Los Alamos National Laboratory

Retiree Medical Benefits Summary
With or Without Medicare

- Dollars and percentages reflect the member's payment responsibility
- Always refer to your Summary Plan Description for any limitations or exclusions

Plan Facts	Select EPO	Options PPO NM (In-Network)	Options PPO NM (Out -of-Network)	Options PPO National (In-Network)
Availability	**Living in UHC service areas in NM, NV, or Washington D.C. (Tri-State Area)**	**Living in UHC New Mexico PPO Service Area**	**Living in UHC New Mexico PPO Service Area**	**Living in UHC New Mexico PPO Service Area outside New Mexico**
Costs				
Calendar year deductible: Individual	$150	$250	$500	$250
Calendar year deductible: Family	$450	$750	$1,500	$750
Annual Out-of-pocket maximum: Individual	$2,000	$3,000	$6,000	$3,000
Annual Out-of-pocket maximum: Family	$6,000	$9,000	$18,000	$9,000
Lifetime Maximum	None	None	$2,000,000	None
Hospital Services				
Inpatient	10%	**10%	40% + $250 copayment	10%
Surgeon/Assistant Surgeon	10%	10%	40%	10%
Emergency Room	*10% emergency, Non-emergency not covered	*10% emergency, 40% Non-emergency	*10% emergency, 40% Non-emergency	*10% emergency, 40% Non-emergency
Ambulance	*10% emergency, Non-emergency not covered	*10% emergency, 40% Non-emergency	*10% emergency, 40% Non-emergency	*10% emergency, 40% Non-emergency
Physician Visits				
Office Visit	$20	$20 (no charge up through age 2)	40%	$20 (no charge up through age 2)
Hospital Visit	None	None	40%	None
Preventive Physical Exam	$20 (no charge up through age 2)	$20 (no charge ages 2 through 5)	40% ages 2 through 18; no deductible	$20 (no charge ages 2 through 5)
Maternity Outpatient Care	No charge ($20 for first visit to diagnose pregnancy)	No charge ($20 for first visit to diagnose pregnancy)	40%	No charge ($20 for first visit to diagnose pregnancy)
Maternity Inpatient Care	None	No charge ($20 for first visit to diagnose pregnancy)	40%	No charge ($20 for first visit to diagnose pregnancy)
Well Baby Care	No charge through age 2	No charge through age 2	40% through age 2; no deductible	No charge through age 2
Alternative Care				
Hospice (Inpatient)	10%; no deductible	**10%; no deductible	**40%; no deductible (maximum $7,400 per lifetime)	**10%; no deductible (maximum $7,400 per lifetime)
Home Health Care	10%; no deductible; Notification required	10%; no deductible; Notification required	40% (100 visits per calendar year); no deductible. Notification required	10%; no deductible; Notification required
Skilled Nursing Facility	10% (100 day per calendar year); no deductible	**10% (70 days per calendar year); no deductible	**40% (70 days per calendar year); no deductible	**10% (100 days per calendar year); no deductible
Other Benefits				
Outpatient X-ray and Lab work	10%	10%	40%	10%
Eye Exams	$20 if medically necessary. Routine exams not covered.	$20 if medically necessary. Routine exams not covered.	40% if medically necessary. Routine exams not covered.	$20 if medically necessary. Routine exams not covered.
Chiropractor	$20 (20 visits per calendar year)	$20 (20 visits per calendar year)	40% (20 visits per calendar year)	$20 (20 visits per calendar year)
Acupuncture: some services require pre-notification. Refer to SPD	$20 (20 visits per calendar year)	$20 (20 visits per calendar year)	40% (20 visits per calendar year)	$20 (20 visits per calendar year)
Prescription Drugs				
Retail	1 copayment for up to a 31-day supply ($15, $30, or $45)	1 copayment for up to a 31-day supply ($15, $30, or $45)	1 copayment for up to a 31-day supply ($15, $30, or $45)	1 copayment for up to a 31-day supply ($15, $30, or $45)
Mail Order	1 copayment for up to a 31-day supply; 2 copayments for a 32 to 90-day supply ($30, $60, or $90)	1 copayment for up to a 31-day supply; 2 copayments for a 32 to 90-day supply ($30, $60, or $90)	1 copayment for up to a 31-day supply; 2 copayments for a 32 to 90-day supply ($30, $60, or $90)	1 copayment for up to a 31-day supply; 2 copayments for a 32 to 90-day supply ($30, $60, or $90)
Behavioral Health				
Mental Health Inpatient	No copayment	No copayment	Not Covered	10% ($250 calendar year deductible for all inpatient and outpatient services.
Mental Health Outpatient	$15 per visit copayment	$15 per visit copayment	Not Covered	10% ($250 calendar year deductible for all inpatient and outpatient services.
Substance Abuse Inpatient: Detox	20% of authorized charges; no deductible	20% of authorized charges; no deductible	Not Covered	20% of authorized charges; no deductible
Substance Abuse Inpatient: Rehab	20% of authorized charges (50% for non-compliance) $250 calendar year deductible	20% of authorized charges (50% for non-compliance) $250 calendar year deductible	Not Covered	20% of authorized charges (50% for non-compliance) $250 calendar year deductible
Substance Abuse Outpatient	20% of authorized charges; no deductible	20% of authorized charges. Calendar year benefit maximum per person: $3,500	Not Covered	20% of authorized charges Calendar year benefit maximum per person: $3,500

How benefits are coordinated with Medicare:

1. Calculate what would have been paid if no other insurance was involved.
2. Subtract from this calculation the amount Medicare paid. The plan will pay the lesser of this amount or the patient responsibility remaining after Medicare's payment.

*Add a $75 copayment, waived if admitted to the hospital

**$300 Penalty if services not preauthorized

Definitions

Copayments: Shown in dollars, represents the amount you pay.

Coinsurance: Percentage of eligible expense or allowable costs for which you are responsible. Refer to the appropriate Summary Plan Description (SPD)

Calendar Year Deductible: The amount you must pay for medical services before the plan will provide benefits.

Annual Out-of-Pocket Maximum: The amount you must pay during the calendar year before the plan will pay 100% of covered charges.

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Plan Facts	Options PPO National (Out-of-Network)	Options PPO (Out-of-Area)	Core-New Mexico	Core-New Mexico with Medicare
Availability	**Living in UHC PPO service area outside of New Mexico**	**Living in UHC PPO service area or living abroad**	**Provides Worldwide Coverage**	**Provides Worldwide Coverage**
Costs				
Calendar year deductible: Individual	$500	$250	$3,000	$200
Calendar year deductible: Family	$1,500	$750	per individual	per individual
Annual Out-of-pocket maximum: Individual	$6,000	$3,000	$7,600	$1,260 medical; $1,000 pharmacy (tier 1 & 2 only)
Annual Out-of-pocket maximum: Family	$18,000	$9,000	per individual	per individual
Lifetime Maximum	$2,000,000	$2,000,000	$2,000,000	$2,000,000
Hospital Services				
Inpatient	**40% + $250 copayment	**10% + $250 copayment	20% ($500 penalty if services are not preauthorized)	20%
Surgeon/Assistant Surgeon	40%	10%	20%	20%
Emergency Room	*10% emergency; 40% Non-emergency	*10% emergency; Non-emergency not covered	20%	20%
Ambulance	10% emergency; 40% Non-emergency	10% emergency; Non-emergency not covered	20% emergency; non-emergency not covered	20% emergency; Non-emergency not covered
Physician Visits				
Office Visit	40%	10%	20%	20%
Hospital Visit	40%	10%	20%	20%
Preventive Physical Exam	40% ages 2 through 18 -no deductible; not covered age 19 and over	10%; no deductible ages 2 through 18	20%	20%
Maternity Outpatient Care	40%	10%	20%	20%
Maternity Inpatient Care	40%	10%	20%	20%
Well Baby Care	40% through age 2; no deductible	10% through age 2; no deductible	20%	20%
Alternative Care				
Hospice	**40%; no deductible (Lifetime Maximum combined in-and out-of network $7,400)	**10%; no deductible (Lifetime Maximum combined in & out of network $7,400)	20% (Lifetime Maximums: Inpatient 30 days/Outpatient $5,000)	20% (Lifetime Maximums: Inpatient 30 days/Outpatient $5,000)
Home Health Care	40% (100 visits/calendar year); no deductible	**10% (100 visits per calendar year); no deductible	20% (100 visits per calendar year)	20% (100 visits per calendar year)
Skilled Nursing Facility	**40% (70 days/calendar year); no deductible	**10% (70 days per calendar year); no deductible	20% (120 days per calendar year)	20% (120 days per calendar year)
Other Benefits				
Outpatient X-ray and Lab work	40%	10%	20%	20%
Eye Exams	40% if medically necessary Routine exams not covered.	10% if medically necessary Routine exams not covered.	20% if medically necessary	20% if medically necessary
Chiropractor	40% (20 visits per calendar year, combined in-and out-of network)	10% (20 visits per calendar year)	20%	20%
Acupuncture	40% (20 visits per calendar year, combined in-and out-of network)	10% (20 visits per calendar year)	20% ($500 maximum per calendar year)	20% ($500 maximum per calendar year)
Prescription Drugs				
Retail	1 copayment for up to a 31-day supply ($15, $30, or $45)	1 copayment for up to a 31-day supply ($15, $30, or $45)	20%	1 copayment for up to a 31-day supply ($15, $30, or $45)
Mail Order	1 copayment for up to a 31-day supply; 2 copayments for a 32 to 90-day supply ($30, $60, or $90)	1 copayment for up to a 31-day supply; 2 copayments for a 32 to 90-day supply ($30, $60, or $90)	No mail order benefit	1 copayment for up to a 31-day supply; 2 copayments for a 32 to 90-day supply ($30, $60, or $90)
Behavioral Health				
Mental Health Inpatient	Not Covered	10% ($250 calendar year deductible for all inpatient & outpatient services)	Not Covered	Not Covered
Mental Health Outpatient	Not Covered	10% ($250 calendar year deductible for all inpatient & outpatient services)	Not Covered	Not Covered
Substance Abuse Inpatient: Detox	Not Covered	20% of authorized charges; no deductible	Not Covered	Not Covered
Substance Abuse Inpatient: Rehab	Not Covered	20% of authorized charges (50% for non-compliance) $250 calendar year deductible	Not Covered	Not Covered
Substance Abuse Outpatient	Not Covered	20% of authorized charges. Calendar year benefit maximum per person: $3,500	Not Covered	Not Covered

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