

Local 424-34 - Matrix Effective 10/01/2023		Employees hired after Contract Ratification may only elect Lumenos HSA plan ↓↓↓
Benefit	PPO Plan - 2023	High Deductible Health Plan - 2023
Cost Shares	<p>In Network services subject to copays</p> <p>Out-of- Network services subject to deductible and coinsurance</p> <p><u>In-Network</u>: \$6,600 Ind / \$13,200 family cost share maximum;</p> <p>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</p> <p>\$75 High Cost Diagnostic up to \$375 maximum per year</p> <p>Lifetime Max. In & Out Network - Unlimited</p>	<p>Deductible: \$2,000 Ind / \$4,000 family shared in and out of network</p> <p><u>In-Network</u>: covered at 90% after deductible; <u>Out-of-Network</u>: covered at 60% after deductible</p> <p><u>In-Network</u>: \$4,000 Ind / \$8,000 family cost share maximum;</p> <p>As of July 1, 2016 no one member of a family plan will have out of pocket cost exceeding \$6,850</p> <p><u>Out-of-Network</u>: \$6,000 Ind / \$12,000 family cost share maximum</p> <p>Lifetime Max. In & Out Network - Unlimited</p>
Out-of-Network (OON) Benefit		
	<p>OON Network Deductible - \$2,000 Ind / \$4,000 family</p> <p>Coinsurance - member pays 20% after deductible</p> <p>Cost Share Maximum - \$6,000 Ind / \$12,000 family</p> <p>Lifetime Max. In & Out Network - Unlimited</p>	<p>OON Network Deductible (combined with In-Net) - \$2,000 Ind / \$4,000 family</p> <p>Coinsurance - member pays 40% after deductible</p> <p>Cost Share Maximum - \$10,000 Ind / \$20,000 family</p> <p>Lifetime Max. In & Out Network - Unlimited</p>
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		
	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		
<i>All Preventive services are provided in accordance with guidelines established by Health Care Reform</i>		
Pediatric	<p>No Copay</p> <p>Exams allowed per established Health Care Reform Schedules. Visit: https://www.healthcare.gov/preventive-care-children/ for more information</p>	<p>Deductible Waived - No Copay</p> <p>Exams allowed per established Health Care Reform Schedules. Visit: https://www.healthcare.gov/preventive-care-children/ for more information</p>
Adult	<p>No Copay</p> <p>Exams allowed per established Health Care Reform Schedules. Visit: https://www.healthcare.gov/preventive-care-adults/ for more information</p>	<p>Deductible Waived - No Copay</p> <p>Exams allowed per established Health Care Reform Schedules. Visit: https://www.healthcare.gov/preventive-care-adults/ for more information</p>
Immunizations	Per Healthcare Reform guidelines	Per Healthcare Reform guidelines
Gynelological / Obstetrics	<p>\$0 Copay for annual preventive exam</p> <p>\$30 Copay Maternity - First Visit Only</p>	<p>Deductible waived - No Copay for annual preventive exam</p> <p>10% after deductible for maternity</p>
Mammography	<p>Age 40-49 as recommended by provider</p> <p>\$0 Copay age 50 and over once every 2 years</p>	<p>Age 40-49 as recommended by provider</p> <p>Deductible waived - No copay age 50 and over once every 2 years</p>
Vision (See Blue View Vision rider fact sheet for additional vision benefits)	No Copay (once every 2 calendar years)	Deductible 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 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	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	10% after deductible 60 Combined Visits for PT, OT, ST
Chiropractic Services	\$30 Copay 20 visit maximum per calendar year	10% after deductible 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 Diagnostic (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 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	10% after deductible up to out of pocket maximum 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 \$200 Copay at Hospital Facility; \$100 Copay Ambulatory Surgical Center	Prior Authorization May Be Required 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 OON-\$50 Deductible & 20% Coinsurance	10% after deductible up to out of pocket maximum 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 subjek to service location	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	10% after deductible up to out of pocket maximum Coverage up to State Mandate Level - Prior Auth required 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