2021 SUMMARY OF BENEFITS

ADVANTAGE PPO SAVER 2500

Deductible and Out-of-Pocket Maximums

Individual/Family	In-network	Out-of-network
Deductible (medical and pharmacy combined)	$2500/$5000	$5000/$10000
Out-of-Pocket Maximum (includes medical and pharmacy deductibles, coinsurance, and copayments)	$6900/$13800	$20700/$41400

Medical Benefits

Preventive Services	In-network	Out-of-network (after deductible)
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	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 $30 copay	40% coinsurance
Specialist Office Visits	Deductible then $30 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)	Covered in full	40% coinsurance
Nutritional Counseling (when medically necessary)	Deductible then $30 copay	40% coinsurance
Allergy Injections	Covered in full after deductible	40% coinsurance
Speech Therapy (when medically necessary)	Deductible then $30 copay	40% coinsurance
Short-term Physical and Occupational Therapy (30 visits for each type of service per plan year)	Deductible then $30 copay	40% coinsurance
Spinal Manipulation and Acupuncture	Deductible then $30 copay	40% coinsurance
Colonoscopies: Diagnostic - Without Surgical Intervention	Covered in full after deductible	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 $50 copay	40% coinsurance
Diagnostic Imaging - High-Tech Imaging (MRIs, CT/CAT Scans, PET Scans, and Nuclear Cardiology)	Deductible then $50 copay	40% coinsurance
Lab Tests (such as blood work)	Deductible then $25 copay	40% coinsurance

Day Surgery	Deductible then $150 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 $250 copay	40% coinsurance
Skilled Nursing in Skilled Nursing Facility (up to 100 days per plan year)	Covered in full after deductible	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	Covered in full after deductible	Same as in-network level of benefits

Mental Health and Substance Abuse	**In-network**	**Out-of-network (after deductible)**
Outpatient Care	Deductible then $30 copay	40% coinsurance
Inpatient Care (services provided at a designated facility)	Deductible then $250 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	Covered in full after deductible	40% coinsurance
Home Health Care	Covered in full after deductible	40% coinsurance

Prescription Drug Benefits (copayments apply after deductible)

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	$70 copay	$210 copay
Tier 3	$110 copay	$330 copay
Tier 4	25% coinsurance (Max $250 per fill)	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.