NECA FMCP Family Medical Care Plan

Benefit Plan Comparison
Effective January 1, 2018

Medical Benefits Provided by: Anthem Blue Cross/Blue Shield

	Plan 15	Plan 16	Plan 17	Plan 18
Benefit Period	Calendar Year	Calendar Year	Calendar Year	Calendar Year
Deductibles				
PPO				
Per person	$350	$200	$500	$1,000
Per family	$1,050	$400	$1,000	$3,000
Non-PPO				
Per person	Combined w/ PPO	$400	$500	Combined w/ PPO
Per family	--	$800	$1,000	--
Out-of-Pocket Limits				
PPO				
Per person	$1,900	$1,400	$2,100	$4,000
Per family	$3,800	$2,800	$4,200	$8,000
Non-PPO				
Per person	No limit	$1,400	$5,100	No limit
Per family	No limit	$2,800	$10,200	No limit

Plan Payment Percentage / Member Co-Insurance

	Plan	*Member*	*Plan*	*Member*	*Plan*	*Member*	*Plan*	*Member*
PPO	85%	15%	100%	0	90%	10%	70%	30%
Non-PPO	75%	25%	80%	20%	70%	30%	60%	40%

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All co-payment and co-insurance costs shown
are after your deductible has been met, if a deductible applies.

Medical Services	Plan 15		Plan 16		Plan 17		Plan 18	
	Your Cost ***In-Network***	*Your Cost* ***Out-of-Network***	*Your Cost* ***In-Network***	*Your Cost* ***Out-of-Network***	*Your Cost* ***In-Network***	*Your Cost* ***Out-of-Network***	*Your Cost* ***In-Network***	*Your Cost* ***Out-of-Network***
Primary Care or Specialist Visit	15% co-ins	25% co-ins	$20 co-pay	20% co-ins	$10 co-pay	30% co-ins	30% co-ins	40% co-ins
Preventive Care	No charge	Not covered	No charge	Not covered	No charge	Not covered	No charge	Not covered
Emergency Room Services	$100 deductible* 15% co-ins * *waived if admitted*		$100 deductible* No charge * *waived if admitted*		$100 deductible* 10% co-ins * *waived if admitted*		30% co-ins	
Urgent Care Facility	15% co-ins	25% co-ins	$20 co-pay	20% co-ins	$10 co-pay	30% co-ins	30% co-ins	40% co-ins
Inpatient Facility *(hospital room)*	15% co-ins	25% co-ins	No charge	20% co-ins	10% co-ins	30% co-ins	30% co-ins	40% co-ins
Failure to Pre-Certify Benefit Reduction	$250	$250	$250	$250	$250	$250	$250	$250
Outpatient Facility Fee *(ambulatory surgery center)*	15% co-ins	Not covered	No charge	Not covered	10% co-ins	Not covered	30% co-ins	Not covered
Home Health Care	15% co-ins *120 visits/yr*	25% co-ins *120 visits/yr*	No charge *120 visits/yr*	20% co-ins *120 visits/yr*	10% co-ins *120 visits/yr*	30% co-ins *120 visits/yr*	30% co-ins *120 visits/yr*	40% co-ins *120 visits/yr*
Skilled Nursing Care	15% co-ins *30 days/yr*	25% co-ins *30 days/yr*	No charge *60 days/yr*	20% co-ins *60 days/yr*	10% co-ins *30 days/yr*	30% co-ins *30 days/yr*	30% co-ins *30 days/yr*	40% co-ins *30 days/yr*
Hospice Services	No charge	25% co-ins	No charge	20% co-ins	No charge	30% co-ins	No charge	40% co-ins
Chiropractic Services	15% co-ins *15 visits/yr*	25% co-ins *15 visits/yr*	No charge 30 visits/yr	20% co-ins *30 visits/yr*	10% co-ins *15 visits/yr*	30% co-ins *15 visits/yr*	30% co-ins *15 visits/yr*	40% co-ins *15 visits/yr*
Mental Behavioral Health & Substance Abuse Inpatient and Outpatient	15% co-ins	25% co-ins	No charge	20% co-ins	10% co-ins	30% co-ins	30% co-ins	40% co-ins
Rehabilitation Services (PT, OT and Cardio)	15% co-ins	25% co-ins	No charge	20% co-ins	10% co-ins	30% co-ins	30% co-ins	40% co-ins
Durable Medical Equipment	15% co-ins	25% co-ins	No charge	20% co-ins	10% co-ins	30% co-ins	30% co-ins	40% co-ins
Restorative Speech Therapy due to Stroke	15% co-ins *35 visits/yr*	25% co-ins *35 visits/yr*	No charge *50 visits/yr*	20% co-ins *50 visits/yr*	10% co-ins *35 visits/yr*	30% co-ins *35 visits/yr*	30% co-ins *35 visits/yr*	40% co-ins *35 visits/yr*
Developmental Speech Therapy	Not covered							
Bariatric Surgery	Not covered							
Standard Hearing Aids	One per ear per lifetime							
Orthotics	One pair custom molded foot orthotics every two years when prescribed and performed in network							

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Prescription Benefits Provided by: Sav-Rx

Benefits Shown Apply to All FMCP Plans

Out-of-Pocket Limits		
Per person	$1,000 per calendar year	
Per family	$2,000 per calendar year	
Member Co-Pays / Co-Insurance		
Out-of-network = Not covered	*Your Cost In-Network*	*Your Cost In-Network*
	Retail	**Mail**
Generic drugs (mandatory) (Tier 1)	No charge	No charge
Preferred brand drugs (Tier 2)	20% co-ins	20% co-ins
Non-preferred brand drugs (Tier 3)	30% co-ins *(minimum $40)*	30% co-ins *(minimum $80)*

Wal-Mart and Sam's Club are NOT part of the labor-friendly Sav-Rx network, and the Plan will not cover drugs purchased from their pharmacies.

Dental Benefits Provided by: MetLife

Dental Benefits are not available to retirees.

	Plan 15		Plan 16		Plan 17		Plan 18
Benefit Period	Calendar Year		Calendar Year		Calendar Year		*Not applicable*
Deductibles							
Per person	None		$25		None		
Per family	None		$75		None		
Maximum Payable Benefits							
Per person	$1,000		$1,500		$1,000		
Plan Payment Percentage							
	Plan	*Member*	*Plan*	*Member*	*Plan*	*Member*	
Preventative	80%	20%	100%	0	80%	20%	
Minor Restorative	80%	20%	80%	20%	80%	20%	
Major Restorative	50%	50%	60%	40%	50%	50%	
Other Benefits							
Orthodontia	50% up to $1,000		50% up to $2,000 *(children up to age 26)*		$50% up to $1,000		

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Vision Benefits Provided by: Vision Service Plan (VSP)

Vision Benefits are not available to retirees.

Benefits Shown Apply to FMCP Plans 15, 16 and 17 Only

	*Your Cost If Using an **In-Network** Provider*	*Your Cost If Using an **Out-of-Network** Provider*
Benefits		
Vision Exam	No charge	$35
Frames	$180	$35
Lenses (per pair):		
Single vision	No charge	$30
Lined bifocal	No charge	$40
Lined trifocal	No charge	$55
Lined lenticular	No charge	$55
Contacts (elective)	$150	$120
Safety Glasses *		
Frames	$65	$25
Lenses (per pair):		
Single vision	No charge	$30
Bifocal	No charge	$35
Trifocal	No charge	$45
Lenticular	No charge	$60

Accident Death & Dismemberment

	Plan 15	Plan 16	Plan 17	Plan 18
Benefits				
Employee Death	$10,000	$20,000	$10,000	$5,000
Employee AD &D	$10,000	$20,000	$10,000	$5,000
Retiree Death	$7,500	$7,500	$7,500	None

Weekly Disability Benefits

(Employees Only)

Benefits	**Plans 15, 16 & 17 Only**
Benefit Period	26 weeks
Amount Per Week	
Occupational	$125 per week
Non-Occupational	$250 per week

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