

2020 SUMMARY OF BENEFITS



ADVANTAGE PPO SAVER 2500

Deductible and Out-of-Pocket Maximums

| Individual/Family | In-network | Out-of-network |
|--|----------------|-----------------|
| Deductible | \$2500/\$5000 | \$5000/\$10000 |
| Out-of-Pocket Maximum (includes medical and pharmacy deductibles, coinsurance, and copayments) | \$6500/\$13000 | \$19500/\$39000 |

Medical Benefits

| Preventive Services | In-network | Out-of-network (after deductible) |
|---|-----------------|-----------------------------------|
| Routine Physical Exams, including: <ul style="list-style-type: none"> 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 | 40% coinsurance |
| Colonoscopies: Screenings (in the absence of symptoms or personal history) | Covered in full | 40% coinsurance |

| Outpatient Medical Care | In-network | Out-of-network (after deductible) |
|--|----------------------------------|-----------------------------------|
| Primary Care Office Visits | Deductible then \$20 copay | 40% coinsurance |
| Specialist Office Visits | Deductible then \$20 copay | 40% coinsurance |
| Routine eye exams with an EyeMed Vision Care provider (1 visit every 12 months) | \$35 copay | 40% coinsurance |
| Pediatric (Under age 19) Routine eye exams with an EyeMed Vision Care provider (1 visit every 12 months) | Covered in full | 40% coinsurance |
| Telehealth (Teladoc) | Deductible then covered in full | 40% coinsurance |
| Nutritional Counseling (when medically necessary) | Deductible then \$20 copay | 40% coinsurance |
| Allergy Injections | Covered in full after deductible | 40% coinsurance |
| Speech Therapy (when medically necessary) | Deductible then \$20 copay | 40% coinsurance |
| Short-term Physical and Occupational Therapy (30 visits for each type of service per plan year) | Deductible then \$20 copay | 40% coinsurance |
| Spinal Manipulation and Acupuncture | Deductible then \$20 copay | 40% coinsurance |
| Colonoscopies: Diagnostic - Without Surgical Intervention | Deductible then covered in full | 40% coinsurance |
| Colonoscopies: Diagnostic - With Surgical Intervention | See Day Surgery for cost share | 40% coinsurance |
| Diagnostic Imaging – General Imaging (such as X-rays and ultrasounds) | Deductible then covered in full | 40% coinsurance |
| Diagnostic Imaging - High-Tech Imaging (MRIs, CT/CAT Scans, PET Scans, and Nuclear Cardiology) | Deductible then covered in full | 40% coinsurance |
| Lab Tests (such as blood work) | Deductible then \$20 copay | 40% coinsurance |
| Day Surgery | Deductible then \$100 copay | 40% coinsurance |

| Inpatient Hospital Care (semiprivate room, unless private room is medically necessary) | In-network | Out-of-network (after deductible) |
|---|---------------------------------|--|
| All Hospital Services — Acute Care and Maternity Care | Deductible then \$200 copay | 40% coinsurance |
| Skilled Nursing in Skilled Nursing Facility (up to 100 days per plan year) | Deductible then covered in full | 40% coinsurance |

| Emergency & Urgent Care | In-network | Out-of-network |
|--|---------------------------------|--------------------------------------|
| In Emergency Room (copayment waived if admitted) | Deductible then \$100 copay | Same as in-network level of benefits |
| Urgent Care | Deductible then covered in full | Same as in-network level of benefits |

| Mental Health and Substance Abuse | In-network | Out-of-network (after deductible) |
|---|-----------------------------|--|
| Outpatient Care | Deductible then \$20 copay | 40% coinsurance |
| Inpatient Care (services provided at a designated facility) | Deductible then \$200 copay | 40% coinsurance |

| Other Health Services | In-network | Out-of-network (after deductible) |
|------------------------------|---------------------------------|--|
| Durable Medical Equipment | Deductible then 30% coinsurance | 30% coinsurance |
| Emergency Ambulance Service | Deductible then \$50 copay | Same as in-network level of benefits |
| Hospice Care | Deductible then covered in full | 40% coinsurance |
| Home Health Care | Deductible then covered in full | 40% coinsurance |

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.