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 deducitble	80%	60%
- Plan copays do not count towards the satisfaction of the deductible.		
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
- 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.*		
Pharmacy Out-of-Pocket Maximum		
Individual	$3,100	N/A
Family	$6,200	N/A
- Excluded drugs, reference priced drugs and brand drugs where generic is available do not apply towards the pharmacy out-of-pocket maximum.		

Covered Services and Benefits

Office Visits/Urgent Care		
Eligible preventive care	Plan pays 100% No deducitble	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.
**Excluded drugs, reference priced drugs and brand drugs where generic is available do not apply towards the pharmacy out-of-pocket maximum.*	

Advanced Imaging		
*****Advanced Imaging (high-tech radiology services)	Plan pays 80% after deductible	Plan pays 60% after deductible

Allergy Services		
Specialist office visit	$50 copay	Plan pays 60% after deductible
*Testing & serum formulation	Plan pays 80% after deductible	Plan pays 60% after deductible
Allergy Injections	$0	Plan pays 60% after deductible

Ambulance Services		
Air ambulance transportation	Plan pays 90%, No Deductible	Plan pays 90%, No Deductible
*Ground transportation	$50 copay	$50 copay

Behavioral/Mental Health & Substance Abuse Services		
Office visit	$25 copay	Plan pays 60% after deductible
Psychological testing	$35 copay	Plan pays 60% after deductible
*Inpatient services	Plan pays 80% after deductible	Plan pays 60% after deductible
Outpatient services (intensive outpatient)	Plan pays 80% after deductible	Plan pays 60% after deductible
Residential Treatment	Plan pays 80% after deductible	Plan pays 60% after deductible

Dental Services		
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	Plan pays 80% after deductible	Plan pays 60% after deductible
Glucometer	Plan pays 80% after deductible	Plan pays 60% after deductible
Diabetic self-management training	$0	Plan pays 60% after deductible
Diabetic testing supplies paid 100% by the Plan if member is in the ARBenefits sponsored Diabetes Management Program.		

Durable Medical Equipment	In Network Benefits	Out of Network Benefits
DME/Enteral feeding	Plan pays 80% after deductible	Plan pays 60% 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		
*Hearing Screening **Hearing Aids	$50 copay $0 (see benefit below)	$50 copay $0 (see benefit below)
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Home Health Services/Hospice Care		
Home health services	Plan pays 80% after deductible	Plan pays 60% after deductible
Home intravenous drugs and solutions	Plan pays 80% after deductible	Plan pays 60% after deductible
Hospice care	Plan pays 80% after deductible	Plan pays 60% after deductible

Hospital Services		
Inpatient services	Plan pays 80% after deductible	Plan pays 60% after deductible
Outpatient services	Plan pays 80% after deductible	Plan pays 60% after deductible
Diagnostic services	Plan pays 80% after deductible	Plan pays 60% after deductible
-		

Maternity & Family Planning	In Network Benefits	
Prenatal & postnatal outpatient care	Plan pays 80% after deductible	Plan pays 60% after deductible
Inpatient maternity services	Plan pays 80% 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*		
Infertility diagnostic evaluation: office visit	$50 copay	Plan pays 60% after deductible
Infertility testing	Plan pays 80% after deductible	Plan pays 60% after deductible

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*		

Rehabilitation Services	In Network Benefits	Out of Network Benefits
Inpatient services	Plan pays 80% after deductible	Plan pays 60% after deductible
Outpatient services:		
Chiropractic	$25 copay	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	$25 copay	Plan pays 60% after deductible
Occupational therapy	$25 copay	Plan pays 60% after deductible
Speech therapy	$25 copay	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)		
SNF services	Plan pays 80% after deductible	Plan pays 60% after deductible

Temporomandibular Joint (TMJ)/Dysfunction Services		
TMJ/TMD services	Plan pays 80% after deductible	Plan pays 60% after deductible

Transplant Services	In Network Benefits	Out of Network Benefits
Organ/Bone marrow transplant	$250 copay then Plan pays 80% after deductible	Not covered
**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.*		

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