Local 3144 - Matrix Effective 07/01/2023

Benefit	PPO Plan - 2023	High Deductible Health Plan - 2023
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	**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	OON Network Deductible (combined with In-Net) - $2,000 Ind / $4,000 family Coinsurance - member pays 40% after deductible Cost Share Maximum - $10,000 Ind / $20,000 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 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	***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	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	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
Gynelogical / Obstetrics	$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 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 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 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 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 subjec 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