2010 Plan Design Product Grid

	Prime (HMOPOS)		**Select** (PPO)		**Value** (HMO)
Plan Type	(HMO)	(POS)*	(PPO)	(PPO)	(HMO)
PLAN DEDUCTIBLE	**None**		**None**		**None**
Out of Pocket Maximum	$2,500 combined In–Network or Point of Service Does not include premium or Part D Out of Pocket, but includes combined cost shares paid at in and out of network.		In Network $3,400 Does not include premium or Part D Out of Pocket	Out of Network $5,000 Does not include premium or Part D Out of Pocket	$3,000 Does not include premium
	In-Network Coverage	**Out-of-Network Coverage**	**In-Network Coverage**	**Out-of-Network Coverage**	**In-Network Coverage**
Part B Drugs Including chemo therapy	20% Coinsurance, no deductible Authorization Required	20% Coinsurance, no deductible Authorization Required	20% Coinsurance, no deductible Authorization Required	20% Coinsurance, no deductible	20% Coinsurance, no deductible Authorization Required
Inpatient Hospital Care	For each admission: Days 1–7: $100 Copay per day Days 8 and beyond: No Copay Authorization Required	N/A	For each admission: Days 1–7: $150 Copay per day Days 8 and beyond: No Copay Authorization Required	30% Coinsurance, no deductible	For each admission: Days 1–7: $125 Copay per day Days 8 and beyond: No Copay Authorization Required
Inpatient Mental Health	For each admission: Days 1–7: $100 Copay per day Days 8 and beyond: No Copay 190 days lifetime limit for psychiatric hospitalization BHCP Authorization Required	N/A	For each admission: Days 1–7: $150 Copay per day Days 8 and beyond: No Copay 190 days lifetime limit for psychiatric hospitalization BHCP Authorization Required	8% Coinsurance, no deductible 190 days lifetime limit for psychiatric hospitalization	For each admission: Days 1–7: $125 Copay per day Days 8 and beyond: No Copay 190 days lifetime limit for psychiatric hospitalization BHCP Authorization Required
Skilled Nursing Facility	For each benefit period: No copay days 1–20 $125 copay per days 21–100 No prior hospital stay required Authorization Required	N/A	For each benefit period: No copay days 1–20 $150 copay per days 21–100 No prior hospital stay required Authorization Required	14% Coinsurance, no deductible Days 1–100 No prior hospital stay required	For each benefit period: No copay days 1–20 $125 copay per days 21–100 No prior hospital stay required Authorization Required

Revised: 10/01/09

Only unless noted—Medicare covered services

**Point of Service (POS)—for services out of network, $25,000 yearly maximum—including plan and member payments*

	Prime (HMOPOS)		**Select** (PPO)		**Value** (HMO)
Plan Type	(HMO) **In-Network Coverage**	(POS)* **Out-of-Network Coverage**	(PPO) **In-Network Coverage**	(PPO) **Out-of-Network Coverage**	(HMO) **In-Network Coverage**
Home Health Care	No copay for Medicare covered services	N/A	No copay for Medicare covered services	20% Coinsurance, no deductible	No copay for Medicare covered services
Hospice Care	Must receive care from Medicare certified hospice		Must receive care from Medicare certified hospice		Must receive care from Medicare certified hospice
Doctor Office Visits– **Primary Care**	No Copay per PCP visit Members MUST sign up with network PCP	$30 Copay per PCP visit when member is out of the service area	$20 Copay per PCP visit	30% Coinsurance, no deductible	$20 Copay per PCP visit Members MUST sign up with network PCP
Specialist	$15 Copay specialist visit Authorization may be allowed for non–network specialist visit when a network provider is not available.	$30 Copay specialist visit	$25 Copay specialist visit Authorization may be allowed for non–network specialist visit when the member is in the service area.	30% Coinsurance, no deductible	$25 Copay specialist visit Authorization required for non-network provider
Outpatient Services/ Surgery	$75 Copay for outpatient hospital facility/ambulatory surgery center Authorization Required	$125 Copay for outpatient hospital facility/ambulatory surgery center Authorization Required	$125 Copay for outpatient hospital facility/ambulatory surgery center Authorization Required	30% Coinsurance, no deductible	$100 Copay for outpatient hospital facility/ambulatory surgery center Authorization Required
	$50 Copay partial hospitalization MH/SA BHCP Authorization Required	N/A	$50 Copay partial hospitalization MH/SA BHCP Authorization Required	30% Coinsurance, no deductible	$50 Copay partial hospitalization MH/SA BHCP Authorization Required
	$75 Copay for other hospital outpatient visits Authorization Required	$125 Copay for other hospital outpatient visits Authorization Required	$125 Copay for other hospital outpatient visits Authorization Required	30% Coinsurance, no deductible	$100 Copay for other hospital outpatient visits Authorization Required

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**Point of Service (POS)—for services out of network, $25,000 yearly maximum—including plan and member payments*

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	Prime (HMOPOS)		**Select** (PPO)		**Value** (HMO)
Plan Type	(HMO) **In-Network Coverage**	(POS)* **Out-of-Network Coverage**	(PPO) **In-Network Coverage**	(PPO) **Out-of-Network Coverage**	(HMO) **In-Network Coverage**
Emergency Care	$50 Copay per emergency room visit Copay waived if admitted within 24 hours. Worldwide coverage.		$50 Copay per visit Copay waived if admitted within 24 hours. Worldwide coverage.		$50 Copay per visit Copay waived if admitted within 24 hours. Worldwide coverage.
Urgently Needed Care	$35 Copay per visit Copay waived if admitted within 24 hours.		$35 Copay per emergency room visit Copay waived if admitted within 24 hours.		$35 Copay per visit Copay waived if admitted within 24 hours.
Outpatient Mental Health Care	$15 copay for each individual visit No copay for each group visit BHCP Authorization Required	$30 copay for each individual visit $20 copay for each group visit BHCP Authorization Required	$25 copay for each individual visit $15 copay for each group visit BHCP Authorization Required	30% Coinsurance, no deductible 30% Coinsurance, no deductible	$25 copay for each individual visit $15 copay for each group visit BHCP Authorization Required
Outpatient Substance Abuse Care	$15 copay for each individual visit No copay for each group visit BHCP Authorization Required	$30 copay for each individual visit $20 copay for each group visit BHCP Authorization Required	$25 copay for each individual visit $15 copay for each group visit BHCP Authorization Required	30% Coinsurance, no deductible 30% Coinsurance, no deductible	$25 copay for each individual visit $15 copay for each group visit BHCP Authorization Required
Ambulance Services	$100 copay per trip in or out–of–network		$150 copay per trip in or out–of–network		$150 copay per trip in or out–of–network
Chiropractic Services	$15 copay per visit, Medicare covered services	$30 copay per visit, Medicare covered services	$25 copay per visit, Medicare covered services	30% Coinsurance, no deductible, Medicare covered services	$25 copay per visit, Medicare covered services
Podiatry Services	$15 copay per visit, Medicare covered services	$30 copay per visit, Medicare covered services	$25 copay per visit, Medicare covered services	30% Coinsurance, no deductible, Medicare covered services	$25 copay per visit, Medicare covered services
Hearing Services	No copay–One routine hearing exam per year $15 copay per visit for Medicare covered services	No copay–One routine hearing exam per year $30 copay per visit for Medicare covered services	No copay–One routine hearing exam per year $25 copay per visit for Medicare covered services	30% Coinsurance, no deductible	No copay–One routine hearing exam per year $25 copay per visit for Medicare covered services

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**Point of Service (POS)—for services out of network, $25,000 yearly maximum—including plan and member payments*

	Prime (HMOPOS)		**Select** (PPO)		**Value** (HMO)
Plan Type	(HMO) **In-Network Coverage**	(POS)* **Out-of-Network Coverage**	(PPO) **In-Network Coverage**	(PPO) **Out-of-Network Coverage**	(HMO) **In-Network Coverage**
Vision Services	No copay–One routine eye exam per year $15 copay for each eye exam for diagnosis/ treatment of eye diseases No copay for Medicare covered eyeglasses or contacts (1 per year) Medicare covers glasses or contacts for post cataract surgery only	No copay–One routine eye exam per year $30 copay for each eye exam for diagnosis/ treatment of eye diseases No copay for Medicare covered eyeglasses or contacts (1 per year) Medicare covers glasses or contacts for post cataract surgery only	No copay–One routine eye exam per year $25 copay for each eye exam for diagnosis/ treatment of eye diseases No copay for Medicare covered eyeglasses or contacts (1 per year) Medicare covers glasses or contacts for post cataract surgery only	30% Coinsurance, no deductible	No copay–One routine eye exam per year $25 copay for each eye exam for diagnosis/ treatment of eye diseases No copay for Medicare covered eyeglasses or contacts (1 per year) Medicare covers glasses or contacts for post cataract surgery only
Durable Medical Equipment	20% coinsurance for all Medicare covered benefits Some Durable Medical Equipment and medical supplies may require authorization, see separate listing	30% coinsurance for all Medicare covered benefits Some Durable Medical Equipment may require authorization, see separate listing	20% coinsurance for all Medicare covered benefits Some Durable Medical Equipment may require authorization, see separate listing	30% Coinsurance, no deductible	20% coinsurance for all Medicare covered benefits Some Durable Medical Equipment may require authorization, see separate listing
Prosthetic/Medical Supplies	20% coinsurance for all Medicare covered benefits Some Medical Supplies require authorization, see separate listing	30% coinsurance for all Medicare covered benefits Some Medical Supplies require authorization, see separate listing	20% coinsurance for all Medicare covered benefits Some Medical Supplies require authorization, see separate listing	30% Coinsurance, no deductible	20% coinsurance for all Medicare covered benefits Some Medical Supplies require authorization, see separate listing
Diabetes Self–monitoring training and supplies	No coinsurance for Medicare covered supplies No copay for training	20% coinsurance for Medicare covered supplies No copay for training	No coinsurance for Medicare covered supplies No copay for training	30% Coinsurance, no deductible	No coinsurance for Medicare covered supplies No copay for training
Outpatient Rehabilitation – Physical Therapy, Occupational Therapy and Speech Therapy	$20 copay for each visit	$30 copay for each visit	$25 copay for each visit	30% Coinsurance, no deductible	$25 copay for each visit

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**Point of Service (POS)—for services out of network, $25,000 yearly maximum—including plan and member payments*

	Prime (HMOPOS)		Select (PPO)		Value (HMO)
Plan Type	(HMO) **In-Network Coverage**	(POS)* **Out-of-Network Coverage**	(PPO) **In-Network Coverage**	(PPO) **Out-of-Network Coverage**	(HMO) **In-Network Coverage**
Outpatient clinical, diagnostic, therapeutic services	No coinsurance for Medicare covered clinical/ diagnostic services 20% coinsurance for therapeutic radiation therapy, authorization required No coinsurance for most outpatient x–rays and labs 20% coinsurance PET, MRI, CAT	No coinsurance for Medicare covered clinical/ diagnostic services 30% coinsurance for therapeutic radiation therapy, authorization required No coinsurance for most outpatient x–rays and labs 30% coinsurance PET, MRI, CAT	No coinsurance for Medicare covered clinical/ diagnostic services 20% coinsurance for therapeutic radiation therapy, authorization required No coinsurance for most outpatient x–rays and labs 20% coinsurance PET, MRI, CAT	No coinsurance for Medicare covered clinical/ diagnostic services 30% coinsurance for therapeutic radiation therapy No coinsurance for most outpatient x–rays and labs 30% coinsurance PET, MRI, CAT	No coinsurance for Medicare covered clinical/ diagnostic services 20% coinsurance for therapeutic radiation therapy, authorization required No coinsurance for most outpatient x–rays and labs 20% coinsurance PET, MRI, CAT
Cardiac Rehab	$20	N/A	25	30%	25
Chemotherapy	20% coinsurance for chemotherapy visit, authorization required	30% coinsurance for chemotherapy visit, authorization required	20% coinsurance for chemotherapy visit, authorization required	30% Coinsurance for chemotherapy visit	20% coinsurance for chemotherapy visit, authorization required
Medical Nutritional services	No copay Medicare covered services	No copay Medicare covered services	No copay Medicare covered services	20% Coinsurance, no deductible Medicare covered services	No copay Medicare covered services
Physical Exams	No copay 1 physical exam per year	N/A	No copay 1 physical exam per year	20% Coinsurance, no deductible	No copay 1 physical exam per year
Outpatient Blood	No copay for the first three (3) pints	No copay for the first three (3) pints	No copay for the first three (3) pints	30% Coinsurance, no deductible	No copay for the first three (3) pints
Preventive Care	No copays for all Medicare covered services: Immunizations, Pap/Pelvic, Colorectal screening; bone mass measurement; mammograms; prostate cancer screening	N/A	No copays for all Medicare covered services: Immunizations, Pap/Pelvic, Colorectal screening; bone mass measurement; mammograms; prostate cancer screening	30% Coinsurance, no deductible for Medicare covered services: Immunizations, Pap/Pelvic, Colorectal screening; bone mass measurement; mammograms; prostate cancer screening, no coinsurance for seasonal flu on pneumococcal vaccinations	No copays for all Medicare covered services: Immunizations, Pap/Pelvic, Colorectal screening; bone mass measurement; mammograms; prostate cancer screening

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	Prime (HMOPOS)		Select (PPO)		Value (HMO)
Plan Type	(HMO) **In-Network Coverage**	(POS)* **Out-of-Network Coverage**	(PPO) **In-Network Coverage**	(PPO) **Out-of-Network Coverage**	(HMO) **In-Network Coverage**
Visitor/Travel Benefit	Point of Service benefits apply See applicable service category above for details		Not Applicable	Out-of-network benefits apply See applicable service category above for details	US only; same co–pays as in–network; plan will pay up to $2,500/year for specified services.
Value Added Services					
1. Dental Services	$100 towards 1 preventive dental visit, every 6 months		$100 towards 1 preventive dental visit, every 6 months		$100 towards 1 preventive dental visit, every 6 months
2. Hearing Aids	$500 towards hearing aid every three years		Not covered. Beneficiary pays 100% for hearing aids		Not covered. Beneficiary pays 100% for hearing aids
3. Eye Glasses or Contacts **Note:** Medicare covered eyeglasses or contacts following cataract surgery are covered as part of vision coverage and not considered 'value added' (see above)	$100 towards eye glasses or contacts every two years		Not covered. Beneficiary pays 100% for eye glasses and contacts.		Not covered. Beneficiary pays 100% for eye glasses and contacts.
Pharmacy Benefit					
Part D Deductible	None		None		No Part D Benefit
Part D Copays: retail and mail order	Four Tiers (retail): $5, $35, $55 copay, 25% coinsurance; mail order for 3 month supply is 2.5 times monthly retail.		Four Tiers (retail): $5, $35, $55, 25% coinsurance; mail order for 3 month supply is 2.5 times monthly retail.		No Part D Benefit
Part D Coverage gap	Generic: $5 copay. Brand name not covered through coverage gap		Generic: $5 copay. Brand name not covered through coverage gap		No Part D Benefit

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