

City of Hallandale Beach Focused Deductible Open Access Current and Alternate Benefit Comparison

Plan Name	HMO1 - Current	HMO1 - Alternate
Referrals are not required for Covered Services (*)	In-Network	In-Network
	Member Responsibility	Member Responsibility
Plan Copayments		
Copayment Maximums (Individual/Family)	\$2,000 / \$4,000 (Copayments for Prescription drugs do not apply toward the Copayment Maximum)	\$2,000 / \$6,000 (Copayments for Prescription drugs do not apply toward the Copayment Maximum)
Plan Maximums		
Lifetime Maximum Benefit	Unlimited	Unlimited
Hospital Inpatient Services Hospital Deductible per calendar year (applies to all inpt and outpt services at hospital)		
Hospital Deductible	\$250	\$500
Inpatient Hospital Facility Services (includes pre-admission testing, room and board, diagnostic tests, x-rays, operating & recovery room, intensive & special care units, general nursing care, anesthesia, prescribed drugs, radiation therapy & chemotherapy, surgeon services, anesthesiologist services, specialist consultation, physician visits, human organ transplants, maternity care)	After Hosp. Deductible: \$50/day for the first 5 days	After Hosp. Deductible: \$250/day for the first 5 days per admission
Rehabilitative Services (30 days per calendar year)	After Hosp. Deductible: No additional copay	After Hosp. Deductible: Included in hospital co pay
Neonatal Intensive Care Unit (NICU) (admission and subsequent inpatient care)	After Hosp. Deductible: \$50/day for the first 5 days	After Hosp. Deductible: \$250/day for the first 5 days per admission
Outpatient Medical Services		
PCP Office Visits	\$10 Copay	\$20 Copay
Specialist Office Visits (office visits include lab tests, x-rays, hearing & vision screening and outpatient surgery)	\$30 Copay	\$40 Copay
Adult Preventive Care (includes annual physical exams, annual well-woman exams, Pap smears, prostate cancer screening, colon cancer screening, eye exams, health education and counseling and immunizations)	No Copay	No Copay
Child Preventive Care (includes well child and well baby exams and immunizations)	No Copay	No Copay
Routine Mammogram (based on established guidelines)	No Copay	No Copay
Maternity Prenatal and Postnatal Care in a Physician's office	One-time \$30 Copay	One-time \$40 Copay
Maternity Prenatal and Postnatal Care in a Sub-Specialty office	\$30 Copay	\$40 Copay
Outpatient Diagnostic Services at Hospital (including X-ray and lab)	After Hosp. Deductible: \$10 Copay	After Hosp. Deductible: \$80 Copay
Outpatient Diagnostic Services at Freestanding (including X-ray and lab)	\$10 Copay	\$40 Copay
Outpatient Surgery at Hospital (including physician and facility services)	After Hosp. Deductible: \$50 Copay	After Hosp. Deductible: \$250 Copay
Outpatient Surgery at Ambulatory Surgical Center (including physician and facility services)	\$50 Copay	\$125 Copay
Non-Preventive Outpatient Endoscopic Procedures at Hospital (colonoscopy, endoscopy, sigmoidoscopy)	After Hosp. Deductible: \$50 Copay	After Hosp. Deductible: \$250 Copay
Non-Preventive Outpatient Endoscopic Procedures at Ambulatory Surgical Center (colonoscopy, endoscopy, sigmoidoscopy)	\$50 Copay	\$125 Copay
Outpatient Therapy Services at Hospital (1)	After Hosp. Deductible: \$10 Copay	After Hosp. Deductible: \$40 Copay
Outpatient Therapy Services at Freestanding Facility (1)	\$10 Copay	\$40 Copay
Outpatient Radiation & Chemotherapy at Hospital	After Hosp. Deductible: \$25 Copay	After Hosp. Deductible: \$40 Copay
Outpatient Radiation & Chemotherapy at Freestanding Facility	\$25 Copay	\$40 Copay
Outpatient Cardiac and Respiratory Therapy at Hospital	After Hosp. Deductible: \$25 Copay	After Hosp. Deductible: \$40 Copay
Outpatient Cardiac and Respiratory Therapy at Freestanding Facility	\$25 Copay	\$40 Copay
Outpatient Dialysis at Hospital	After Hosp. Deductible: \$25 Copay	After Hosp. Deductible: \$40 Copay per treatment
Outpatient Dialysis at Freestanding Facility	\$25 Copay	\$40 Copay per treatment
Non-Surgical Spine and Back Services (20 visits per calendar year)	\$10 PCP; \$30 Specialist	\$20 PCP; \$40 Specialist
Second Medical and Surgical Opinion Participating Provider	\$30 Copay	\$20 PCP; \$40 Specialist
Second Medical and Surgical Opinion Non-Participating Provider	40% of Allowed Amount	40% of Allowed Amount

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Plan Name Referrals are not required for Covered Services (*)	HMO1 - Current In-Network	HMO1 - Alternate In-Network
Emergency and Urgent Care Services		
Emergency Care in Hospital Emergency Room (waved if admitted)	\$150 Copay	\$200.00
Emergency Care in Urgent Care Center	\$10 Copay	\$20 Copay
Ambulance	No Copay	No Copay
Family Planning Services		
Voluntary Counseling	\$30 Copay	\$40 Copay
Infertility Diagnosis	\$30 Copay	\$40 Copay
Infertility Treatment	Not Covered	Not Covered
Elective Abortion	Not Covered	Not Covered
Elective Sterilization	Copay depending on place of service	At Hospital-After Hosp. Deductible: \$250 Copay At Freestanding Facility: \$250 Copay
Intrauterine Devices (IUD) (device, insertion,removal)	\$30 Copay	\$20 PCP; \$40 Specialist
Mental Health Services		
Inpatient Treatment	After Hosp. Deductible: No Copay	After Hosp. Deductible: \$250/day for the first 1-5 days per admission
Outpatient Treatment	\$10 Copay	\$40 Copay
Substance Abuse Services		
Inpatient detoxification and rehabilitation treatment	After Hosp. Deductible: No Copay	Inpatient Dexotification: After Hosp. Deductible: \$200/Day Inpatient Rehabilitation Treatment: After Hosp Deductible: \$250/Day for the first 1-5 days per admission
Outpatient rehabilitation treatment	\$10 Copay	\$40 Copay
Skilled Nursing, Home Health and Hospice Care Services		
Skilled Nursing Facility Services	No Copay (100 days per calendar year)	\$50/day for the first 5 days per admission (30 days per calendar year)
Home Health Care Services (60 visits per calendar year)	No Copay	No Copay
Hospice (210 days maximum lifetime benefit)	No Copay	No Copay
Other Covered Services		
Durable Medical Equipment	No Copay	No Copay
External Orthotics, Prosthetics and breast prosthetics	No Copay	No Copay
Ophthalmology Services	\$20 Copay	\$40 Copay
Insulin	Applicable copay per prescription	Applicable copay per prescription
Diabetic Supplies (includes glucose monitors, test strips, lancets, etc)	Applicable copay per month	Applicable copay per month
Hearing Aids (other than cochlear implants)	Not Covered	Not Covered
Circumcision in a Hospital prior to postnatal discharge	No additional copay	No additional copay
Circumcision in a Physician's office	Same as office visit copay	Same as office visit copay
Circumcision in a Hospital after postnatal discharge	Same as outpatient surgery	Same as outpatient surgery
Coverage Provided By Rider		
Prescription Drug Rider (2)		
Rx Copayments 30-day supply	Tier 1A - \$3; MO: 1 copay Tier 1B - \$20; MO: 1 copay Tier 2 - \$40; MO: 2 copays Tier 3 - \$55; MO: 3 copays	Tier 1 - \$20; MO: 1 copays Tier 2 - \$40; MO: 2 copays Tier 3 - \$60; MO: 3 copays
Mail Order 90-day supply		
Preventive Dental		
	Refer to Dental Schedule of Benefits	Refer to Dental Schedule of Benefits
Preventive Vision - at a participating Optometrist		
	Refractive eye exams - \$15 Copay Eyeglasses - Discounts available at participating provider	Refractive eye exams - \$15 Copay Eyeglasses - Discounts available at participating provider

(*) PCP referrals are not required for Covered Services, however certain Covered Services require Prior Authorization and approval by Coventry's Medical Management Program.. Please refer to the Certificate of Coverage for further details on Prior Authorization requirements.

(1) Outpatient physical, speech and occupational therapy - Limit 60 visits per calendar year, combined for all therapies

Diabetic supplies are covered as part of the Prescription drug benefit. Tier 4 - Self-Injectables: \$250 per month out-of-pocket limit on Tier 4 (except for diabetic supplies) Prescription drug copayments do not apply toward the out-of-pocket maximum.