Local 3144 & Executive Management - Matrix Effective 11/01/2018

Benefit	Century Preferred PPO-2018	Bluecare POE-2018	Century Preferred Comp Mix-2018	Lumenos HDHP-2018 with H.S.A.
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 Lifetime Max. In/Out Network-Unlimited	In Network Services Only Subject to Copays 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 Lifetime Maximum In Network-Unlimited	In Network Deductible-$750/1500 Coinsurance-20% up to 2000/4000 Out of pocket maximum **Following Services Deductible Waived-** Copay-$15 EPHC PCP Other PCP provider $25 $30 Specialist OV $150 Emergency Room/Urgent Care $100 $75 High Cost Diagnostic up to $375 maximum Lifetime Max. In/Out Network-Unlimited	$2,000 Ind /$4,000 family shared in and out of network covered at **90%** after deductible in network covered at 60% after deductible out of network **$4,000/$8,000 cost share maximum in network** **(As of July 1, 2016 no one member of a family plan will have out of pocket cost exceeding $6850)** **$6,000/$12,000 cost share maximum out of network** Lifetime Max. In/Out Network-Unlimited
Out of Network Benefit				
	OON Network Deductible-$2000/4000 Coinsurance-20% Out of Pocket Maximum-$6000/$12000 Lifetime Max. In/Out Network-Unlimited	No Out of Network Benefits Members Must Use the Bluecare Provider Network to Receive Payment on Services Lifetime Maximum for In network Services is Unlimited	OON Network Deductible-$2000/4000 Coinsurance-60%/40% Out of Pocket Maximum-$6000/$12,000 Lifetime Max. In/Out Network-Unlimited	OON Network Deductible shared with In network-$2000/4000 Coinsurance-60%/40% Out of Pocket Maximum-$10,000/$20,000 Lifetime Max. In/Out Network-Unlimited
Out of State Benefit				
	Uses the National Network and Bluecard PPO	Out of State Benefits are Covered Only in an Emergency or Urgent Situation	Uses the National Network and Bluecard PPO	Uses the National Network and Bluecard PPO
In State Network				
	Uses the Cent Preferred PPO Network for In-Network Services Benefits for any other providers would be an Out of Network Benefit	Members Must Use the Bluecare POE Provider Network to Receive Payment on Services	Uses the Cent Preferred PPO Network for In-Network Services Benefits for any other providers would be an Out of Network Benefit	Uses the Cent Preferred PPO Network for In-Network Services Benefits for 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**	**All Preventive services are provided in accordance with guidelines established by Health Care Reform**
Pediatric	No Copay 7 exams Birth to One 7 exams 1-5 years 5 -22 years-Preventative exams allowed once a year	No Copay 7 exams Birth to One 7 exams 1-5 years 5 -22 years-Preventative exams allowed once a year	No Copay 7 exams Birth to One 7 exams 1-5 years 5 -22 years-Preventative exams allowed once a year	Deductible Waived-No Copay 7 exams Birth to One 7 exams 1-5 years 5 -22 years-Preventative exams allowed once a year
Adult	No Copay 22 and over-Preventative exams allowed once a year	No Copay 22 and over-Preventative exams allowed once a year	No Copay 22 and over-Preventative exams allowed once a year	Deductible Waived-No Copay 22 and over-Preventative exams allowed once a year
Immunizations	Per Healthcare Reform guidelines	Per Healthcare Reform guidelines	Per Healthcare Reform guidelines	Per Healthcare Reform guidelines

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Gynelogical / Obstetrics	$0 Copay for annual exam $30 Copay Maternity-First Visit Only	$0 Copay for annual exam $30 Copay Maternity-First Visit Only	$0 Copay for annual exam $30 Copay Maternity-First Visit Only	Deductible waived-$0 Copay for annual exam 10% after deductible for maternity
Mammography	Age 35-39 Base Line Screening 40 and over once a year (Add'l Exams Available if Recommended by Doctor)	Age 35-39 Base Line Screening 40 and over once a year (Add'l Exams Available if Recommended by Doctor)	Age 35-39 Base Line Screening 40 and over once a year (Add'l Exams Available if Recommended by Doctor)	Age 35-39 Base Line Screening 40 and over once a year (Add'l Exams Available if Recommended by Doctor)
Hearing	No Copay (once every 2 calendar years)	No Copay (once every 2 calendar years)	No Copay (once every 2 calendar years)	No Copay (once every 2 calendar years) Deductible Waived
Vision-(See also BVV rider fact sheet for additional vision benefits)	No Copay (once every 2 calendar years)	No Copay (once every 2 calendar years)	No Copay (once a every 2 calendar years)	No Copay (once every 2 calendar years) Deductible Waived
MEDICAL SERVICES				
	PCP Designation-Members must designate a PCP for subscribers and dependents	**PCP Designation-Members must designate a PCP for subscribers and dependents**	**PCP Designation-Members must designate a PCP for subscribers and dependents**	**PCP Designation-Members must designate a PCP for subscribers and dependents**
Medical office visits	$15 Copay EPHC PCP $25 Other PCP Provider $30 Specilaist	$15 Copay EPHC PCP $25 Other PCP Provider $30 Specilaist	$15 Copay EPHC PCP $25 Other PCP Provider $30 Specilaist	10% after deductible up to out of pocket maximum
	EPHC (Enhanced Personal Healthcare Providers)-These providers have committed to providing enhanced care in terms of managing your overall health			
Physical or Occupational Therapy	$30 Copay 30 Combined Visits for pt, ot st 20 visit for chiro-prior auth is required on pt/ot	$30 Copay 30 Combined Visits for pt, ot st 20 visit for chiro-prior auth is required on pt/ot	$30 Copay 30 Combined Visits for pt, ot st 20 visit for chiro-Prior auth required on pt/ot	10% after deductible 60 Combined Visits for pt, ot st 12 visit for chiro-prior auth is required on pt/ot
Speech Therapy	$30 Copay 30 Combined Visits for pt, ot st 20 visit for chiro-prior auth is required on pt/ot	$30 Copay 30 Combined Visits for pt, ot st 20 visit for chiro-prior auth is required on pt/ot	$30 Copay 30 Combined Visits for pt, ot st 20 visit for chiro-prior auth is required on pt/ot	10% after deductible 60 Combined Visits for pt, ot st 12 visit for chiro-prior auth is required on pt/ot
Chiropractic Services	$30 Copay 30 Combined Visits for pt, ot st 20 visit for chiro-prior auth is required on pt/ot	$30 Copay 30 Combined Visits for pt, ot st 20 visit for chiro-prior auth is required on pt/ot	$30 Copay 30 Combined Visits for pt, ot st 20 visit for chiro-prior auth is required on pt/ot	10% after deductible 60 Combined Visits for pt, ot st 12 visit for chiro-prior auth is required on pt/ot
Allergy Services	$30 Copay 80 visits in 3 years	$30 Copay 80 visits in 3 years	$30 Copay for office visit Injections-20% after deductible 80 visits in 3 years	10% after deductible up to out of pocket maximum unlimited
Diagnostic, Lab & X-ray	Covered High Cost Diagnostic (MRI, MRA, CAT, CTA, PET, Spect) requires prior auth and a $75 copay per service up to a $375 calendar year maximum	Covered High Cost Diagnostic (MRI, MRA, CAT, CTA, PET, Spect) requires prior auth and a $75 copay per service up to a $375 calendar year maximum	20% after deductible up to out of pocket maximum High Cost Diagnostic (MRI, MRA, CAT, CTA, PET, Spect) requires prior auth and a $75 copay per service up to a $375 calendar year maximum	10% after deductible up to out of pocket maximum
Outpatient Mental Health & Substance Abuse	$25 Copay Unlimited Visits Prior auth required	$25 Copay Unlimited Visits Prior auth required	$25 Copay Unlimited Visits Prior auth required	10% after deductible up to out of pocket maximum Unlimited Visits Prior auth required

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EMERGENCY CARE				
Emergency Room	$150 Copay (waived if admitted)	$150 Copay (waived if admitted)	$150 Copay (waived if admitted)	10% after deductible up to out of pocket maximum
Urgent Care	$100 Copay	$100 Copay	$100 Copay	10% after deductible up to out of pocket maximum
Walk-In Centers	$25 Copay	$25 Copay	$25 Copay	10% after deductible up to out of pocket maximum
Ambulance	Unlimited for Land and Air	Unlimited for Land and Air	20% after deductible in or out of network	10% after deductible up to out of pocket maximum
INPATIENT HOSPITAL-				
Inpatient-General / Medical / Surgical / Maternity (Semi-Private)	All Hospital Admissions Require Pre-Cert $250 Per Admission Copay	All Hospital Admissions Require Pre-Cert $250 Per Admission Copay	All Hospital Admission Require Pre-Cert 20% after deductible up to the out of pocket maximum	All Hospital Admissions Require Precert 10% after deductible up to out of pocket maximum
Ancillary Services-Medications and Supplies	Covered	Covered	20% after deductible up to the out of pocket maximum	10% after deductible up to out of pocket maximum
Mental Health	$250 Copay Per Admission Copay Unlimited Days	$250 Copay Per Admission Copay Unlimited Days	20% after deductible up to the out of pocket maximum Unlimited Days	10% after deductible up to out of pocket maximum Unlimited Days
Substance Abuse	$250 Per Admission Copay Unlimited Days	$250 Per Admission Copay Unlimited Days	20% after deductible up to the out of pocket maximum Unlimited Days	10% after deductible up to out of pocket maximum Unlimited Days
Rehabilitative Services	$250 Per Admission Copay 60 Days Per Calendar Year	$250 Per Admission Copay 60 Days Per Calendar Year	20% after deductible up to the out of pocket maximum 60 Days Per Calendar Year	10% after deductible up to out of pocket maximum 100 Days Per Calendar Year
Skilled Nursing Facility	$250 Per Admission Copay 120 Days Per calendar Year	$250 Per Admission Copay 120 Days Per calendar Year	20% after deductible up to the out of pocket maximum 120 Days Per calendar Year	10% after deductible up to out of pocket maximum 100 Days Per Calendar Year
Outpatient Surgery **(Facility Charges)**	Prior Authorization Required $200 Copay Ambulatory surgery - $100	Prior Authorization Required $200 Copay Ambulatory surgery- $100	Prior Authorization Required 20% after deductible up to the out of pocket maximum	Prior Authorization Required 10% after deductible up to out of pocket maximum
Pre-Admission Testing	Covered	Covered	20% after deductible up to out of pocket maximum	10% after deductible up to out of pocket maximum
Diagnostic Lab & X-Ray	Covered High Cost Diagnostic (MRI, MRA, CAT, CTA, PET, Spect) requires prior auth and a $75 copay per service up to a $375 calendar year maximum	Covered High Cost Diagnostic (MRI, MRA, CAT, CTA, PET, Spect) requires prior auth and a $75 copay per service up to a $375 calendar year maximum	20% after deductible up to out of pocket maximum High Cost Diagnostic (MRI, MRA, CAT, CTA, PET, Spect) requires prior auth and a $75 copay per service up to a $375 calendar year maximum	Prior Authorization Required 10% after deductible up to out of pocket maximum

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OTHER SERVICES				
Durable Medical Equipment (Including Prosthetics)	Covered at 100%	Covered at 100%	20% after deductible up to out of pocket maximum	10% after deductible up to out of pocket maximum
Home Health Care	Covered 200 Visits OON-$50 Deductible & 20% Coinsurance	Covered 200 Visits	20%, Deductible waived up to the out of pocket maximum	10% after deductible up to out of pocket maximum 100 Days Per Calendar Year
Hospice	Covered	Covered	20% after deductible up to the out of pocket maximum	10% after deductible up to out of pocket maximum
Acupuncture	$30 Copay	$30 Copay	20% after deductible up to the out of pocket maximum	10% after deductible up to out of pocket maximum
Orthotics	Not Covered	Not Covered	Not Covered	Not Covered
TMJ	Not Covered	Not Covered	Not Covered	Not Covered
Gastric Bypass	Covered	Covered	20% after deductible up to the out of pocket maximum	10% after deductible up to out of pocket maximum
Infertility	$30 ffice Visit Copay State Mandate Level-Prior Auth required Some Restrictions May Apply	$30 Office Visit Copay State Mandate Level-Prior Auth required Some Restrictions May Apply	20% after deductible up to the out of pocket maximum State Mandate Level-Prior Auth required Some Restrictions May Apply	10% after deductible up to out of pocket maximum State Mandate Level-Prior Auth required Some Restrictions May Apply
Prescriptions				
Generics	$5	$5	$5	After deductible, $5
Formulary Brand	$30	$30	$30	After deductible, $30
Non-formulary Brand	$50	$50	$50	After deductible, $50
Mail Order (up to 90 day supply)				
Generic	$10	$10	$10	After deductible, $10
Formulary Brand	$60	$60	$60	After deductible, $60
Non-formulary Brand	$100	$100	$100	After deductible, $100
	Mandatory Mail Order Mandatory Generic Step Therapy Prior Authorization Quantity Limits	Mandatory Mail Order Mandatory Generic Step Therapy Prior Authorization Quantity Limits	Mandatory Mail Order Mandatory Generic Step Therapy Prior Authorization Quantity Limits	Mandatory Mail Order Mandatory Generic Step Therapy Prior Authorization Quantity Limits
Mandatory Specialty	With Half Fill program	With Half Fill program	With Half Fill program	With Half Fill program