PLAN COMPARISON
2016 MEDICAL AND DENTAL PLANS

HRNAVIGATOR

WITHIN NEW ENGLAND

OUTSIDE NEW ENGLAND

MEDICAL	Core		Enhanced		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	**$189.00 Individual / $499.20 Family**		**$222.91 Individual / $592.24 Family**		**$134.00 Individual / $357.20 Family**		**$226.00 Individual / $601.20 Family**	
HSA University Funding	N/A		N/A		$500 Individual / $1,000 Family		N/A	
Annual Deductible	$250 Individual $500 Family	$500 Individual $1,000 Family	None	$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	$2,500 Individual $5,000 Family	$4,000 Individual $8,000 Family	$2,000 Individual $4,000 Family	$4,000 Individual $8,000 Family	$2,500 Individual $5,000 Family	$4,000 Individual $8,000 Family	$2,000 Individual $4,000 Family	$4,000 Individual $8,000 Family
Hospital Inpatient	90% after deductible	70% after deductible	Covered in full	80% after deductible	90% after deductible	70% after deductible	Covered in full	80% after deductible
Outpatient Day Surgery	90% after deductible	70% after deductible	Covered in full	80% after deductible	90% after deductible	70% after deductible	Covered in full	80% after deductible
High-Tech Imaging	90% after deductible	70% after deductible	Free standing: covered in full / Hospital: $100 copay	80% 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	70% after deductible	Covered in full	80% after deductible	Covered in full	70% after deductible	Covered in full	80% after deductible
PCP Visit (non-preventive)	$25 copay	70% after deductible	$20 copay	80% after deductible	90% after deductible	70% after deductible	$25 copay	80% after deductible
Specialist	$35 copay	70% after deductible	$30 copay	80% 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
2016 BENEFIT PLAN OPTIONS

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DENTAL	Value Plus	Value*
Monthly Premiums	$11.54 Individual / $35.84 Family	$8.04 Individual / $24.98 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 an bridges)	50% after deductible	Not covered
Annual Plan Maximum	$1,500	$750
Orthodontia Coinsurance/Copay	50%	N/A
Orthodontia Lifetime Maximum	$1,000	N/A
Adult Orthodontia	No	N/A

VISION	Individual	Family
Monthly Premiums	$5.98/month	$15.26/month

LIFE INSURANCE	Basic	Supplemental
Coverage	2x annual base salary, up to $500,000 at no cost to you (age-reduction schedule applies after age 65 and 70).	You can purchase 1x, 2x, 3x or 4x base salary to a maximum of $500,000 (age-reduction schedule applies at age 65 and 70). A Statement of Health is required.

Total life insurance coverage up to $1 million

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

Northeastern University
Human Resources Management