2020 SUMMARY OF BENEFITS

BALANCED ADVANTAGE HMO 1250

Deductible and Out-of-Pocket Maximums

Individual/Family	
Deductible	$1250/$2500
Out-of-Pocket Maximum (includes medical and pharmacy deductibles, coinsurance, and copayments)	$5000/$10000

Medical Benefits

Preventive Services	
Routine Physical Exams, including: • preventive immunizations • preventive Pap smears and mammograms • well-child care visits • annual gynecological exams • most preventive screenings • routine prenatal and postnatal exams	Covered in full
Colonoscopies: Screenings (in the absence of symptoms or personal history)	Covered in full
Outpatient Medical Care **(No PCP referral is necessary for OB/GYN visits, spinal manipulation, routine eye exams, or mammograms)**	
Primary Care Office Visits	$25 copay
Specialist Office Visits	$45 copay
Routine eye exams with an EyeMed Vision Care provider (1 visit every 24 months)	$15 copay
Pediatric (Under age 19) Routine eye exams with an EyeMed Vision Care provider (1 visit every 12 months)	Covered in full
Telahealth (Teladoc)	Covered in full
Nutritional Counseling (when medically necessary)	$25/$45 copay per visit with rendering provider
Allergy Injections	$5 copay
Speech Therapy (when medically necessary)	$45 copay
Short-term Physical and Occupational Therapy (30 visits for each type of service per plan year)	$45 copay
Spinal Manipulation and Acupuncture	$15 copay
Colonoscopies: Diagnostic - Without Surgical Intervention	Deductible then 20% coinsurance
Colonoscopies: Diagnostic - With Surgical Intervention	See Day Surgery for cost share
Diagnostic Imaging – General Imaging (such as X-rays and ultrasounds)	Deductible then $60 copay
Diagnostic Imaging - High-Tech Imaging (MRIs, CT/CAT Scans, PET Scans, and Nuclear Cardiology)	Deductible then $200 copay
Lab Tests (such as blood work)	$40 copay
Day Surgery	Deductible then 20% coinsurance

Inpatient Hospital Care (semiprivate room, unless private room is medically necessary)	
All Hospital Services - Acute Care and Maternity Care	Deductible then 20% coinsurance
Skilled Nursing in Skilled Nursing Facility (up to 100 days per plan year)	Deductible then 20% coinsurance
Emergency & Urgent Care	
In Emergency Room	$250 copay
Urgent Care Center	$40 copay
Mental Health and Substance Abuse	
Outpatient Care	$25 copay
Inpatient Care (services provided at a designated facility)	Deductible then 20% coinsurance
Other Health Services	
Durable Medical Equipment	Deductible then 30% coinsurance
Emergency Ambulance Service	Deductible then $50 copay
Hospice Care	Deductible then 20% coinsurance
Home Health Care	Deductible then 20% coinsurance

Prescription Drug Benefits

Prescription Drug Coverage	For up to a 30-day supply at a participating retail pharmacy	For up to a 90-day supply through our mail order service
Low Cost Generics Program	$5 copay	$10 copay
Tier 1	$20 copay	$40 copay
Tier 2	$75 copay	$150 copay
Tier 3	$100 copay	$300 copay
Tier 4	$150 copay	N/A

- This summary reflects benefits that are in compliance with the Affordable Care Act (ACA).
- This is a summary only. Please refer to the member benefit document for a detailed explanation of your coverage. If there is a difference between the information in this benefit summary and your member benefit document, the terms of your member benefit document will govern. If you have additional questions, please call Member Services at 1-800-462-0224.