| Local 3144 - Proposed - Matrix Effective 07/01/2023 | | |
|---|---|---|
| **Benefit** | **Century Preferred PPO - 2023** | **Lumenos HDHP - 2023 with H.S.A.** |
| **Cost Shares** | In Network services subject to copays<br>Out-of- Network services subject to deductible and coinsurance<br>Copay - $15 EPHC PCP; Other PCP provider $25; $30 Specialist OV<br>$150 Emergency Room; Ambulatory Services $100; Urgent Care $100; $200 Outpatient Surgery; $250 Hospital Admission<br>$75 High Cost Diagnostic up to $375 maximum per year<br>Lifetime Max. In & Out Network - Unlimited | **Deductible:** $2,000 Ind / $4,000 family shared in and out of network<br>In-Network: covered at 90**%** after deductible;<br>Out-of-Network: covered at 60% after deductible<br>In-Network: $4,000 Ind / $8,000 family cost share maximum;<br>**As of July 1, 2016 no one member of a family plan will have out of pocket cost exceeding $6,850**<br>Out-of-Network: $6,000 Ind / $12,000 family cost share maximum<br>Lifetime Max. In & Out Network - Unlimited |
| **Out-of-Network (OON) Benefit** | | |
| | OON Network Deductible - $2,000 Ind / $4,000 family<br>Coinsurance - member pays 20% after deductible<br>Cost Share Maximum - $6,000 Ind / $12,000 family<br>Lifetime Max. In & Out Network - Unlimited | OON Network Deductible (combined with In-Net) - $2,000 Ind / $4,000 family<br>Coinsurance - member pays 40% after deductible<br>Cost Share Maximum - $10,000 Ind / $20,000 family<br>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 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** | Uses the National BlueCard PPO Network for In-Network Services - **Services from any other providers would be an Out-of-Network** |
| **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** |
| **Pediatric** | No Copay<br>Exams allowed per established Health Care Reform Schedules. Visit: https://www.healthcare.gov/preventive-care-children/ for more information | Deductible Waived - No Copay<br>Exams allowed per established Health Care Reform Schedules. Visit: https://www.healthcare.gov/preventive-care-children/ for more information |
| **Adult** | No Copay<br>Exams allowed per established Health Care Reform Schedules. Visit: https://www.healthcare.gov/preventive-care-adults/ for more information | Deductible Waived - No Copay<br>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<br>$30 Copay Maternity - First Visit Only | Deductible waived - No Copay for annual preventive exam<br>10% after deductible for maternity |
| **Mammography** | Age 40-49 as recommended by provider<br>$0 Copay age 50 and over once every 2 years | Age 40-49 as recommended by provider<br>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) | Deductibe waived - No Copay (once every 2 calendar years) |

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| **MEDICAL SERVICES** | | |
| **PCP Designation** | **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<br>EPHC (Enhanced Personal Healthcare Providers)-These providers have committed to providing enhanced care in terms of managing your overall | 10% after deductible up to out of pocket maximum |
| **Physical or Occupational Therapy** | $30 Copay<br>30 Combined Visits for PT, OT, ST; prior auth is required on pt/ot | 10% after deductible<br>60 Combined Visits for PT, OT, ST; prior auth is required on pt/ot |
| **Speech Therapy** | $30 Copay<br>30 Combined Visits for PT, OT, ST | 10% after deductible<br>60 Combined Visits for PT, OT, ST |
| **Chiropractic Services** | $30 Copay<br>20 visit maximum per calendar year | 10% after deductible<br>12 visit maximum per calendar year |
| **Allergy Services** | $30 Copay | 10% after deductible up to out of pocket maximum |
| **Diagnostic, Lab & X- ray** | Covered | 10% after deductible up to out of pocket maximum |
| **High Cost Diatnostic (MRI, MRA, CAT, CTA, PET, Spect Scans)** | $75 copay per service up to $375 maximum per year; requires prior auth | 10% after deductible up to out of pocket maximum; requires prior auth |
| **Outpatient Mental Health & Substance Abuse** | $25 Copay | 10% after deductible up to out of pocket maximum |
| **EMERGENCY CARE** | | |
| **Emergency Room** | $150 Copay (waived if admitted) | 10% after deductible up to out of pocket maximum |
| **Urgent Care** | $100 Copay | 10% after deductible up to out of pocket maximum |
| **Walk-In Centers** | $25 Copay | 10% after deductible up to out of pocket maximum |
| **Ambulance (Land, Air, Water)** | No charge - subject to medical necessity | 10% after deductible up to out of pocket maximum - subject to medical necessity |
| **INPATIENT HOSPITAL - All admissions require Pre-Certification** | | |
| **Inpatient - General / Medical / Surgical / Maternity (Semi-Private)** | $250 Per Admission Copay | 10% after deductible up to out of pocket maximum |
| **Ancillary Services, Medications, and Supplies** | Covered | 10% after deductible up to out of pocket maximum |
| **Mental Health** | $250 Copay Per Admission | 10% after deductible up to out of pocket maximum |
| **Substance Abuse** | $250 Copay Per Admission | 10% after deductible up to out of pocket maximum |
| **Rehabilitative Services** | $250 Copay Per Admission<br>60 Days Per Calendar Year | 10% after deductible up to out of pocket maximum<br>100 Days Per Calendar Year |
| **Skilled Nursing Facility** | $250 Copay Per Admission<br>120 Days Per calendar Year | 10% after deductible up to out of pocket maximum<br>100 Days Per Calendar Year |
| **Pre-Admission Testing** | Covered | 10% after deductible up to out of pocket maximum |

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| **OTHER SERVICES** | | |
| **Outpatient Surgery** | Prior Authorization May Be Required<br>$200 Copay at Hospital Facility; $100 Copay Ambulatory Surgical Center | Prior Authorization May Be Required<br>10% after deductible up to out of pocket maximum |
| **Durable Medical Equipment (Including Prosthetics)** | Covered at 100% | 10% after deductible up to out of pocket maximum |
| **Home Health Care** | Covered - up to 200 visist per calendar year<br>OON-$50 Deductible & 20% Coinsurance | 10% after deductible up to out of pocket maximum<br>up to 100 Days Per Calendar Year |
| **Hospice** | Covered | 10% after deductible up to out of pocket maximum |
| **Acupuncture** | $30 Copay | 10% after deductible up to out of pocket maximum |
| **Orthotics** | Not Covered | Not Covered |
| **TMJ** | Not Covered | Not Covered |
| **Gastric Bypass** | Covered - copay subjec to service location | 10% after deductible up to out of pocket maximum |
| **Infertility** | $30 Office Visit Copay<br>Coverage up to State Mandate Level - Prior Auth required<br>Some Restrictions May Apply | 10% after deductible up to out of pocket maximum<br>Coverage up to State Mandate Level - Prior Auth required<br>Some Restrictions May Apply |
| **PRESCRIPTIONS** | | |
| **RETAIL (up to 30 day supply)** | | |
| **Generics** | $15 | After deductible, $15 |
| **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 |
| **Non-Formulary Brand** | $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 Accumulator Rules |