

## Operating Engineers – Local 877

Medical Benefits for Group AB9 Effective 11/1/2014



	NETWORK Harvard Pilgrim HealthCare	NON-NETWORK
<b>Annual Deductible</b>		
Single:	N/A	\$200
Family:	N/A	\$500
<b>Annual Out-Of-Pocket Maximum</b>		
Single:	\$2,500	\$2,500
Family*:	\$5,000	\$5,000
<b>Preventive Care</b>		
Routine Physicals (1 per person; per calendar year – age 20+)	100%	85% after deductible
Well Child Care (up to age 20, includes immunizations)	100%	85% after deductible
Routine Mammography (1 annually)	100%	85% after deductible
Routine GYN Exam (1 per person; per calendar year)	100%	85% after deductible
<b>Doctor's Services</b>		
Office Visits – including all charges billed with visit	\$10 copay then 100%	85% R&C* after deductible
Chiropractic Care (maximum 30 visits per person per calendar year)	100%	not covered (paid in network with MAP approval)
Speech, Physical & Occupational Therapy (due to illness)	100%	85% R&C* after deductible
Physical & Occupational Therapy (due to developmental delay)	not covered	not covered
Chemotherapy & Radiation Therapy	100%	85% R&C* after deductible
Maternity	100%	85% R&C* after deductible
Anesthesia	100%	85% R&C* after deductible
<b>Hospital Services</b>		
Inpatient**	100%	85% R&C* after deductible
Outpatient	100%	85% R&C* after deductible
Medical Emergency	100%	85% R&C* after deductible
Non-Medical Emergency	\$25 copay then 100%	\$25 copay then 85%
<b>Mental Health/Substance Abuse</b>		
Inpatient <sup>+</sup>	100%	85% R&C* after deductible
Outpatient	100%	85% R&C* after deductible (paid in network with MAP approval)
<b>*PRECERTIFICATION MUST BE WITH MODERN ASSISTANCE PROGRAMS. FAILURE TO PRECETIFY WILL RESULT IN PENALTY OF 15% FOR ALL SERVICES</b>		
<b>Other Services</b>		
Skilled Nursing Facility Care/Extended Care Facility (90 days per illness)	100%	85% R&C* after deductible
Home Health Care (100 visit or 200 hours per calendar year)	100%	85% R&C* after deductible
Hospice Care	100%	85% R&C* after deductible
Prosthetics	100%	85% R&C* after deductible
Treatment for Temporomandibular Joint Dysfunction (\$750 per person per calendar year)	100%	85% R&C* after deductible
Ambulance	100%	100%
Durable Medical Equipment	100%	85% R&C* after deductible
Diagnostic Lab, X-Ray & Clinical Tests	100%	85% R&C* after deductible
Allergy Injections	100%	85% R&C* after deductible
Infertility Testing	100%	85% R&C* after deductible
Infertility Treatment	not covered	not covered
Vision Benefit (includes 1 exam, frames, lenses & contacts up to \$300 per person per calendar year)	100%	100%
Hearing Benefit 1 exam every 2 years plus \$1,000 an ear for hearing aids every 5 years when services are rendered by a HearUSA, Inc. provider		
Health Club Membership (\$200 individual/\$400 family)	100%	100%
Alternative/Complementary Benefit (\$1,000 per person per calendar year) (includes, but not limited to, acupuncture, acupressure, homeopathy, naturopathy, weight loss, smoking cessation, massage therapy)	100%	100%
<b>Express Scripts Discount Prescription Drug Benefit</b>	RX Out-Of-Pocket Maximum	Single: \$3,500 Family: \$7,000
Plan pays 100% after copay		
Retail: 34 day supply	\$5 Generic/\$10 Brand	
Mail Order: 34-90 day supply	\$0 Generic / \$10 Brand	
Charges for birth control medication and pre-natal vitamins are covered under the prescription card. Smoking Cessation Medications (prescription only) are covered under the drug card.		

\*The plan participant is also responsible to pay any amount above the reasonable and customary allowance when services are rendered by an out-of-network provider.

**\*\*UTILIZATION REVIEW / HOSPITAL PRE-CERTIFICATION/COMPLEX CASE MANAGEMENT** is provided by Care Management Services (CMS). The CMS toll-free number is located on your ID card. If you fail to follow the pre-admission certification requirements, your benefits will be reduced by 15% on otherwise covered charges of a hospital or other facility for each admission.

**NOTES:** This Summary provides you with an overview of your Plan benefits and is not a complete statement of all Plan provisions, limitations and exclusions. Please refer to your Plan Document and amendments for complete details. In the event of any inconsistency between this Summary and your Plan Document, the Plan Document and any applicable amendments will govern.

---

The Plan Sponsor believes that this is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Act). As permitted by the Act, a grandfathered plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being grandfathered means the plan may not include certain consumer protections of the Act that apply to other plans, such as providing preventive health services without any cost sharing. However, a grandfathered plan must comply with certain other consumer protections of the Act, such as the elimination of annual and lifetime limits on most benefits.

Questions about which protections do or do not apply, and what causes a plan to change from grandfathered health plan status can be directed to the Plan Administrator at (781) 769-5789.