## National Laboratory National Laboratory 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%
<u> </u>	*10% emergency,	*10% emergency,	*10% emergency,	*10% emergency,
Emergency Room	Non-emergency not covered	40% Non-emergency	40% Non-emergency	40% Non-emergency
	*10% emergency,	*10% emergency,	*10% emergency,	*10% emergency,
Ambulance	Non-emergency not covered	40% Non-emergency	40% Non-emergency	40% Non-emergency
Physician Visits	Non emergency not covered	TO 70 NOTE CHIEF GETTCY	40 /0 Non emergency	40 /0 Non emergency
Office Visit	\$20	\$20 (no charge up through age 2)	40%	\$20 (no charge up through age 2)
Hospital Visit	None	None	40%	None
Hospital visit	ivone	ivolle	40% 40% 40% 40% ages 2 through 18;	ivoile
Preventive Physical Exam	¢20 (no chargo un through age 3)	#20 (no charge acce 2 through 5)		#30 (no charge ages 3 through 5)
Preventive Physical Exam	\$20 (no charge up through age 2)	\$20 (no charge ages 2 through 5)	no deductible	\$20 (no charge ages 2 through 5)
	No charge (\$20 for first visit to	No charge (\$20 for first visit to		No charge (\$20 for first visit to
Maternity Outpatient Care	diagnose pregnancy)	diagnose pregnancy)	40%	diagnose pregnancy)
		No charge (\$20 for first visit to		No charge (\$20 for first visit to
Maternity Inpatient Care	None	diagnose pregnancy)	40%	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				
			**40%; no deductible	**10%; no deductible
Hospice (Inpatient)	10%; no deductible	**10%; no deductible	(maximum \$7,400 per lifetime)	(maximum \$7,400 per lifetime)
, , ,	10%; no deductible;	10%; no deductible;	40% (100 visits per calendar year);	10%; no deductible;
Home Health Care	Notification required	Notification required	no deductible. Notification required	Notification required
	10% (100 day per calendar year);	**10% (70 days per calendar year);	**40% (70 days per calendar year);	**10% (100 days per calendar year);
Skilled Nursing Facility	no deductible	no deductible	no deductible	no deductible
Other Benefits	110 deddeti510			iio acaaciisic
Outpatient X-ray and Lab work	10%	10%	40%	10%
outputient X Tay and Eab Work	\$20 if medically necessary.	\$20 if medically necessary.	40% if medically necessary.	\$20 if medically necessary.
Eye Exams	Routine exams not covered.	Routine exams not covered.	Routine exams not covered.	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-	\$20 (20 visits per calendar year)	\$20 (20 visits per calendar year)	40% (20 visits per calendar year)	\$20 (20 Visits per calendar year)
·	t20 (20 visits nor calendar vess)	#20 (20 visits non colondar vess)	400/ (20 visits non colondar vess)	#20 (20 visits nor calendar vess)
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	1 copayment for up to a 31-day supply	1 consument for up to 2.21 day cumply	1 copayment for up to a 31-day supply	1 copayment for up to a 31-day supply
Retail	(\$15, \$30, or \$45)	1 copayment for up to a 31-day supply (\$15, \$30, or \$45)	(\$15, \$30, or \$45)	(\$15, \$30, or \$45)
Retail	(\$15, \$50, 01 \$45)	(\$13, \$30, 01 \$43)	(\$13, \$30, 01 \$43)	(\$13, \$30, 01 \$43)
	1 copayment for up to a 31-day supply;	1 copayment for up to a 31-day supply;	1 copayment for up to a 31-day supply;	1 copayment for up to a 31-day supply;
	2 copayments for a 32 to 90-day supply	2 copayments for a 32 to 90-day supply	2 copayments for a 32 to 90-day supply	2 copayments for a 32 to 90-day supply
Mail Order	(\$30, \$60, or \$90)	(\$30, \$60, or \$90)	(\$30, \$60, or \$90)	(\$30, \$60, or \$90)
Behavioral Health	(455) 455)	(400) 400) 0. 450)	(430) 400)	(430) 400)
				10% (\$250 calendar year deductible for
Mental Health Inpatient	No copayment	No copayment	Not Covered	all inpatient and outpatient services.
Mental Health Inpatient	по сораутнеть	по сорауттеле	Not covered	an impatient and outpatient services.
				100/ (#350 salandar vaar dadustible fo
Montal Hoalth Outpations	t1E nonviolt	#1E non viole	Not Coursed	10% (\$250 calendar year deductible for
Mental Health Outpatient	\$15 per visit copayment	\$15 per visit copayment	Not Covered	all inpatient and outpatient services.
	20% of authorized charges;	20% of authorized charges;		20% of authorized charges;
Substance Abuse Inpatient: Detox	no deductible	no deductible	Not Covered	no deductible
	20% of authorized charges	20% of authorized charges		20% of authorized charges
	(50% for non-compliance)	(50% for non-compliance)		(50% for non-compliance)
Substance Abuse Inpatient: Rehab	\$250 calendar year deductible	\$250 calendar year deductible	Not Covered	\$250 calendar year deductible
		2004 6 11 1 1		20% of authorized charges
		20% of authorized charges.		20% of authorized charges
	20% of authorized charges;	20% of authorized charges. Calendar year benefit maximum per		Calendar year benefit maximum per

<sup>\*</sup>Add a \$75 copayment, waived if admitted to the hospital

**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.

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.

<sup>\*\*\$300</sup> Penalty if services not preauthorized

## Los Alamos Retiree Medical Benefits Summary National Laboratory 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	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
				\$1,260 medical;
Annual Out-of-pocket maximum: Individual	\$6,000	\$3,000	\$7,600	\$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				
	*** 400/	**100( . +250	20% (\$500 penalty if services are not	2004
Inpatient Common (Assistant Common Co	**40% + \$250 copayment	**10% + \$250 copayment	preauthorized)	20%
Surgeon/Assistant Surgeon	40%	10%	20%	20%
	*10% emergency;	*10% emergency;	2004	2004
Emergency Room	40% Non-emergency	Non-emergency not covered	20%	20%
	10% emergency;	10% emergency;	20% emergency;	20% emergency;
Ambulance	40% Non-emergency	Non-emergency not covered	non-emergency not covered	Non-emergency not covered
Physician Visits	100/	100/	2004	2004
Office Visit	40%	10%	20%	20%
Hospital Visit	40%	10%	20%	20%
	40% ages 2 through 18 -no deductible;	10%;		
Preventive Physical Exam	not covered age 19 and over	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				
	**40%; no deductible	**10%; no deductible (Lifetime		
	(Lifetime Maximum combined in-and out-	Maximum combined in & out of network	20% (Lifetime Maximums: Inpatient 30	20% (Lifetime Maximums: Inpatient 30
Hospice	of network \$7,400)	\$7,400)	days/Outpatient \$5,000)	days/Outpatient \$5,000)
	40% (100 visits/calendar year);	**10% (100 visits per calendar year);		
Home Health Care	no deductible	no deductible	20% (100 visits per calendar year)	20% (100 visits per calendar year)
	**40% (70 days/calendar year);	**10% (70 days per calendar year);		
Skilled Nursing Facility	no deductible	no deductible	20% (120 days per calendar year)	20% (120 days per calendar year)
Other Benefits	100/	1001	2004	9.004
Outpatient X-ray and Lab work	40%	10%	20%	20%
	40% if medically necessary	10% if medically necessary		000/16 11 11
Eye Exams	Routine exams not covered.	Routine exams not covered.	20% if medically necessary	20% if medically necessary
	40% (20 visits per calendar year,	100/ (20 : ::	2004	2007
Chiropractor	combined in-and out-of network)	10% (20 visits per calendar year)	20%	20%
	40% (20 visits per calendar year,	4004 400 1 11		
Acupuncture	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	1 comprome the force to the control of the complete	1 comprime out for run to a 21 days grounds		1 comprises the form we to a 21 day comply
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)
Retail	1 copayment for up to a 31-day supply;	1 copayment for up to a 31-day supply;	20 70	1 copayment for up to a 31-day supply;
	2 copayments for a 32 to 90-day supply	2 copayments for a 32 to 90-day supply		2 copayments for a 32 to 90-day supply
Mail Order	(\$30, \$60, or \$90)	(\$30, \$60, or \$90)	No mail order benefit	(\$30, \$60, or \$90)
Behavioral Health				
		10% (\$250 calendar year deductible for		
Mental Health Inpatient	Not Covered	all inpatient & outpatient services)	Not Covered	Not Covered
		10% (\$250 calendar year deductible for		
Mental Health Outpatient	Not Covered	all inpatient & outpatient services)	Not Covered	Not Covered
		20% of authorized charges;		
Substance Abuse Inpatient: Detox	Not Covered	no deductible	Not Covered	Not Covered
		20% of authorized charges		
		(50% for non-compliance)		
Substance Abuse Inpatient: Rehab	Not Covered	\$250 calendar year deductible	Not Covered	Not Covered
		20% of authorized chardes.		
		20% of authorized charges. Calendar year benefit maximum per		

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