

Benefits	HMO (no Rx)		Changes
Contract ID	H3907		
PBP(s)	Western Pennsylvania - 002; Lancaster - 038		
	2015	2016	
Premium	\$0.00	\$0.00	
ANNUAL MAXIMUMS			
Annual Deductible	n/a	n/a	
Out-of-Pocket Maximum	\$3,400	\$3,400	
INPATIENT CARE			
Inpatient Hospital <i>*prior auth required</i>	\$350 copay per stay	\$350 copay per stay	
Inpatient Mental Health Care <i>*prior auth required</i>	\$350 copay per stay	\$350 copay per stay	
Skilled Nursing Facility <i>*prior auth required</i> <i>100 day limit per benefit period</i>	\$25 copay per day - days 1-5 \$40 copay per day - days 6-20 \$80 copay per day - days 21-100	\$40 copay per day - days 1-20 \$80 copay per day - days 21-100	Increased copayment and day range
Home Health Care <i>*prior auth required</i>	\$0 copay	\$0 copay	
OUTPATIENT CARE			
Primary Care Doctor Visits	\$5 copay	\$5 copay	
Specialist Visits	\$45 copay	\$45 copay	
Chiropractic Services	\$20 copay	\$20 copay	
Routine Chiropractic Services <i>(6 visits every year)</i>	\$20 copay	\$20 copay	
Podiatry Services	\$45 copay	\$45 copay	
Routine Podiatry Services <i>(4 visits every year)</i>	\$45 copay	\$45 copay	
Outpatient Mental Health	\$40 copay	\$40 copay	
Outpatient Psychiatric Services	\$40 copay	\$40 copay	
Outpatient Substance Abuse	\$40 copay	\$40 copay	
Partial Hospitalization <i>*prior auth required</i>	\$0 copay	\$0 copay	
Outpatient Surgery and Ambulatory Surgical Center <i>*prior auth required</i>	\$0 - \$225 copay (Outpatient) \$225 copay (ASC)	\$225 copay	
Ambulance Services	\$125 copay per one way trip	\$125 copay per one way trip	
Emergency Care <i>(waived if admitted within 3 days)</i>	\$65 copay	\$75 copay	Increased copayment
Urgently Needed Care (Clinics) <i>(out-of-area; urgent care clinics)</i>	\$45 copay	\$50 copay	Increased copayment
Outpatient Rehab Services <i>(PT, OT, ST)</i>	\$40 copay	\$40 copay	
Cardiac/Pulmonary Rehab	\$0 copay	\$0 copay	
OUTPATIENT MEDICAL AND SUPPLIES			
Durable Medical Equipment/Oxygen <i>*prior auth required</i>	20% coinsurance	20% coinsurance	
Prosthetic Devices and Medical Supplies	20% coinsurance	20% coinsurance	
Diabetes Training and Diabetic Supplies	\$0 copay - training \$25 copay test strips / \$10 copay lancets (30-day supply) \$50 copay test strips / \$30 copay lancets (90-day supply)	\$0 copay - training 20% test strips/lancets (30/90-day supply)	Changed supplies to coinsurance
Diabetic Shoes or Inserts	\$25 copay per pair	20% coinsurance	Changed to coinsurance
Part B Drugs <i>*prior auth required</i>	20% coinsurance all Part B drugs; chemotherapy / self-administered	20% coinsurance all Part B drugs; chemotherapy / self-administered	
Kidney Disease Training and Renal Dialysis (ESRD)	\$0 copay - training 20% coinsurance - dialysis	\$0 copay - training 20% coinsurance - dialysis	
Lab Services	\$0 copay per day - preventive \$5 copay per day - non-preventive	\$0-\$5 copay per day	
Diagnostic Procedures/Tests	\$0 copay per day - preventive \$5 copay per day - non-preventive	\$0-\$5 copay per day	
X-Ray Services	\$30 copay	\$30 copay	
Diagnostic Radiological Services (Advanced Imaging) <i>*prior auth required</i>	\$110 copay	\$110 copay	
Therapeutic Radiological Services (Radiation)	\$25 copay	\$25 copay	
PREVENTIVE SERVICES			
Immunizations <i>(influenza, pneumonia, Hepatitis B)</i>	\$0 copay	\$0 copay	
Annual Wellness Visit	\$0 copay	\$0 copay	
Screening Exams <i>Includes: Bone Mass Measurement, Colorectal Screening, Mammograms, Pap & Pelvic, Prostate Exams, all Medicare- covered Preventive Services</i>	\$0 copay	\$0 copay	

Benefits	HMO (no Rx)		Changes
Contract ID	H3907		
PBP(s)	Western Pennsylvania - 002; Lancaster - 038		
	2015	2016	
ADDITIONAL SERVICES			
Dental Services			
Medicare-covered Dental Services	\$45 copay	\$45 copay	
Routine Dental Oral Exam & Cleaning	not covered	not covered	
Routine Dental Bitewing X-rays	not covered	not covered	
Hearing Services			
Medicare-covered Hearing Services	\$45 copay	\$45 copay	
Routine Hearing Exam	not covered	not covered	
Routine Hearing Aid Fitting	not covered	not covered	
Routine Hearing Aids	VAIS discount	VAIS discount	
Vision Services			
Medicare-covered Vision Services	\$45 copay	\$45 copay	
Medicare-covered Glaucoma Screening and Diabetic Retinal Eye Exam	\$0 copay	\$0 copay	
Medicare-covered Eyewear <i>Cataract Glasses/Lens</i>	\$0 copay	\$0 copay	
Routine Vision Exam & Eyewear <i>(once every two years)</i> Allowance must be used for both routine eye exam and eyewear.	\$150 allowance	\$150 allowance	
Other Services			
Health & Wellness <i>Fitness Center Benefit</i>	Silver & Fit	Silver & Fit	
Remote Technologies	N/A	\$5 for eVisits / \$38 for eDerm	New Supplemental Benefit
Worldwide Emergency Coverage	Assist America Travel Benefit	Assist America Travel Benefit	

UPMC for Life 2016 HMO Deductible with Rx - Western Pennsylvania (28 Counties) - Final 8/31/2015			
Benefits	HMO Deductible with Rx		Changes
Contract ID	H3907		
PBP(s)	Western Pennsylvania - 037; Lancaster - 039		
	2015	2016	
Premium	\$18 - Western Pennsylvania \$0 - Lancaster	\$22 - Western Pennsylvania \$0 - Lancaster	\$4 Increase in Western Pennsylvania
ANNUAL MAXIMUMS			
Annual Deductible	\$750	\$750	
Out-of-Pocket Maximum	\$4,000	\$4,000	
INPATIENT CARE			
Inpatient Hospital <i>*prior auth required</i>	\$200 copay per stay after deductible	\$300 copay per stay after deductible	Increased copayment
Inpatient Mental Health Care <i>*prior auth required</i>	\$200 copay per stay after deductible	\$300 copay per stay after deductible	Increased copayment
Skilled Nursing Facility <i>*prior auth required 100 day limit per benefit period</i>	\$0 copay per day - days 1-20 \$125 copay per day - days 21-100 excluded from deductible	\$0 copay per day - days 1-20 \$160 copay per day - days 21-100 excluded from deductible	Increased copayment
Home Health Care <i>*prior auth required</i>	\$0 copay after deductible	\$0 copay after deductible	
OUTPATIENT CARE			
Primary Care Doctor Visits	\$5 copay excluded from deductible	\$5 copay (WPA) \$10 copay (Lancaster) excluded from deductible	Increased copayment in Lancaster
Specialist Visits	\$50 copay excluded from deductible	\$50 copay excluded from deductible	
Chiropractic Services	\$20 copay excluded from deductible	\$20 copay excluded from deductible	
Routine Chiropractic Visits	no routine coverage	no routine coverage	
Podiatry Services	\$50 copay excluded from deductible	\$50 copay after deductible	Benefit applies to deductible
Routine Podiatry Services	no routine coverage	no routine coverage	
Outpatient Mental Health	\$40 copay excluded from deductible	\$40 copay after deductible	Benefit applies to deductible
Outpatient Psychiatric Services	\$40 copay excluded from deductible	\$40 copay after deductible	Benefit applies to deductible
Outpatient Substance Abuse	\$40 copay excluded from deductible	\$40 copay after deductible	Benefit applies to deductible
Partial Hospitalization <i>*prior auth required</i>	\$0 copay after deductible	\$0 copay after deductible	
Outpatient Surgery and Ambulatory Surgical Center <i>*prior auth required</i>	\$0 - \$125 copay (Outpatient) \$125 copay (ASC) after deductible	\$125 copay after deductible	
Ambulance Services	\$0 copay after deductible	\$100 copay after deductible	Increased copayment
Emergency Care <i>(waived if admitted within 3 days)</i>	\$65 copay excluded from deductible	\$75 copay excluded from deductible	Increased copayment
Urgently Needed Care (Clinics) <i>(out-of-area; urgent care clinics)</i>	\$50 copay excluded from deductible	\$50 copay excluded from deductible	
Outpatient Rehab Services <i>(PT, OT, ST)</i>	\$0 copay after deductible	\$0 copay after deductible	
Cardiac/Pulmonary Rehab	\$0 copay after deductible	\$0 copay after deductible	
OUTPATIENT MEDICAL AND SUPPLIES			
Durable Medical Equipment/Oxygen <i>*prior auth required</i>	\$0 copay after deductible	\$0 copay after deductible	
Prosthetic Devices and Medical Supplies	\$0 copay after deductible	\$0 copay after deductible	
Diabetes Training and Diabetic Supplies	\$0 copay - training excluded from deductible 10% coinsurance - supplies after deductible	\$0 copay - training excluded from deductible 20% coinsurance - supplies after deductible	Increased coinsurance
Diabetic Shoes or Inserts	10% coinsurance after deductible 20% coinsurance	20% coinsurance after deductible	Increased coinsurance
Part B Drugs <i>*prior auth required</i>	all Part B drugs; chemotherapy / self-administered excluded from deductible	all Part B drugs; chemotherapy / self-administered excluded from deductible	
Kidney Disease Training and Renal Dialysis (ESRD)	\$0 copay - training excluded from deductible 20% coinsurance - dialysis excluded from deductible	\$0 copay - training excluded from deductible 20% coinsurance - dialysis after deductible	Benefit applies to deductible
Lab Services	\$0-\$5 copay per day excluded from deductible	\$0-\$10 copay per day excluded from deductible	Increased copayment
Diagnostic Procedures/Tests	\$0-\$5 copay per day excluded from deductible	\$0-\$10 copay per day excluded from deductible	Increased copayment
X-Ray Services	\$10 copay after deductible	\$10 copay after deductible	
Diagnostic Radiological Services (Advanced imaging) <i>*prior auth required</i>	\$50 copay after deductible	\$100 copay after deductible	Increased copayment
Therapeutic Radiological Services (Radiation)	\$0 copay after deductible	\$0 copay after deductible	
PREVENTIVE SERVICES			
Immunizations <i>(influenza, pneumonia, Hepatitis B)</i>	\$0 copay excluded from deductible	\$0 copay excluded from deductible	
Annual Wellness Visit	\$0 copay excluded from deductible	\$0 copay excluded from deductible	
Screening Exams <i>Includes: Bone Mass Measurement, Colonorectal Screening, Mammograms, Pap & Pelvic, Prostate Exams, all Medicare- covered Preventive Services</i>	\$0 copay excluded from deductible	\$0 copay excluded from deductible	

Benefits	HMO Deductible with Rx		Changes
Contract ID	H3907		
PBP(s)	Western Pennsylvania - 037; Lancaster - 039		
	2015	2016	
ADDITIONAL SERVICES			
Dental Services			
Medicare-covered Dental Services	\$50 copay excluded from deductible	\$50 copay excluded from deductible	
Routine Dental Oral Exam & Cleaning <i>(once every 6 months)</i>	\$15 copay excluded from deductible	\$15 copay excluded from deductible	
Routine Dental Bitewing X-rays <i>(once every year)</i>	\$15 copay excluded from deductible	\$15 copay excluded from deductible	X-rays were every 3 years
Hearing Services			
Medicare-covered Hearing Services	\$50 copay excluded from deductible	\$50 copay excluded from deductible	
Routine Hearing Exam	not covered	not covered	
Routine Hearing Aid Fitting	not covered	not covered	
Routine Hearing Aids	VAIS discount	VAIS discount	
Vision Services			
Medicare-covered Vision Services	\$50 copay excluded from deductible	\$50 copay excluded from deductible	
Medicare-covered Glaucoma Screening and Diabetic Retinal Eye Exam	\$0 copay excluded from deductible	\$0 copay excluded from deductible	
Medicare-covered Eyewear <i>Cataract Glasses/Lens</i>	\$0 copay excluded from deductible	\$0 copay excluded from deductible	
Routine Vision Exam & Eyewear <i>(once every two years)</i> Allowance must be used for both routine eye exam and eyewear.	\$150 allowance excluded from deductible	\$150 allowance excluded from deductible	
Other Services			
Health & Wellness <i>Fitness Center Benefit</i>	Silver & Fit excluded from deductible	Silver & Fit excluded from deductible	
Remote Technologies	N/A	\$5 for eVisits / \$38 for eDerm excluded from deductible	New Supplemental Benefit
Worldwide Emergency Coverage	Assist America Travel Benefit excluded from deductible	Assist America Travel Benefit excluded from deductible	
Part D Prescription Drugs			
Tier 1: Generic Drugs	\$10 copay - 30 day supply (retail) \$30 copay - 90 day supply (retail) \$20 copay - 90 day supply (mail-order)	\$14 copay - 30 day supply (retail) \$42 copay - 90 day supply (retail) \$28 copay - 90 day supply (mail-order)	Increased copayment
Tier 2: Preferred Brand Drugs	\$45 copay - 30 day supply (retail) \$135 copay - 90 day supply (retail) \$112.50 copay - 90 day supply (mail-order)	\$47 copay - 30 day supply (retail) \$141 copay - 90 day supply (retail) \$117.50 copay - 90 day supply (mail-order)	Increased copayment
Tier 3: Non-Preferred Brand Drugs	\$95 copay - 30 day supply (retail) \$285 copay - 90 day supply (retail) \$285 copay - 90 day supply (mail-order)	\$100 copay - 30 day supply (retail) \$300 copay - 90 day supply (retail) \$300 copay - 90 day supply (mail-order)	Increased copayment
Tier 4: Specialty Drugs	33% coinsurance - 30 day supply only	33% coinsurance - 30 day supply only	
Tier 5: Select Care Drugs	\$0 copay - 30 day supply (retail) \$0 copay - 90 day supply (retail) \$0 copay - 90 day supply (mail-order)	\$0 copay - 30 day supply (retail) \$0 copay - 90 day supply (retail) \$0 copay - 90 day supply (mail-order)	
Initial Coverage Limit	\$2,960	\$3,310	CMS Limit Change
Out-of-Pocket Limit (TrOOP)	\$4,700	\$4,850	CMS Limit Change
Gap Coverage	Member pays 65% for generic drugs and 45% plus a dispensing fee for brand-name drugs through the coverage gap	Member pays 58% for generic drugs and 45% plus a dispensing fee for brand-name drugs through the coverage gap	CMS Annual Change
Catastrophic Copays	Greater of: \$2.65 generic/brand treated as generic \$6.60 or 5% all others	Greater of: \$2.95 generic/brand treated as generic \$7.40 or 5% all others	CMS Limit Change

Benefits	HMO Rx		Changes
Contract ID	H3907		
PBP(s)	029		
	2015	2016	
Premium	\$78.00	\$83.00	\$6.00
ANNUAL MAXIMUMS			
Annual Deductible	n/a	n/a	
Out-of-Pocket Maximum	\$3,400	\$3,400	
INPATIENT CARE			
Inpatient Hospital <i>*prior auth required</i>	\$350 copay per stay	\$350 copay per stay	
Inpatient Mental Health Care <i>*prior auth required</i>	\$350 copay per stay	\$350 copay per stay	
Skilled Nursing Facility <i>*prior auth required</i> <i>100 day limit per benefit period</i>	\$25 copay per day - days 1-5 \$40 copay per day - days 6-20 \$80 copay per day - days 21-100	\$40 copay per day - days 1-20 \$80 copay per day - days 21-100	Increased copayment and day range
Home Health Care <i>*prior auth required</i>	\$0 copay	\$0 copay	
OUTPATIENT CARE			
Primary Care Doctor Visits	\$5 copay	\$5 copay	
Specialist Visits	\$40 copay	\$40 copay	
Chiropractic Services	\$20 copay	\$20 copay	
Routine Chiropractic Services <i>(6 visits every year)</i>	\$20 copay	\$20 copay	
Podiatry Services	\$40 copay	\$40 copay	
Routine Podiatry Services <i>(4 visits every year)</i>	\$40 copay	\$40 copay	
Outpatient Mental Health	\$40 copay	\$40 copay	
Outpatient Psychiatric Services	\$40 copay	\$40 copay	
Outpatient Substance Abuse	\$40 copay	\$40 copay	
Partial Hospitalization <i>*prior auth required</i>	\$0 copay	\$0 copay	
Outpatient Surgery and Ambulatory Surgical Center <i>*prior auth required</i>	\$0 - \$250 copay (Outpatient) \$250 copay (ASC)	\$250 copay	
Ambulance Services	\$100 copay per one way trip	\$200 copay per one way trip	Increased copayment
Emergency Care <i>(waived if admitted within 3 days)</i>	\$65 copay	\$75 copay	Increased copayment
Urgently Needed Care (Clinics) <i>(out-of-area; urgent care clinics)</i>	\$40 copay	\$50 copay	Increased copayment
Outpatient Rehab Services <i>(PT, OT, ST)</i>	\$40 copay	\$40 copay	
Cardiac/Pulmonary Rehab	\$0 copay	\$0 copay	
OUTPATIENT MEDICAL AND SUPPLIES			
Durable Medical Equipment/Oxygen <i>*prior auth required</i>	20% coinsurance	20% coinsurance	
Prosthetic Devices and Medical Supplies	20% coinsurance	20% coinsurance	
Diabetes Training and Diabetic Supplies	\$0 copay - training \$25 copay test strips / \$10 copay lancets (30-day supply) \$50 copay test strips / \$30 copay lancets (90-day supply)	\$0 copay - training 20% test strips/lancets (30/90-day supply)	Changed supplies to coinsurance
Diabetic Shoes or Inserts	\$25 copay per pair	20% coinsurance	Changed to coinsurance
Part B Drugs <i>*prior auth required</i>	20% coinsurance all Part B drugs; chemotherapy / self-administered	20% coinsurance all Part B drugs; chemotherapy / self-administered	
Kidney Disease Training and Renal Dialysis (ESRD)	\$0 copay - training 20% coinsurance - dialysis	\$0 copay - training 20% coinsurance - dialysis	
Lab Services	\$0-\$5 copay per day	\$0-\$5 copay per day	
Diagnostic Procedures/Tests	\$0-\$5 copay per day	\$0-\$5 copay per day	
X-Ray Services	\$40 copay	\$40 copay	
Diagnostic Radiological Services (Advanced Imaging) <i>*prior auth required</i>	\$150 copay	\$200 copay	Increased copayment
Therapeutic Radiological Services (Radiation)	\$25 copay	\$25 copay	
PREVENTIVE SERVICES			
Immunizations <i>(influenza, pneumonia, Hepatitis B)</i>	\$0 copay	\$0 copay	
Annual Wellness Visit	\$0 copay	\$0 copay	
Screening Exams <i>Includes: Bone Mass Measurement, Colorectal Screening, Mammograms, Pap & Pelvic, Prostate Exams, all Medicare-covered Preventive Services</i>	\$0 copay	\$0 copay	

UPMC for Life 2016 HMO Rx - Western Pennsylvania (28 Counties) - Final 8/5/2015			
Benefits	HMO Rx		Changes
Contract ID	H3907		
PBP(s)	029		
	2015	2016	
ADDITIONAL SERVICES			
Dental Services			
Medicare-covered Dental Services	\$40 copay	\$40 copay	
Routine Dental Oral Exam & Cleaning <i>(once every 6 months)</i>	\$15 copay	\$15 copay	
Routine Dental Bitewing X-rays <i>(once every year)</i>	\$15 copay	\$15 copay	X-rays were every 3 years
Hearing Services			
Medicare-covered Hearing Services	\$40 copay	\$40 copay	
Routine Hearing Exam	not covered	not covered	
Routine Hearing Aid Fitting	not covered	not covered	
Routine Hearing Aids	VAIS discount	VAIS discount	
Vision Services			
Medicare-covered Vision Services	\$40 copay	\$40 copay	
Medicare-covered Glaucoma Screening and Diabetic Retinal Eye Exam	\$0 copay	\$0 copay	
Medicare-covered Eyewear <i>Cataract Glasses/Lens</i>	\$0 copay	\$0 copay	
Routine Vision Exam & Eyewear <i>(once every two years)</i> Allowance must be used for both routine eye exam and eyewear.	\$175 allowance	\$175 allowance	
Other Services			
Health & Wellness <i>Fitness Center Benefit</i>	Silver & Fit	Silver & Fit	
Remote Technologies	N/A	\$5 for eVisits / \$38 for eDerm	New Supplemental Benefit
Worldwide Emergency Coverage	Assist America Travel Benefit	Assist America Travel Benefit	
Part D Prescription Drugs			
Tier 1: Generic Drugs	\$8 copay - 30 day supply (retail) \$24 copay - 90 day supply (retail) \$16 copay - 90 day supply (mail-order)	\$12 copay - 30 day supply (retail) \$36 copay - 90 day supply (retail) \$24 copay - 90 day supply (mail-order)	Increased copayment
Tier 2: Preferred Brand Drugs	\$45 copay - 30 day supply (retail) \$135 copay - 90 day supply (retail) \$112.50 copay - 90 day supply (mail-order)	\$47 copay - 30 day supply (retail) \$141 copay - 90 day supply (retail) \$117.50 copay - 90 day supply (mail-order)	Increased copayment
Tier 3: Non-Preferred Brand Drugs	\$95 copay - 30 day supply (retail) \$285 copay - 90 day supply (retail) \$285 copay - 90 day supply (mail-order)	\$100 copay - 30 day supply (retail) \$300 copay - 90 day supply (retail) \$300 copay - 90 day supply (mail-order)	Increased copayment
Tier 4: Specialty Drugs	33% coinsurance - 30 day supply only	33% coinsurance - 30 day supply only	
Tier 5: Select Care Drugs	\$0 copay - 30 day supply (retail) \$0 copay - 90 day supply (retail) \$0 copay - 90 day supply (mail-order)	\$0 copay - 30 day supply (retail) \$0 copay - 90 day supply (retail) \$0 copay - 90 day supply (mail-order)	
Initial Coverage Limit	\$2,960	\$3,310	CMS Limit Change
Out-of-Pocket Limit (TrOOP)	\$4,700	\$4,850	CMS Limit Change
Gap Coverage	Member pays 65% for generic drugs and 45% plus a dispensing fee for brand-name drugs through the coverage gap Greater of:	Member pays 58% for generic drugs and 45% plus a dispensing fee for brand-name drugs through the coverage gap Greater of:	CMS Annual Change
Catastrophic Copays	\$2.65 generic/brand treated as generic \$6.60 or 5% all others	\$2.95 generic/brand treated as generic \$7.40 or 5% all others	CMS Limit Change

UPMC for Life
2016 HMO Rx Enhanced - Western Pennsylvania (28 Counties) - Final 8/5/2015

Benefits	HMO Rx Enhanced		Changes
Contract ID	H3907		
PBP(s)	006		
	2015	2016	
Premium	\$223.00	\$242.00	\$19 increase
ANNUAL MAXIMUMS			
Annual Deductible	n/a	n/a	
Out-of-Pocket Maximum	\$3,400	\$3,400	
INPATIENT CARE			
Inpatient Hospital <i>*prior auth required</i>	\$125 copay per stay \$375 annual limit	\$125 copay per stay	Removed annual benefit maximum
Inpatient Mental Health Care <i>*prior auth required</i>	\$125 copay per stay \$375 annual limit	\$125 copay per stay	Removed annual benefit maximum
Skilled Nursing Facility <i>*prior auth required 100 day limit per benefit period</i>	\$10 copay per day - days 1-20 \$60 copay per day - days 21-73 \$0 copay per day - days 74-100	\$10 copay per day - days 1-20 \$60 copay per day - days 21-100	Increased day range
Home Health Care <i>*prior auth required</i>	\$0 copay	\$0 copay	
OUTPATIENT CARE			
Primary Care Doctor Visits	\$5 copay	\$5 copay	
Specialist Visits	\$25 copay	\$25 copay	
Chiropractic Services	\$20 copay	\$20 copay	
Routine Chiropractic Services <i>(6 visits every year)</i>	\$20 copay	\$20 copay	
Podiatry Services	\$25 copay	\$25 copay	
Routine Podiatry Services <i>(4 visits every year)</i>	\$25 copay	\$25 copay	
Outpatient Mental Health	\$25 copay	\$25 copay	
Outpatient Psychiatric Services	\$25 copay	\$25 copay	
Outpatient Substance Abuse	\$25 copay	\$25 copay	
Partial Hospitalization <i>*prior auth required</i>	\$0 copay	\$0 copay	
Outpatient Surgery and Ambulatory Surgical Center <i>*prior auth required</i>	\$0 - \$80 copay (Outpatient) \$80 copay (ASC)	\$80 copay	
Ambulance Services	\$100 copay per one way trip	\$100 copay per one way trip	
Emergency Care <i>(waived if admitted within 3 days)</i>	\$65 copay	\$75 copay	Increased copayment
Urgently Needed Care (Clinics) <i>(out-of-area; urgent care clinics)</i>	\$25 copay	\$50 copay	Increased copayment
Outpatient Rehab Services <i>(PT, OT, ST)</i>	\$25 copay	\$25 copay	
Cardiac/Pulmonary Rehab	\$0 copay	\$0 copay	
OUTPATIENT MEDICAL AND SUPPLIES			
Durable Medical Equipment/Oxygen <i>*prior auth required</i>	20% coinsurance	20% coinsurance	
Prosthetic Devices and Medical Supplies	20% coinsurance	20% coinsurance	
Diabetes Training and Diabetic Supplies	\$0 copay - training \$15 copay test strips / \$10 copay lancets (30-day supply) \$30 copay test strips / \$30 copay lancets (90-day supply)	\$0 copay - training 20% test strips/lancets (30/90-day supply)	Changed supplies to coinsurance
Diabetic Shoes or Inserts	\$15 copay per pair	20% coinsurance	Changed to coinsurance
Part B Drugs <i>*prior auth required</i>	20% coinsurance all Part B drugs; chemotherapy / self-administered	20% coinsurance all Part B drugs; chemotherapy / self-administered	
Kidney Disease Training and Renal Dialysis (ESRD)	\$0 copay - training 20% coinsurance - dialysis	\$0 copay - training 20% coinsurance - dialysis	
Lab Services	\$0 copay per day	\$0 copay per day	
Diagnostic Procedures/Tests	\$0 copay per day	\$0 copay per day	
X-Ray Services	\$20 copay	\$20 copay	
Diagnostic Radiological Services (Advanced Imaging) <i>*prior auth required</i>	\$75 copay	\$75 copay	
Therapeutic Radiological Services (Radiation)	\$0 copay	\$0 copay	
PREVENTIVE SERVICES			
Immunizations <i>(influenza, pneumonia, Hepatitis B)</i>	\$0 copay	\$0 copay	
Annual Wellness Visit	\$0 copay	\$0 copay	
Screening Exams <i>Includes: Bone Mass Measurement, Colorectal Screening, Mammograms, Pap & Pelvic, Prostate Exams, all Medicare-covered Preventive Services</i>	\$0 copay	\$0 copay	

Benefits	HMO Rx Enhanced		Changes
Contract ID	H3907		
PBP(s)	006		
	2015	2016	
ADDITIONAL SERVICES			
Dental Services			
Medicare-covered Dental Services	\$25 copay	\$25 copay	
Routine Dental Oral Exam & Cleaning (once every 6 months)	\$15 copay	\$15 copay	
Routine Dental Bitewing X-rays (once every year)	\$15 copay	\$15 copay	X-rays were every 3 years
Hearing Services			
Medicare-covered Hearing Services	\$25 copay	\$25 copay	
Routine Hearing Exam (once every year)	\$25 copay	\$25 copay	
Routine Hearing Aid Fitting (once every 3 years)	\$25 copay	\$25 copay	
Routine Hearing Aids (once every 3 years)	\$1,500 allowance	\$1,500 allowance	
Vision Services			
Medicare-covered Vision Services	\$25 copay	\$25 copay	
Medicare-covered Glaucoma Screening and Diabetic Retinal Eye Exam	\$0 copay	\$0 copay	
Medicare-covered Eyewear Cataract Glasses/Lens	\$0 copay	\$0 copay	
Routine Vision Exam & Eyewear (once every year) Allowance must be used for both routine eye exam and eyewear.	\$200 allowance	\$200 allowance	
Other Services			
Health & Wellness Fitness Center Benefit	Silver & Fit	Silver & Fit	
Remote Technologies	N/A	\$5 for eVisits / \$25 for eDerm	New Supplemental Benefit
Worldwide Emergency Coverage	Assist America Travel Benefit	Assist America Travel Benefit	
Part D Prescription Drugs			
Tier 1: Generic Drugs	\$8 copay - 30 day supply (retail) \$24 copay - 90 day supply (retail) \$16 copay - 90 day supply (mail-order)	\$12 copay - 30 day supply (retail) \$36 copay - 90 day supply (retail) \$24 copay - 90 day supply (mail-order)	Increased copayment
Tier 2: Preferred Brand Drugs	\$45 copay - 30 day supply (retail) \$135 copay - 90 day supply (retail) \$112.50 copay - 90 day supply (mail-order)	\$47 copay - 30 day supply (retail) \$141 copay - 90 day supply (retail) \$117.50 copay - 90 day supply (mail-order)	Increased copayment
Tier 3: Non-Preferred Brand Drugs	\$95 copay - 30 day supply (retail) \$285 copay - 90 day supply (retail) \$285 copay - 90 day supply (mail-order)	\$100 copay - 30 day supply (retail) \$300 copay - 90 day supply (retail) \$300 copay - 90 day supply (mail-order)	Increased copayment
Tier 4: Specialty Drugs	33% coinsurance - 30 day supply only	33% coinsurance - 30 day supply only	
Tier 5: Select Care Drugs	\$0 copay - 30 day supply (retail) \$0 copay - 90 day supply (retail) \$0 copay - 90 day supply (mail-order)	\$0 copay - 30 day supply (retail) \$0 copay - 90 day supply (retail) \$0 copay - 90 day supply (mail-order)	
Initial Coverage Limit	\$2,960	\$3,310	CMS Limit Change
Out-of-Pocket Limit (TrOOP)	\$4,700	\$4,850	CMS Limit Change
Gap Coverage	Member pays 65% for generic drugs and 45% plus a dispensing fee for brand-name drugs through the coverage gap	Member pays 58% for generic drugs and 45% plus a dispensing fee for brand-name drugs through the coverage gap	CMS Annual Change
Catastrophic Copays	Greater of: \$2.65 generic/brand treated as generic \$6.60 or 5% all others	Greater of: \$2.95 generic/brand treated as generic \$7.40 or 5% all others	CMS Limit Change