

HMO Benefits

Health Maintenance Organization (HMO) members are required to stay within the health plan provider network. No out-of-network services are available, other than listed below. Members will need to select a primary care physician (PCP) from a network of participating providers. The PCP will direct all healthcare services and make referrals to specialists and hospitalization. Benefits are outlined in each plan's Summary Plan Document (SPD). It is the member's responsibility to know and follow the specific requirements of the HMO plan selected. For a copy of the SPD, contact the plan administrator (see page 7).

HMO Plan Design

| | | |
|---------------------------------|--------------------|----------------|
| Plan Year Out-of-Pocket Maximum | \$3,000 Individual | \$6,000 Family |
|---------------------------------|--------------------|----------------|

Hospital Services

| | In-Network | Out-of-Network |
|---------------------------------------|-------------------------------|-----------------|
| Emergency Room Services | \$200 copayment per visit | \$200 copayment |
| Inpatient Hospitalization | \$250 copayment per admission | Not covered |
| Inpatient Alcohol and Substance Abuse | \$250 copayment per admission | Not covered |
| Inpatient Psychiatric Admission | \$250 copayment per admission | Not covered |
| Outpatient Surgery | \$150 copayment per visit | Not covered |
| Skilled Nursing Facility | 100% covered | Not covered |
| Diagnostic Lab and X-ray | 100% covered | Not covered |

Transplant Services

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|------------------------------|---|
| Organ and Tissue Transplants | \$250 copay, limited to network transplant facilities as determined by the medical plan administrator. To assure coverage, the transplant candidate must contact your plan provider prior to beginning evaluation services. |
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Professional and Other Services

| | In-Network | Out-of-Network |
|--|--------------------------|----------------|
| Preventive Care/Well-Baby/Immunizations | 100% covered | Not covered |
| Physician Office Visit | \$20 copayment per visit | Not covered |
| Specialist Office Visit | \$20 copayment per visit | Not covered |
| Telemedicine | \$10 copayment | Not covered |
| Outpatient Psychiatric and Substance Abuse | \$20 copayment per visit | Not covered |
| Durable Medical Equipment | 80% covered | Not covered |
| Home Health Care | \$15 copayment per visit | Not covered |

Prescription Drugs

Preventive Prescription Drugs – \$0

| | Reduced Tier I * | Tier I | Tier II | Tier III |
|----------------------------|------------------|--------|---------|----------|
| Copayments (30-day supply) | \$4 | \$10 | \$20 | \$40 |
| Copayments (90-day supply) | \$10 | \$25 | \$50 | \$100 |

* Applies to specific medications as defined by plan.
Some HMOs may have benefit limitations based on a calendar year.