2014 MEDICAL PLAN COMPARISON

Coverage	HDHP		HMO	POS		PPO*	
	In-Network	Out-of-Network	In-Network Only	PCP/Plan Approved	Self-Referred	In-Network	Out-of-Network
Premiums							
Employee	$27.72 weekly / $60.07 semi-monthly		$44.57 weekly / $96.57 semi-monthly	$51.31 weekly / $111.18 semi-monthly		$53.63 weekly / $116.21 semi-monthly	
Family	$73.11 weekly / $158.40 semi-monthly		$118.11 weekly / $255.90 semi-monthly	$135.82 weekly / $294.28 semi-monthly		$142.13 weekly / $307.94 semi-monthly	
Annual Deductible							
Per Member	$1,500	$2,500	$0	$0	$500	$0	$500
Per Family	$3,000	$5,000	$0	$0	$1,000	$0	$1,000
Annual Out-of-Pocket Maximum							
Per Member	$2,500	$4,000	n/a	n/a	$1,000	n/a	$1,000
Per Family	$5,000	$8,000	n/a	n/a	$2,000	n/a	$2,000
Services							
Annual Physical *(Preventive)*	No charge	30% coinsurance *(after deductible)*	No charge	No charge	20% coinsurance *(after deductible)*	No charge	20% coinsurance *(after deductible)*
PCP Office/ Specialist Visit	10% coinsurance *(after deductible)*	30% coinsurance *(after deductible)*	$20 PCP $30 Specialist	$20 PCP $30 Specialist	20% coinsurance *(after deductible)*	$25 PCP $25 Specialist	20% coinsurance *(after deductible)*
Diagnostic X-Ray/Lab Tests	No charge *(after deductible)*	30% coinsurance *(after deductible)*	No charge	No charge	20% coinsurance *(after deductible)*	No charge	20% coinsurance *(after deductible)*
Inpatient/ Outpatient Hospital *(including maternity)*	10% coinsurance *(after deductible)*	30% coinsurance *(after deductible)*	No charge	No charge	20% coinsurance *(after deductible)*	No charge	20% coinsurance *(after deductible)*
Emergency Room Visit	10% coinsurance *(after deductible; copayment waived if admitted or for observation stay)*	10% coinsurance *(after deductible; copayment waived if admitted or for observation stay)*	$100 copay *(waived if admitted to the hospital or for observation stay)*	$100 per visit *(waived if admitted to the hospital or for observation stay)*	20% coinsurance** *(after deductible)*	$100 copay *(no deductible)* *(waived if admitted to the hospital or for observation stay)*	$100 copay *(no deductible)* *(waived if admitted to the hospital or for observation stay)*

PPO is available only if resident state is outside of New England.

****$100 copay will apply if admitted to hospital.***

Coverage	HDHP		HMO	POS		PPO	
	In-Network	Out-of-Network	In-Network Only	PCP/Plan Approved	Self-Referred	In-Network	Out-of-Network
Prescription Drugs							
Generic	$5 retail / $10 mail service*	Not covered	$5 retail / $10 mail service	$5 retail / $10 mail service	Not covered	$5 retail / $10 mail service	Not covered
Preferred brand	$30 retail / $60 mail service*	Not covered	$30 retail / $60 mail service	$30 retail / $60 mail service	Not covered	$30 retail / $60 mail service	Not covered
Non-preferred	$50 retail / $100 mail service*	Not covered	$50 retail / $100 mail service	$50 retail / $100 mail service	Not covered	$50 retail / $100 mail service	Not covered
Specialty	Applicable cost share (generic, preferred, non-preferred)*	Not covered	$25 / supply	$25 / supply	Not covered	$25 / supply	Not covered

**Must satisfy Annual Deductible then copays will apply.*

Northeastern University
Human Resources Management