

Covered Medical Benefits	<u>Current L145 HMO Plan</u>	<u>NEW L145 Select HMO Plan</u>
Overall Deductible	\$0	\$0
Out-of-Pocket Limit	\$1,500 single / \$3,000 family	\$1,500 single / \$3,000 family
Preventive care/screening/immunization	No charge	No charge
Doctor Home and Office Services Primary care visit to treat an injury or illness	\$20 copay per visit	\$20 copay per visit
Specialist care visit	\$20 copay per visit	\$20 copay per visit
Prenatal and Post-natal Care	\$20 copay per visit	\$20 copay per visit
Other services in an office: Allergy testing Chemo/radiation therapy Hemodialysis Prescription drugs <i>For the drugs itself dispensed in the office thru infusion/injection</i>	\$20 copay per visit \$20 copay per visit \$20 copay per visit 20% coinsurance up to \$150 per visit	\$20 copay per visit \$20 copay per visit \$20 copay per visit 20% coinsurance up to \$150 per visit
Diagnostic Services Lab: Office Freestanding Lab Outpatient Hospital	No charge No charge No charge	No charge No charge No charge
X-ray: Office Freestanding Radiology Center Outpatient Hospital	No charge No charge No charge	No charge No charge No charge
Advanced diagnostic imaging (for example, MRI/PET/CAT scans): Office <i>Costs may vary by site of service.</i>	\$100 copay per test	\$100 copay per test

<p>Freestanding Radiology Center <i>Costs may vary by site of service.</i></p> <p>Outpatient Hospital <i>Costs may vary by site of service.</i></p>	<p>\$100 copay per test</p> <p>\$100 copay per test</p>	<p>\$100 copay per test</p> <p>\$100 copay per test</p>
<p>Emergency and Urgent Care</p> <p>Emergency room facility services</p> <p><i>This is for the hospital/facility charge only. The ER physician charge may be separate. Copay waived if admitted.</i></p> <p>Emergency room doctor and other services</p>	<p>\$100 copay per visit</p> <p>No charge</p>	<p>\$100 copay per visit</p> <p>No charge</p>
<p>Ambulance (air and ground)</p>	<p>\$100 copay per trip for ground and air</p>	<p>\$100 copay per trip for ground and air</p>
<p>Urgent Care (office setting) <i>Copay waived if admitted.</i></p>	<p>\$20 copay per visit</p>	<p>\$20 copay per visit</p>
<p>Outpatient Mental/Behavioral Health and Substance Abuse</p> <p>Doctor office visit</p> <p>Facility visit: Facility fees</p>	<p>\$20 copay for non-preventive visit.</p> <p>No charge</p>	<p>\$20 copay for non-preventive visit.</p> <p>No charge</p>
<p>Outpatient Surgery</p> <p>Facility fees: Hospital Freestanding Surgical Center</p> <p>Doctor and other services</p>	<p>\$100 copay per admission</p> <p>\$100 copay per admission</p> <p>No charge</p>	<p>No charge</p> <p>No charge</p> <p>No charge</p>
<p>Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse)</p> <p>Facility fees (for example, room & board)</p> <p>Doctor and other services</p>	<p>\$200 copay per admission</p> <p>No charge</p>	<p>No charge</p> <p>No charge</p>
<p>Recovery & Rehabilitation</p> <p>Home health care</p> <p><i>Coverage for In-Network Provider is limited to 100 visit limit per benefit period.</i></p>	<p>\$20 copay per visit</p>	<p>\$20 copay per visit</p>
<p>Skilled nursing care (in a facility)</p>		

<i>Coverage for In-Network Provider is limited to 100 day limit per benefit period.</i>	No charge	No charge
Hospice	No charge	No charge
Durable Medical Equipment	20% coinsurance	20% coinsurance
Prosthetic Devices	No charge	No charge

Prescription Drug Coverage		
Tier1 - Typically Generic <i>Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program) You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days.</i>	\$15 copay per prescriptions	Tier1a - Typically Lower Cost Generic \$5 copay per prescription Tier1b- Typically Generic \$15 copay per prescription
Tier2 - Typically Preferred / Brand <i>Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program)</i>	\$30 copay per prescription	\$30 copay per prescription
Tier3 - Typically Non-Preferred / Specialty Drugs <i>Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program)</i>	\$50 copay per prescription	\$50 copay per prescription
Tier4 - Typically Specialty Drugs <i>Covers up to a 30 day supply (retail pharmacy and home delivery program)</i>	30% coinsurance up to \$150 per prescription (retail) and \$300 per prescription (home delivery)	30% coinsurance up to \$250 per prescription (retail and home delivery)