

2011		HMO-1	POS-2	
Health Insurance Comparison Chart Locals 1035 and Locals 1035B only		(union monthly cap \$175)	(union monthly cap \$250)	
		10% premium contribution monthly contribution amt	12% premium contribution monthly contribution amt	
	Single	\$52.36	\$66.96	
	Employee/Child	\$96.50	\$123.41	
	Employee/Spouse Family	\$109.95 \$169.38	\$140.61 \$216.61	
			In-Plan	Out-of-Plan
Co-Pays	as listed below		as listed below	
Annual Deductibles	n/a		\$250 individual/ \$500 family	\$500 individual/ \$1000 family
Co-Insurance	n/a		10% of eligible expenses, unless otherwise specified	30% of eligible expenses, unless otherwise specified
Annual Out-of-Pocket Limit	n/a		\$500 individual/ \$1000 family	\$1500 individual/ \$3000 family
				Coverage for Out-of-Network services which require Prior Authorization as listed in the Point of Service Plan Rider will have a 50% benefit reduction up to a max of \$500/occurrence if the services are not Prior Authorized.
This comparison chart is not a guarantee of coverage, please refer to the Certificate of Coverage, and Riders for detailed benefit information restrictions, limitations and exclusions that apply to that coverage.				
		HMO-1	POS-2	
Services			In-Plan	Out-of-Plan
Wellness/ Preventive Health	• Well Child Care Exams	No Charge	No Charge	Deductible/Co-insurance
	• Periodic Physical Exams	No Charge	No Charge	Deductible/Co-insurance
	• Immunizations	No Charge	No Charge	Deductible/Co-insurance
	• Routine Mammography Services	No Charge	No Charge	Deductible/Co-insurance

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		HMO-1	POS-2	
Services			In-Plan	Out-of-Plan
Physician and Practitioner Services	Primary Care Practitioner			
	• Office and Home visits	\$10 Co-pay per visit	\$15 Co-pay per visit	Deductible/Co-insurance
	• Inpatient visits	No Charge	No Charge	Deductible/Co-insurance
	Specialty Physician			
	• Office and Home visits	\$10 Co-pay per visit	\$15 Co-pay per visit	Deductible/Co-insurance
	• Routine Eye Exams <i>(limited to one per 12-month period)</i>	\$10 Co-pay per visit	\$15 Co-pay per visit	Deductible/Co-insurance
	• Chiropractic office visits and manipulations	\$10 Co-pay per visit	\$15 Co-pay per visit	Deductible/Co-insurance
	• Allergy Immunizations	No Charge	No Charge	Deductible/Co-insurance
	• Accidental Dental Services	No Charge	No Charge	No Charge
	• Radiation/Chemotherapy Services	No Charge	No Charge	Deductible/Co-insurance
	• Dialysis Services	No Charge	No Charge	Deductible/Co-insurance
	• Surgery & Anesthesiology Services	No Charge	No Charge	Deductible/Co-insurance
	• Routine Maternity (pre & post natal care)	No Charge	No Charge	Deductible/Co-insurance
• Inpatient visits	No Charge	No Charge	Deductible/Co-insurance	
• Injectables administered in a Physician's office	<i>Please refer to your Prescription drug benefit levels</i>	<i>Please refer to your Prescription drug benefit levels</i>	<i>Please refer to your Prescription drug benefit levels</i>	
Diagnostic Services	• X-Ray, Lab, Pathology <i>(practitioner's office or outpatient)</i>	No Charge	No Charge	Deductible/Co-insurance
	• Diagnostic Mammography Services	No Charge	No Charge	Deductible/Co-insurance
	• PET Scans, MRI's, MRA's, CT Scans <i>(no coverage if not prior authorized)</i>	No Charge	No Charge	Deductible/Co-insurance
	• Stress Tests	No Charge	No Charge	Deductible/Co-insurance
	• Ultrasounds/Echocardiograms	No Charge	No Charge	Deductible/Co-insurance
Hospital Services	• Inpatient Hospital <i>(no coverage if not prior authorized)</i>	No Charge	Deductible/Co-insurance	Deductible/Co-insurance
	• Outpatient Services or Procedures <i>(including cardiac rehabilitation)</i>	No Charge	Deductible/Co-insurance	Deductible/Co-insurance

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		HMO-1	POS-2	
Services			In-Plan	Out-of-Plan
Hospital Services (cont'd)	• Ambulatory Surgical Center (such as a colonoscopy)	No Charge	Deductible/Co-insurance	Deductible/Co-insurance
Rehabilitation Services	• Therapy – Physical/Occupational/Speech	\$10 Co-pay per visit	\$15 Co-pay per visit	Deductible/Co-insurance
Ambulance Services	• Land and Air	No Charge	No Charge	No Charge
Home Health Care	• Limited to 40 visits per 12-month period (no coverage if not prior authorized)	No Charge	No Charge	Deductible/Co-insurance
Hospice Care	No Coverage if not prior authorized	No Charge	No Charge	Deductible/Co-insurance
Durable Medical Equipment	• DME, Orthotics & Prosthetics (Prior authorization required for Durable Medical Equipment/Orthotics over \$500 and prosthetics over \$1,000. No coverage if not prior authorized.)	No Charge	Deductible/Co-insurance	Deductible/Co-insurance
Diabetic Supplies	(Please refer to your Prescription Summary of Member Responsibility Table)			
Medical Supplies	Including insulin pump supplies	No Charge	No Charge	Deductible/Co-insurance
Health Educational Programs	Please refer to the Certificate of Coverage for a list of benefits and limitations.	No Charge	No Charge	Not covered
Behavioral Health	Mental Health and Chemical Dependency Services			
	• Inpatient – Limited to 10 days per calendar year (no coverage if not prior authorized)	No Charge	No Charge	Deductible/Co-insurance
	• Transitional – Limited to 20 days per calendar year	No Charge	No Charge	Deductible/Co-insurance
	• Outpatient – Limited to 20 visits per calendar year	No Charge	No Charge	Deductible/Co-insurance

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		HMO-1	POS-2	
Services			In-Plan	Out-of-Plan
Emergency/Urgent Care <i>(Emergency room or hospital based urgent care facility)</i>	• Emergency Room Services <i>(co-pay waived if admitted inpatient within 24 hours)</i>	\$50 Co-pay per visit	\$50 co-pay per visit	\$50 co-pay per visit
	• Urgent Care	\$10 Co-pay per visit	\$15 Co-pay per visit	Deductible/Co-insurance
Maximum Policy Benefit		\$5,000,000 per Member per Lifetime	\$5,000,000 per Member per Lifetime	
Prescription		Retail Pharmacy: \$10/25/50/50/80 co-pay Mail Order Pharmacy: \$25/60/150 co-pay	Retail Pharmacy: \$10/25/50/50/80 co-pay Mail Order Pharmacy: \$25/60/150 co-pay	