2019 PSE Schedule of Benefits - Basic

(Active, COBRA & Non-Medicare Retiree)

	IN-NETWORK	OUT-OF-NETWORK	
Annual Deductible - Individual	$4,000	not covered	
Annual Coinsurance Limit - Individual	$2,450	not covered	
*Out-of-Pocket Max	$6,450	not covered	
Annual Deductible - Family	$8,000	not covered	The plan will pay 100 percent for individuals on family coverage if they reach the individual out-of-pocket amount.
Annual Coinsurance Limit - Family	$4,900	not covered	
*Out-of-Pocket Max - Family	$12,900	not covered	
Paid By Plan After Satisfaction Of Deductible	80%	not covered	

***Deductible, coinsurance and copays are included.**

COVERED BENEFITS AND SERVICES	IN-NETWORK COPAYMENT	IN-NETWORK	OUT-OF-NETWORK	APPLIES TO DEDUCTIBLE
ADVANCED IMAGING				
*Advanced Imaging (Radiology Services)	N/A	20%	not covered	Y
***Requires pre-certification**				
***Charges will not apply when provided in conjunction with Emergency Room or Inpatient Hospital Services**				
ALLERGY SERVICES				
Services and Specialty Providers (Office Visit, Serum Formulation and Testing)	N/A	20%	not covered	Y
Injections	N/A	$0	not covered	Y
AMBULANCE SERVICES				
Air Ambulance Transportation	N/A	10%		Y
Ground Transportation	N/A	20%		Y
***Limited Benefits: $2,000 per member per trip for ground ambulance**				
BEHAVIORAL/MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT SERVICES				
Office Visit	N/A	20%	not covered	Y
Psychological Testing	N/A	20%	not covered	Y
In-Patient Services	N/A	20%	not covered	Y
Outpatient Services (Partial Hospital/Day Treatment)	N/A	20%	not covered	Y
Outpatient Services (Intensive Outpatient)	N/A	20%	not covered	Y
Residential Treatment	N/A	20%	not covered	Y
DENTAL SERVICES				
Repair to Natural Non-Diseased Teeth Due to Accident/Injury	N/A	20%	not covered	Y

COVERED BENEFITS AND SERVICES	IN-NETWORK COPAYMENT	IN-NETWORK	OUT-OF-NETWORK	APPLIES TO DEDUCTIBLE
DIABETES MANAGEMENT SERVICE				
Insulin Pump & Supplies	N/A	20%	**not covered**	Y
Glucometers	N/A	20%	**not covered**	Y
Diabetic Self Management Training	N/A	20%	**not covered**	Y
***Diabetic testing supplies will be paid 100% by the Plan for participants in the Diabetes Management Program through Kannact.**				
***Test strips must be purchased at Pharmacy Only.**				
***Glucometers - Provided through DME/Medical Benefit**				
DURABLE MEDICAL EQUIPMENT/ENTERAL FEEDING				
DME/Enteral Feeding	N/A	20%	**not covered**	Y
***Coverage is provided for medically necessary durable medical equipment. See exclusions. Not all services require pre-certification and may be reviewed for medical necessity by Health Advantage. Refer to Utilization Management section.**				
HEARING SERVICES				
Hearing Screening	$50	0%	**not covered**	N
***Limited Benefits: One screening every three years**				
Hearing Aid	$0	0%	**not covered**	N
***Limited Benefits: $1,400 per ear every three years**				
HOME HEALTH SERVICES				
Home Health Services	N/A	20%	**not covered**	Y
HOME INTRAVENOUS DRUGS				
Home Intravenous Drugs and Solutions	N/A	20%	**not covered**	Y
HOSPICE SERVICES				
Hospice Care	N/A	20%	**not covered**	Y
HOSPITAL SERVICES				
In-Patient Services	N/A	20%	**not covered**	Y
Outpatient Services	N/A	20%	**not covered**	Y
Diagnostic Services	N/A	20%	**not covered**	Y
Emergency Room Visit and Observation Services	N/A	20%	**not covered**	Y
Urgent Care Center	N/A	20%	**not covered**	Y
***Visits deemed non-emergency will be treated as hospital services/outpatient.**				

COVERED BENEFITS AND SERVICES	IN-NETWORK COPAYMENT	IN-NETWORK	OUT-OF-NETWORK	APPLIES TO DEDUCTIBLE
MATERNITY AND FAMILY PLANNING SERVICES				
Prenatal and Postnatal Outpatient Care	N/A	20%	**not covered**	Y
Inpatient Maternity Services	N/A	20%	**not covered**	Y
***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	N/A	20%	**not covered**	Y
Infertility Testing	N/A	20%	**not covered**	Y
***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.**				
PHARMACY BENEFIT - REFER TO RX DRUG COVERAGE SECTION				
Prescription - Generic - Tier I	N/A	20%	N/A	Y
Prescription - Preferred - Tier II	N/A	20%	N/A	Y
Prescription - Non-Preferred - Tier III	N/A	20%	N/A	Y
Prescription Specialty - Tier IV	N/A	20%	N/A	Y
***Excluded drugs, reference price drugs and brand drugs where generic is available does not apply towards the RX Out-of-Pocket Max.**				
PHYSICIAN/SPECIALIST SERVICES				
*Primary Care Physician Office Visit	N/A	20%	**not covered**	Y
*Specialist Office Visit/Specialty Care Services	N/A	20%	**not covered**	Y
***Telemedicine is covered by the ARBenefits Plan. Telemedicine claims are processed as office visits and are subject to the applicable office visit copay and or deductibles/coinsurance.**				
*Other Physician Services provided under Outpatient or In-Patient Care**	N/A	20%	**not covered**	Y
***Includes such services as debridement and/or wound dressing changes performed in an outpatient setting with or without direct physician attention**				
Medication	N/A	20%	**not covered**	Y
***This includes injectable, oral and intravenous medications**				
Radiation Therapy	N/A	20%	**not covered**	Y
****See Professional Services under SPD - Summary of Common Services**				
PREVENTATIVE CARE SERVICES				
Physical Exams/Preventative Care	N/A	0%	**not covered**	N
Well Baby/Child Care Visits	N/A	0%	**not covered**	N
Immunizations	N/A	0%	**not covered**	N
PROSTHETIC AND ORTHOTIC DEVICES				
Prosthetic and Orthotic Devices and Services	N/A	20%	**not covered**	Y

COVERED BENEFITS AND SERVICES	IN-NETWORK COPAYMENT	IN-NETWORK	OUT-OF-NETWORK	APPLIES TO DEDUCTIBLE
REHABILITATION SERVICES (INPATIENT)				
Rehabilitation Services	N/A	20%	**not covered**	Y
REHABILITIATION SERVICES (OUTPATIENT) OR OFFICE VISIT				
Chiropractic	N/A	20%	**not covered**	Y
***Limited Benefit: Fifteen (15) visits per member per plan year**				
Physical Therapy	N/A	20%	**not covered**	Y
Occupational Therapy	N/A	20%	**not covered**	Y
Speech Therapy	N/A	20%	**not covered**	Y
SKILLED NURSING FACILITY (SNF) SERVICES				
SNF Services	N/A	20%	**not covered**	Y
TEMPOROMANDIBULAR JOINT (TMJ)/DYSFUNCTION (TMD) SERVICES				
TMJ/TMD	N/A	20%	**not covered**	Y
***Limited Benefit: $1,000 per member per plan year**				
TRANSPLANT SERVICES				
Organ/Bone Marrow Transplant	N/A	20%	**not covered**	Y
***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**				
VISION SCREENING				
Vision Screening	$50	0%	**not covered**	N
***Limited Benefit: One (1) exam every twenty-four (24) months**				

Certain Limitations Apply - Please check your SPD Exclusions and Limitations section for more information