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Benefit	Century Preferred PPO-2018	Bluecare POE-2018	Lumenos HDHP/H.S.A. Plan
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 Lifetime Max. In/Out Network-Unlimited	In-Network Services only subject to copays 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 Lifetime Maximum In Network-Unlimited	$2,000 Ind /$4,000 family shared in and out of network In-Network Medical covered at 100% after deductible Out of Network covered at 70/30% after deductible Out of Pocket Maximum $4000/$6850 In-Network Out of Pocket Maximum- $4000/$8000 Out-Of-Network RX covered with rx copays after the deductible **Lifetime Maximum - Unlimited**
Health Savings Account			
	N/A	**N/A**	Set up by City for each Member Funded at 65% of Deductible first year by City. Additional funding by member with pre tax $$$ up to $3,500/ $7,000 combined annual limit in 2019
Out of Network Benefit			
	OON Network Deductible-$2000/4000 Coinsurance-20% Out of Pocket Maximum-$6000/$12000 Lifetime Max. In/Out Network-Unlimited	No Out of Network Benefits Members Must Use the Bluecare Provider Network to receive payment on services. Lifetime Maximum for In network Services is Unlimited	OON Network Deductible shared with In network-$2000/4000 Coinsurance-70/30% Out of Pocket Maximum- $4,000/$8,000 out of network Lifetime Max In-Ntwrk Unlimited/Out-Ntwrk-Unlimited
Out of State Benefit			
	Uses the National Network and Bluecare PPO	Out of State Benefits are Covered Only in an Emergency or Urgent Situation	Uses the National Network and Bluecard PPO
In State Network			
	Uses the Cent Preferred PPO Network for In-Network Services Benefits for any other providers would be an Out of Network Benefit	Members Must Use the Bluecare POE Provider Network to receive payment on services.	Uses the Cent Preferred Network for In-Network. Benefits for 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**	**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 7 exams Birth to One 7 exams 1-5 years age 5 -22 years-Preventative exams allowed once a year	No Copay 7 exams Birth to One 7 exams 1-5 years age 5 -22 years-Preventative exams allowed once a year	Deductible Waived-No Copay 7 exams Birth to one 7 exams 1-5 years age 5-22 Preventive exams allowed once a year
Adult	No Copay 22 and over-Preventative exams allowed once a year	No Copay 22 and over-Preventative exams allowed once a year	Deductible Waived-No Copay 22 and over preventive exams allowed once a year
Immunizations	Per Healthcare Reform guidelines	Per Healthcare Reform guidelines	Per Healthcare Reform Guidelines
Gynecological / Obstetrics	$0 Copay for annual exam $30 Copay Maternity-First Visit Only	$0 Copay for annual exam $30 Copay Maternity-First Visit Only	Deductible waived-$0 Copay for annual exam After deductible 100% In Network
Mammography	Age 35-39 Base Line Screening 40 and over once a year (Add'l Exams Available if Recommended by Doctor)	Age 35-39 Base Line Screening 40 and over once a year (Add'l Exams Available if Recommended by Doctor)	Age 35-39 Base Line Screening 40 and over once a year (Add'l Exams Available if Recommended by Doctor)

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Hearing	No Copay (once every 2 calendar years)	No Copay (once every 2 calendar years)	No Copay (once every 2 calendar years) Deductible Waived
Vision-(See also BVV rider fact sheet for additional vision benefits)	No Copay (once every 2 calendar years)	No Copay (once every 2 calendar years)	No Copay (once every 2 calendar years) Deductible Waived
MEDICAL SERVICES			
	PCP Designation-Members must designate a PCP for subscribers and dependents	**PCP Designation-Members must designate a PCP for subscribers and dependents**	**PCP Designation-Members must designate a PCP for subscribers and dependents**
Medical office visits	$15 Copay EPHC PCP $25 Other PCP Provider $30 Specialist	$15 Copay EPHC PCP $25 Other PCP Provider $30 Specialist	After Deductible - 100% Co-Insurance In-Network 70% Out of Network
	EPHC (Enhanced Personal Healthcare Providers)-These providers have committed to providing enhanced care in terms of managing your overall health		
Physical or Occupational Therapy	$30 Copay 30 Combined Visits for pt, ot st 20 visit for chiro-prior auth is required on pt/ot	$30 Copay 30 Combined Visits for pt, ot st 20 visit for chiro-prior auth is required on pt/ot	After Deductible 100% Co-Insurance in network; 70% out of network 50 Combined visits for pt ot st and chiro excess rolls to out of network
Speech Therapy	$30 Copay 30 Combined Visits for pt, ot st 20 visit for chiro-prior auth is required on pt/ot	$30 Copay 30 Combined Visits for pt, ot st 20 visit for chiro-prior auth is required on pt/ot	After Deductible 100% Co-Insurance in network; 70% out of network 50 Combined visits for pt ot st and chiro excess rolls to out of network
Chiropractic Services	$30 Copay 30 Combined Visits for pt, ot st 20 visit for chiro-prior auth is required on pt/ot	$30 Copay 30 Combined Visits for pt, ot st 20 visit for chiro-prior auth is required on pt/ot	After Deductible 100% Co-Insurance in network; 70% out of network 50 Combined visits for pt ot st and chiro excess rolls to out of network
Allergy Services	$30 Copay 80 visits in 3 years	$30 Copay 80 visits in 3 years	After Deductible 100% Co-Insurance in network; 70% out of network Unlimited Injections
Lab & X-Ray	Covered	Covered	Covered
High Cost Diagnostics	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	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	After Deductible High Cost Diagnostic (MRI, MRA, CAT, CTA, PET, Spect) After Deductible 100% Co-Insurance in network; 70% out of network
Outpatient Mental Health & Substance Abuse	$25 Copay Unlimited Visits Prior auth required	$25 Copay Unlimited Visits Prior auth required	After Deductible 100% Co-Insurance in network; 70% out of network Unlimited Visits Prior auth required
EMERGENCY CARE			
Emergency Room	$150 Copay (waived if admitted)	$150 Copay (waived if admitted)	After Deductible 100% Co-Insurance in network; 70% out of network
Urgent Care	$100 Copay	$100 Copay	After Deductible 100% Co-Insurance in network; 70% out of network

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Walk-In Centers	$25 Copay	$25 Copay	After Deductible 100% Co-Insurance in network; 70% out of network
Ambulance	Unlimited for Land and Air	Unlimited for Land and Air	After Deductible 100% Co-Insurance in network; 70% 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 Admissions Require Pre-Cert After Deductible 100% in Network; 70% Out of Network
Ancillary Services-Medications and Supplies	Covered	Covered	All Hospital Admissions Require Pre-Cert After Deductible 100% in Network; 70% Out of Network
Mental Health	$250 Copay Per Admission Copay Unlimited Days	$250 Copay Per Admission Copay Unlimited Days	All Hospital Admissions Require Pre-Cert After Deductible 100% in Network; 70% Out of Network Unlimited Days
Substance Abuse	$250 Per Admission Copay Unlimited Days	$250 Per Admission Copay Unlimited Days	All Hospital Admissions Require Pre-Cert After Deductible 100% in Network; 70% Out of Network Unlimited Days
Rehabilitative Services	$250 Per Admission Copay 60 Days Per Calendar Year	$250 Per Admission Copay 60 Days Per Calendar Year	All Hospital Admissions Require Pre-Cert After Deductible 100% in Network; 70% Out of Network 100 Days Per Calendar Year
Skilled Nursing Facility	$250 Per Admission Copay 120 Days Per calendar Year	$250 Per Admission Copay 120 Days Per calendar Year	All Hospital Admissions Require Pre-Cert After Deductible 100% in Network; 70% Out of Network 120 Days Per calendar Year
Outpatient Surgery (Facility Charges)	Prior Authorization Required $200 Copay Ambulatory surgery - $100	Prior Authorization Required $200 Copay Ambulatory surgery- $100	Prior Authorization Required After Deductible 100% Co-Insurance in network; 70% out of network Ambulatory surgery (in a hospital setting) After Deductible 100% / 70%
Pre-Admission Testing	Covered	Covered	After Deductible 100% Co-Insurance in network; 70% out of network
Lab & X-Ray	Covered	Covered	Covered
High Cost Diagnostics	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	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	Prior Authorization Required High Cost Diagnostic (MRI, MRA, CAT, CTA, PET, Spect) After Deductible 100% Co-Insurance in network; 70% out of network
OTHER SERVICES			
Durable Medical Equipment (Including Prosthetics)	Covered at 100%	Covered at 100%	After Deductible 100% Co-Insurance in network 70% out of network
Foot Orthotics	Not Covered	Not Covered	After Deductible 100% Co-Insurance in network 70% out of network

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Home Health Care	Covered 200 Visits OON-$50 Deductible & 20% Coinsurance	Covered 200 Visits	After Deductible 100% Co-Insurance in network 70% out of network 200 visits 80 aide visits
Hospice	Covered	Covered	After Deductible 100% Co-Insurance in network; 70% out of network Unlimited
Acupuncture	$30 Copay	$30 Copay	After Deductible 100% Co-Insurance in network; 70% out of network unlimited visits
TMJ	Not Covered	Not Covered	Not Covered
Gastric Bypass	Covered	Covered	After Deductible 100% Co-Insurance in network; 70% out of network
Infertility	$30 office Visit Copay State Mandate Level-Prior Auth required Some Restrictions May Apply	$30 Office Visit Copay State Mandate Level-Prior Auth required Some Restrictions May Apply	After Deductible 100% Co-Insurance in network; 70% out of network State Mandate Level-Prior Auth required Some Restrictions May Apply
Oral Surgery	Not Covered	Not Covered	After Deductible 100% Co-Insurance in network; 70% out of network Removal of impacted teeth, cutting procedures, full or partial dentures, fixed bridgework and prompt repair to natural teeth due to accidental injury while covered-including Dental Anesthesia
Private Duty Nursing	No Copay Up to a $15,000 Maximum per member per calendar year	No Copay Up to a $15,000 Maximum per member per calendar year	After Deductible 100% Co-Insurance in network; 70% out of network Up to a $15,000 Maximum per member per calendar year
Prescriptions			
Tier 1 - Generics	$5	$5	After deductible, $5
Tier 2 - Formulary Brand	$30	$30	After deductible, $15
Tier 3 - Non-Formulary	$50	$50	After deductible, $25
Tier 4 - Speciality	Specialty Drugs	Specialty Drugs	
Mail Order (up to 90 day supply)			
Tier 1 - Generics	$10	$10	After deductible, $10
Tier 2 - Formulary Brand	$60	$60	After deductible, $30
Tier 3 - Non-Formulary	$100	$100	After deductible, $50
Tier 4 - Speciality	Specialty Drugs	Specialty Drugs	
	Mandatory Mail Order / Mandatory Generic Step Therapy Prior Authorization Quantity Limits	Mandatory Mail Order / Mandatory Generic Step Therapy Prior Authorization Quantity Limits	Mandatory Generic Step Therapy Prior Authorization Quantity Limits Diabetic medication is subject to deductible and Rx copays
Mandatory Specialty	With Half Fill program	With Half Fill program	