

	UnitedHealthcare Senior Premier PPO		CIGNA Senior Premier PPO		Presbyterian MediCare PPO <sup>‡</sup> (NM)		Lovelace Senior Plan <sup>‡</sup> (NM)	Kaiser Senior Advantage Plan <sup>‡</sup> (CA)
Type of Plan	Preferred Provider Organization – PPO		Preferred Provider Organization – PPO		Medicare Advantage PPO**		Medicare Advantage HMO** – Health Maintenance Organization	Medicare Advantage HMO** – Health Maintenance Organization
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only	In-Network Only
<b>Annual Calendar Year Deductible</b>	Individual: N/A Family: N/A		Individual: N/A Family: N/A		Individual: N/A Family: N/A		Individual: N/A Family: N/A	Individual: None Family: None
<b>Annual Calendar Year Out-of-Pocket Maximum</b>	Individual: \$1,000 per person		Individual: \$1,000 per person				Individual: N/A Family: N/A	Individual: \$1,500 <sup>†</sup> Family: \$3,000 (two or more)
<b>Preventive Care</b>								
Annual Routine Physical	No Charge	20% of U&C	No Charge	20% of U&C	No Copay	\$30 copay	\$5 copay	\$15 copay
Immunizations/Flu Shots*	No Charge	20% of U&C	No Charge	20% of U&C	No Copay	0%	No Copay	No Copay
Certain Cancer Screenings	No Charge	20% of U&C	No Charge	20% of U&C	No Copay	0%	\$0-\$50 copay \$20 copay for each Medicare covered visit	No Copay
Vision Screening	Not Available	Not Available	Not Available	Not Available	\$25 copay (Optometrist only)	\$50 copay (Optometrist only)	\$30 copay routine annual exam \$150 eyewear benefit	\$15 Copay
<b>Outpatient Services</b>								
Office Visit – PCP	20% of negotiated fees	20% of U&C	20% of negotiated fees	20% of U&C	\$10 copay	\$30 copay	\$5 copay	\$15 copay
Office Visit – Specialist	20% of negotiated fees	20% of U&C	20% of negotiated fees	20% of U&C	\$25 copay	\$50 copay	\$20 copay	\$15 copay
Urgent Care	20% of negotiated fees	20% of U&C	20% of negotiated fees	20% of U&C	\$25 copay	\$50 copay	\$20 copay/\$50 copay	\$15 copay per visit
Emergency Room	20% of negotiated fees	20% of U&C	20% of negotiated fees	20% of U&C	\$50 copay (not waived if admitted)	\$50 copay (not waived if admitted)	\$50 per visit (waived if admitted)	\$50 per visit (waived if admitted within 24 hours with same condition)
Outpatient Surgery	20% of negotiated fees	20% of U&C	20% of negotiated fees	20% of U&C	\$75 copay	20% of Medicare allowable	\$50 copay	\$50 copay
Chiropractic/Acupuncture	20% <sup>1</sup> of negotiated fees	20% of U&C	20% <sup>1</sup> of negotiated fees	20% <sup>1</sup> of U&C	\$25 copay**** (acupuncture not covered)	\$50 copay**** (acupuncture not covered)	\$20 chiropractic \$15 acupuncture	\$15 copay per visit
Speech, Physical/Occupational Therapy	20% of negotiated fees	20% of U&C	20% of negotiated fees	20% of U&C	\$10 copay***	\$30 copay (if prior authorization received)	\$10 copay per visit	\$15 copay per visit (max. of 60 consecutive days/condition/lifetime)
<b>Lab/Radiology (Outpatient)</b>	20% of negotiated fees	20% of U&C	20% of negotiated fees	20% of U&C	No copay	10% lab 20% radiation therapy	\$0 lab/general x-ray \$20 radiation therapy \$50 CT/MRI/PET	No copay
<b>Hospital Services</b>								
Inpatient Admit	20% of negotiated fees	20% of U&C	20% of negotiated fees	20% of U&C	\$250 deductible**** (Certification required)	\$750 deductible (if prior authorization received)	\$200 copay	\$250 copay
Ambulance	20% of negotiated fees	20% of U&C	20% of negotiated fees	20% of U&C	\$50 copay (not waived if admitted)	\$50 copay (not waived if admitted)	\$75 copay	\$50 copay
Hospice (Inpatient)	20% of negotiated fees	20% of U&C	20% of negotiated fees	20% of U&C	Covered by Medicare	Covered by Medicare	No copay (in Medicare-certified facility)	No copay
Skilled Nursing Facility	20% of negotiated fees	20% of U&C	20% of negotiated fees	20% of U&C	No copay **/*** 100 days per benefit period (Certification required)	Days 1-20: \$0 copay/day Days 21-100: \$125 copay per day (if prior authorization received)	No copay for up to 100 days per benefit period	No copay for up to 100 days per benefit period
<b>Other Benefits</b>								
Durable Medical Equipment/ External Prosthetic Appliances	20% of negotiated fees	20% of U&C	20% of negotiated fees	20% of U&C	\$10	\$40 for each piece (if prior authorization received)	\$0	No copay
<b>Prescription Drugs</b>								
<b>Retail</b>								
• Generic	20% of retail network price with a \$6 minimum and \$12 max. (up to 30-day supply)	50% retail network price less applicable minimum copay (up to 30-day supply)	20% of retail network price with a \$6 minimum and \$12 max. (up to 30-day supply)	50% retail network price less applicable minimum copay (up to 30-day supply)	\$5 copay <sup>o</sup> (max. of 30 days)	\$5 copay <sup>o</sup> (max. of 30 days)	\$5 copay* (max. of 30 days)	\$10 copay (up to 30-day supply)
• Brand-Name	Preferred—30% of retail network price with a \$25 minimum and \$40 max. (up to 30-day supply)	50% retail network price less applicable minimum copay (up to 30-day supply)	Preferred—30% of retail network price with a \$25 minimum and \$40 max. (up to 30-day supply)	50% retail network price less applicable minimum copay (up to 30-day supply)	\$35 copay <sup>o</sup> (max. of 30 days)	\$35 copay <sup>o</sup> (max. of 30 days)	\$32 copay* (max. of 30 days)	\$20 copay (up to 30-day supply)
	Non Preferred—40% of retail network price with a \$40 minimum and \$60 max. (up to 30-day supply)	50% retail network price less applicable minimum copay (up to 30-day supply)	Non Preferred—40% of retail network price with a \$40 minimum and \$60 max. (up to 30-day supply)	50% retail network price less applicable minimum copay (up to 30-day supply)	\$55 copay <sup>o</sup> (max. of 30 days) 25% specialty drugs (max. of 30 days)	\$55 copay <sup>o</sup> (max. of 30 days)	\$62 copay* (max. of 30 days) Includes specialty drugs	N/A
<b>Mail Order</b>								
• Generic	\$18 copay (up to 90-day supply)	N/A	\$18 copay (up to 90-day supply)	N/A	\$10 copay <sup>o</sup> (max. of 90 days)	\$10 copay <sup>o</sup> (max. of 90 days)	\$15 copay* (max. of 90 days)	\$20 copay (up to 100-day supply)
• Brand-Name	Preferred—\$65 copay (up to 90-day supply)	N/A	Preferred—\$65 copay (up to 90-day supply)	N/A	Preferred—\$87.50 copay <sup>o</sup> (max. of 90 days)	Preferred—\$87.50 copay <sup>o</sup> (max. of 90 days)	\$96 copay* (max. of 90 days)	\$40 copay (up to 100-day supply)
	Non Preferred—\$100 copay (up to 90-day supply)	N/A	Non Preferred—\$100 copay (up to 90-day supply)	N/A	Non Preferred—\$165 copay <sup>o</sup> (max. of 90 days)	Non Preferred—\$165 copay <sup>o</sup> (max. of 90 days)	\$186 copay* (max. of 90 days)	N/A
<b>Behavioral Health</b>								
<b>Mental Health</b>								
• Inpatient	20% of negotiated fees (max. of 90 days/CY) <sup>2</sup>	50% of U&C <sup>2</sup> (max. of 90 days/CY)	20% of negotiated fees <sup>2</sup> (max. of 90 days/CY)	50% of U&C <sup>2</sup> (max. of 90 days/CY)	\$250 deductible**** (190-day lifetime limit (Certification required))	\$750 deductible (if prior authorization received) 190-day lifetime limit	\$200 copay (max. of 190 days/ lifetime)	\$250 copay (max. of 45 days/ CY)
• Outpatient	20% (unlimited visits)	50% of U&C (unlimited visits)	20% of negotiated fees (unlimited visits)	50% of U&C (unlimited visits)	\$25 copay	50% of Medicare allowable	\$20 copay/individual therapy \$15 copay/group visit	\$15 copay (20 ind./group therapy visits/CY with 20 additional group therapy visits if criteria met)
<b>Substance Abuse</b>								
• Inpatient	20% of negotiated fees <sup>2</sup> (max. of 90 days/CY)	50% of U&C <sup>2</sup> (max. of 90 days/CY)	20% of negotiated fees <sup>2</sup> (max. of 90 days/CY)	50% of U&C <sup>2</sup> (max. of 90 days/CY)	See "Mental Health" above	See "Mental Health" above	\$200 copay	\$250 copay per admission Transitional Residential Recovery Services \$100 copay/ stay
• Outpatient	20% of negotiated fees (unlimited visits)	50% of U&C (unlimited visits)	20% of negotiated fees (unlimited visits)	50% of U&C (unlimited visits)	\$25 copay for individual or group therapy	50% of Medicare allowable	\$20 copay/individual visit \$15 copay/group visit	\$15 copay (unlimited visits)

## NOTES

The following services (to be provided as determined by consultation between the attending physician and the patient) are covered for members who receive benefits in connection with a mastectomy and who elect breast reconstruction:

- Reconstruction of the breast on which the mastectomy was performed,

- Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- Prosthesis and physical complications in all stages of mastectomy, including lymphedema.

This coverage is subject to the

same deductible, copay, and coinsurance provisions that apply to other benefits under the applicable Plan. There are no limitations on the number of prostheses and no time limitations from the date of the mastectomy.

<sup>1</sup>Member is responsible for tracking annual out-of-pocket costs through accumulation of Kaiser receipts (excludes prescription copays).

<sup>‡</sup> Pending CMS approval.  
<sup>\*</sup> Does not apply to out-patient drugs  
<sup>\*\*</sup> Requires assignment of Medicare benefits.  
<sup>1</sup> Combined maximum of \$1500/ calendar year for in-network and Out-Of-Network charges for Chiropractic and Acupuncture care.  
<sup>2</sup> Combined maximum of 90 days/ calendar year for In-network and Out-of-network charges for Inpatient

Mental Health and Inpatient Substance Abuse.  
<sup>o</sup> Copays until you reach \$4,050 in out-of-pocket costs. After your yearly out-of-pocket drug costs reach \$4,050, you pay the greater of:  
 \$2.25 for generic or preferred brand drug treated as generic.  
 All other drugs with prior authorization \$5.60 or 5%

coinsurance, whichever is greater.  
<sup>\*\*</sup> Benefit period begins 1<sup>st</sup> day of hospitalization or skilled nursing facility confinement; new benefit period begins with 60 day lapse between confinements.  
<sup>\*\*\*</sup> Prior authorization required for in-network services. If you do not receive prior authorization for out-of-network services, your out-of-pocket cost sharing could be higher.

<sup>\*\*\*\*</sup> Manual manipulation of the spine to correct subluxation only.  
<sup>o</sup> Copays until you reach \$3,600 for the year, and then you pay the greater of: \$2 formulary generic or formulary brand, and \$5 for all other drugs, or 5% coinsurance  
<sup>◇</sup> Deductible per benefit period. Benefit period begins the day you are admitted to a hospital or skilled nursing facility and ends when you

have not received hospital or skilled nursing care for 60 days in a row. This information is a condensed summary and does not replace or modify the Summary Plan Description (SPD) or Evidence of Coverage/Member Handbook (EOC) for the plans. If there is any discrepancy in the information on this grid, the SPD or the EOC, the SPD or EOC supercedes.



	UnitedHealthcare Premier PPO		CIGNA Premier PPO		UnitedHealthcare High Deductible Health Plan (Health Savings Account Compatible Plan)		CIGNA In-Network Plan	Kaiser (CA) HMO
Type of Plan	Preferred Provider Organization – PPO		Preferred Provider Organization – PPO		Preferred Provider Organization – PPO		Exclusive Provider Organization (EPO) (An HMO “Look - Alike”)	Health Maintenance Organization – HMO
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	In-Network Only
<b>Annual Calendar Year Deductible</b>	Individual: \$250 Family: \$750	Individual: \$750 Family: \$2,250	Individual: \$250 Family: \$750	Individual: \$750 Family: \$2,250	Individual: \$1,200 Family: \$2,400 Aggregate	Individual: \$2,000 Family: \$4,000 Aggregate	Individual: None Family: None	Individual: None Family: None
<b>Annual Calendar Year Out-of-Pocket Maximum</b>	Individual: \$1,750 Family: \$3,500	Individual: \$3,500 Family: \$7,000	Individual: \$1,750 Family: \$3,500	Individual: \$3,500 Family: \$7,000	Individual: \$2,500 Family: \$5,000 Aggregate	Individual: \$5,000 Family: \$10,000 Aggregate	Individual: \$1,500 Family: \$3,000	Individual: \$1,500* Family: \$3,000 (two or more)
<b>Preventive Care</b>								
Annual Routine Physical	No Charge	30%* of U&C	No Charge	30%* of U&C	No Charge	30%* of U&C	No Copay	\$15 copay
Immunizations/Flu Shots**	No Charge	30%* of U&C	No Charge	30%* of U&C	No Charge	30%* of U&C	No Copay	No Copay
Certain Cancer Screenings	No Charge	30%* of U&C	No Charge	30%* of U&C	No Charge	30%* of U&C	No Copay	No Copay
<b>Outpatient Services</b>								
Office Visit – PCP	\$15 copay*	30%* of U&C	\$15 copay*	30%* of U&C	20%* of negotiated fees	30%* of U&C	\$15 copay	\$15 copay
Office Visit – Specialist	\$25 copay*	30%* of U&C	\$25 copay*	30%* of U&C	20%* of negotiated fees	30%* of U&C	\$25 copay	\$15 copay
Urgent Care	15%* of negotiated fees	30%* of U&C	15%* of negotiated fees	30%* of U&C	20%* of negotiated fees	30%* of U&C	\$40 copay per visit	\$15 copay per visit
Emergency Room	15%* of negotiated fees	30%* of U&C	15%* of negotiated fees	30%* of U&C	20%* of negotiated fees	30%* of U&C	\$100 per visit	\$100 per visit
Outpatient Surgery	15%* of negotiated fees	30%* of U&C	15%* of negotiated fees	30%* of U&C	20%* of negotiated fees	30%* of U&C	\$100 copay	\$50 copay per procedure
Allergy Treatment								
• Testing	\$25 copay	30%* of U&C	\$25 copay	30%* of U&C	20%* of negotiated fees	30%* of U&C	\$25 copay	\$15 copay
• Serum	15%* of negotiated fees	30%* of U&C	15%* of negotiated fees	30%* of U&C	20%* of negotiated fees	30%* of U&C	No copay	No copay
• Shot Only	15%* of negotiated fees	30%* of U&C	15%* of negotiated fees <sup>1</sup>	30%* of U&C	20%* of negotiated fees	30%* of U&C	\$10 copay	\$5 copay
Chiropractic/Acupuncture	15%* of negotiated fees <sup>1</sup>	30%* of U&C <sup>1</sup>	15%* of negotiated fees <sup>1</sup>	30%* of U&C <sup>1</sup>	20%* of negotiated fees <sup>2</sup>	30%* of U&C <sup>2</sup>	\$15 copay per visit <sup>3</sup>	\$15 copay per visit <sup>7</sup>
Speech, Physical/ Occupational Therapy	15%* of negotiated fees	30%* of U&C	15%* of negotiated fees	30%* of U&C	20%* of negotiated fees	30%* of U&C	\$15 copay per visit <sup>3</sup>	\$15 copay per visit (max. of 60 consecutive days/condition/lifetime)
<b>Lab/Radiology (Outpatient)</b>	15%* of negotiated fees	30%* of U&C	15%* of negotiated fees	30%* of U&C	20%* of negotiated fees	30%* of U&C	No copay	No copay
<b>Hospital Services</b>								
Inpatient Admit	15%* of negotiated fees	30%* of U&C	15%* of negotiated fees	30%* of U&C	20%* of negotiated fees	30%* of U&C	\$200 per day up to \$500	\$250 per admission
Ambulance	15%* of negotiated fees	30%* of U&C	15%* of negotiated fees	30%* of U&C	20%* of negotiated fees	30%* of U&C	\$50 copay	\$75 copay
Hospice (Inpatient)	15%* of negotiated fees	30%* of U&C	15%* of negotiated fees	30%* of U&C	20%* of negotiated fees	30%* of U&C	No copay	No copay
Skilled Nursing Facility	15%* of negotiated fees	30%* of U&C	15%* of negotiated fees	30%* of U&C	20%* of negotiated fees	30%* of U&C	No copay Limit of 60 days/CY	No copay**
<b>Other Benefits</b>								
Durable Medical Equipment/External Prosthetic Appliances	15%* of negotiated fees Pre-authorization required for over \$1000 purchased or cumulative rental value	30%* of U&C Pre-authorization required for over \$1000 purchased or cumulative rental value	15%* of negotiated fees Pre-authorization required for over \$1000 purchased or cumulative rental value	30%* of U&C Pre-authorization required for over \$1000 purchased or cumulative rental value	20%* of negotiated fees Pre-authorization required for over \$1000 purchased or cumulative rental value	30%* of U&C Pre-authorization required for over \$1000 purchased or cumulative rental value	No copay <sup>8</sup> EPA - \$200 deductible, then no charge	No copay
<b>Prescription Drugs</b>								
Retail								
• Generic	20% of retail network price with a \$6 minimum and \$12 max. (up to 30-day supply)	50% retail network price less applicable minimum copay (up to 30-day supply)	20% of retail network price with a \$6 minimum and \$12 max. (up to 30-day supply)	50% retail network price less applicable minimum copay (up to 30-day supply)	20%* of negotiated fees	30%* of U&C	\$10 copay (up to 30-day supply)	\$10 copay (up to 30-day supply)
• Brand-Name	Preferred—30% of retail network price with a \$25 minimum and \$40 max. (up to 30-day supply)	50% retail network price less applicable minimum copay (up to 30-day supply)	Preferred—30% of retail network price with a \$25 minimum and \$40 max. (up to 30-day supply)	50% retail network price less applicable minimum copay (up to 30-day supply)	20%* of negotiated fees	30%* of U&C	\$30 copay (up to 30-day supply)	\$25 copay (up to 30-day supply)
Mail Order	Non Preferred—40% of retail network price with a \$40 minimum and \$60 max. (up to 30-day supply)	50% retail network price less applicable minimum copay (up to 30-day supply)	Non Preferred—40% of retail network price with a \$40 minimum and \$60 max. (up to 30-day supply)	50% retail network price less applicable minimum copay (up to 30-day supply)	20%* of negotiated fees	30%* of U&C	N/A	N/A
• Generic	\$18 copay (up to 90-day supply)	N/A	\$18 copay (up to 90-day supply)	N/A	20%* of negotiated fees	30%* of U&C	\$20 copay (up to 90-day supply)	\$20 copay (up to 100-day supply)
• Brand-Name	Preferred—\$65 copay (up to 90-day supply) Non Preferred—\$100 copay (up to 90-day supply)	N/A	Preferred—\$65 copay (up to 90-day supply) Non Preferred—\$100 copay (up to 90-day supply)	N/A	20%* of negotiated fees 20%* of negotiated fees	30%* of U&C 30%* of U&C	\$60 copay (up to 90-day supply) N/A	\$50 copay (up to 100-day supply) N/A
<b>Behavioral Health</b>								
Mental Health								
• Inpatient	15%* of negotiated fees <sup>4</sup> (max. of 90 days/CY)	50%* of U&C <sup>4</sup> (max. of 90 days/CY)	15%* of negotiated fees <sup>4</sup> (max. of 90 days/CY)	50%* of U&C <sup>4</sup> (max. of 90 days/CY)	20%* of negotiated fees <sup>5</sup> (max. of 60 days/CY)	50%* of U&C <sup>5</sup> (max. of 60 days/CY)	\$200 per day up to \$500 (max. of 45 days/CY)	\$250 copay (max. of 45 days/CY)
• Outpatient	15%* of negotiated fees (unlimited visits)	50%* of U&C (unlimited visits)	15%* of negotiated fees (unlimited visits)	50%* of U&C (unlimited visits)	20%* of negotiated fees <sup>6</sup> (max. of 20 visits/CY)	50%* of U&C <sup>6</sup> (max. of 20 visits/CY)	\$25 copay (max. of 30 visits/CY)	\$15 copay (20 ind./group therapy visits/CY with 20 additional group therapy visits if criteria met)
Substance Abuse								
• Inpatient	15%* of negotiated fees <sup>4</sup> (max. of 90 days/CY)	50%* of U&C <sup>4</sup> (max. of 90 days/CY)	15%* of negotiated fees <sup>4</sup> (max. of 90 days/CY)	50%* of U&C <sup>4</sup> (max. of 90 days/CY)	20%* of negotiated fees <sup>5</sup> (max. of 60 days/CY)	50%* of U&C <sup>5</sup> (max. of 60 days/CY)	\$200 per day up to \$500 (max. of 15 days/CY)	\$250 copay Transitional Residential Recovery Services \$100 copay/stay
• Outpatient	15%* of negotiated fees (unlimited visits)	50%* of U&C (unlimited visits)	15%* of negotiated fees (unlimited visits)	50%* of U&C (unlimited visits)	20%* of negotiated fees <sup>6</sup> (max. of 20 visits/CY)	50%* of U&C <sup>6</sup> (max. of 20 visits/CY)	\$25 copay (max. of 30 visits/CY)	\$15 copay (unlimited visits)

**NOTES**

The following services (to be provided as determined by consultation between the attending physician and the patient) are covered for members who receive benefits in connection with a mastectomy and who elect breast reconstruction:

- Reconstruction of the breast on which the mastectomy was performed,
- Surgery and

reconstruction of the other breast to produce a symmetrical appearance, and  
– Prosthesis and physical complications in all stages of mastectomy, including lymphedema.

This coverage is subject to the same deductible, copay, and coinsurance provisions that apply to other benefits under the applicable Plan. There are

no limitations on the number of prostheses and no time limitations from the date of the mastectomy.  
\* Subject to deductible.

\*\*Does not apply to out-patient drugs

† Member is responsible for tracking annual out-of-pocket costs through accumulation of Kaiser receipts (excludes prescription copays).

- Lab, radiology, supplies, diagnostic tests and injections,

other than immunizations, performed in a physician's office will result in a 15% coinsurance.  
\*\*Benefit period begins 1<sup>st</sup> day of hospitalization or skilled nursing facility confinement; new benefit period begins with 60-day lapse between confinements.  
<sup>1</sup> Combined maximum of \$1500/ calendar year for In-network and Out-of-network charges for Chiropractic and Acupuncture care.

<sup>2</sup> Combined maximum of 10 visits/ calendar year for In-network and Out-of-network charges for Chiropractic and Acupuncture care.

<sup>3</sup> Combined maximum of 60 visits/ calendar year for In-network and Out-of-network charges for Chiropractic, Acupuncture, Speech Therapy, Physical Therapy, and Occupational Therapy.

<sup>4</sup> Combined maximum of 90 days/ calendar year for In-network and Out-of-network charges for Inpatient Mental Health and Inpatient Substance Abuse.  
<sup>5</sup> Combined maximum of 60 days/ calendar year for In-network and Out-of-network charges for Inpatient Mental Health and Inpatient Substance Abuse.

<sup>6</sup> Combined maximum of 20 visits/ calendar year for In-network and Out-of-network charges for Outpatient Mental Health and

Outpatient Substance Abuse.  
<sup>7</sup> Chiropractic care with a maximum of 30 visits/calendar year. Acupuncture allowed with referral for Medical Management of Chronic Pain only.

<sup>8</sup> \$200 annual deductibles for external prosthetic appliances. Benefit is unlimited.

This information is a condensed summary and does not replace or modify the Summary Plan Description (SPD) for the plans. If there is any discrepancy in the information on this grid and in the SPD, the SPD supercedes.

Last Updated: 10/31/2007