

# 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
<b>Annual Deductible</b>	
Individual	\$6,450
Family	\$12,900
Paid by Plan after satisfaction of deductible	100%
- Deductible does not apply to eligible preventive care. - Plan copays do not count towards the satisfaction of the deductible.	
<b>Coinsurance / co-pay limits</b>	
Individual	N/A
Family	N/A
<b>Medical Out-of-Pocket Maximum</b>	
Individual	\$6,450
Family	\$12,900
- Out-of-pocket maximum includes member deductible, co-pay 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
<b>Eligible preventive care</b>	Plan pays 100% No deductible
<b>Doctor visits/urgent care</b>	
Primary care physician (PCP) office visit	Plan pays 100% after deductible
Specialist office visit	Plan pays 100% after deductible
Urgent Care visit	Plan pays 100% after deductible
Emergency Room visit & observation	Plan pays 100% after deductible
<b>Diagnostic tests &amp; services</b>	
All covered non-preventive tests and services	Plan pays 100% after deductible
<b>Telemedicine</b>	Telemedicine claims are processed as office visits and are subject to the applicable office visit co-pay 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

<b>Advanced Imaging</b>	
*Advanced Imaging (high-tech radiology services)	Plan pays 100% after deductible

<b>Allergy Services</b>	<b>In Network Benefits</b>
Specialist office visit	Plan pays 100% after deductible
Testing & serum formulation	Plan pays 100% after deductible
Allergy injections	\$0

<b>Ambulance Services</b>	<b>In Network Benefits</b>
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.	

<b>Behavioral/Mental Health &amp; Substance Abuse Services</b>	<b>In Network Benefits</b>
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.	

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

<b>Diabetes Management</b>	<b>In Network Benefits</b>
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.	

<b>Durable Medical Equipment</b>	<b>In Network Benefits</b>
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.	

<b>Hearing Services</b>	<b>In Network Benefits</b>
*Hearing Screening	\$50 co-pay
**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.	

<b>Home Health Services/Hospice Care</b>	<b>In Network Benefits</b>
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

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

<b>Maternity &amp; Family Planning</b>	<b>In Network Benefits</b>
Prenatal & postnatal outpatient care	Plan pays 100% after deductible
Inpatient maternity services	Plan pays 100% after deductible
<i>*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.</i>	
Infertility diagnostic evaluation: office visit	Plan pays 100% after deductible
Infertility testing	Plan pays 100% after deductible
<i>*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.</i>	

<b>Prosthetic and Orthotic Devices</b>	<b>In Network Benefits</b>
Prosthetic and orthotic devices & services	Plan pays 100% after deductible
<i>* 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.</i>	

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

<b>Skilled Nursing Facility (SNF)</b>	<b>In Network Benefits</b>
SNF services	Plan pays 100% after deductible

<b>Temporomandibular Joint (TMJ)/Dysfunction Services</b>	<b>In Network Benefits</b>
TMJ/TMD services	Plan pays 100% after deductible

<b>Transplant Services</b>	<b>In Network Benefits</b>
Organ/Bone marrow transplant	Plan pays 100% after deductible
<i>*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>	

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