2020 SUMMARY OF BENEFITS

HMO BASIC

Out-of-Pocket Maximums

Individual/Family	
Out-of-Pocket Maximum (includes medical and pharmacy deductibles, coinsurance, and copayments)	$4000/$8000

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	$30 copay
Specialist Office Visits	$30 copay
Routine eye exams with an EyeMed Vision Care provider (1 visit every 24 months)	$30 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)	$30 copay
Allergy Injections	$5 copay
Speech Therapy (when medically necessary)	$30 copay
Short-term Physical and Occupational Therapy (30 visits for each type of service per plan year)	$30 copay
Spinal Manipulation and Acupuncture	$30 copay
Colonoscopies: Diagnostic - Without Surgical Intervention	Covered in full
Colonoscopies: Diagnostic - With Surgical Intervention	See Day Surgery for cost share
Diagnostic Imaging – General Imaging (such as X-rays and ultrasounds)	$30 copay
Diagnostic Imaging - High-Tech Imaging (MRIs, CT/CAT Scans, PET Scans, and Nuclear Cardiology)	$100 copay
Lab Tests (such as blood work)	Covered in full
Day Surgery	$500 copay

Inpatient Hospital Care (semiprivate room, unless private room is medically necessary)	
All Hospital Services — Acute Care and Maternity Care	$500 copay
Skilled Nursing in Skilled Nursing Facility (up to 100 days per plan year)	Covered in full
Emergency & Urgent Care	
In Emergency Room (copayment waived if admitted)	$200 copay
Urgent Care	$40 copay
Mental Health and Substance Abuse	
Outpatient Care	$30 copay
Inpatient Care (services provided at a designated facility)	$500 copay per admission
Other Health Services	
Durable Medical Equipment	30% coinsurance
Emergency Ambulance Service	$100 copay
Hospice Care	Covered in full
Home Health Care	Covered in full

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	$25 copay	$50 copay
Tier 2	$40 copay	$80 copay
Tier 3	$70 copay	$210 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.