Health Insurance Plans for City of Hammond Effective January 1, 2013

		CDUD 1	215			
Covered Benefits	Network	Non-Network	Network No	Non-Network	Network	Non-Network
Family coverage requires the family deductible to be met before coincidence applies.	Single:	Single: \$2,500	Single: \$1,500	\$1,500	Single: \$750	Single: \$1,500
CDHP Plans only - deductible included in OOP	Family:	Family: \$5,000	Family \$3,000	\$3,000	Family: \$1,500	Family: \$3,000
The Single deductible only applies to the PPO option						
Out-of-Pocket Limit (OOP)	Single: \$4,000	\$4,000	Single	3 000	cindo: ca soo	Fig. 45 000
Family coverage requires the family OOP to be met before 100% coverage applies.	Family:	Family: \$8.000	Family \$6 000	35,000	Samily: \$2,500	Single: \$5,000
CDHP Plans only - deductible included in OOP			i dining	,,,,,,	railliy. \$3,000	ramily: \$10,000
The single OOP only applies to the PPO option						
Physician Home and Office Services						
Primary Care Physician (PCP/Specialty Care Physician (SCP)						
including office surgeries and allergy serum:						
 allergy injections (PCP and SCP) and allergy testing 	80/20%	60/40%	80/20%	60/40%	\$35/\$70	50/50%
• non-routine mammograms				90, 1000	4004	20/30%
 diabetic education (regardless of outpatient setting) 						
 MRAs, MRIs, PETS, C-scans, nuclear cardiology imaging studies and non-maternity related ultrasounds 						
Preventive Care Services						
Services include but are not limited to:						
Annual physical exams, pelvic exams, pap testing, PSA tests, immunizations, annual						
diabetic eye exam, routine vision and hearing exams						
 Physician home and office visits (PCP/SCP) 		40% (not		10% (pot		
 Other outpatient services @ hospital/alternative care facility 	No deductible/	subject to	No deductible/	subject to	No deductible/	50% (not subject
Routine mammograms	coinsurance	deductible)	coinsurance	deductible)	coinsurance	to deductible)
screening colorectal cancer exam/laboratory testing	2					
senarably or if the originary purpose of the office party and the original person of the office visit is billed						
be imposed for the office visit						
Emergency and Urgent Care					2001	
 Emergency Room services @ hospital (facility/other covered services) 	80/20%	80/20%	80/20%	80/20%	admitted)	20/20%
Urgent Care Center services				20/2010	\$100	80/20%
Maternity Services	80/20%	60/40%	80/20%	60/40%	2007,08	50/50%
Inpatient and Outpatient Professional Services			2002 100	00/10/0	00/20/0	20/20%
Include but are not limited to:	80 /708/	20/100				
• Medical care visits, intensive medical care, concurrent care, consultations, surgery	00/20/0	60/40%	80/20%	60/40%	80/20%	50/50%
and administration to general anestnessa and Newborn exams						
Ditation's reality devices Outparters reality devices Outpation's reality devices	80/20%	60/40%	80/20%	60/40%	80/20%	50/50%
Surgery and administration of general anesthesia	80/20%	60/40%	80/20%	60/40%	80/20%	50/50%
Other Outpatient Services (including but not limited to):						20,000
 Non-Surgical outpatient services for example: MRIs, C-scans, chemotherapy, 						
ultrasounds and other diagnostic outpatient services						
Home care services (network/non-network combined)						
Unlimited visits (includes IV therapy) (\$5,000 Private Duty Nursing lifetime max	80/20%	60/40%	80/20%	60/40%	207708	50/508/
applies)(No RN/LPN unless billed through a home health care agency)			20/20/0	2077070	9/02/08	20/20%
Durable medical equipment and orthotics (network/non-network combined) Unlimited						
benefit maximum (including medical supplies)						
Physical medicine therapy day rehabilitation programs						
Hospice care Ambulance carrieses	80/20%	%0C/08	%07\08	80/208/	no (non)	
Ambulance services	80/20%	80/20%	80/20%	80/20%	80/20%	80/20%

The state of the s						
50/50%	80/20%	60/40%	80/20%	60/40%	80/20%	 Acquisition and transplant procedures, harvest and storage
					20 (200)	Human Organ and Tissue Transplants
						is not obtained, benefits will not be allowed.
						Authorization of all inpatient and outpatient psychiatric and substance abuse services is required. If authorization
	•			*		• Other outpatient services @ hospital/alternative care facility
50/50%	80/20%	60/40%	80/20%	60/40%	80/20%	Physician home and office visits (PCP/SCP)
						• Inpatient facility services (Residential MH/SA covered as inpatient)
						Mental Health and Substance Abuse
						Behavioral Health Services:
						• Speech therapy: 25 visits
						Manipulation therapy: 12 visits
						Occupational therapy: 25 visits
50/50%	80/20%	60/40%	80/20%	60/40%	80/20%	Physical therapy: 25 visits
						 Other outpatient services @ hospital/alternative care facility
						Physician home and office visits (PCP/SCP)
						(Combined network and non-network limits apply)
	_	_	_	_		Outpatient Therapy Services

Prescription Drug Coverage	HDHP Options (HSA)	РРО
-	Medical Deductible then:	\$250 Individual Deductible
	,	3 times Max. Family Deductible
Seneric Seneric	\$15	\$15
Formulary	\$25	\$25
Brand Non-Formulary	\$40	\$40
Specialty	\$60	\$60
wali urder nx (up to a su-day supply)	Medical Deductible then:	\$250 Individual Deductible
7)		3 times Max. Family Deductible
Verific.	\$30	\$30 .
Profit Man Francisco	\$50	\$50
Specialty	\$80	\$80
	\$120	\$120
* 7)		

- * Non-network human organ and tissue transplants are excluded from the out-of-pocket limits.

 * When choosing a non-network provider, the member is responsible for any balance due after the plan payment.

Employee Contributions	The second secon		The same of the sa			
AND SECTION OF COMPANY	CDHP 1		CDHP 2	2	PI	PPO
Employee Contributions - Bi-Weekly	With	HRA/Blood		With HRA/Blood		With HRA/Blood
Single	\$30.67 \$	\$5.67	\$55.51	\$30.51	\$45.00	\$30.00
Family	\$40.82 \$3	15.82	\$110.90	\$85.90	\$90.00	\$60.00
Employee Contributions - Annually	With I	HRA/Blood		With HRA/Blood		With HRA/Blood
Single	\$797.42 \$1	\$147.42	\$1,443.26	\$793.26	\$1,170,00	\$780.00
Family	\$1,061.32 \$4	411.32	\$2,883.40	\$2,233.40	\$2,340.00	\$1,560.00
Employer Annual HSA Contributions	CDHP 1		CDHP 2	72	P	PPO
	\$1,123.20		\$673.92	92	z	N/A
Family	\$2,249.52		\$1,347.84	7.84	z	N/A

prevails. This summary of benefits is intended to highlight certain aspects of the plans. Please refer to the entire summary plan document for final benefit determination.