## Specialty visits require a Primary Care Physician referral except for OB-GYN

<table>
<thead>
<tr>
<th>Specialty visits</th>
<th>HMO Primary Choice Platinum 750</th>
<th>HMO Primary Choice Gold 2300</th>
<th>HMO Primary Choice Silver 3900</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DEDUCTIBLE</strong></td>
<td>IN-NETWORK</td>
<td>IN-NETWORK</td>
<td>IN-NETWORK</td>
</tr>
<tr>
<td>Individual/family</td>
<td>$750/$1,500</td>
<td>$2,300/$4,600</td>
<td>$3,900/$7,800</td>
</tr>
<tr>
<td><strong>COINSURANCE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Member</td>
<td>0%</td>
<td>20%</td>
<td>30%</td>
</tr>
<tr>
<td><strong>OUT-OF-POCKET LIMIT</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual/family</td>
<td>$2,000/$4,000</td>
<td>$6,000/$12,000</td>
<td>$8,150/$16,300</td>
</tr>
</tbody>
</table>

### Preventive Care

Periodic physical exams, well-baby and child exams, immunizations, routine eye and prenatal visits. Related lab tests and X-rays. Pap smears and mammograms.

### Outpatient Services

- **Telehealth** – online through HAP’s contracted telehealth services provider
  - Covered
- **PCP visit to treat an injury or illness**
  - Covered
- **Specialist visit (including postnatal visit)**
  - Covered
- **Diagnostic test (X-ray, lab)**
  - Covered
- **Imaging (CT and PET scans, MRIs)**
  - Covered
- **Chemotherapy and radiation**
  - Covered
- **Dialysis**
  - Covered
- **Outpatient surgery and related services**
  - Covered
- **Routine eye exam (one per year)**
  - Covered
- **Eye and audiology exams (for medical reasons)**
  - Covered
- **Chiropractic care (20-visit limit)**
  - Covered

### Emergency Services

- **Emergency room services**
  - $200 copay
- **Urgent care centers or facilities**
  - $65 copay
- **Emergency transport and ambulance**
  - Covered

### Inpatient Services

- **Inpatient hospital, labor and delivery, and related services (intensive, cardiac and other specialty care units as medically necessary)**
  - Covered

### Mental Health, Behavioral Health and Substance Abuse Services

- **Inpatient services**
  - Covered
- **Outpatient services**
  - $5 copay

### Ancillary Services

- **Home health care services (unlimited)**
  - Covered
- **Hospice services (unlimited)**
  - Covered
- **Skilled nursing facility (45 days)**
  - Covered
- **Durable medical equipment and prosthetic devices**
  - Covered
- **Rehabilitation services – physical therapy and occupational therapy (30 visits), speech therapy (30 visits)**
  - $5 copay
- **Habilitation services – physical therapy and occupational therapy (30 visits), speech therapy (30 visits)**
  - $5 copay
- **Medical prescription drugs**
  - Covered

### Other Services

- **Pediatric vision hardware**
  - Covered
- **Pediatric and adult dental**
  - Optional riders available

### Prescription Drugs

- **Preferred generic/nonpreferred generic**
  - $5/$15
- **Preferred brand/nonpreferred brand**
  - $30/$60
- **Preferred specialty**
  - 20% to $200/script
- **Nonpreferred specialty**
  - 50% to $500/script

The above comparisons are to be used for general reference only. Please refer to the individual summaries for benefit levels for each service. Differences between your former group plan and the new group plan exist due to the Affordable Care Act requirements. Please see HAP's contracts, policies, riders and prescription formulary to review changes that may impact your group plan.