2021 SUMMARY OF BENEFITS

ADVANTAGE PPO SAVER 6900

Deductible and Out-of-Pocket Maximums

Individual/Family	In-network	Out-of-network
Deductible (combined medical and pharmacy deductible)	$6900/$13800	$13800/$27600
Out-of-Pocket Maximum (includes medical and pharmacy deductibles, coinsurance, and copayments)	$6900/$13800	$13800/$27600

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	20% coinsurance
Colonoscopies: Screenings (in the absence of symptoms or personal history)	Covered in full	20% coinsurance
Outpatient Medical Care	**In-network**	**Out-of-network (after deductible)**
Primary Care Office Visits	Covered in full after deductible	20% coinsurance
Specialist Office Visits	Covered in full after deductible	20% coinsurance
Routine eye exams with an EyeMed Vision Care provider (1 visit every 24 months)	$35 copay	20% coinsurance
Pediatric (Under age 19) Routine eye exams with an EyeMed Vision Care provider (1 visit every 12 months)	Covered in full	20% coinsurance
Telehealth (Teladoc)	Covered in full	20% coinsurance
Nutritional Counseling (when medically necessary)	Covered in full after deductible	20% coinsurance
Allergy Injections	Covered in full after deductible	20% coinsurance
Speech Therapy (when medically necessary)	Covered in full after deductible	20% coinsurance
Short-term Physical and Occupational Therapy (30 visits for each type of service per plan year)	Covered in full after deductible	20% coinsurance
Spinal Manipulation and Acupuncture	Covered in full after deductible	20% coinsurance
Colonoscopies: Diagnostic - Without Surgical Intervention	Covered in full after deductible	20% coinsurance
Colonoscopies: Diagnostic - With Surgical Intervention	See Day Surgery for cost share	20% coinsurance
Diagnostic Imaging – General Imaging (such as X-rays and ultrasounds)	Covered in full after deductible	20% coinsurance
Diagnostic Imaging - High-Tech Imaging (MRIs, CT/CAT Scans, PET Scans, and Nuclear Cardiology)	Covered in full after deductible	20% coinsurance

Lab Tests (such as blood work)	Covered in full after deductible	20% coinsurance
Day Surgery	Covered in full after deductible	20% 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	Covered in full after deductible	20% coinsurance
Skilled Nursing in Skilled Nursing Facility (up to 100 days per plan year)	Covered in full after deductible	20% coinsurance

Emergency & Urgent Care	**In-network**	**Out-of-network** (after deductible)
In Emergency Room (copayment waived if admitted)	Covered in full after deductible	Same as in-network level of benefits
Urgent Care (members can receive urgent care services when they are outside the standard service area for the in-network cost share)	Covered in full after deductible	20% coinsurance
Mental Health and Substance Abuse	**In-network**	**Out-of-network** (after deductible)
Outpatient Care	Covered in full after deductible	20% coinsurance
Inpatient Care (services provided at a designated facility)	Covered in full after deductible	20% coinsurance
Other Health Services	**In-network**	**Out-of-network** (after deductible)
Durable Medical Equipment	Deductible then 30% coinsurance	30% coinsurance
Emergency Ambulance Service	Covered in full after deductible	Same as in-network level of benefits
Hospice Care	Covered in full after deductible	20% coinsurance
Home Health Care	Covered in full after deductible	20% 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	Covered in full	Covered in full
Tier 1	Covered in full	Covered in full
Tier 2	Covered in full	Covered in full
Tier 3	Covered in full	Covered in full
Tier 4	Covered in full	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.