2019 PSE Schedule of Benefits - Premium

(Active, COBRA & Non-Medicare Retiree)

	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible - Individual	$750	$2,000
Annual Coinsurance/Copay Limit - Individual	$2,500	N/A
*Medical Out-of-Pocket Max	$3,250	N/A
Annual Deductible - Family	$1,500	$4,000
Annual Coinsurance/Copay Limit - Family	$5,000	N/A
*Medical Out-of-Pocket Max - Family	$6,500	N/A
Paid By Plan After Satisfaction Of Deductible	80%	60%

ARBenefits

The Plan will pay 100 percent for individuals on family coverage if they reach the individual out-of-pocket

***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)	$0	20%	40%	Y
***Requires pre-certification**				
***Charges will not apply when provided in conjunction with Emergency Room or Inpatient Hospital Services**				
ALLERGY SERVICES				
Specialist Office Visit	$50	0%	40%	N
Testing and Serum Formulation	$0	20%	40%	Y
Injections	$0	$0	40%	N
***Formulation of allergy serum requires coinsurance**				
AMBULANCE SERVICES				
Air Ambulance Transportation		10%		N
Ground Transportation		$50 copay		N
***Limited Benefits: $2,000 per member per trip for ground ambulance**				
BEHAVIORAL/MENTAL HEALTH & SUBSTANCE ABUSE TREATMENT SERVICES				
Office Visit	$25	0%	40%	N
Psychological Testing	$35	0%	40%	N
In-Patient Services	$0	20%	40%	Y
Outpatient Services (Partial Hospital/Day Treatment)	$0	20%	40%	Y
Outpatient Services (Intensive Outpatient)	$0	20%	40%	Y
Residential Treatment	$0	20%	40%	Y
DENTAL SERVICES				
Repair to Natural Non-Diseased Teeth Due to Accident/Injury	$0	20%	40%	Y

COVERED BENEFITS AND SERVICES	IN-NETWORK COPAYMENT	IN-NETWORK	OUT-OF-NETWORK	APPLIES TO DEDUCTIBLE
DIABETES MANAGEMENT SERVICE				
Insulin Pump & Supplies	$0	20%	40%	Y
Glucometers	$0	20%	40%	Y
Diabetic Self Management Training	$0	0%	40%	N
***Diabetic testing supplies will be paid 100% by the Plan for participants in the Diabetes Management Program thourgh Kannact**				
***Test strips must be purchased at Pharmacy Only.**				
***Glucometers - Provided through DME/Medical Benefit**				
DURABLE MEDICAL EQUIPMENT/ENTERAL FEEDING				
DME/Enteral Feeding	$0	20%	40%	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%	$50	N
***Limited Benefits: One screening every three years**				
Hearing Aid	$0	0%	0%	N
***Limited Benefits: $1,400 per ear every three years**				
HOME HEALTH SERVICES				
Home Health Services	$0	20%	40%	Y
HOME INTRAVENOUS DRUGS				
Home Intravenous Drugs and Solutions	$0	20%	40%	Y
HOSPICE SERVICES				
Hospice Care	$0	20%	40%	Y
HOSPITAL SERVICES				
In-Patient Services	$0	20%	40%	Y
Outpatient Services	$0	20%	40%	Y
Diagnostic Services	$0	20%	40%	Y
Emergency Room Visit and Observation Services	$250	0%	0%	N
***ER copay may be waived. See Summary Plan Description (SPD)**				
Urgent Care Center	$100	0%	0%	N
***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	$0	20%	40%	Y
Inpatient Maternity Services	$0	20%	40%	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	$50	0%	40%	N
Infertility Testing	$0	20%	40%	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	$15			
Prescription - Preferred - Tier II	$40			
Prescription - Non-Preferred - Tier III	$80			
Prescription Specialty - Tier IV	$100			
*RX Out-of-Pocket Max (Individual/Family)	$3350/$6700			
***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	$25	$0	40%	N
*Specialist Office Visit/Specialty Care Services	$50	$0	40%	N
***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**	$0	20%	40%	Y
***Includes such services as debridement and/or wound dressing changes performed in an outpatient setting with or without direct physician attention**				
* *Medication	$0	20%	40%	Y
***This includes injectable, oral and intravenous medications**				
Radiation Therapy	$0	20%	40%	Y
****See Professional Services under SPD - Summary of Common Services**				
PREVENTATIVE CARE SERVICES				
Physical Exams/Preventative Care	$0	0%	40%	N
Well Baby/Child Care Visits	$0	0%	40%	N
Immunizations	$0	0%	0%	N
PROSTHETIC AND ORTHOTIC DEVICES				
Prosthetic and Orthotic Devices and Services	$0	20%	40%	Y

COVERED BENEFITS AND SERVICES	IN-NETWORK COPAYMENT	IN-NETWORK	OUT-OF-NETWORK	APPLIES TO DEDUCTIBLE
REHABILITATION SERVICES (INPATIENT)				
Rehabilitation Services	$0	20%	40%	Y
REHABILITIATION SERVICES (OUTPATIENT) OR OFFICE VISIT				
Chiropractic	$25	0%	40%	N
***Limited Benefit: Fifteen (15) visits per member per plan year. Diagnostic services such as lab or xray, subject to Plan deductible and coinsurance.**				
Physical Therapy	$25	0%	40%	N
Occupational Therapy	$25	0%	40%	N
Speech Therapy	$25	0%	40%	N
***Therapy services billed by or provided by a Specialist MD will have the Specialist Copay ($50)**				
SKILLED NURSING FACILITY (SNF) SERVICES				
SNF Services	$0	20%	40%	Y
TEMPOROMANDIBULAR JOINT (TMJ)/DYSFUNCTION (TMD) SERVICES				
TMJ/TMD	$0	20%	40%	Y
***Limited Benefit: $1,000 per member per plan year**				
TRANSPLANT SERVICES				
Organ/Bone Marrow Transplant	$250	20%	Not Covered	N
***Copayment is applied to the Professional Services of the transplant provider** ***Limited Benefit: Two (2) organ transplants of the same organ per member per lifetime.**				
VISION SCREENING				
Vision Screening	$50	0%	$50	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