Local 933 Teachers - Medical Benefit Matrix Effective 07/01/2023

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Teachers hired after 09/20/2016 may elect only the High Deductible Health Plan

Teachers hired between 07/01/2010 - 09/20/2016 may select from the Comp Mix or High Deductible Health Plan

Teachers hired prior to 07/01/2010 may select from all four plans

Benefit	PPO Plan - 2023	POE Plan - 2023	Comp Mix - 2023	High Deductible Health Plan
Cost Shares	In Network services subject to copays Out-of- Network services subject to deductible and coinsurance In-Network: $6,600 Ind / $13,200 family cost share maximum 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 **Only** Out-of- Network services subject to deductible and coinsurance In-Network: $6,600 Ind / $13,200 family cost share maximum 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 OR deductible & 20% coinsurance Out-of- Network services subject to deductible and coinsurance In-Network: $6,600 Ind / $13,200 family cost share maximum Copay - $15 EPHC PCP; Other PCP provider $25; $30 Specialist OV $150 Emergency Room; Urgent Care $100; High Cost Diagnostic $75 up to $375 maximum per year Ambulatory Services, Outpatient Surgery, Hospital Admission subject to In-Network Deductible $750 Ind / $1,500 family then 20% after deductible Lifetime Max. In & Out Network - Unlimited	**Deductible:** $2,000 Ind / $4,000 family shared in and out of network In-Network: covered at 90**%** after deductible; Out-of-Network: covered at 60% after deductible In-Network: $4,000 Ind / $8,000 family cost share maximum; **As of July 1, 2016 no one member of a family plan will have out of pocket cost exceeding $6,850** Out-of-Network: $6,000 Ind / $12,000 family cost share maximum Lifetime Max. In & Out Network - Unlimited
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	No Out-of-Network Benefits; Members Must Use the BlueCare Provider Network to Receive Payment on Services	OON Network Deductible - $2,000 Ind / $4,000 family Coinsurance - member pays 40% 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 40% after deductible Cost Share Maximum -$6,000 Ind / $12,000 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 BlueCare Network for In-Network Services - **Services from any other providers would not be covered outside of an emergency**	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				
	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 Emrgency Situation	Uses the National BlueCard PPO Network for In-Network Services - **Services from any other providers would be an Out-of-Network Benefit**	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**	**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	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	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	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	$0 Copay for annual preventive exam $30 Copay Maternity - First Visit Only	Deductible waived - No Copay for annual preventive exam 10% 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 $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)	No Copay (once every 2 calendar years)	Deductibe waived - No Copay (once every 2 calendar years)
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**	**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	$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	10% after deductible up to out of pocket maximum
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	$30 Copay 30 Combined Visits for PT, OT, ST; prior auth is required on pt/ot	10% after deductible 60 Combined Visits for PT, OT, ST; 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	$30 Copay 30 Combined Visits for PT, OT, ST	10% after deductible 60 Combined Visits for PT, OT, ST
Chiropractic Services	$30 Copay 20 visit maximum per calendar year	$30 Copay 20 visit maximum per calendar year	$30 Copay 20 visit maximum per calendar year	10% after deductible 12 visit maximum per calendar year

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Benefit	PPO Plan - 2023	POE Plan - 2023	Comp Mix - 2023	High Deductible Health Plan
MEDICAL SERVICES - Continued				
Allergy Services	$30 Copay	$30 Copay	$30 Copay Office Visit; 20% after deductible Injections	10% after deductible up to out of pocket maximum
Diagnostic, Lab & X- ray	Covered	Covered	20% after deductible up to out of pocket maximum	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	$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	10% after deductible up to out of pocket maximum; requires prior auth
Outpatient Mental Health & Substance Abuse	$25 Copay	$25 Copay	$25 Copay	10% after deductible up to out of pocket maximum
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 (Land, Air, Water)	No charge - subject to medical necessity	No charge - subject to medical necessity	20% after in network deductible	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	$250 Per Admission Copay	20% after deductible up to out of pocket maximum	10% after deductible up to out of pocket maximum
Ancillary Services, Medications, and Supplies	Covered	Covered	20% after deductible up to out of pocket maximum	10% after deductible up to out of pocket maximum
Mental Health	$250 Copay Per Admission	$250 Copay Per Admission	20% after deductible up to out of pocket maximum	10% after deductible up to out of pocket maximum
Substance Abuse	$250 Copay Per Admission	$250 Copay Per Admission	20% after deductible up to out of pocket maximum	10% after deductible up to out of pocket maximum
Rehabilitative Services	$250 Copay Per Admission 60 Days Per Calendar Year	$250 Copay Per Admission 60 Days Per Calendar Year	20% after deductible up to 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 Copay Per Admission 120 Days Per calendar Year	$250 Copay Per Admission 120 Days Per calendar Year	20% after deductible up to out of pocket maximum 120 Days Per calendar Year	10% after deductible up to out of pocket maximum 100 Days Per Calendar Year
Pre-Admission Testing	Covered	Covered	20% after deductible up to out of pocket maximum	10% after deductible up to out of pocket maximum
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 20% after deductible up to out of pocket maximum	Prior Authorization May Be Required 10% after deductible up to out of pocket maximum
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 - up to 200 visist per calendar year OON-$50 Deductible & 20% Coinsurance	Covered - up to 200 visist per calendar year OON-$50 Deductible & 20% Coinsurance	20% deductible waived - up to 200 visist per calendar year OON-$50 Deductible & 20% Coinsurance	10% after deductible up to out of pocket maximum up to 100 Days Per Calendar Year
Hospice	Covered	Covered	20% after deductible up to out of pocket maximum	10% after deductible up to out of pocket maximum
Acupuncture	$30 Copay	$30 Copay	20% after deductible up to 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 - copay subjec to service location	Covered - copay subjec to service location	20% after deductible up to out of pocket maximum	10% after deductible up to out of pocket maximum
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	20% after deductible up to out of pocket maximum Coverage up to State Mandate Level - Prior Auth required Some Restrictions May Apply	10% after deductible up to out of pocket maximum Coverage up to State Mandate Level - Prior Auth required Some Restrictions May Apply

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Benefit	PPO Plan - 2023	POE Plan - 2023	Comp Mix - 2023	High Deductible Health Plan
PRESCRIPTIONS				
RETAIL (up to 30 day supply)				
Generics	$5	$5	$5	After deductible, $5
Formulary Brand	$35	$35	$35	After deductible, $35
Non-Formulary Brand	$60	$60	$60	After deductible, $60
SPECIALTY MEDICATIONS	Covered based on designated tier above per formulary	Covered based on designated tier above per formulary	Covered based on designated tier above per formulary	Covered after deductible based on designated tier above per formulary
MAIL ORDER (up to 90 day supply)				
Generic	$10	$10	$10	After deductible, $10
Formulary Brand	$70	$70	$70	After deductible, $70
Non-Formulary Brand	$120	$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 Cost Relief	Mandatory Mail Order; Mandatory Generic; Step Therapy; Prior Authorization; Quantity Limits; Half Fill Program; Specialty Accumulator

***The Student age for all plans is 26**

***This does not constitute the actual health plan or insurance policy. It is only a general description of the plan.**