# 2020 SUMMARY OF BENEFITS

**PREMIER GOLD 2000**

## Deductible and Out-of-Pocket Maximums

| Individual/Family | |
|---|---|
| Deductible | $2000/$4000 |
| Rx Deductible | $250/$500 |
| Out-of-Pocket Maximum (includes medical and pharmacy deductibles, coinsurance, and copayments) | $5600/$11200 |

## Medical Benefits

| Preventive Services | |
|---|---|
| Routine Physical Exams, including:<br>• preventive immunizations<br>• preventive Pap smears and mammograms<br>• well-child care visits<br>• annual gynecological exams<br>• most preventive screenings<br>• routine prenatal and postnatal exams | Covered in full |
| Colonoscopies: Screenings (in the absence of symptoms or personal history) | Covered in full |
| **Outpatient Medical Care**<br>**(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 | $55 copay |
| Routine eye exams with an EyeMed Vision Care provider<br>(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/$55 copay per visit with rendering provider |
| Allergy Injections | Covered in full after deductible |
| Speech Therapy (when medically necessary) | $55 copay |
| Short-term Physical and Occupational Therapy<br>(30 visits for each type of service per plan year) | $55 copay |
| Spinal Manipulation and Acupuncture | $30 copay |
| Colonoscopies: Diagnostic - Without Surgical Intervention | Covered in full after deductible |
| Colonoscopies: Diagnostic - With Surgical Intervention | See Day Surgery for cost share |
| Diagnostic Imaging – General Imaging<br>(such as X-rays and ultrasounds) | Deductible then $75 copay |
| Diagnostic Imaging - High-Tech Imaging<br>(MRIs, CT/CAT Scans, PET Scans, and Nuclear Cardiology) | Deductible then $300 copay |
| Lab Tests (such as blood work) | Deductible then $75 copay |
| Day Surgery | Deductible then $500 copay |

| **Inpatient Hospital Care** (semiprivate room, unless private room is medically necessary) | |
|---|---|
| All Hospital Services - Acute Care and Maternity Care | Deductible then $750 copay |
| Skilled Nursing in Skilled Nursing Facility (up to 100 days per plan year) | Deductible then $750 copay |
| **Emergency & Urgent Care** | |
| In Emergency Room | $350 copay |
| Urgent Care Center | $55 copay |
| **Mental Health and Substance Abuse** | |
| Outpatient Care | $30 copay |
| Inpatient Care (services provided at a designated facility) | Deductible then $750 copay |
| **Other Health Services** | |
| Durable Medical Equipment | Deductible then 20% coinsurance |
| Emergency Ambulance Service | $50 copay |
| Hospice Care | Covered in full after deductible |
| Home Health Care | Covered in full after deductible |

# Prescription Drug Benefits

| Prescription Drug Coverage | For up to a 30-day supply at a participating retail pharmacy (after deductible) | For up to a 90-day supply through our mail order service (after deductible) |
|---|---|---|
| Low Cost Generics Program | $5 copay | $10 copay |
| Tier 1 | $25 copay | $50 copay |
| Tier 2 | $50 copay | $100 copay |
| Tier 3 | $100 copay | $300 copay |
| Tier 4 | N/A | 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.