

2020 SUMMARY OF BENEFITS



LIFESPAN PREMIER CHOICE HMO COPAY (55%)

Deductible and Out-of-Pocket Maximums

Individual/Family	Tier 1	Tier 2
Deductible (For both Tier 1 and Tier 2)	N/A	\$2000/\$4000
Out-of-Pocket Maximum (includes medical and pharmacy deductibles, coinsurance, and copayments)	\$8000/\$16000	

Medical Benefits

Preventive Services		
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	
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)		
	Tier 1	Tier 2
Primary Care Office Visits	\$25 copay	\$55 copay
Specialist Office Visits	\$25 copay	\$55 copay
Routine eye exams with an EyeMed Vision Care provider (1 visit every 12 months)	\$25 copay	
Pediatric (Under age 19) Routine eye exams with an EyeMed Vision Care provider (1 visit every 12 months)	Covered in full	
Telehealth (Teladoc)	Covered in full	
Nutritional Counseling (when medically necessary)	\$25 copay	\$55 copay
Allergy Injections	\$5 copay	
Speech Therapy (when medically necessary)	\$25 copay	
Short-term Physical and Occupational Therapy (30 visits for each type of service per plan year)	\$25 copay	
Spinal Manipulation and Acupuncture	\$25 copay	
Colonoscopies: Diagnostic - Without Surgical Intervention (In an outpatient hospital setting)	Deductible then covered in full	Deductible then covered in full
Colonoscopies: Diagnostic - With Surgical Intervention (In an outpatient hospital setting)	See Day Surgery for cost share	See Day Surgery for cost share
Diagnostic Imaging – General Imaging (such as X-rays and ultrasounds)	Covered in full	Deductible then 45% coinsurance
Diagnostic Imaging- High-Tech Imaging (MRIs, CT/CAT scans, PET scans, and nuclear cardiology)	\$100 copay	Deductible then 45% coinsurance
Lab Tests (such as blood work)	Covered in full	Deductible then 45% coinsurance
Day Surgery	\$200 copay	Deductible then 45% coinsurance

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

All Hospital Services - Acute Care and Maternity Care	\$200 Copay	Deductible then 45% coinsurance
Skilled Nursing in Skilled Nursing Facility (up to 100 days per plan year)	Covered in full	Covered in full

Emergency & Urgent Care

In Emergency Room (copayment waived if admitted)	\$200 copay
Urgent Care	\$25 copay

Mental Health and Substance Abuse

Outpatient Care	\$25 copay
Inpatient Care (services provided at a designated facility)	\$200 copay

Other Health Services

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

Prescription Drug Benefits

Prescription Drug Coverage	For up to a 30-day supply at a participating retail pharmacy	For up to a 90-day supply through our mail order service
Low Cost Generics Program	\$5 copay	\$10 copay
Tier 1	\$25 copay	\$50 copay
Tier 2	\$60 copay	\$180 copay
Tier 3	\$80 copay	\$240 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.