Local 18 - Benefit Matrix Effective 07/01/2023

Benefit	Century Preferred PPO	Bluecare POE	Century Preferred Comp Mix	Lumenos HDHP/H.S.A. Plan
Cost Shares	In Network services subject to copays	In Network Services Only	In Network Deductible- $1000/2000	$2,000 Ind /$4,000 family shared in and out of network
	Out-of- Network services subject to deductible and coinsurance	Subject to Copays	Coinsurance-20% up to 3000/6000 Out of pocket maximum	Medical covered at 90% after deductible in network
			Following Services Deductible Waived-	$4000/$8,000 out of pocket maximum in network
		Copay-$15 PCP Office Visit/$25 Specialist OV	$20 Medical Office Visit ($15 If EPHC for PCP) /$0 Preventative Care	RX covered at 100% after deductible subject to Co-Pay
	Copay-$15 PCP Office Visit/$25 Specialist OV	$100 Emergency Room/Ambulatory Services $100	$100 Emergency Room/$75 High Cost Diagnostic	covered at 60/40% after deductible out of network
	$100 Emergency Room/Ambulatory Services $100	$200 Outpatient Surgery, $250 Hospital Admission	$75 Urgent Care/Walk In Center $20	Out of Pocket Maximum- $6,000/$12,000 out of network
	$200 Outpatient Surgery, $250 Hospital Admission	Lifetime Maximum In Network-Unlimited	Lifetime Max In-Ntwrk & Out Ntwrk Unlimited	**Lifetime Maximum - Unlimited**
Health Savings Account				
	N/A	**N/A**	**N/A**	Set up by City for each Member - Funded at 50% of Deductible each year by City.
Out of Network Benefit				
	OON Network Deductible- $2000/4000	No Out of Network Benefits	OON Network Deductible- $2000/4000	OON Network Deductible shared with In network-$2000/4000
	Coinsurance-20%	Members Must Use the Bluecare Provider Network to Receive Payment on Services	Coinsurance-40%	Coinsurance-60/40%
	Out of Pocket Maximum- $6000/$12000		Out of Pocket Maximum- $6000/$12,000	Out of Pocket Maximum- $6,000/$12,000 out of network
	Lifetime Max In-Ntwrk Unlimited/Out-Ntwrk- Unlimited	Lifetime Maximum for In network Services is Unlimited	Lifetime Max In-Ntwrk Unlimited/Out-Ntwrk- Unlimited	Lifetime Max In-Ntwrk Unlimited/Out-Ntwrk- 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 Network for In-Network	Members Must Use the Bluecare Provider Network to Receive Payment on Services	Uses the Cent Preferred Network for In-Network	Uses the Cent Preferred Network for In-Network
	Benefits for any other providers would be an Out of Network Benefit		Benefits for any other providers would be an Out of Network Benefit	Benefits for any other providers would be an Out of Network Benefit
PREVENTIVE CARE				
Pediatric	No Copay	No Copay	No Copay	Deductible Waived-No Copay
Age based schedule	7 exams Birth to One 7 exams 1-5 years	7 exams Birth to One 7 exams 1-5 years	7 exams Birth to One 7 exams 1-5 years	7 exams Birth to One 7 exams 1-5 years
	5 -22 years-Preventative exams allowed once a year	5 -22 years-Preventative exams allowed once a year	5 -22 years-Preventative exams allowed once a year	5 -22 years-Preventative exams allowed once a year
Adult	No Copay	No Copay	No Copay	Deductible Waived-No Copay
Age Based Schedule	22 and over-Preventative exams allowed once a year	22 and over-Preventative exams allowed once a year	22 and over-Preventative exams allowed once a year	22 and over- Preventative exams allowed once a year
Immunizations	As part of Preventative Exam	As part of Preventative Exam	As part of Preventative Exam	As part of Preventative Exam
Gynelogical/Obstetrics	$0 Copay for annual exam $25 Copay Maternity-First Visit Only	$0 Copay for annual exam $25 Copay Maternity-First Visit Only	$0 Copay for annual exam $20 Copay Maternity-First Visit Only	Deductible waived-$0 Copay for annual exam After deductible 90% In Network
	Age 35-39 Base Line Screening 40 and over once a year	Age 35-39 Base Line Screening 40 and over once a year	Age 35-39 Base Line Screening 40 and over once a year	Age 35-39 Base Line Screening 40 and over once a year

Mammography	(Add'l Exams Available if Recommended by Doctor)	(Add'l Exams Available if Recommended by Doctor)	(Add'l Exams Available if Recommended by Doctor)	(Add'l Exams Available if Recommended by Doctor) Deductible Waived
Vision	No Copay (once every 2 calendar years)	No Copay (once every 2 calendar years)	$0 Copay (once a every 2 years)	No Copay (once every 2 calendar years) Deductible Waived
MEDICAL SERVICES				
Medical office visits	$15 Copay PCP	$15 Copay PCP	$20 Copay ($15 if EPHC for PCP)	After Deductible 90% Co-Insurance in
	$25 Specialist	$25 Specialist	Unlimited Visits	Network 60% Out of Network
Physical or Occupational	$25 Copay	$25 Copay	$20 Copay	After Deductible 90%Co-Insurance in network 60% out of network
Therapy	30 Combined Visits for pt, ot st per member per year	30 Combined Visits for pt, ot st per member per year	30 Combined Visits for pt, ot st per member per year	60 Combined Visits for pt, ot st per member per year
	20 visit for chiro-prior auth is required on pt/ot	20 visit for chiro-prior auth is required on pt/ot	20 visit for chiro-Prior auth required on pt/ot	12 visit for chiro-prior auth is required on pt/ot
Speech Therapy	$25 Copay	$25 Copay	$20 Copay	After Deductible 90% Co- Insurance in network 60% out of network
	30 Combined Visits for pt, ot st	30 Combined Visits for pt, ot st	30 Combined Visits for pt, ot st	60 Combined Visits for pt, ot st
Chiropractic Services	20 visit for chiro-prior auth is required on pt/ot	20 visit for chiro-prior auth is required on pt/ot	20 visit for chiro-Prior auth required on pt/ot	12 visit for chiro-prior auth is required on pt/ot
	$25 Copay	$25 Copay	$20 Copay	After Deductible 90% Co-Insurance in network 60% out of network
Allergy Services	$25 Copay	$25 Copay	Injections-20% after deductible	After Deductible 90% Co- Insurance in network 60% out of network
	80 visits in 3 years	80 visits in 3 years	80 visits in 3 years	80 visits in 3 years
Diagnostic, Lab & X-ray	Covered	Covered	Covered	After Deductible
	High Cost Diagnostic (MRI, MRA, CAT, CTA, PET, Spect)	High Cost Diagnostic (MRI, MRA, CAT, CTA, PET, Spect)	High Cost Diagnostic (MRI, MRA, CAT, CTA, PET, Spect)	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	requires prior auth and a $75 copay per service up to a $375 calendar year maximum	requires prior auth and a $75 copay per service up to a $375 calendar year maximum	After Deductible 90% Co- Insurance in network 60% out of network
Outpatient Mental Health & Substance Abuse	$25 Copay	$25 Copay	$20 Copay	After Deductible 90% Co- Insurance in network 60%
	Unlimited Visits	Unlimited Visits	Unlimited Visits	Unlimited Visits
	Prior auth required	Prior auth required	Prior auth required	Prior auth required
EMERGENCY CARE				
Emergency Room	$100 Copay (waived if admitted)	$100 Copay (waived if admitted)	$100 Copay (waived if admitted)	After Deductible 90% Co-Insurance in network 60% out of network
Urgent Care	$75 Copay	$50 Copay	$75 Copay	After Deductible 90% Co- Insurance in network --- 60% out of network
Walk-In Centers	$15 Copay	$15 Copay	$20 Copay	After Deductible 90% Co- Insurance in network --- 60% out of network
Ambulance	Unlimited for Land and Air	Unlimited for Land and Air	20% after deductible in or out of network	After Deductible 90% Co- Insurance in network --- - 60% out of network
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 Pre-Cert After Deductible 90% in Network 60% Out of Network
Ancillary Services- Medications and Supplies	Covered	Covered	20% after deductible up to the out of pocket maximum	All Hospital Admissions Require Pre-Cert After Deductible 90% in Network 60% Out of Network
Mental Health	$250 Copay Per Admission Copay	$250 Per Admission Copay	20% after deductible up to the out of pocket maximum	All Hospital Admissions Require Pre-Cert After Deductible 90% in Network 60% Out of Network
(Biologically Based)	Unlimited Days	Unlimited Days		Unlimited Days
Mental Health	$250 Copay Per Admission Copay	$250 Copay Per Admission Copay	20% after deductible up to the out of pocket maximum	All Hospital Admissions Require Pre-Cert After Deductible 90% in Network 60% Out of Network

(Non-Biologically Based)	Unlimited Days	Unlimited Days	Unlimited Days	Unlimited Days
Substance Abuse	$250 Per Admission Copay	$250 Per Admission Copay	20% after deductible up to the out of pocket maximum	All Hospital Admissions Require Pre-Cert After Deductible 90% in Network 60% Out of Network
	Unlimited Days	Unlimited Days	Unlimited Days	Unlimited Days
Rehabilitative Services	$250 Per Admission Copay	$250 Per Admission Copay	20% after deductible up to the out of pocket maximum	All Hospital Admissions Require Pre-Cert After Deductible 90% in Network 60% Out of Network
	60 Days Per Calendar Year	60 Days Per Calendar Year	60 Days Per Calendar Year	100 Days Per Calendar Year
Skilled Nursing Facility	$250 Per Admission Copay	$250 Per Admission Copay	20% after deductible up to the out of pocket maximum	All Hospital Admissions Require Pre-Cert After Deductible 90% in Network 60% Out of Network
	120 Days Per calendar Year	120 Days Per calendar Year	120 Days Per calendar Year	100 Days Per calendar Year
Outpatient Surgery	Prior Authorization Required	Prior Authorization Required	Prior Authorization Required	Prior Authorization Required
(Facility Charges)	$200 Copay	$200 Copay	20% after deductible up to the out of pocket maximum	After Deductible 90% Co-Insurance in network 60% out of network
	Ambulatory surgery (in a hospital setting) $100	Ambulatory surgery (in a hospital setting) $100		Ambulatory surgery (in a hospital setting) After Deductible 90% / 60%
Pre-Admission Testing	Covered	Covered	After Deductible 80% Co- Insurance in network 60% out of network	After Deductible 90% Co-Insurance in network 60% out of network
Diagnostic Lab & X-Ray	Covered	Covered	Covered	Prior Authorization Required
	High Cost Diagnostic (MRI, MRA, CAT, CTA, PET, Spect)	High Cost Diagnostic (MRI, MRA, CAT, CTA, PET, Spect)	High Cost Diagnostic (MRI, MRA, CAT, CTA, PET, Spect)	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	requires prior auth and a $75 copay per service up to a $375 calendar year maximum	requires prior auth and a $75 copay per service up to a $375 calendar year maximum	After Deductible 90% Co- Insurance in network 60% out of network
OTHER SERVICES				
Durable Medical Equipment	Covered at 100% In Network	Covered at 100%	Covered at 80% after deductible	Covered at 50% after deductible is met
(Including Prosthetics)	Out Ntwrk - Deductible and Co- Insurance			
Home Health Care	Covered	Covered	Deductible waived	After Deductible 90% Co- Insurance in network 60% out of network
	200 Visits	200 Visits	Covered at 80% in and out of network up to the out of pocket maximum	100 Days Per Calendar Year
	OON-$50 Deductible & 20% Coinsurance		200 Visits	
Hospice	Covered up to Last 6 Months of Life	Covered up to Last 6 Months of Life	Covered up to Last 6 Months of Life	Covered up to Last 6 Months of Life
			After Deductible 80% Co-Insurance in network 60% out of network	After Deductible 90% Co-Insurance in network 60% out of network
Acupuncture	Not Covered	Not Covered	Not Covered	Not Covered
Orthotics	$50 Co-Pay	$50 Co-Pay	$50 Co-Pay	After Deductible 90% Co- Insurance in network, 60% out of network
TMJ	Not Covered	Not Covered	Not Covered	Not Covered
Gastric Bypass	Not Covered	Not Covered	Not Covered	Not Covered
Infertility	$25 Office Visit Copay	$25 Office Visit Copay	After Deductible 80% Co-Insurance in network 60% out of network	After Deductible 90% Co- Insurance in network 60% out of network
	State Mandate Level-Prior Auth required	State Mandate Level-Prior Auth required	State Mandate Level-Prior Auth required	State Mandate Level- Prior Auth required
	Some Restrictions May Apply	Some Restrictions May Apply	Some Restrictions May Apply	Some Restrictions May Apply
	$10/$25/$40	$10/$25/$40	$10/$25/$40	After deductible- $10/$25/$40
Drug Rider	Mail order $10/$25/$40	Mail order $10/$25/$40	Mail order $10/$25/$40	Mail order $10/$25/$40
	30/90 day supply	30/90 day supply	30/90 day supply	30/90 day supply
	Mandatory Generic and Mail order	Mandatory Generic and Mail order	Mandatory Generic and Mail order	Mandatory Generic
***The Student age for all three plans is 26/26.**				
***This does not constitute the actual health plan or insurance policy.** It **is only a general description of the plan.**				

	Managed Three Tier Drug Rider
Network	**Access to over 680 Pharmacies in CT Access to over 65,000 pharmacies nationwide**

Participating Pharmacy

Retail Copay-Generic	**$10.00**
Listed Brand Copay	**$25.00**
Non-Listed Brand Copay	**$40.00**

Non-Participating Pharmacy

Deductible	**$0.00**
Co-insurance*	**20%**

Supply Limits

Retail	**30 day - 1 copay**
Mail Order Copays	**31-90 day supply-1 copay on generic or brand**

Mail Order Program

[*1] Mandatory Mail Order	**Yes-Mandatory On Maintenance Medications (Except HDHP)**
Drug Rider Maximums	**Unlimited Per member per calendar year**
[*2] Dispensed As Written Clause	**MD Override <u>not</u> allowed - Mandatory Generic Substitution**
[*3]Age / Gender	**yes**
[*4]Refill Too Soon	**yes (up to 85% of prescription needs to be completed)**
[*5]Duplicate Therapy	**yes**
[*6]Quantity Limits	**yes**
[*7]Step Therapy	**yes**
[*8]Prior Authorization	**yes**
Diabetic Supplies	**Not Subject to Copays and Maximums**
Pill Bill	**Covered**

***Non-par pharmacists reimbursed at 80% of in network allowance. Member is also responsible for the difference between Anthem Blue Cross and Blue Shield's payment and the pharmacist's actual charge**

[*1]**<u>Mandatory Mail Order-</u>**You are required to use mail order on maintenance medication after 3 refills at the retail pharmacy

[*2]**<u>Dispensed as Written-</u>**Allows the member to receive a brand when the generic is available at just the brand copay when the doctor writes "Dispensed as Written" on the prescription. If the doctor fails to write "Dispensed as Written" on the prescription and member requests the brand with the generic available, the member will pay the difference between the cost of the generic and brand drug and the brand drug co-pay

[*3]**<u>Age Gender-</u>**No benefits are available for medications prescribed outside the FDA age/gender recommendations

[*4]**<u>Refill Too Soon-</u>**Benefits will not be available for refill medications until a percentage of the prior medication has been used. (see% listed above)

[*5]**<u>Duplicate Therapy-</u>**Identifies drugs with the same therapeutic value and can prevent toxicity

[*6]**<u>Quantity Limits-</u>**Certain medications will be limited to quantities recommended to maintain clinically appropriate utilization and administration

[*7]**<u>Step Therapy-</u>**No benefits are available for Step Therapy protocol drugs without documented other medication failure

[*8]**Prior Authorization-**Certain medications will require a prior authorization prior to receiving the medication