PLAN COMPARISON

2015 MEDICAL AND DENTAL PLANS

HRNAVIGATOR

WITHIN NEW ENGLAND

OUTSIDE NEW ENGLAND

MEDICAL	Enhanced		Core		HDHP w/ HSA		PPO	
	PCP / Plan Approved	Self-referred	PCP / Plan Approved	Self-referred	In-Network	Out-of-Network	In-Network	Out-of-Network
Monthly Premiums	**$212.50 Individual / $564.58 Family**		**$181.80 Individual / $480.60 Family**		**$131.50 Individual / $349.58 Family**		**$231.80 Individual / $616.60 Family**	
HSA University Funding	N/A		N/A		$500 Individual / $1,000 Family		N/A	
Annual Deductible	None	$500 Individual / $1,000 Family	$250 Individual / $500 Family	$500 Individual / $1,000 Family	$1,500 Individual / $3,000 Family	$2,500 Individual/ $5,000 Family	None	$500 Individual / $1,000 Family
Out-of-Pocket Maximum	$2,000 Individual / $4,000 Family	$4,000 Individual / $8,000 Family	$2,500 Individual/ $5,000 Family	$4,000 Individual / $8,000 Family	$2,500 Individual / $5,000 Family	$4,000 Individual / $8,000 Family	$2,000 Individual / $4,000 Family	$4,000 Individual / $8,000 Family
Hospital Inpatient	Covered in full	80% after deductible	90% after deductible	70% after deductible	90% after deductible	70% after deductible	Covered in full	80% after deductible
Outpatient Day Surgery	Covered in full	80% after deductible	90% after deductible	70% after deductible	90% after deductible	70% after deductible	Covered in full	80% after deductible
High-Tech Imaging	Free standing: covered in full / Hospital: $100 copay	80% after deductible	90% after deductible	70% after deductible	90% after deductible	70% after deductible	Free standing: covered in full / Hospital: $100 copay	80% after deductible
Emergency Room	$100 copay		$100 copay		90% after deductible		$100 copay	
OFFICE VISITS								
Preventive Care	Covered in full	80% after deductible	Covered in full	70% after deductible	Covered in full	70% after deductible	Covered in full	80% after deductible
PCP Visit (non-preventive)	$20 copay	80% after deductible	$25 copay	70% after deductible	90% after deductible	70% after deductible	$25 copay	80% after deductible
Specialist	$30 copay	80% after deductible	$35 copay	70% after deductible	90% after deductible	70% after deductible	$25 copay	80% after deductible
PRESCRIPTION DRUGS								
Retail (up to 30-day supply)	$5 / $30 / $50	not covered	$5 / $30 / $50	not covered	$5 / $30 / $50 after deductible	not covered	$5 / $30 / $50	not covered
Mail (up to 90-day supply)	$10 / $60 / $100	not covered	$10 / $60 / $100	not covered	$10/$60/$100 after deductible	not covered	$10 / $60 / $100	not covered

PLAN COMPARISON

2015 MEDICAL AND DENTAL PLANS

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DENTAL	Enhanced	Value*
Monthly Premiums	**$19.95 Individual / $62.04 Family**	**$7.69 Individual / $23.90 Family**
Annual Deductible	$50 Individual / $100 Family	$50 Individual / $100 Family
Coinsurance for Type I Services: Preventive and diagnostic services	100% — no deductible	100% — no deductible
Coinsurance for Type II Services: Basic restorative services (e.g. fillings)	80% after deductible	50% after deductible
Coinsurance for Type III Services : Major restorative services (e.g. crowns and bridges)	50% after deductible	Not covered
Annual Plan Maximum	$2,000	$750
Orthodontia Coinsurance/Copay	50%	N/A
Orthodontia Lifetime Maximum	$1,000	N/A
Adult Orthodontia	No	N/A

* The Value plan does not allow for a roll over of the unused portion of the annual maximum benefit.

Northeastern University
Human Resources Management