Medical Benefit Matrix Summary

Local 1303-467 - Matrix Effective 07/01/2023		Employees hired after 7/1/2023 may only elect Lumenos HSA Plan ↓ ↓ ↓
Benefit	**Century Preferred PPO - 2023**	**Lumenos HDHP - 2023 with H.S.A.**
Cost Shares	In Network services subject to copays Out-of- Network services subject to deductible and coinsurance 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	Uses the Century Preferred PPO Network for In-Network Services - Services from any other providers would be an Out-of-Network
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	Uses the National BlueCard PPO Network for In-Network Services - Services from any other providers would be an Out-of-Network
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
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	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