# *HC MEP PPO*

## *Current Plan compared to 9/19/12 MOU*

| | HC MEP Current Plan | | HC MEP - Tenatative Agreement -9/19/12 | |
|---|---|---|---|---|
| | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** |
| **Contributions** | | | | |
| | None | | ■ 2012: $30/$60[1]<br>■ 2013: $45/$90[1]<br>■ 2014: $50/$100[1]<br>■ 2015: $55/$110[1] | |
| **Deductible** | | | | |
| Individual | ■ $250<br>■ Retirees: based on retirement date | | ■ 2013: $400<br>■ 2014: $450<br>■ 2015: $475<br>■ Retirees: based on retirement date<br>■ Retired on or after January 1, 2013: same as active<br>Combined in- and out-of-network | |
| | | | — | ■ 2013: $250<br>■ 2014: $250<br>■ 2015: $250<br>■ Additional applied to out-of-network |
| Family | ■ 2.5 × Individual<br>■ Retirees: based on retirement date | | ■ 2.5× Individual [2] | ■ 2.5× Individual [2] |
| Hospital | None | None | Deductible applies | Deductible applies |
| Carryover | Expenses applied during October, November or December also apply to the next year's deductible | | Expenses applied during October, November or December also apply to the next year's deductible | |

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| | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** |
| Charges Excluded From Deductible | ■ Copays for office visits<br>■ Copays for visits to urgent care facilities or emergency rooms<br>■ Charges paid for failure to follow precertification procedures<br>■ Expenses for mental health & substance abuse treatment<br>■ Expenses for prescription drugs<br>■ Charges paid for non-covered services and supplies<br>■ Charges in excess of R&C, NNF, or other Medical Plan limits<br>■ Amounts for LASIK services | | ■ Flat dollar copays paid for medical care<br>■ Copays for visits to urgent care facilities or emergency rooms<br>■ Charges paid for failure to follow precertification procedures<br>■ Expenses for prescription drugs<br>■ Charges paid for non-covered services and supplies<br>■ Charges in excess of MAA, NNF, or other Medical Plan limits<br>■ Amounts for LASIK services | |
| | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** |
| **Out-of-Pocket Maximums (Calendar Year)** | | | | |
| Individual | ■ $700<br>■ MH/SA: $200 | | ■ 2013: $1,050<br>■ 2014: $1,100<br>■ 2015: $1,150<br>Combined in- and out-of-network | |
| | | | — | ■ 2013: $950<br>■ 2014: $900<br>■ 2015: $900<br>Additional applied to out- of-network |
| Family | Maximums are per individual per year; combined family max is not applicable | | 2.5x Individual[2] | |

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| Charges Excluded From Out-of-Pocket Maximum | ■ Copays for Office Visits<br>■ Copays for visits to urgent care facilities or emergency rooms<br>■ Charges that are not considered "Other Covered Charges"<br>■ Amounts paid to satisfy the deductible<br>■ Charges in excess of obesity annual and infertility lifetime maximums<br>■ Some amounts for out-of-network outpatient mental health care<br>■ Charges for services and supplies not covered by the Medical Plan<br>■ Additional amounts paid for not following precertification program procedures<br>■ Charges that exceed R&C, NNF or other Medical Plan limits<br>■ Expenses for prescription drugs<br>■ Amounts for LASIK services | | ■ Flat dollar copays paid for medical care<br>■ Charges in excess of obesity annual and infertility lifetime maximums<br>■ Charges for services and supplies not covered by the Medical Plan<br>■ Additional amounts paid for not following precertification program procedures<br>■ Charges that exceed MAA, NNF or other Medical Plan limits<br>■ Expenses for prescription drugs<br>■ Amounts for LASIK services | |
| **Coinsurance Based On:** | | | | |
| | Network Negotiated Fee (NNF) | Reasonable and Customary Charges (R&C) | Network Negotiated Fee (NNF) | Maximum Allowed Amount (MAA) |
| | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** |
| **Outpatient Treatment** | | | | |
| Doctors' Home or Office Visits | $15 copay ($5 copay Medicare-eligible) | 80% covered after deductible; Reasonable and Customary limits apply | $20 copay ($10 copay Medicare-eligible) | 70% covered after deductible |
| Preventive Care | 100% covered, no deductible; age/frequency limits apply | 80% covered after deductible for routine adult physical exam (age/frequency limits apply); 100% covered (no deductible) for well-woman exam, mammogram, and pap test (age/frequency limits apply) | 100% covered, no deductible; age and frequency provisions of the Affordable Care Act applies | 100% covered, no deductible; age and frequency provisions of the Affordable Care Act applies |
| Routine Well-Baby and Well-Child Care (Pediatric Exams) | 100% covered, no deductible; age/frequency limits apply | 80% covered after deductible; age/frequency limits apply | 100% covered, no deductible; age and frequency provisions of the Affordable Care Act applies | 100% covered, no deductible; age and frequency provisions of the Affordable Care Act applies |
| X rays and Lab Tests | 100% covered, no deductible | 100% covered, no deductible | $20 copay ($10 copay Medicare-eligible) | 70% covered after deductible |

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| Radiation Therapy/ Chemotherapy/ Electroshock Therapy/ Hemodialysis | 100% covered, no deductible outpatient facility; $15 copay ($5 copay Medicare-eligible) if done in the physician's office | 100% covered, no deductible | 90% covered after deductible outpatient facility; $20 copay ($10 copay Medicare-eligible if done in physician's office | 70% covered after deductible |
| Physical, Occupational and Speech Therapy | 80% covered after deductible; number of visits based on medical necessity | 80% covered after deductible; number of visits based on medical necessity; Reasonable and Customary limits apply | 80% covered after deductible; number of visits based on medical necessity | 70% covered after deductible; number of visits based on medical necessity |
| Licensed Chiropractor | 80% covered after deductible; number of visits based on medical necessity | 80% covered after deductible; number of visits based on medical necessity; Reasonable and Customary limits apply | 80% covered after deductible; limited to 60 visits per calendar year (not to exceed 1 visit per day); limit combined in- and out-of- network | $20 copay plus difference between $92 flat fee and cost of service; limited to 60 visits per calendar year (not to exceed 1 visit per day); limit combined in- and out-of-network |
| Home Health Care | 100% covered, no deductible; precertification required | 100% covered, no deductible; precertification required | 100% covered, no deductible; precertification required | 70% covered after deductible; precertification required |
| **Inpatient Hospital Service** | | | | |
| | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** |
| Hospital Copay | None | None | None | None |
| Room and Board | 100% covered, no deductible | 100% covered, no deductible; precertification required | 90% covered after deductible | 70% covered after deductible; precertification required |
| In-Hospital Physician's Visits | 100% covered, no deductible | 98% covered, no deductible | 90% covered after deductible | 70% covered after deductible |
| X rays and Lab Tests | 100% covered, no deductible | 100% covered, no deductible | 90% covered after deductible | 70% covered after deductible |
| Maternity Care (Pre/Post Natal) | 100% covered, no deductible | 98% covered, no deductible | $20 copay ($10 copay Medicare-eligible)—initial visit only | 70% covered after deductible |
| Newborn Baby Care | 100% covered, no deductible | 98% covered, no deductible | 90% covered after deductible[4] | 70% covered after deductible[4] |

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| | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** |
| Skilled Nursing Facilities | 100% covered, no deductible; precertification required | 100% covered, no deductible; precertification required | 100% covered, no deductible; precertification required | 70% covered after deductible; precertification required |
| Birthing Centers | 100% covered, no deductible | 100% covered no deductible; precertification required | 90% covered after deductible | 70% covered after deductible; precertification required |
| Hospice Care | ■ 100% covered, no deductible; precertification required<br>■ Bereavement counseling covered at 50% covered during six months following death | ■ 100% covered, no deductible; precertification required<br>■ Bereavement counseling covered at 50% covered during six months following death | 100% covered, no deductible; precertification required | 70% covered after deductible; precertification required |
| **Surgery and Anesthesia** | | | | |
| Second Opinions | 100% covered, no deductible | 100% covered, no deductible | $20 copay ($10 copay Medicare-eligible | 70% covered after deductible |
| Inpatient Surgery | 100% covered, no deductible; precertification required | 98% covered, no deductible; precertification required | 90% covered after deductible; precertification required | 70% covered after deductible; precertification required |
| Outpatient Surgery | 100% covered, no deductible | 100% covered, no deductible | 90% covered, after deductible outpatient facility; $20 copay ($10 copay Medicare-eligible) if done in the physician's office | 70% covered after deductible |
| Anesthesia | 100% covered, no deductible | 98% covered, no deductible | 90% covered after deductible | 70% covered after deductible |
| **Lifetime Maximum** | | | | |
| Medical | None | | None | |
| Infertility | $20,000 per family (combined with prescription drugs and for both in-network and out-of-network); 100% covered after deductible[4] precertification required | $20,000 per family (combined with prescription drugs and for both in-network and out-of-network); 80% covered after deductible[4]; precertification required | $20,000 per family (combined with prescription drugs and for both in-network and out-of-network); 90% covered after deductible[3] precertification required | $20,000 per family (combined with prescription drugs and for both in-network and out-of-network); 70% covered after deductible[3] precertification required |
| Obesity | Not covered except medically necessary nutritional counseling prescribed by a doctor and furnished by a licensed dietician or nutritionist up to $500 a year | | Not covered except medically necessary nutritional counseling prescribed by a doctor and furnished by a licensed dietician or nutritionist up to $500 a year | |

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| | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** |
| **Mental Health/Substance Abuse** | | | | |
| Inpatient Mental Health Care | Days 1–30: 100% covered, no deductible; days 31+: 80% covered after deductible; precertification required | Days 1–30: 80% covered, no deductible; Days 31+: 80% covered after deductible; precertification required; Reasonable and Customary limits apply[1] | 90% covered after deductible; | 70% covered after deductible; precertification required |
| Outpatient Mental Health Care | 80% covered after deductible | 80% covered after deductible; limited to $80 copay per visit ($85 copay per visit for psychiatrists), 1 visit per day to a maximum of 52 visits per year; Reasonable and Customary limits apply[2] | $20 copay ($10 copay Medicare-eligible) | 70% covered after deductible |
| Inpatient Substance Abuse Treatment | 100% covered of R&C charges or NNF, no deductible, up to 30 days per confinement in an approved facility[3] | | 90% covered after deductible | 70% covered after deductible |
| | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** |
| Outpatient Substance Abuse Treatment | 80% covered after deductible; limited to a maximum of 52 visits per covered person per year if an approved facility is not used; counseling services that are not part of a day service program or an outpatient program are limited to 52 visits per calendar year[3] | | $20 copay ($10 copay Medicare-eligible) | 70% covered after deductible |
| **Other Services** | | | | |
| Durable Medical Equipment | 80% covered after deductible | 80% covered after deductible | 80% covered after deductible; precertification required for items over $5,000 | 70% covered after deductible; precertification required for items over $5,000 |
| Ambulance Services | 100% covered, no deductible | 100% covered, no deductible | ■ 90% covered after deductible if an emergency<br>■ 70% after deductible if non-emergency | |
| Prosthetic Devices | 80% covered after deductible | 80% covered after deductible | 80% covered after deductible; precertification required for items over $5,000 | 70% covered after deductible; precertification required for items over $5,000 |
| Urgent Care | $15 copay ($5 copay Medicare-eligible) | | $20 copay ($10 copay Medicare-eligible) | |
| Emergency Room Care | $15 copay ($5 copay Medicare-eligible); copay waived if admitted | | $75 copay ($25 copay Medicare-eligible); copay waived if admitted | |

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| ***Footnotes*** | | |
| | [1] If care is received through a non- network provider and there is no network provider within 40 miles of the member's home, the plan pays 100% covered of R&C (no deductible); precertification is required<br>[2] If care is received through a non- network provider and there is no network provider within 40 miles of the member's home, benefits shall be limited to $90 per visit ($110 per visit after OOP maximum reached)<br>[3]Note: Class II Dependents and Sponsored Children are not eligible for coverage for Substance Abuse treatment<br>[4]Coverage includes advanced reproductive technology such as GIFT, ZIFT and artificial insemination | [1]Contribution amounts assume $100 annual credit for completion of HRA and $600 annual credit for non-tobacco user status.<br>[2] Family amount can be any combination of family members but an individual would never satisfy more than his/her own individual amount<br>[3]Coverage includes advanced reproductive technology such as GIFT, ZIFT and artificial insemination<br>[4]If newborn is not released with the mother a separate deductible and coinsurance applies |