

# 2020 SUMMARY OF BENEFITS



## SELECT ADVANTAGE HMO 1000

### Deductible and Out-of-Pocket Maximums

#### Individual/Family

Deductible	\$1000/\$2000
Out-of-Pocket Maximum (includes medical and pharmacy deductibles, coinsurance, and copayments)	\$7000/\$14000

### Medical Benefits

#### Preventive Services

Routine Physical Exams, including: <ul style="list-style-type: none"> <li>preventive immunizations</li> <li>preventive Pap smears and mammograms</li> <li>well-child care visits</li> <li>annual gynecological exams</li> <li>most preventive screenings</li> <li>routine prenatal and postnatal exams</li> </ul>	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)	\$25 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 copay/\$45 copay per visit with rendering provider
Allergy Injections	\$5 copay
Speech Therapy (when medically necessary)	\$40 copay
Short-term Physical and Occupational Therapy (30 visits for each type of service per plan year)	\$40 copay
Spinal Manipulation and Acupuncture	\$25 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 (such as X-rays and ultrasounds)	Deductible then \$50 copay
Diagnostic Imaging - High-Tech Imaging (MRIs, CT/CAT Scans, PET Scans, and Nuclear Cardiology)	Deductible then \$125 copay
Lab Tests (such as blood work)	\$25 copay
Day Surgery	Deductible then \$150 copay

**Inpatient Hospital Care (semiprivate room, unless private room is medically necessary)**

All Hospital Services - Acute Care and Maternity Care	Deductible then \$250 copay
Skilled Nursing in Skilled Nursing Facility (up to 100 days per plan year)	Covered in full after deductible

**Emergency & Urgent Care**

In Emergency Room	\$300 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 \$250 copay

**Other Health Services**

Durable Medical Equipment	Deductible then 30% coinsurance
Emergency Ambulance Service	Deductible then \$50 copay
Hospice Care	Covered in full after deductible
Home Health Care	Covered in full after deductible

## Prescription Drug Benefits

<b>Prescription Drug Coverage</b>	<b>For up to a 30-day supply at a participating retail pharmacy</b>	<b>For up to a 90-day supply through our mail order service</b>
Low Cost Generics Program	\$5 copay	\$10 copay
Tier 1	\$25 copay	\$50 copay
Tier 2	\$60 copay	\$120 copay
Tier 3	\$90 copay	\$270 copay
Tier 4	\$160 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.