

Health Benefits and Copays - Plan Type 2 effective 7/1/08

Benefit	Copay
Outpatient care	
Office visit to your primary care provider (PCP)	\$10
Office visit to a specialist	\$18
Radiology, imaging (x-rays), lab work	\$0
Outpatient surgery at a hospital or ambulatory surgery center	\$50
Abortion	\$50
Inpatient care	
Hospital stay, may include surgery, x-rays, lab services, and room and board (copay is per stay)	\$50 *
Emergency care	
Emergency room visit (no copay if you are admitted to the hospital)	\$50
Prescription drugs	
30 day supply from a pharmacy	
• Generic drug	\$10
• Drug on your plan's preferred list	\$20
• Drug not on your plan's preferred list	\$40
3-month supply, by mail	
• Generic drug	\$20
• Drug on your plan's preferred list	\$40
• Drug not on your plan's preferred list	\$120
Alcohol, drug abuse and mental health care	
Outpatient or office visit	\$10
Inpatient care (copay is per stay)	\$50 *
Methadone maintenance (dosing, counseling, screens)	\$0
Vision	
Eye exam every 24 months	\$10
Free glasses every 24 months	\$0
Diabetes care	
Office visit to PCP or podiatrist for routine foot care (may include foot orthotics)	\$5
Visit to specialist (may include foot orthotics)	\$10
Rehabilitation services	
Extended inpatient care (100 total days per year)	
• In a skilled nursing facility	\$0
• In a rehabilitation hospital or chronic disease hospital (copay is per stay)	\$50 *
Physical therapy, speech or hearing therapy, pulmonary or occupational therapy (need plan approval for more than 20 visits)	\$10
Cardiac rehabilitation	\$0
Home health care	\$0
Maternity and family planning	
Outpatient office visit	\$0
Other benefits	
Ambulance (emergency only)	\$0
Prosthetics, oxygen and respiratory therapy equipment, other durable medical equipment	\$0
Hospice	\$0
Maximum copays **	
Total out-of-pocket maximum you will pay for all prescriptions in a year	\$500
Total out-of-pocket maximum you will pay for services excluding prescription drugs in a year	\$750

* copay waived if transferred from another inpatient unit

** Maximum copays is the total out-of-pocket that a member will pay in copays for covered medical benefits during a benefit period

Health Benefits and Copays - Plan Type 3 effective 7/1/08

Benefit	Copay
Outpatient care	
Office visit to your primary care provider (PCP)	\$15
Office visit to a specialist	\$22
Radiology, imaging (x-rays), lab work	\$0
Outpatient surgery at a hospital or ambulatory surgery center	\$125
Abortion	\$100
Inpatient care	
Hospital stay, may include surgery, x-rays, lab services, and room and board (copay is per stay)	\$250 *
Emergency care	
Emergency room visit (no copay if you are admitted to the hospital)	\$100
Prescription drugs	
30 day supply from a pharmacy	
• Generic drug	\$12.50
• Drug on your plan's preferred list	\$25
• Drug not on your plan's preferred list	\$50
3-month supply, by mail	
• Generic drug	\$25
• Drug on your plan's preferred list	\$50
• Drug not on your plan's preferred list	\$150
Alcohol, drug abuse and mental health care	
Outpatient or office visit	\$15
Inpatient care (copay is per stay)	\$250 *
Methadone maintenance (dosing, counseling, screens)	\$0
Vision	
Eye exam every 24 months	\$20
Free glasses every 24 months	\$0
Diabetes care	
Office visit to PCP or podiatrist for routine foot care (may include foot orthotics)	\$10
Visit to specialist (may include foot orthotics)	\$20
Rehabilitation services	
Extended inpatient care (100 total days per year)	
• In a skilled nursing facility	\$0
• In a rehabilitation hospital or chronic disease hospital (copay is per stay)	\$250 *
Physical therapy, speech or hearing therapy, pulmonary or occupational therapy (need plan approval for more than 20 visits)	\$20
Cardiac rehabilitation	\$0
Home health care	\$0
Maternity and family planning	
Outpatient office visit	\$0
Other benefits	
Ambulance (emergency only)	\$0
Prosthetics, oxygen and respiratory therapy equipment, other durable medical equipment.	10%
Hospice	\$0
Maximum copays **	
Total out-of-pocket maximum you will pay for all prescriptions in a year	\$800
Total out-of-pocket maximum you will pay for services excluding prescription drugs in a year	\$1500

* copay waived if transferred from another inpatient unit

** Maximum copays is the total out-of-pocket that a member will pay in copays for covered medical benefits during a benefit period