

Retired Employees with Medicare Parts A & B

This chart provides a summary of benefits. It is not a contract. For a more detailed description of benefits and exclusions for each plan, please review each plan's Evidence of Coverage, available on www.myhss.org.

CITY HEALTH PLAN PPO administered by UnitedHealthcare	In-Network Providers	Out-of-Network Providers*	Out-of-Area Providers*
DEDUCTIBLES			
Plan year deductible	\$250 retiree only; \$500 retiree + 1 \$750 retiree + 2 or more Includes Medicare deductible Plan year out-of-pocket maximum \$3,750/person	\$250 retiree only; \$500 retiree + 1 \$750 retiree + 2 or more Includes Medicare deductible Plan year out-of-pocket maximum \$7,500/person	\$250 retiree only; \$500 retiree + 1 \$750 retiree + 2 or more Includes Medicare deductible Plan year out-of-pocket maximum \$3,750/person
PREVENTATIVE & GENERAL CARE			
Routine physical	100% covered no deductible	Not covered	100% covered no deductible
Immunizations and inoculations	100% covered no deductible	50% covered no deductible	100% covered no deductible
Routine gynecologic wellness exam	100% covered no deductible	50% covered after deductible	100% covered no deductible
Routine pre/post-partum care	85% covered after deductible	50% covered after deductible	85% covered after deductible
PHYSICIAN & OTHER PROVIDER CARE			
Office and home visits	85% covered after deductible	50% covered after deductible	85% covered after deductible
Hospital visits	85% covered after deductible	50% covered after deductible	85% covered after deductible
PRESCRIPTION DRUGS			
Pharmacy: generic drugs	\$5 co-pay 30-day supply	50% covered after \$5 co-pay; 30-day supply	\$5 co-pay 30-day supply
Pharmacy: brand-name drugs	\$20 co-pay 30-day supply	50% covered after \$20 co-pay; 30-day supply	\$20 co-pay 30-day supply
Pharmacy: non-formulary drugs	\$45 co-pay 30-day supply	50% covered after \$45 co-pay; 30-day supply	\$45 co-pay 30-day supply
Mail order: generic drugs	\$10 co-pay 90-day supply	Not covered	\$10 co-pay 90-day supply
Mail order: brand-name drugs	\$40 co-pay 90-day supply	Not covered	\$40 co-pay 90-day supply
Mail order: non-formulary drugs	\$90 co-pay 90-day supply	Not covered	\$90 co-pay 90-day supply
Specialty drugs	Same as all above	Same as all above	Same as all above
OUTPATIENT SERVICES			
Diagnostic x-ray and laboratory	85% covered after deductible	50% covered after deductible	85% covered after deductible
EMERGENCY			
Hospital emergency room	85% covered after deductible; 50% after deductible if non-emergency	85% covered after deductible; 50% after deductible if non-emergency	85% covered after deductible; 50% after deductible if non-emergency
Urgent care facility	85% covered after deductible	50% covered after deductible	85% covered after deductible
HOSPITAL/SURGERY			
Inpatient	85% covered after deductible	50% covered after deductible	85% covered after deductible
Outpatient	85% covered after deductible	50% covered after deductible	85% covered after deductible

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REHABILITATIVE			
Physical/Occupational therapy	85% covered after deductible; 60 visits/year	50% covered after deductible; 60 visits/year	85% covered after deductible; 60 visits/year
Acupuncture	50% covered after deductible; \$1,000/year	50% covered after deductible; \$1,000/year	50% covered after deductible; \$1,000/year
Chiropractic	50% covered after deductible; \$1,000/year	50% covered after deductible; \$1,000/year	50% covered after deductible; \$1,000/year
TRANSGENDER			
Office visits and outpatient surgery	85% covered after deductible; prior notification required; \$75,000 lifetime max	50% covered after deductible; prior notification required; \$75,000 lifetime max	85% covered after deductible; prior notification required; \$75,000 lifetime max
DURABLE MEDICAL EQUIPMENT			
Home medical equipment	85% covered after deductible; notification required	50% covered after deductible; notification required	85% covered after deductible; notification required
Prosthetics/orthotics	85% covered after deductible; when medically necessary; notification required	50% covered after deductible; when medically necessary; notification required	85% covered after deductible; when medically necessary; notification required
Hearing evaluation and aids	100% covered after deductible; 1 per ear every 36 months; \$2,500 max	100% covered after deductible; 1 per ear every 36 months; \$2,500 max	100% covered after deductible; 1 per ear every 36 months; \$2,500 max
MENTAL HEALTH			
Inpatient hospitalization	85% covered after deductible; notification required	50% covered after deductible; notification required	85% covered after deductible; notification required
Outpatient treatment	85% covered after deductible; notification required	50% covered after deductible; notification required	85% covered after deductible; notification required
CHEMICAL DEPENDENCY			
Inpatient detox	85% covered after deductible; notification required	50% covered after deductible; notification required	85% covered after deductible; notification required
Residential rehabilitation	85% covered after deductible; authorization required	50% covered after deductible; authorization required	85% covered after deductible; authorization required
EXTENDED & END-OF-LIFE CARE			
Extended care / Skilled nursing facility	85% covered after deductible; up to 120 days max; custodial care not covered	50% covered after deductible; up to 120 days max; custodial care not covered	85% covered after deductible; up to 120 days max; custodial care not covered
Hospice	85% covered after deductible; authorization required	50% covered after deductible; authorization required	85% covered after deductible; authorization required
OUTSIDE SERVICE AREA			
Care access and limitations	Coverage worldwide. In-network and out-of-network percentages and co-pays apply.	Coverage worldwide. In-network and out-of-network percentages and co-pays apply.	Coverage worldwide. Out-of-area coverage percentages and co-pays apply.