Elm City Local Plans - Effective January 1, 2025

Benefit	Century Preferred PPO - 2025	BlueCare POE - 2025	High Deductible Health Plan - 2025
Cost Shares	In Network services subject to copays Out-of- Network services subject to deductible and coinsurance Copay - $15 EPHC PCP; Other PCP provider $25; $30 Specialist OV $150 Emergency Room; Ambulatory Services $100; Urgent Care $100; $200 Outpatient Surgery; $250 Hospital Admission $75 High Cost Diagnostic up to $375 maximum per year Lifetime Max. In & Out Network - Unlimited	In Network services subject to copays No Out of Network Benefits Copay - $15 EPHC PCP; Other PCP provider $25; $30 Specialist OV $150 Emergency Room; Ambulatory Services $100; Urgent Care $100; $200 Outpatient Surgery; $250 Hospital Admission $75 High Cost Diagnostic up to $375 maximum per year Lifetime Max. In & Out Network - Unlimited	**Deductible:** $2,000 Ind / $4,000 family shared in and out of network In-Network: covered at 100**%** after deductible; Out-of-Network: covered at 70% after deductible In-Network: $4,000 Ind / $6,850 family cost share maximum; Rx covered with copays after the deductible Out-of-Network: $4,000 Ind / $8,000 family cost share maximum Lifetime Max. In & Out Network - Unlimited
Health Savings Account / Health Reimbursement Arrangement			
	N/A	**N/A**	Set up by City for each Member, City to fund 50% of deductible, 1/2 in July / 1/2 in January Additional funding in excess of above schedule can be provided by member with pre tax dollars up to annual limit set by IRS Members not eligible for an HSA contribution (eg: enrollment in Medicare, Tricare, etc) will be enrolled in an HRA with 50% deductible funding
Out-of-Network (OON) Benefit			
	OON Network Deductible - $2,000 Ind / $4,000 family Coinsurance - member pays 20% after deductible Cost Share Maximum - $6,000 Ind / $12,000 family Lifetime Max. In & Out Network - Unlimited	**N/A**	OON Network Deductible (combined with In-Net) - $2,000 Ind / $4,000 family Coinsurance - member pays 30% after deductible Cost Share Maximum - $4,000 Ind / $8,000 family Lifetime Max. In & Out Network - Unlimited
Participating In State Network			
	Uses the Century Preferred PPO Network for In-Network Services - **Services from any other providers would be an Out-of-Network**	Uses the BlueCare POE ProviderNetwork for In-Network Services - **Services from any other providers would be not covered**	Uses the Century Preferred PPO Network for In-Network Services - **Services from any other providers would be an Out-of-Network**
Participating Out of State Network			
	Uses the National BlueCard PPO Network for In-Network Services - **Services from any other providers would be an Out-of-Network Benefit**	Out of State Benefits are covered only in an Emergency or Urgent Situation	Uses the National BlueCard PPO Network for In-Network Services - **Services from any other providers would be an Out-of-Network Benefit**
PREVENTIVE CARE	**All Preventive services are provided in accordance with guidelines established by Health Care Reform**	**All Preventive services are provided in accordance with guidelines established by Health Care Reform**	**All Preventive services are provided in accordance with guidelines established by Health Care Reform**
Pediatric	No Copay Exams allowed per established Health Care Reform Schedules. Visit: https://www.healthcare.gov/preventive-care-children/ for more information	No Copay Exams allowed per established Health Care Reform Schedules. Visit: https://www.healthcare.gov/preventive-care-children/ for more information	Deductible Waived - No Copay Exams allowed per established Health Care Reform Schedules. Visit: https://www.healthcare.gov/preventive-care-children/ for more information
Adult	No Copay Exams allowed per established Health Care Reform Schedules. Visit: https://www.healthcare.gov/preventive-care-adults/ for more information	No Copay Exams allowed per established Health Care Reform Schedules. Visit: https://www.healthcare.gov/preventive-care-adults/ for more information	Deductible Waived - No Copay Exams allowed per established Health Care Reform Schedules. Visit: https://www.healthcare.gov/preventive-care-adults/ for more information
Immunizations	Per Healthcare Reform guidelines	Per Healthcare Reform guidelines	Per Healthcare Reform guidelines
Gynelogical / Obstetrics	$0 Copay for annual preventive exam $30 Copay Maternity - First Visit Only	$0 Copay for annual preventive exam $30 Copay Maternity - First Visit Only	Deductible waived - No Copay for annual preventive exam 0% after deductible for maternity
Mammography	Age 40-49 as recommended by provider $0 Copay age 50 and over once every 2 years	Age 40-49 as recommended by provider $0 Copay age 50 and over once every 2 years	Age 40-49 as recommended by provider Deductible waived - No copay age 50 and over once every 2 years
Vision (See BVV rider fact sheet for additional vision benefits)	No Copay (once every 2 calendar years)	No Copay (once every 2 calendar years)	Deductibe waived - No Copay (once every 2 calendar years)

Elm City Local Plans - Effective January 1, 2025

Benefit	Century Preferred PPO - 2025	BlueCare POE - 2025	High Deductible Health Plan - 2025
MEDICAL SERVICES			
PCP Designation	**Members must designate a PCP for subscribers and dependents**	**Members must designate a PCP for subscribers and dependents**	**Members must designate a PCP for subscribers and dependents**
Medical office visits	$15 EPHC PCP; Other PCP provider $25; $30 Specialist OV EPHC (Enhanced Personal Healthcare Providers)-These providers have committed to providing enhanced care in terms of managing your overall health	$15 EPHC PCP; Other PCP provider $25; $30 Specialist OV EPHC (Enhanced Personal Healthcare Providers)-These providers have committed to providing enhanced care in terms of managing your overall health	In-Network: covered 100% after deductible Out-of-Network: covered 70% after deductible
Physical or Occupational Therapy	$30 Copay 30 Combined Visits for PT, OT, ST; prior auth is required on pt/ot	$30 Copay 30 Combined Visits for PT, OT, ST; prior auth is required on pt/ot	In-Network: covered 100% after deductible; Out-of-Network: covered 70% after deductible 50 Combined Visits for PT, OT, ST & Chiro - excess rolls to out-of-network ; prior auth is required on pt/ot
Speech Therapy	$30 Copay 30 Combined Visits for PT, OT, ST	$30 Copay 30 Combined Visits for PT, OT, ST	In-Network: covered 100% after deductible; Out-of-Network: covered 70% after deductible 50 Combined Visits for PT, OT, ST & Chiro - excess rolls to out-of-network
Chiropractic Services	$30 Copay 20 visit maximum per calendar year	$30 Copay 20 visit maximum per calendar year	In-Network: covered 100% after deductible; Out-of-Network: covered 70% after deductible 50 Combined Visits for PT, OT, ST & Chiro - excess rolls to out-of-network
Allergy Services	$30 Copay	$30 Copay	In-Network: covered 100% after deductible; Out-of-Network: covered 70% after deductible
Diagnostic, Lab & X- ray	Covered	Covered	In-Network: covered 100% after deductible; Out-of-Network: covered 70% after deductible
High Cost Diagnostic (MRI, MRA, CAT, CTA, PET, Spect Scans)	$75 copay per service up to $375 maximum per year; requires prior auth	$75 copay per service up to $375 maximum per year; requires prior auth	In-Network: covered 100% after deductible; Out-of-Network: covered 70% after deductible; requires prior auth
Outpatient Mental Health & Substance Abuse	$25 Copay	$25 Copay	In-Network: covered 100% after deductible; Out-of-Network: covered 70% after deductible
EMERGENCY CARE			
Emergency Room	$150 Copay (waived if admitted)	$150 Copay (waived if admitted)	covered 100% after deductible
Urgent Care	$100 Copay	$100 Copay	In-Network: covered 100% after deductible; Out-of-Network: covered 70% after deductible
Walk-In Centers	$25 Copay	$25 Copay	In-Network: covered 100% after deductible; Out-of-Network: covered 70% after deductible
Ambulance (Land, Air, Water)	No charge - subject to medical necessity	No charge - subject to medical necessity	In-Network: covered 100% after deductible; Out-of-Network: covered 70% after deductible
INPATIENT HOSPITAL - All admissions require Pre-Certification			
Inpatient - General / Medical / Surgical / Maternity (Semi-Private)	$250 Per Admission Copay	$250 Per Admission Copay	In-Network: covered 100% after deductible; Out-of-Network: covered 70% after deductible
Ancillary Services, Medications, and Supplies	Covered	Covered	In-Network: covered 100% after deductible; Out-of-Network: covered 70% after deductible
Mental Health	$250 Copay Per Admission	$250 Copay Per Admission	In-Network: covered 100% after deductible; Out-of-Network: covered 70% after deductible
Substance Abuse	$250 Copay Per Admission	$250 Copay Per Admission	In-Network: covered 100% after deductible; Out-of-Network: covered 70% after deductible
Rehabilitative Services	$250 Copay Per Admission 60 Days Per Calendar Year	$250 Copay Per Admission 60 Days Per Calendar Year	In-Network: covered 100% after deductible; Out-of-Network: covered 70% after deductible 100 Days Per Calendar Year
Skilled Nursing Facility	$250 Copay Per Admission 120 Days Per calendar Year	$250 Copay Per Admission 120 Days Per calendar Year	In-Network: covered 100% after deductible; Out-of-Network: covered 70% after deductible 120 Days Per Calendar Year
Pre-Admission Testing	Covered	Covered	In-Network: covered 100% after deductible; Out-of-Network: covered 70% after deductible

Elm City Local Plans - Effective January 1, 2025

Benefit	Century Preferred PPO - 2025	BlueCare POE - 2025	High Deductible Health Plan - 2025
OTHER SERVICES			
Outpatient Surgery	Prior Authorization May Be Required $200 Copay at Hospital Facility; $100 Copay Ambulatory Surgical Center	Prior Authorization May Be Required $200 Copay at Hospital Facility; $100 Copay Ambulatory Surgical Center	Prior Authorization May Be Required In-Network: covered 100% after deductible; Out-of-Network: covered 70% after deductible
Durable Medical Equipment (Including Prosthetics)	Covered at 100%	Covered at 100%	In-Network: covered 100% after deductible; Out-of-Network: covered 70% after deductible
Orthotics	Not Covered	Not Covered	In-Network: covered 100% after deductible; Out-of-Network: covered 70% after deductible
Home Health Care	Covered - up to 200 visist per calendar year OON-$50 Deductible & 20% Coinsurance	Covered - up to 200 visits per calendar year	In-Network: covered 100% after deductible; Out-of-Network: covered 75% after deductible up to 200 vistis Per Calendar Year; 80 aide visits
Hospice	Covered	Covered	In-Network: covered 100% after deductible; Out-of-Network: covered 70% after deductible
Acupuncture	$30 Copay	$30 Copay	In-Network: covered 100% after deductible; Out-of-Network: covered 70% after deductible
TMJ	Not Covered	Not Covered	Not Covered
Gastric Bypass	Covered - copay subject to service location	Covered - copay subject to service location	In-Network: covered 100% after deductible; Out-of-Network: covered 70% after deductible
Infertility	$30 Office Visit Copay Coverage up to State Mandate Level - Prior Auth required Some Restrictions May Apply	$30 Office Visit Copay Coverage up to State Mandate Level - Prior Auth required Some Restrictions May Apply	In-Network: covered 100% after deductible; Out-of-Network: covered 70% after deductible Coverage up to State Mandate Level - Prior Auth required Some Restrictions May Apply
Oral Surgery	Not Covered	Not Covered	In-Network: covered 100% after deductible; Out-of-Network: covered 70% after deductible Limited coverage; some restrictions apply
Private Duty Nursing	Covered Up to a $15,000 maximum per member per calendar year	Covered Up to a $15,000 maximum per member per calendar year	In-Network: covered 100% after deductible; Out-of-Network: covered 70% after deductible Up to a $15,000 maximum per member per calendar year
PRESCRIPTIONS			
RETAIL (up to 30 day supply)			
Generics	$15	$15	After deductible, $15
Formulary Brand	$35	$35	After deductible, $35
Non-Formulary Brand	$60	$60	After deductible, $60
SPECIALTY MEDICATIONS	$75	$75	After deductible, $75
MAIL ORDER (up to 90 day supply)			
Generic	$30	$30	After deductible, $30
Formulary Brand	$70	$70	After deductible, $70
Non-Formulary Brand	$120	$120	After deductible, $120
ADDITIONAL PROVISIONS	Mandatory Mail Order; Mandatory Generic; Step Therapy; Prior Authorization; Quantity Limits; Half Fill Program; Specialty Cost Relief	Mandatory Mail Order; Mandatory Generic; Step Therapy; Prior Authorization; Quantity Limits; Half Fill Program; Specialty Cost Relief	Mandatory Mail Order;Mandatory Generic;Step Therapy;Prior Authorization; Quantity Limits; Half Fill Program; Specialty Accumulator Rules

Elm City Local Plans - Effective July 1, 2025

Benefit	Century Preferred PPO - 2025	High Deductible Health Plan - 2025
Cost Shares	In Network services subject to copays Out-of- Network services subject to deductible and coinsurance Copay - $15 EPHC PCP; Other PCP provider $25; $30 Specialist OV $150 Emergency Room; Ambulatory Services $100; Urgent Care $100; $200 Outpatient Surgery; $250 Hospital Admission $75 High Cost Diagnostic up to $375 maximum per year Lifetime Max. In & Out Network - Unlimited	**Deductible:** $2,000 Ind / $4,000 family shared in and out of network In-Network: covered at 100**%** after deductible; Out-of-Network: covered at 70% after deductible In-Network: $4,000 Ind / $6,850 family cost share maximum; Rx covered with copays after the deductible Out-of-Network: $4,000 Ind / $8,000 family cost share maximum Lifetime Max. In & Out Network - Unlimited
Health Savings Account / Health Reimbursement Arrangement		
	N/A	Set up by City for each Member, City to fund 1/2 in July / 1/2 in January as follows: First year in plan: Funded at 60% of Deductible Second year and beyond in plan: Funded at 50% of Deductible Additional funding in excess of above schedule can be provided by member with pre tax dollars up to annual limit set by IRS Members not eligible for an HSA contribution (eg: enrollment in Medicare, Tricare, etc) will be enrolled in an HRA with 50% deductible funding
Out-of-Network (OON) Benefit		
	OON Network Deductible - $2,000 Ind / $4,000 family Coinsurance - member pays 20% after deductible Cost Share Maximum - $6,000 Ind / $12,000 family Lifetime Max. In & Out Network - Unlimited	OON Network Deductible (combined with In-Net) - $2,000 Ind / $4,000 family Coinsurance - member pays 30% after deductible Cost Share Maximum - $4,000 Ind / $8,000 family Lifetime Max. In & Out Network - Unlimited
Participating In State Network		
	Uses the Century Preferred PPO Network for In-Network Services - **Services from any other providers would be an Out-of-Network Benefit**	Uses the Century Preferred PPO Network for In-Network Services - **Services from any other providers would be an Out-of-Network Benefit**
Participating Out of State Network		
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Adult	No Copay Exams allowed per established Health Care Reform Schedules. Visit: https://www.healthcare.gov/preventive-care-adults/ for more information	Deductible Waived - No Copay Exams allowed per established Health Care Reform Schedules. Visit: https://www.healthcare.gov/preventive-care-adults/ for more information
Immunizations	Per Healthcare Reform guidelines	Per Healthcare Reform guidelines
Gynelogical / Obstetrics	$0 Copay for annual preventive exam $30 Copay Maternity - First Visit Only	Deductible waived - No Copay for annual preventive exam 0% after deductible for maternity
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Outpatient Mental Health & Substance Abuse	$25 Copay	In-Network: covered 100% after deductible; Out-of-Network: covered 70% after deductible
EMERGENCY CARE		
Emergency Room	$150 Copay (waived if admitted)	covered 100% after deductible
Urgent Care	$100 Copay	In-Network: covered 100% after deductible; Out-of-Network: covered 70% after deductible
Walk-In Centers	$25 Copay	In-Network: covered 100% after deductible; Out-of-Network: covered 70% after deductible
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Skilled Nursing Facility	$250 Copay Per Admission 120 Days Per calendar Year	In-Network: covered 100% after deductible; Out-of-Network: covered 70% after deductible 120 Days Per Calendar Year
Pre-Admission Testing	Covered	In-Network: covered 100% after deductible; Out-of-Network: covered 70% after deductible

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Formulary Brand	$35	After deductible, $35
Non-Formulary Brand	$60	After deductible, $60
SPECIALTY MEDICATIONS	$75	After deductible, $75
MAIL ORDER (up to 90 day supply)		
Generic	$30	After deductible, $30
Formulary Brand	$70	After deductible, $70
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ADDITIONAL PROVISIONS	Mandatory Mail Order; Mandatory Generic; Step Therapy; Prior Authorization; Quantity Limits; Half Fill Program; Specialty Cost Relief	Mandatory Mail Order;Mandatory Generic;Step Therapy;Prior Authorization; Quantity Limits; Half Fill Program; Specialty Accumulator Rules