductible
Specialist office visit	\$50 copay	Plan pays 60% after deductible
Urgent Care visit	\$100 copay	N/A
Emergency Room visit & observation	\$250 copay	N/A
Diagnostic tests & services		
Covered non-preventive tests and services	Plan pays 80% after deductible	Plan pays 60% after deductible
Telemedicine	Telemedicine claims are processed as office visits, subject to the applicable office visit copay and/or deductible and coinsurance.	

Pharmacy Benefits	In-Network Benefits
Prescription - Generic - Tier I	\$15 copay
Prescription - Preferred - Tier II	\$40 copay
Prescription - Non-Preferred - Tier III	\$80 copay
Prescription - Specialty - Tier IV	\$100 copay
Reference Priced Drugs	Plan pays certain amount per pill/unit. Member is responsible for the remaining cost.
<i>*Excluded drugs, reference priced drugs and brand drugs where generic is available do not apply towards the pharmacy out-of-pocket maximum.</i>	

Advanced Imaging	In-Network Benefits	Out-of-Network Benefits
*Advanced Imaging (high-tech radiology services)	Plan pays 80% after deductible	Plan pays 60% after deductible
<i>*Services require prior approval.</i>		

Allergy Services	In-Network Benefits	Out-of-Network Benefits
Specialist office visit *Testing & serum formulation Allergy Injections	\$50 copay Plan pays 80% after deductible \$0	Plan pays 60% after deductible Plan pays 60% after deductible Plan pays 60% after deductible
<i>*Formulation of allergy serum requires coinsurance.</i>		

Ambulance Services	In-Network Benefits	Out-of-Network Benefits
Air ambulance transportation *Ground transportation	Plan pays 90%, No Deductible \$50 copay	Plan pays 90%, No Deductible \$50 copay
<i>*Limited benefit of \$2,000 per trip for ground ambulance *International air evacuation is not covered.</i>		

Behavioral/Mental Health & Substance Abuse Services	In-Network Benefits	Out-of-Network Benefits
Office visit Psychological testing *Inpatient services Outpatient services (intensive outpatient) Residential Treatment	\$25 copay \$35 copay Plan pays 80% after deductible Plan pays 80% after deductible Plan pays 80% after deductible	Plan pays 60% after deductible Plan pays 60% after deductible Plan pays 60% after deductible Plan pays 60% after deductible Plan pays 60% after deductible
<i>*Inpatient services include partial hospital/day treatment.</i>		

Dental Services	In-Network Benefits	Out-of-Network Benefits
Repair to natural non-diseased teeth due to accidental trauma/injury	Plan pays 80% after deductible	Plan pays 60% after deductible

Diabetes Management	In-Network Benefits	Out-of-Network Benefits
Insulin pump and supplies Glucometer Diabetic self-management training	Plan pays 80% after deductible Plan pays 80% after deductible \$0	Plan pays 60% after deductible Plan pays 60% after deductible Plan pays 60% after deductible
<i>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.</i>		

Durable Medical Equipment	In-Network Benefits	Out-of-Network Benefits
DME/Enteral feeding	Plan pays 80% after deductible	Plan pays 60% after deductible
<i>*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.</i>		

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

Home Health Services/Hospice Care	In-Network Benefits	Out-of-Network Benefits
Home health services Home intravenous drugs and solutions Hospice care	Plan pays 80% after deductible Plan pays 80% after deductible Plan pays 80% after deductible	Plan pays 60% after deductible Plan pays 60% after deductible Plan pays 60% after deductible

Hospital Services	In-Network Benefits	Out-of-Network Benefits
Inpatient services Outpatient services Diagnostic services	Plan pays 80% after deductible Plan pays 80% after deductible Plan pays 80% after deductible	Plan pays 60% after deductible Plan pays 60% after deductible Plan pays 60% after deductible
Visits deemed non-emergency will be treated as outpatient.		

Maternity & Family Planning	In-Network Benefits	Out-of-Network Benefits
Prenatal & postnatal outpatient care Inpatient maternity services	Plan pays 80% after deductible Plan pays 80% after deductible	Plan pays 60% after deductible Plan pays 60% 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 Infertility testing	\$50 copay Plan pays 80% after deductible	Plan pays 60% after deductible Plan pays 60% 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	Out-of-Network Benefits
Prosthetic and orthotic devices & services	Plan pays 80% after deductible	Plan pays 60% 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	Out-of-Network Benefits
Inpatient services <u>Outpatient services:</u> Chiropractic	Plan pays 80% after deductible \$25 copay	Plan pays 60% after deductible Plan pays 60% 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 Occupational therapy Speech therapy	\$25 copay \$25 copay \$25 copay	Plan pays 60% after deductible Plan pays 60% after deductible Plan pays 60% after deductible
*Therapy services billed by or provided by a specialty provider will have the Specialist Copay (\$50). Prior approval required for outpatient therapy.		

Skilled Nursing Facility (SNF)	In-Network Benefits	Out-of-Network Benefits
SNF services	Plan pays 80% after deductible	Plan pays 60% after deductible

Temporomandibular Joint (TMJ)/Dysfunction Services	In-Network Benefits	Out-of-Network Benefits
TMJ/TMD services	Plan pays 80% after deductible	Plan pays 60% after deductible
<i>*Limited benefit: \$1,000 per member per plan year</i>		

Transplant Services	In-Network Benefits	Out-of-Network Benefits
Organ/Bone marrow transplant	\$250 copay then Plan pays 80% after deductible	Not covered
<i>*Copay is applied to the Professional Services of the transplant provider. *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.</i>		

Vision Services	In-Network Benefits	Out-of-Network Benefits
*Vision screening	\$50 copay	\$50 copay
<i>*Limited Benefit: One (1) exam covered every twenty-four (24) months.</i>		