HealthPlans, Inc.

Summary of Benefits

# *Operating Engineers – Local 877*

*Medical Benefits for Group **AB9***  *Effective 1/1/2017*

| | NETWORK Harvard Pilgrim Health Care | NON-NETWORK |
|---|---|---|
| **Annual Deductible** | | |
| Single: | $250 | $500 |
| Family: | $500 | $1,000 |
| **Annual Out-Of-Pocket Maximum** | | |
| Single: | $2,500 | $2,500 |
| Family*: | $5,000 | $5,000 |
| **Preventive Care** | | |
| 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 |
| **Doctor's Services** | | |
| Office Visits – including all charges billed with visit | $15 copay then 100% | 85% R&C* after deductible |
| Chiropractic Care (maximum 30 visits per person per calendar year) | $15 copay then 100% | not covered |
| Speech, Physical & Occupational Therapy (due to illness) | $15 copay then 100% | 85% R&C* after deductible |
| Physical & Occupational Therapy (due to developmental delay) | not covered | not covered |
| Chemotherapy & Radiation Therapy | 100% after deductible | 85% R&C* after deductible |
| Maternity | 100% after deductible | 85% R&C* after deductible |
| Anesthesia | 100% after deductible | 85% R&C* after deductible |
| **Hospital Services** | | |
| Inpatient** | 100% after deductible | 85% R&C* after deductible |
| Outpatient | 100% after deductible | 85% R&C* after deductible |
| Emergency Room (copay waived if admitted) | $100 copay then 100% | Paid at In Network Level |
| **Mental Health/Substance Abuse** | | |
| Inpatient+ | 100% after deductible | 85% R&C* after deductible |
| Outpatient | 100% deductible waived | 85% R&C* after deductible (paid in network with MAP approval) |
| +***PRECERTIFICATION MUST BE WITH MODERN ASSISTANCE PROGRAMS. FAILURE TO PRECERTIFY WILL RESULT IN PENALTY OF 20% FOR ALL SERVICES*** | | |
| **Other Services** | | |
| Skilled Nursing Facility Care/Extended Care Facility (90 days per illness) | 100% after deductible | 85% R&C* after deductible |
| Home Health Care (100 visit or 200 hours per calendar year) | 100% after deductible | 85% R&C* after deductible |
| Hospice Care | 100% deductible waived | 85% R&C* after deductible |
| Prosthetics | 100% after deductible | 85% R&C* after deductible |
| Treatment for Temporomandibular Joint Dysfunction ($750 per person per calendar year) | 100% deductible waived | 85% R&C* after deductible |
| Ambulance | 100% after deductible | 100% |
| Durable Medical Equipment | 100% after deductible | 85% R&C* after deductible |
| Diagnostic Lab, X-Ray & Clinical Tests | 100% after deductible | 85% R&C* after deductible |
| Allergy Injections | 100% after deductible | 85% R&C* after deductible |
| Infertility Testing | 100% after deductible | 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% deductible waived | 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 ($400 per person per calendar year) | 100% deductible waived | 100% |
| Alternative/Complementary Benefit ($500 per person per calendar year) (see Funds Office for eligible benefits) | 100% deductible waived | 100% |
| **Caremark Discount Prescription Drug Benefit** | RX Out-Of-Pocket Maximum | Single: $3,500 Family: $7,000 |
| Plan pays 100% after copay | | |
| Retail: 34 day supply | $7 Generic / $15 Preferred Brand / $30 Non Preferred Brand and Specialty | |
| Mail Order: 34-90 day supply | $15 Generic / $30 Preferred Brand / $60 Non Preferred Brand and Specialty | |

Charges for birth control medication and pre-natal vitamins are covered under the prescription plan. Smoking Cessation Medications (prescription only) are covered under the prescription plan.

**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.