

MATC MEDICAL PLANS EFFECTIVE SEPT. 1, 2007

Local 587

MATC PPO Plan

Medical Services can be provided by any qualified health care practitioner; use of in-network providers yields higher benefit payment.

Humana Premier HMO

Medical services must be provided by in-network providers for any coverage.

<u>Per Paycheck Contribution (Pre-tax)</u>	\$10.16/paycheck - single coverage \$27.58/paycheck - family coverage	\$9.87/paycheck - single coverage \$26.04/paycheck - family coverage
1 Deductible	\$200 individual; \$400 family annual deductible. Deductible is waived for mammograms and for visits to in-network family physician or specialist physician (with referral from family physician)	None
2 Out-of-Pocket Maximum	Maximum is limited to \$300 /individual or \$600/family for covered, in-network services	Co-insurance only applies to mental health services or drug/alcohol abuse treatment
3 Prescription Drugs	Rx card with \$5/\$10 co-payment; 90-day mail order option \$5/\$10. Smoking cessation products covered.	Rx card with \$5/\$10 co-payment; 90-day mail order option \$5/\$10. Smoking cessation products covered.
<u>IN-HOSPITAL SERVICES</u>		
4 Hospitalization	Paid at 100% after \$25 in-network co-payment/admission. Paid at 80% after \$50 co-payment/admission for out-of-network facility. Pre-admission notification to Quantum Community Care Coordinators is required or penalty applies.	\$25 co-payment per admission
5 Surgical/Medical Treatment	100% in-network providers; 80% out of network	Provided in full.
6 Pre-admission Lab/X-ray	100% in-network providers; 80% out of network. No co-payments	Provided in full.
7 Physician In-Hospital Visits	100% in-network providers; 80% out of network	Provided in full.
8 Misc. Hospital Expenses	In-network: Paid 100% after \$25 co-payment per admission/ Out-of-network: 80% after \$50 co-payment per admission.	Provided in full.
9 Skilled Nursing Home Care	30 days covered at 90% in-network or 80% out-of-network if immediately follows inpatient hospital stay.	Semi-private room or ward rate provided in full, as set by Dept. of Health and Human Services.
10 Maternity	Paid same as any other diagnosis. Dependent daughters covered.	Paid same as any other diagnosis. Dependent daughters covered.
<u>OUTPATIENT SERVICES</u>		
11 Out-Patient Surgery	In-network: 100%. Out-of-network: 80%.	Provided in full.
12 Out-Patient Medical Procedure	In-network: 100%. Out-of-network: 80%	Provided in full.
13 X-ray and Lab Tests	In-network: 100%. Out-of-network: 80%	Provided in full.
14 Radiation or Chemotherapy	In-network: 100%. Out-of-network: 80%. Out-patient co-payment of \$25 with max of 3 co-payments/yr.	Provided in full.
<u>EMERGENCY SERVICES</u>		
15 Ambulance	90% after \$25 co-payment, in- or out-of-network.	\$25 co-payment per trip.
16 Emergency Room for Accident/Illness	100% after \$50 co-payment, in- or out-of-network. Co-payment waived if admitted to hospital or referred by urgent care physician.	Provided in full after \$50 co-payment. Co-payment waived if admitted to hospital or referred by urgent care physician.
17 Urgent Care Center	100% in-network or out-of-network with \$25 co-payment. Co-payment waived if admitted to hospital.	Provided in full after \$25 co-payment. Co-payment waived if admitted to hospital or referred by urgent care physician.
<u>OFFICE VISITS WITH:</u>		
18 Primary Care Physician	95% with deductible waived for <u>in-network provider</u> . 80% after deductible for out-of-network provider.	\$10 co-payment per visit.
(A.) Specialist Physician	95% with deductible waived for <u>in-network provider AND referral</u> from Primary Care Physician	\$10 co-payment per visit WITH referral from Primary Care Physician
(B.) Specialist Physician	90% after deductible for <u>in-network provider</u> and <u>NO REFERRAL</u> from Primary Care Physician	Not applicable.
(C.) Specialist Chiropractor	80% after deductible for <u>out-of-network</u> provider	Not applicable.
Allergist Svcs.	95% with deductible waived for <u>in-network provider</u> for visits 1-24; 80% for visits 25+. 80% after deductible for out-of-network provider for visits 1-24; 75% for visits 25+ 90% in-network providers; 80% out of network	\$10 co-payment per visit WITH referral from Primary Care Physician

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Physical Therapy	90% in-network providers; 80% out of network	\$10 co-payment per visit WITH referral from Primary Care Physician
Well Baby Care	90% in-network providers; 80% out of network	Provided in full.
19 Medical Supplies	90% in-network providers; 80% out of network	Provided in full.
20 Immunizations/ Injections	90% in-network providers; 80% out of network	Included in physician visits.
<u>MENTAL HEALTH</u>		
21 Out-Patient Care	100% in-network after deductible up to first \$1,800, 90% thereafter. 80% out-of-network	Behavioral managed care network. After the \$10 co-payment per visit, 100% payment for up to 20 visits. Additional visits paid at 80%
22 In-Patient Care	100% in-network/80% out-of-network. 365 days limit per disability in a hospital; 70 days per confinement in qualified treatment facility.	\$50 co-payment per admission. Up to 30 days paid at 100%. Up to an additional 90 days paid at 80%.
23 Transitional Care	100% in-network after deductible up to first \$1,800, 90% thereafter. 80% out-of-network	14 visits per calendar year.
<u>DRUG/ALCOHOL ABUSE SERVICES</u>		
24 Out-Patient	100% in-network after deductible up to first \$1,800, 90% thereafter. 80% out-of-network	Greater of 35 visits or \$1,800 per person/cal yr. Additional visits at 80%.
25 In-Patient	100% in-network/80% out-of-network. 365 days limit per disability in a hospital; 70 days per confinement in qualified treatment facility.	\$50 co-payment per admission. Up to 30 days paid at 100%. Up to an additional 90 days paid at 80%.
26 Transitional Care	100% in-network after deductible up to first \$1,800, 90% thereafter. 80% out-of-network	100% of up to \$2,700. On additional visit for mental health treatment only.
<u>IN-HOME CARE</u>		
27 Home Health Care	Up to 40 visits/cal yr paid in full.	Provided in full.
28 Private Duty Nursing	90% in-network; 80% out-of-network	Provided in full.
<u>DENTAL SURGERY</u>		
29 Oral Surgery	13 specific oral procedures covered under medical plan, including gingivectomy, alveoectomy and apicoectomy.	13 specific oral procedures covered under medical plan after \$25/procedure co-payment. Includes gingivectomy, alveoectomy and apicoectomy. Network provider must be used.
<u>HEARING/VISION</u>		
30 Routine Eye Exams	Not covered under medical plan.	One eye exam per year for prescription only.
31 Hearing Exams	Not covered under medical plan.	One exam per calendar year. \$10 co-payment per visit.
32 Hearing Aids	Not covered under medical plan.	Once in a 36-month period, aids paid at 100% of reasonable & customary charges.
<u>HEALTH COUNSELING & PHYSICAL FITNESS</u>		
33 Health Counseling	Not covered under medical plan.	\$10 co-payment per visit.
34 Physical Fitness Program	Not covered under medical plan.	\$100 per person, up to \$300 per family reimbursement for health club memberships, exercise classes.
<u>APPLIES TO ALL PLANS</u>		
35 Lifetime Maximum Benefits	Unlimited.	Unlimited.
36 Dependents Coverage	Spouse and IRS-dependent children from birth through the month they marry or if earlier, through the calendar year they turn 25.	Spouse and IRS-dependent children from birth through the month they marry or if earlier, through the calendar year they turn 25.
37 Wellness & Disease Management Programs	PPO plan offers services through Quantum Health Care Coordinators	See "Physical Fitness Program" and "Health Counseling" above