



**Lay Benefit Comparison
Effective January 1, 2009**

	HMO Plan Option 1	PPO Plan Option 2
	YOU PAY	IN Network YOU PAY
Annual Deductible – Individual/Family	No deductible	\$500/\$1500 per calendar year
OUTPATIENT CARE		
Doctor’s Office and Urgent Care Visits	\$15 per visit copayment to your Primary Care Physician (PCP) \$35 per visit copayment to a Specialist.	\$15 per visit copayment to a Primary Care Physician (PCP) \$25 per visit copayment to a Specialist. (deductible does not apply)
Diagnostic lab and x-ray tests, allergy shots,	No copayment after the per visit copayment to PCP or referred specialist Injectable medications- 20% coinsurance \$100 copay for high cost radiology	20% coinsurance (deductible applies)
Routine Wellness Care	\$15 per visit copayment to your PCP \$35 per visit copayment to a specialist	\$15 per visit copayment to a Primary Care Physician, \$25 copayment to a Specialist, no coinsurance, no deductible.
Mammography Screenings	\$35 per visit copayment	\$ 0 per visit copayment (no coinsurance, no deductible)
Well Woman Gynecological Visit (one per year)	\$15 per visit copayment to PCP or specialist	\$25 per visit copayment (no coinsurance, no deductible)
Well Child Coverage to the date the child reaches age 7	\$15 per visit copayment to your PCP (no age limit)	\$15 per visit copayment, no coinsurance for screenings, diagnostic tests, or for immunizations (no deductible) \$25 per visit copayment to a Specialist.
Maternity Care	\$100 One time per pregnancy copayment for OB/GYN. \$35 per visit copayment for diagnostic testing	20% coinsurance (deductible applies)
Specialist Office Visit	\$35 per visit copayment with a PCP referral	\$25 per visit copayment
Accidental Injury Care	\$15 per visit copayment to your PCP \$35 per visit copayment to specialist with PCP referral	\$15 per visit copayment in a Primary Care Physicians office, \$25 per visit copayment in a Specialist office, 20% coinsurance lab and diagnostic tests (deductible applies)
Vision Exams – one every contract year	\$15 per visit copayment	Not Covered
Outpatient Hospital Care	\$100 Emergency Room per visit copayment (waived if admitted) \$100 Facility copayment for outpatient surgery	20% coinsurance (deductible applies)



	HMO Plan Option 1	PPO Plan Option 2
Outpatient Mental Health and Substance Abuse Care	\$20 per visit copayment (no PCP referral required) \$30 over 30 min max	\$25 copayment per visit (limited to 30 visits per calendar year (deductible does not apply))
	YOU PAY	IN Network YOU PAY
Spinal Manipulations	\$25 copay 30 visit maximum per year, referral	20% coins(deductible applies)\$500 year max
Home Health Care	Covered, no copayment	20% coinsurance (deductible applies) 90 visit limit per calendar year.
Outpatient Speech Therapy	\$25 per visit copayment (limited to 30 days per calendar year)	20% coinsurance (deductible applies)
INPATIENT CARE		
	Pre-admission Certification Required	Advance Hospital Admission Review Required
Inpatient Hospital Care for illness, injury or maternity. Semi-private room, ancillaries, intensive care unit or similar unit	\$250 per admission copayment, requires pre-admission certification by your PCP or the HMO to be covered	No copayment 20% coinsurance (deductible applies) \$500 additional copayment if Hospital Admission Review is not obtained for Out-of-Network services only
In-Hospital Physician's Services	Covered, no copayment	20% coinsurance (deductible applies)
Mental Health and Substance Abuse Care	\$250 per admission copayment, requires pre-admission certification by HMO	20% coinsurance (deductible applies) 90 day limit per calendar year. Up to 10 days may be converted to partial day treatment (limited to 15 days per calendar year)
Skilled Nursing Facility Care (limited to 100 days per illness or condition)	Covered, no copayment	20% coinsurance (deductible applies)
OTHER COVERED SERVICES		
Durable medical equipment and supplies	Covered, no copayment. Limited to \$2,000 per year. (Prosthetics 20% coins, not included in the \$2,000 DME limit)	20% coinsurance (deductible applies)
Ambulance Services	Covered, no copayment, no dollar limit	20% coinsurance (deductible applies, \$3000 limit per calendar year)
Private Duty Nursing Visits	Covered, no copayment (covered through home health care benefits only)	20% coinsurance (deductible applies, \$500 limit per calendar year)
Outpatient Physical and Occupational Therapy	\$25 per visit copayment, therapy benefits are combined for up to 30 visits per cal year.	20% coinsurance (deductible applies)
Hospice Services for members diagnosed with a terminal illness with a life expectancy of 6 months or less	Covered, no copayment	20% coinsurance (deductible applies)



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Early Intervention Services up to \$5000 maximum per member up to age 3 per calendar year when certified: physical therapy, occupational therapy, speech and language therapy, assistive technology devices and services	Copayment determined by services received	Not Covered
	YOU PAY	IN Network YOU PAY
Annual Out-of-Pocket Expense Limit This limit is reached through your deductibles, coinsurance, for PPO plan or copayments, for covered services under the HMO plan. Exceptions are noted below this chart. After the out-of-pocket expense limit has been reached, benefits will be provided at 100% of the allowable charge for covered services for the remainder of the calendar year	\$2000/Individual* \$4000/Family*	\$2000/Individual** \$4000/Family** No copayments will count toward deductible or out of pocket maximums.
Lifetime Maximum – for each covered person as long as coverage is in effect	No limit	No limit

*Does not include copayments for prescriptions, any vision benefits. ** Does not include copayments for prescriptions or office visits. This is only a summary of benefits, for more details refer to the plan document.

OUTPATIENT PRESCRIPTION DRUGS *		
PPO Retail Prescription Drugs (up to a 31-day supply per prescription or refill)	See HMO Retail Prescription Drug section	\$10 copayment for each prescription (Tier 1) \$20 copayment for each prescription (Tier 2) \$35 copayment for each prescription (Tier 3)
HMO Retail Prescription Drugs (up to a 31-day supply or 100 units, whichever is less, per prescription)	\$10 copayment for each prescription (Tier 1) \$20 copayment for each prescription (Tier 2) \$35 copayment for each prescription (Tier 3)	See PPO Prescription Drug section
Mail Order Program (up to a 90-day supply per prescription or refill)	\$20 copayment for each prescription (Tier 1) \$40 copayment for each prescription (Tier 2) \$70 copayment for each prescription (Tier 3)	\$20 copayment for each prescription (Tier 1) \$40 copayment for each prescription (Tier 2) \$70 copayment for each prescription (Tier 3)

*Diabetic supplies including syringes, lancets, test strips and one glucometer each 12-month period are available through the prescription drug program.



	DENTAL CORE OPTION 1	DENTAL HIGH OPTION 2
YOUR DENTAL BENEFITS		
Annual Dental Benefits Maximum for each enrolled family member	\$750	\$1000
Diagnostic and Preventive Care , such as: Two exams annually. Oral exam, normal exam x-rays (full x-ray of the mouth is covered once every 36 months), cleaning the teeth (prophylaxis), palliative tooth pain care, biopsies, space maintainers, and fluoride treatments under age 19	No Deductible, no coinsurance	No Deductible, no coinsurance
Primary Dental Care , such as: Fillings, amalgam or tooth colored materials, extracting teeth, root canal treatment (endodontics), denture repairs, oral surgery and anesthesia (except when given by the dentists performing the surgery), care of the gums (periodontics), recementing crowns, inlays and bridges	20% coinsurance after \$50 annual deductible	20% coinsurance after \$50 annual deductible
Prosthetic and Complex Restorative Services , such as: Inlays, onlays, crowns, dentures, bridges, relining dentures to improve fit	Not covered	50% coinsurance after \$50 annual deductible
Orthodontic Services , such as: Installation of orthodontic appliances, treatment to correct malocclusions and side effects, diagnostic services. There is a separate lifetime benefit limit for orthodontic care of \$1000 per person	Not covered	50% coinsurance after \$50 annual deductible