

Mid-Atlantic MEP PPO Side-by-Side—Current Plan and 9/14 MOU

	Current Plan		9/14 MOU	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Contributions	None		<ul style="list-style-type: none"> ■ 2012: \$30/\$600 ■ 2013: \$45/\$900 ■ 2014: \$50/\$1000 ■ 2015: \$55/\$1100 	
Deductible				
Individual	<ul style="list-style-type: none"> ■ \$250 ■ Retirees: based on retirement date 		<ul style="list-style-type: none"> ■ 2013: \$400 ■ 2014: \$450 ■ 2015: \$475 ■ Retirees: based on retirement date ■ Retired on or after January 1, 2013: same as active 	
			Combined in- and out-of-network	
			<ul style="list-style-type: none"> ■ 2013: \$250 ■ 2014: \$250 ■ 2015: \$250 ■ Additional applied to out-of-network 	
Family	2.5 x Individual		2.5 x Individual [2]	
Hospital	None	Deductible applies to certain services	Deductible applies	Deductible applies
Carryover	Expenses applied during October, November or December also apply to the next year's deductible		Expenses applied during October, November or December also apply to the next year's deductible	
Charges Excluded From Deductible	<ul style="list-style-type: none"> ■ Copay for office visits ■ Copays for visits to urgent care facilities or emergency rooms ■ Charges payable when pre-admission testing is done on an inpatient basis and the inpatient admission is not considered medically necessary ■ Charges payable when select outpatient surgery is performed on an inpatient basis and the admission is considered not medically necessary ■ Charges for services and supplies not covered by the Medical Plan ■ Expenses for prescription drugs ■ Charges that exceed R&C, NNF or other Medical Plan limits 		<ul style="list-style-type: none"> ■ Flat dollar copays paid for medical care ■ Copays for visits to urgent care facilities or emergency rooms ■ Charges paid for failure to follow precertification procedures ■ Charges for services and supplies not covered by the Medical Plan ■ Expenses for prescription drugs ■ Charges that exceed MAA, NNF or other Medical Plan limits ■ Amounts for LASIK services 	

	Current Plan		9/14 MOU	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Out-of-Pocket Maximums (Calendar Year)				
Individual	\$1,000		<ul style="list-style-type: none"> ■ 2013: \$1,050 ■ 2014: \$1,100 ■ 2015: \$1,150 Combined in- and out-of-network	
			—	<ul style="list-style-type: none"> ■ 2013: \$950 ■ 2014: \$900 ■ 2015: \$900 Additional applied to out-of-network
Family	Maximums are per individual per year; combined family max is not applicable		2.5x Individual(2)	
Charges Excluded From Out-of-Pocket Maximum	<ul style="list-style-type: none"> ■ Copays for office visits, hospital charges, surgery, outpatient laboratory tests and outpatient x-rays ■ Copays for visits to urgent care facilities or emergency rooms ■ Amounts paid to satisfy the deductible ■ Charges for services and supplies not covered by the Medical Plan ■ Additional amounts paid for not following precertification program procedures ■ Charges that exceed R&C, NNF or other Medical Plan limits ■ Expenses for prescription drugs 		<ul style="list-style-type: none"> ■ Flat dollar copays paid for medical care ■ Charges in excess of obesity annual and infertility lifetime maximums ■ Charges for services and supplies not covered by the Medical Plan ■ Additional amounts paid for not following precertification program procedures ■ Charges that exceed MAA, NNF or other Medical Plan limits ■ Expenses for prescription drugs ■ Amounts for LASIK services 	
Coinsurance Based On:				
	Network Negotiated Fee (NNF)	Reasonable and Customary Charges (R&C)	Network Negotiated Fee (NNF)	Maximum Allowed Amount (MAA)

	Current Plan		9/14 MOU	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Outpatient Treatment				
Doctors' Home or Office Visits	\$15 copay (\$5 copay Medicare-eligible)	80% covered after deductible; Reasonable and Customary limits apply	\$20 copay (\$10 copay Medicare-eligible)	70% covered after deductible
Preventive Care	100% covered, no deductible; age/frequency limits apply	100% covered, no deductible; age/frequency limits apply; Reasonable and Customary limits apply	100% covered, no deductible; age and frequency provisions of the Affordable Care Act apply	100% covered, no deductible; age and frequency provisions of the Affordable Care Act apply
Routine Well-Baby and Well-Child Care (Pediatric Exams)	100% covered, no deductible; age/frequency limits apply	100% covered, no deductible; age/frequency limits apply; Reasonable and Customary limits apply	100% covered, no deductible; age and frequency provisions of the Affordable Care Act apply	100% covered, no deductible; age and frequency provisions of the Affordable Care Act apply
X rays and Lab Tests	100% covered, no deductible	100% covered (deductible applies if hospital charges billed for diagnostic, no deductible for preventive); Reasonable and Customary limits apply	\$20 copay (\$10 copay Medicare-eligible)	70% covered after deductible
Radiation Therapy/ Chemotherapy/ Electroshock Therapy/ Hemodialysis	100% covered, no deductible hospital outpatient; \$15 copay (\$5 copay Medicare-eligible) if done in physician's office	100% covered, no deductible; Reasonable and Customary limits apply	90% covered after deductible outpatient facility; \$20 copay (\$10 copay Medicare-eligible) if done in physician's office	70% covered after deductible
Physical, Occupational and Speech Therapy	80% covered of NNF4 after deductible	80% covered after deductible; Reasonable and Customary limits apply	80% covered after deductible; number of visits based on medical necessity	70% covered after deductible; number of visits based on medical necessity

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	In-Network	Out-of-Network	In-Network	Out-of-Network
Licensed Chiropractor	80% covered of NNF4 after deductible; limited to \$750 per calendar year; limit combined in- and out-of-network; \$750 limit does not apply to IBEW local 827; maintenance services are not covered	80% covered after deductible; limited to \$750 per calendar year; limit combined in- and out-of-network; \$750 limit does not apply to IBEW local 827; maintenance services are not covered; Reasonable and Customary limits apply	80% covered after deductible; number of visits based on medical necessity; limited to \$750 per calendar year; limit combined in- and out-of-network	70% covered after deductible; number of visits based on medical necessity; limited to \$750 per calendar year; limit combined in- and out-of-network
Home Health Care	100% covered, no deductible; precertification required; limited to 120 visits per plan year1	100% covered, no deductible; precertification required; limited to 120 visits per plan year1	100% covered, no deductible; precertification required	70% covered after deductible; precertification required
Inpatient Hospital Service				
Hospital Copay Room and Board	None 100% covered, no deductible; no precertification required1	None 100% covered after deductible; limited to 120 days per admit; 80% covered after the 120th day; precertification required1	None 90% covered after deductible	None 70% covered after deductible; precertification required
In-Hospital Physician's Visits	100% covered, no deductible	98% covered, no deductible	90% covered after deductible	70% covered after deductible
X rays and Lab Tests	100% covered, no deductible	100% covered, no deductible; Reasonable and Customary limits apply	90% covered after deductible	70% covered after deductible
Maternity Care (Pre/Post Natal)	100% covered, no deductible	98% covered, no deductible	\$20 copay (\$10 copay Medicare-eligible)—initial visit only	70% covered after deductible
Newborn Baby Care	100% covered, no deductible	98% covered, no deductible	90% covered after deductible3	70% covered after deductible3

	Current Plan		9/14 MOU	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Skilled Nursing Facilities	100% covered, no deductible; precertification required ¹	100% covered, no deductible; precertification required ¹ ; limited to 120 days per admit; 80% covered after deductible after the 120th day; Reasonable and Customary limits apply	100% covered, no deductible; precertification required	70% covered after deductible; precertification required
Birth Centers	100% covered, no deductible; precertification required	100% covered after deductible; precertification required	90% covered after deductible	70% covered after deductible; precertification required
Hospice Care	100% covered, no deductible; precertification required; lifetime limit of 180 days, of which no more than 60 days may be for inpatient Hospice Care ²	100% covered, no deductible; precertification required; lifetime limit of 180 days, of which no more than 60 days may be for inpatient Hospice Care ²	100% covered, no deductible; precertification required	70% covered after deductible; precertification required
Surgery and Anesthesia				
Second Opinions	100% covered, no deductible	100% covered, no deductible	\$20 copay (\$10 copay Medicare-eligible)	70% covered after deductible
Inpatient Surgery	100% covered, no deductible; precertification required	98% covered, no deductible; precertification required	90% covered after deductible; precertification required	70% covered after deductible; precertification required
Outpatient Surgery	100% covered, no deductible	98% covered, no deductible	90% covered after deductible outpatient facility; \$20 copay (\$10 copay Medicare-eligible) if done in the physician's office	70% covered after deductible
Anesthesia	100% covered, no deductible	98% covered, no deductible	90% covered after deductible	70% covered after deductible

	Current Plan		9/14 MOU	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Lifetime Maximum	None		None	
Medical	None		None	
Infertility	\$20,000 per family (combined with prescription drugs and for both in-network and out-of-network); 100% covered after deductible5 precertification required	\$20,000 per family (combined with prescription drugs and for both in-network and out-of-network); 80% covered after deductible5; precertification required	\$20,000 per family (combined with prescription drugs and for both in-network and out-of-network); 90% covered after deductible4 precertification required	\$20,000 per family (combined with prescription drugs and for both in-network and out-of-network); 70% covered after deductible4; precertification required
Obesity	Covered for medically necessary treatment of clinical obesity when pre-authorized by claims administrator. Includes medically necessary nutritional counseling when prescribed by physician, up to \$500 per year		Covered for medically necessary treatment of clinical obesity when pre-authorized by claims administrator. Includes medically necessary nutritional counseling when prescribed by physician, up to \$500 per year	

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	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health/Substance Abuse				
Inpatient Mental Health Care	100% covered after deductible is met; limited to 30 days; 80% covered for additional days; precertification required	100% covered after deductible is met; limited to 30 days; 80% covered for additional days; precertification required; Reasonable and Customary limits apply	90% covered after deductible	70% covered after deductible; precertification required
Outpatient Mental Health Care	80% covered after deductible is met ³	80% covered after deductible is met; Reasonable and Customary limits apply ³	\$20 copay (\$10 copay Medicare-eligible)	70% covered after deductible
Inpatient Substance Abuse Treatment	100% covered after deductible is met; limited to 60 days per lifetime; limits combined in- and out-of-network and inpatient and outpatient; each outpatient visit counts as one-half day toward limit ³	100% covered after deductible is met; limited to 60 days per lifetime; limits combined in- and out-of-network and inpatient and outpatient; each outpatient visit counts as one-half day toward limit; Reasonable and Customary limits apply ³	90% covered after deductible	70% covered after deductible
Outpatient Substance Abuse Treatment	100% covered after deductible is met; limited to 60 days per lifetime; limits combined in- and out-of-network and inpatient and outpatient; each outpatient visit counts as one-half day toward limit ³	100% covered after deductible is met; limited to 60 days per lifetime; limits combined in- and out-of-network and inpatient and outpatient; each outpatient visit counts as one-half day toward limit; Reasonable and Customary limits apply ³	\$20 copay (\$10 copay Medicare-eligible)	70% covered after deductible

	Current Plan		9/14 MOU	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Other Services				
Durable Medical Equipment	80% covered of NNF4 after deductible	80% covered after deductible; Reasonable and Customary limits apply	80% covered after deductible; precertification required for items over \$5,000	70% covered after deductible; precertification required for items over \$5,000
Ambulance Services	80% covered of NNF4 after deductible	80% covered after deductible; Reasonable and Customary limits apply	<ul style="list-style-type: none"> ■ 90% covered after deductible if an emergency ■ 70% covered after deductible if non-emergency 	
Prosthetic Devices	80% covered of NNF4 after deductible	80% covered after deductible; Reasonable and Customary limits apply	80% covered after deductible; precertification required for items over \$5,000	70% covered after deductible; precertification required for items over \$5,000
Urgent Care	\$15 copay		\$20 copay (\$10 copay Medicare-eligible)	
Emergency Room Care	\$25 copay; copay waived if admitted		\$75 copay (\$25 copay Medicare-eligible); copay waived if admitted	
Footnotes				
	<p>[1] To calculate the 120-day limit, each day in a hospital counts as a full day, each day in a skilled nursing facility counts as one half-day, and each home health care visit counts as one-fifth of a day. The 120-day limit is a cumulative number for all inpatient stays per Plan year (and is a combination of all inpatient hospital stays, stays in a skilled nursing facility and home health care visits).</p> <p>[2] After 180 days, up to an additional 45 days may be authorized, as determined by the claims administrator.</p> <p>[3] Note: Class II Dependents and Sponsored Dependents are not eligible for coverage for Substance Abuse or Outpatient Mental Health treatment</p> <p>[4] Coinsurance applied to NNF or actual price if lower than NNF.</p> <p>[5] Coverage includes advanced reproductive technology such as GIFT, ZIFT and artificial insemination</p>		<p>[1] Contribution amounts assume \$100 annual credit for completion of Health Risk Assessment and \$600 annual credit for non-tobacco user status.</p> <p>[2] Family amount can be any combination of family members but an individual would never satisfy more than his/her own individual amount</p> <p>[3] If newborn is not released with the mother a separate deductible and coinsurance applies</p> <p>[4] Coverage includes advanced reproductive technology such as GIFT, ZIFT and artificial insemination</p>	