COMPARATIVE HIGHLIGHTS OF MATC HEALTH INSURANCE PLANS

For All MATC Benefit-Eligible Administrators, Local 212 and Local 715 Members

		Humana Premier HMO	**MATC PPO - High Benefit Level**	**MATC PPO - Low Benefit Level**
		All services must be done by Premier network providers or no benefits payable.	*All services subject to annual deductible unless otherwise specified. Svcs may be from any qualified health practitioner - Higher benefits paid when in-network providers used.*	*Services may be from any qualified health practitioner - Higher benefits paid when in-network providers used.*
Your cost per pay period*		**Single: $19.50; Family: $39.00**	**Single: $16.50; Family: $33.00**	**Single: $0; Family: $0**
Benefit Highlights				
1	**Deductible**	None	$250 individual; $500 family annual deductible. Deductible applies to all services listed below except mammograms and prescription drugs or unless otherwise specified.	$1,250 individual; $2,500 family annual deductible. Deductible applies to all services including prescription drugs. 80% co-insurance for in-network services; 50% co-insurance for out-of-network services.
2	**Maximum Annual Out-of-Pocket Limit (Co-insurance Limit)**	Co-insurance applies to mental health services and drug/alcohol abuse treatment.	Employee's co-insurance cost limited to $350 individual/$700 family for in network services. Limited to $550 individual/$900 family for out of network services.	$2,000 individual; $4,000 family
3	**Prescription Drugs**	Prescription drug card with $5 generic/$15 brand-name co-pay. 90-day mail order option $5/$15 also. Smoking cessation Rx covered.	Prescription drug card with $5 generic/$15 brand-name co-pay. 90-day mail order option $5/$15 also. Smoking cessation Rx covered.	All services, including prescription drugs, first subject to deductible, then co-insurance up to out-of-pocket maximum. Afterward, covered charges paid at 100% of drug card discount price.
<u>INPATIENT SERVICES</u>				
4	**Hospitalization (including pregnancy)**	$50 co-pay per admission.	Paid at 100% after $50 co-pay per in network admission. Paid at 80% after $50 co-pay per out of network admission. Care Coordinator must be notified of admission or $500 penalty.	All services first subject to deductible, then co-insurance up to out-of-pocket maximum. Afterward, covered charges paid at 100% for balance of calendar year.
5	**Surgical-Medical Care**	Provided in full.	100% in network/80% out of network.	Same as given under "Hospitalization"
6	**Pre-Admission Lab and X-Rays**	Provided in full.	100% in network/80% out of network.	Same as given under "Hospitalization" above.
7	**Physician In-hospital Visits**	Provided in full.	100% in network/80% out of network.	Same as given under "Hospitalization" above.
8	**Miscellaneous Hospital Expenses**	Provided in full.	Paid at 100% after $25 in network co-pay per admission. Paid at 80% out of network after $50 co-pay per admission. Health Care Coordinator notification required.	Same as given under "Hospitalization" above.
9	**Skilled Nursing Home Care**	Provided in full. Semi-private room or ward payable at daily rate set by Dept of Health & Social Services.	30 days covered if immediately following hospital stay at 90% in network/80% out of network subject to out of pocket maximums.	Same as given under "Hospitalization" above.
10	**Surgery performed as outpatient (no hospital admission)**	Provided in full.	Paid at 100% in network. Paid at 80% out of network.	Same as given under "Hospitalization" above.

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		Humana Premier HMO	MATC PPO - High Benefit Level	MATC PPO - Low Benefit Level
11	**Medical procedure performed as outpatient (no hospital admission)**	Provided in full.	100% in network/80% out of network. No co-pay.	Same as given under "Hospitalization" above.
12	**X-Rays and Lab Tests**	Provided in full.	100% in network/80% out of network, except routine mammograms paid full.	Same as given under "Hospitalization" above.
13	**Radiation and Chemotherapy**	Provided in full.	100% in network/ 80% out of network. Outpatient $25 co-pay in or out of network. Limit 3 co-pays per year.	Same as given under "Hospitalization" above.
EMERGENCY SERVICES				
14	**Ambulance**	$25 co-pay per trip.	$25 co-pay. Paid at 90% thereafter, in or out of network.	Same as given under "Hospitalization"
15	**Emergency Room**	$75 co-pay. Waived if admitted or referred by urgent care physician.	100% after $75 co-pay, in or out of network. Co-pay waived if admitted or referred by urgent care physician.	Same as given under "Hospitalization" above.
16	**Urgent Care Center**	$25 co-pay. Co-pay waived if admitted or referred to an emergency room.	90% in network/80% out of network/ $25 co-pay. Co-pay waived if admitted or referred to an emergency room.	Same as given under "Hospitalization" above.
OFFICE VISITS				
17	**• Primary Care Physician (PCP)**	$15 office co-pay per visit.	95% with deductible waived for in-network/80% out-of-network.	Same as given under "Hospitalization" above.
	• Specialist Physician	$15 office co-pay per visit.	Visit charges: 95% with deductible waived with in-network "referral" from PCP; 90% after deductible if no referral to in-network provider; 80% after deductible for out-of-network provider.	Same as given under "Hospitalization" above.
	• Physical Therapy Expenses	Same as "Specialist Physician" above	90% in network/80% out of network.	Same as given under "Hospitalization" above.
	• Allergy Care (other than office visit)	Same as "Specialist Physician" above	90% in network/80% out of network.	Same as given under "Hospitalization" above.
	• Chiropractor	Same as "Specialist Physician" above	Same as given under "Specialist Physician" above.	Same as given under "Hospitalization" above.
	• Well Baby Care	Pediatrician paid same as Primary Care Physician above	95% with deductible waived for in-network when infant Primary Care Physician is used/80% out-of-network.	Same as given under "Hospitalization" above.
18	**Medical Supplies**	Provided in full.	90% in network/80% out of network.	Same as given under "Hospitalization"
19	**Immunizations and Injections**	Included in physician visit.	90% in network/80% out of network.	Same as given under "Hospitalization" above.
MENTAL HEALTH				

COMPARATIVE HIGHLIGHTS OF MATC HEALTH INSURANCE PLANS

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		Humana Premier HMO	MATC PPO - High Benefit Level	MATC PPO - Low Benefit Level
20	**Outpatient**	Behavioral managed care network. After $10 office co-pay per visit, 20 visits paid at 100%. Unlimited additional visits paid at 80%	Behavioral managed care network. 100% in network after deductible up to first $1,800; 90% in network thereafter; 80% out of network.	Same as given under "Hospitalization" above.
21	**Inpatient Hospital**	$50 co-pay per admission. 30 days paid at 100%.	100% in network/80% out of network. 365 days/per disability in a hospital; 70 days per confinement in a qualified treatment facility.	Same as given under "Hospitalization" above.
22	**Transitional Care**	14 visits per calendar year.	100% in network after deductible up to first $1,800; 90% in network thereafter; 80% out of network.	Same as given under "Hospitalization" above.
DRUG AND ALCOHOL ABUSE TREATMENT				
23	**Outpatient**	35 visits or $1,800 per person each calendar year, whichever is greater; additional visits at 80%. (Same benefit—network may change).	100% in network after deductible up to first $1,800; 90% in network thereafter; 80% out of network.	Same as given under "Hospitalization" above.
24	**Inpatient**	$50 co-pay per admission. 30 days paid at 100%. Additional 90 days paid at 80%.	100% in network/80% out of network. 365 days/per disability in a hospital; 70 days per disability in a qualified treatment facility	Same as given under "Hospitalization" above.
25	**Transitional Care**	100% of $2,700. Thereafter, one additional visit for mental health treatment only.	100% in network after deductible up to first $1,800; 90% in network thereafter; 80% out of network.	Same as given under "Hospitalization" above.
IN-HOME CARE				
26	**Home Health**	Provided in full.	Up to 40 visits/calendar year paid in full.	Same as given under "Hospitalization"
27	**Private Duty Nursing**	Provided in full.	90% in network/80% out of network.	Same as given under "Hospitalization"
DENTAL SURGERY				
28	**Oral Surgery**	13 specific oral surgical procedures/$25 co-pay per procedure, including gingivectomy, alveolectomy and apicoectomy. Must use a network provider.	13 specific oral surgical procedures, including gingivectomy, alveoectomy and apicoectomy.	Same as given under "Hospitalization" above.
29	**Routine Eye Care**	One in-network eye exam/cal yr.; for prescription glasses and contact lenses only. $125 reimbursable towards purchase of hardware/lenses/frames, for each eligible dependent.	One eye exam per calendar year. For prescription glasses and contact lenses only. $125 reimbursable towards purchase of hardware/lenses/frames, for each eligible dependent.	Not covered under medical plan -- covered under vision benefit only.
30	**Hearing Exams**	$15 co-pay per office visit.	Not covered.	Not covered.

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31	**Hearing Aids**	100% of usual & customary charges, once each 36-month period.	Not covered.	Not covered.
HEALTH COUNSELING/PHYSICAL FITNESS				
32	**Health Counseling**	$15 co-pay per office.	Not covered.	Not covered.
33	**Physical Fitness Programs**	$100 per person/$300 per family paid for certain classes or memberships; call Humana for details.	Not covered.	Not covered.
APPLICABLE TO ALL PLANS				
34	**Lifetime Maximum**	Unlimited.	Unlimited.	Unlimited
35	**Dependent Coverage**	Dependent children covered from birth through the earlier of the date they marry or the end of the calendar year they become 25, if receiving more than 50% of their support from the subscriber. Same-sex domestic partners can be included (with tax consequences). Dependents of partner not eligible.	Dependent children covered from birth through the earlier of the end of the month they marry or the end of the calendar year they become 25, if receiving more than 50% of their support from the subscriber. Same-sex domestic partners can be included (with tax consequences). Dependents of partner not eligible.	Dependent children covered from birth through the earlier of the end of the month they marry or the end of the calendar year they become 25, if receiving more than 50% of their support from the subscriber. Same-sex domestic partners can be included (with tax consequences). Dependents of partner not eligible.
36	**Wellness and Disease Management Programs**	$100 per person/$300 per family paid for certain classes or memberships; call Humana for details. Mammogram covered at 100% whether in or out of network and not subject to deductible associated with any plan.	Health risk assessment, disease classification, stratification, education, and personal disease manager for chronically ill participants. Wellness benefits/incentives for those who participate. Mammogram covered at 100% whether in or out of network and not subject to deductible associated with any plan.	Health/Care Coordinator service available (through Quantum Health) on voluntary basis for those who seek assistance with wellness-related activities. Mammogram covered at 100% in or out of network and not subject to deductible associated with any plan.

*** Payroll deductions are automatically taken on a pre-tax basis unless the employee has provided Human resources with written instructions to the contrary.**

This comparison describes MATC's benefit programs in general terms. The terms and conditions of contracts with insurance carriers dictate all interpretations of information included here.