2020 SUMMARY OF BENEFITS

ADVANTAGE HMO SAVER 2500

Deductible and Out-of-Pocket Maximums

Individual/Family	
Deductible	$2500/$5000
Out-of-Pocket Maximum (includes medical and pharmacy deductibles, coinsurance, and copayments)	$6500/$13000

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	Deductible then covered in full
Specialist Office Visits	Deductible then $30 copay
Routine eye exams with an EyeMed Vision Care provider (1 visit every 12 months)	$35 copay
Pediatric (Under age 19) Routine eye exams with an EyeMed Vision Care provider (1 visit every 12 months)	Covered in full
Telehealth (Teladoc)	Deductible then covered in full
Nutritional Counseling (when medically necessary)	Deductible then $30 copay
Allergy Injections	Deductible then covered in full
Speech Therapy (when medically necessary)	Deductible then covered in full
Short-term Physical and Occupational Therapy (30 visits for each type of service per plan year)	Deductible then covered in full
Spinal Manipulation and Acupuncture	Deductible then covered in full
Colonoscopies: Diagnostic - Without Surgical Intervention	Deductible then covered in full
Colonoscopies: Diagnostic - With Surgical Intervention	See Day Surgery for cost share
Diagnostic Imaging – General Imaging (such as X-rays and ultrasounds)	Deductible then covered in full
Diagnostic Imaging - High-Tech Imaging (MRIs, CT/CAT Scans, PET Scans, and Nuclear Cardiology)	Deductible then covered in full
Lab Tests (such as blood work)	Deductible then $20 copay
Day Surgery	Deductible then $100 copay
Inpatient Hospital Care (semiprivate room, unless private room is medically necessary)	
All Hospital Services - Acute Care and Maternity Care	Deductible then $200 copay
Skilled Nursing in Skilled Nursing Facility (up to 100 days per plan year)	Deductible then covered in full

Emergency & Urgent Care	
In Emergency Room	Deductible then $100 copay
Urgent Care Center	Deductible then covered in full
Mental Health and Substance Abuse	
Outpatient Care	Deductible then covered in full
Inpatient Care (services provided at a designated facility)	Deductible then $200 copay
Other Health Services	
Durable Medical Equipment	Deductible then 30% coinsurance
Emergency Ambulance Service	Deductible then $50 copay
Hospice Care	Deductible then covered in full
Home Health Care	Deductible then covered in full

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	$40 copay	$80 copay
Tier 2	$60 copay	$180 copay
Tier 3	$100 copay	$300 copay
Tier 4	$125 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.