Nortel FLEX 2013 Enrollment

Summary of Health Benefits

Summary of Health Benefits – Medical – Network Area

The chart below outlines the main features of the Medical Plan options available to you if you live in a network area.

Network Area Medical Options				
Benefit Description	80/60 Preferred Provider Organization (PPO) Option		90/70 Preferred Provider Organization (PPO) Option	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Calendar year deductible [10] • Individual • Family	• $400/person • $1,200/family	• $600/person • $1,800/family	• $300/person • $750/family	• $500/person • $1,500/family
Hospital inpatient stay copayment	$350[1]	$500[1]	$350[1]	$500[1]
Outpatient surgery copayment	$250[1]	$500[1]	$250[1]	$500[1]
Calendar year out-of-pocket maximum [8] [10] • Individual • Family	• $3,500/person • $7,000/family	• $7,500/person • $15,000/family	• $3,500/person • $7,000/family	• $7,500/person • $15,000/family
Lifetime maximum benefit/person	Unlimited	Unlimited	Unlimited	Unlimited
Physician Services				
Primary care physician office visits	$25 copayment	60%[3,4]	$25 copayment	70%[3,4]
Specialist office visits	$30 copayment	60%[3,4]	$30 copayment	70%[3,4]
Prenatal visits	$30 copayment (for first visit only; excludes X-ray and lab)	60%[3,4]	$30 copayment (for first visit only; excludes X-ray and lab)	70%[3,4]
Inpatient surgeon's fees	80%[1,4]	60%[1,3,4]	90%[1,4]	70%[1,3,4]
Anesthetic services and ancillary services	80%[1,4]	60%[3,4]	90%[1,4]	70%[3,4]
Inpatient hospital services	80%[1,4]	60%[1,3,4]	90%[1,4]	70%[1,3,4]
Allergy injections	$30 copayment[9]	60%[3,4]	$30 copayment[9]	70%[3,4]
Other Professional Services				
CIGNA Outpatient short-term rehabilitation: physical, speech (pre-certification required), and occupational therapy, up to 90 visits per condition per calendar year;	$30 copayment[5,7]	60%[3,4,5,7]	$30 copayment[5,7]	70%[3,4,5,7]

Network Area Medical Options				
Benefit Description	80/60 Preferred Provider Organization (PPO) Option		90/70 Preferred Provider Organization (PPO) Option	
	In-Network	Out-of-Network	In-Network	Out-of-Network
includes chiropractic services				
Anthem Outpatient short-term rehabilitation: Physical therapy: (30 visits per calendar year) Speech therapy: (30 visits per calendar year) Occupational therapy: (30 visits per calendar year)	$30 copayment[5,7]	60%[3,4,5,7]	$30 copayment[5,7]	70%[3,4,5,7]
Anthem Chiropractic services	$30 copayment[7]	60%, up to 24 visits per calendar year[2,3,4,7]	$30 copayment[7]	70%, up to 24 visits per calendar year[2,3,4,7]
Private duty nursing	80%[2,4]	60% up to $10,000/person/ calendar year[2,3,4]	90%[2,4]	70% up to $10,000/person/ calendar year[2,3,4]
Preventive Care				
Well-baby care (up to age 6)	$0 copayment	60%[3,4]	$0 copayment	70%[3,4]
Child physical exam (age 6+)	$0 copayment	60%[3,4]	$0 copayment	70% [3,4]
Adult physical exam	$0 copayment	60%[3,4]	$0 copayment	70%[3,4]
Routine OB/GYN exam (includes routine mammogram)	$0 copayment	60%[3,4]	$0 copayment	70%[3,4]
X-ray and laboratory – preventive screening	100%	60%[3,4]	100%	70%[3,4]
Hospital Services				
Inpatient treatment	80% after each hospital inpatient stay copayment[1,4]	60% after each hospital inpatient stay copayment[1,3,4]	90% after each hospital inpatient stay copayment[1,4]	70% after each hospital inpatient stay copayment[1,3,4]
Outpatient treatment	80%[1,4]	60%[1,3,4]	90%[1,4]	70%[1,3,4]
Outpatient surgery	80% after each outpatient surgery copayment[1,4]	60% after each outpatient surgery copayment[1,3,4]	90% after each outpatient surgery copayment[1,4]	70% after each outpatient surgery copayment[1,3,4]
Emergency room	80% after $100 copayment (waived if admitted)	60% after $100 copayment (waived if admitted)[3]	90% after $100 copayment (waived if admitted)	70% after $100 copayment (waived if admitted)[3]
Urgent care	80%[4]	60%[3,4]	90%[4]	70%[3,4]
Skilled nursing facility,	80%[1,4,5]	60%[1,3,4,5]	90%[1,4,5]	70%[1,3,4,5]

Network Area Medical Options				
Benefit Description	80/60 Preferred Provider Organization (PPO) Option		90/70 Preferred Provider Organization (PPO) Option	
	In-Network	Out-of-Network	In-Network	Out-of-Network
up to 60 days/ calendar year				
Hospice	80%[4]	60%[3,4]	90%[4]	70%[3,4]
Other Medical Services				
Assisted reproduction, up to $5,000 lifetime maximum per person	80%[4,6]	60%[3,4,6]	90%[4,6]	70%[3,4,6]
Infertility diagnosis and treatment	80%[4]	60%[3,4]	90%[4]	70%[3,4]
Home health care	80%[2,4]	60% up to 100 visits/calendar year[2,3,4]	90%[2,4]	70% up to 100 visits/calendar year[2,3,4]
Diagnostic X-ray and lab	80%[4] (must use network labs)	60%[3,4]	90%[4] (must use network labs)	70%[3,4]
Radiation and chemotherapy	80%[4]	60%[3,4]	90%[4]	70%[3,4]
Durable medical equipment	80%[2,4]	60% [2,3,4]	90%[2,4]	70% [2,3,4]

[1]Precertification required for all inpatient admissions and may be required for certain outpatient procedures.

[2]In-network benefits count toward out-of-network maximum benefit.

[3]Subject to reasonable and customary (R&C) limits.

[4]Subject to calendar year deductible.

[5]Benefits paid for both in-network and out-of-network care count toward the Medical Plan's calendar year benefit limit. Examples of a calendar year benefit limit include "60 days/calendar year" or "30 visits calendar year."

[6]The Medical Plan pays up to a $5,000 lifetime maximum/participant for assisted reproduction services (e.g., impregnation or fertilization). Benefits paid for both in-network and out-of-network care count toward the Medical Plan's lifetime benefit limit.

[7]When outpatient short-term rehabilitation services are received on an outpatient basis at a hospital facility, the Medical Plan's benefits are described under "Hospital Services - Outpatient Treatment."

[8]Charges in excess of the R&C limits, charges above plan maximum amounts, charges applied to the deductible, and any expenses you incur under the plan's prescription drug benefits do not count toward the calendar year out-of-pocket maximum.

[9]If not part of an office visit, no charge for the injection.

[10]Deductibles and Out of pocket maximum do not cross accumulate between in and out of network care.

Summary of Health Benefits – Medical – Non-Network Area

The chart below outlines the main features of the CIGNA Out-of-Area Comprehensive option available to you if you live in a non-network area.

Non-Network Area Medical Option	
Benefit Description	**Out-of-Area Comprehensive Option**
Calendar year deductible • Individual • Family	 • $300/person • $900/family
Hospital inpatient stay copayment	$300[1]
Calendar year out-of-pocket maximum[5] • Individual • Family	 • $2,000/person • $4,000/family
Lifetime maximum benefit/person	Unlimited
Physician Services	
Primary care physician office visits	80%[2,3]
Specialist office visits	80%[2,3]
Prenatal visits	80%[2,3]
Outpatient surgeon's fees	80%[2,3]
Inpatient surgeon's fees	80%[1,2,3]
Anesthetic services and ancillary services	80%[2,3]
Inpatient hospital services	80%[1,2,3]
Other Professional Services	
Outpatient short-term rehabilitation: physical, speech, and occupational therapy, up to 90 visits per condition per calendar year Also includes chiropractic services under this description	80%[2,3] 80%[2,3]
Private duty nursing	80% up to $10,000/person/calendar year[2,3]
Preventive Care	
Well-baby care (up to age 6)	100% with no deductible[2]
Child physical exam (age 6+)	100% with no deductible[2]
Adult physical exam	100% with no deductible[2]
Routine OB/GYN exam (includes routine mammogram)	100% with no deductible[2]
Hospital Services	
Inpatient treatment	80% after each hospital inpatient stay copayment[2,3]
Outpatient treatment	80%[1,2,3]
Emergency room	80%[2,3]
Skilled nursing facility, up to 60 days/calendar year	80%[1,2,3]
Hospice	80%[2,3]
Other Medical Services	
Assisted reproduction, up to $5,000 lifetime maximum per person	80%[2,3,4]
Infertility diagnosis and treatment	80%[2,3]
Home health care	80% up to 100 visits/calendar year[2,3]
Diagnostic X-ray and lab	80%[2,3]
Radiation and chemotherapy	80%[2,3]
Durable medical equipment	80% [2,3]

[1]Precertification required.

[2]Subject to reasonable and customary (R&C) limits.

[3]Subject to calendar year deductible.

[4]The Medical Plan pays up to a $5,000 lifetime maximum/participant for assisted reproduction services (e.g., impregnation or fertilization).

[5]Charges in excess of the R&C limits, charges above plan maximum amounts, charges applied to the deductible, and any expenses you incur under the plan's prescription drug benefit do not count toward the calendar year out-of-pocket maximum.

Summary of Health Benefits – Prescription Drugs

The following chart outlines the prescription drug benefits available to you if you enroll in a PPO or Out-of-Area Comprehensive option. There are no changes in plan benefits for 2013.

Your Prescription Drug Benefit At-A-Glance[1]				
	Retail Pharmacy[2] (up to a 30-day supply)		Home Delivery Pharmacy Service (up to a 90-day supply)	
	In-Network	***Out-of-Network***	***In-Network***	***Out-of-Network***
Out-of-Pocket Maximum	Not applicable	Not applicable	$3,000/year/per person[3]	Not applicable
Generic Drugs	20% coinsurance ($7 minimum, $25 maximum)[4,5]	60% coinsurance	20% coinsurance ($15 minimum, $50 maximum)[4,5]	Not applicable
Preferred Brand-Name Drugs	20% coinsurance ($15 minimum, $50 maximum)[4,5]	60% coinsurance	20% coinsurance ($45 minimum, $100 maximum)[4,5]	Not applicable
Non-Preferred Brand-Name Drugs	30% coinsurance ($30 minimum, $65 maximum)[4,5]	60% coinsurance	30% coinsurance ($90 minimum, $130 maximum)[4,5]	Not applicable

[1]If a brand-name drug is filled when a generic equivalent is available, you'll pay the brand-name drug employee coinsurance plus the difference in cost between the generic and brand-name drug.
[2]You're allowed one initial prescription plus two refills at the above coverage for maintenance medications filled at a retail pharmacy. For three or more refills, you'll pay 60% of the prescription cost.
[3]The amount of the difference between the brand-name drug and generic alternative does not count toward satisfying the out-of-pocket maximum.
[4]Coinsurance is a portion (percentage) of covered expenses. For example, if your coinsurance is 20% of the amount of covered expenses, you'll pay 20% of the cost and the plan will cover 80% of the cost.
[5]On occasion, the discounted cost of your prescription is less than the stated minimum coinsurance amount. In those instances, you will be charged the discounted cost of the drug.

Summary of Health Benefits – Mental Health & Substance Abuse Treatment

This chart outlines the mental health and substance abuse treatment benefits available if you enroll in a PPO or Out-of-Area Comprehensive option under the Medical Plan.

Mental Health and Substance Abuse Treatment Benefits		
Feature	**In-Network**	**Out-of-Network**
Calendar year deductible	None	$200/person[2,6]
Calendar year out-of-pocket maximum[2,6]	• $3,500/person • $7,000/family	• $7,500/person • $15,000/family
Lifetime maximum benefit (all services combined)	Unlimited	Unlimited
Inpatient services (Precertification required) • Mental health	• 100%[1]	• 70% of eligible charges after $200 calendar year deductible and $150 deductible/hospital admission[1, 2,,3,]
• Substance abuse	• 100% [1]	• 70% of eligible charges after $200 calendar year deductible and $150 deductible/hospital admission[1,2,3]
Intermediate care Mental health and substance abuse	100%[1,3]	80% of eligible charges after $200 calendar year deductible and $150 deductible/hospital admission[1,2,3,]
Outpatient services Individual Treatment	• Visits 1 - 17: $20 copayment (Does not include EAP visits) • Visits over 17: $25 copayment	70% after $200 calendar year deductible, [2,3]
Group Treatment	• Visits 1 - 17: $10 copayment (Does not include EAP visits) • Visits over 17: $20 copayment	70% after $200 calendar year deductible [2,3]
In-home mental health care	100%	70% of eligible charges after $200 calendar year deductible are met up to 100 visits per calendar year'[3]
Drug testing as an adjunct to substance abuse treatment	100%	70% after $200 calendar year deductible [2,3]
Medication management[5]	$5 copayment for up to 30-minute visit; no limit	70% after $200 calendar year deductible for up to a 30-minute visit; unlimited visits [2,3]

[1] Precertification required for all inpatient admissions and intermediate care. If hospital or intermediate care is not pre-certified, there is a non-notification penalty of 20%. There is a 48-hour grace period for emergencies. The non-notification penalty does not count toward the out-of-pocket maximum. 100% denial for no authorization

[2]The annual out-of-network mental health and substance abuse treatment deductible and out of pocket maximum cross accumulates with the medical deductible and out of pocket maximum.

[3]Subject to reasonable and customary (R&C) limits.

[4]Includes, but is not limited to, 24-hour intermediate care facilities (e.g., residential treatment, group homes,

halfway houses, therapeutic foster care, partial hospital/day treatment, structured outpatient treatment programs). Intermediate care is subject to the same plan maximums that apply to inpatient care benefits.

[5] Medication management visits that exceed 30 minutes are considered under outpatient individual treatment sessions.

[6] Deductibles and Out of pocket maximum do not cross accumulate between in and out of network care. Behavioral Health Out-of- Pocket Maximum includes charges for medical, mental health and substance abuse treatment. Does not include charges in excess of the R&C limits, charges above plan maximum amounts, and charges applied to the deductible.

Summary of Health Benefits – Dental/Vision/Hearing Care

The chart below outlines the main features of the Dental/Vision/Hearing Care Plan Comprehensive and Plus options.

Dental/Vision/Hearing Care Plan Options		
Feature	**Comprehensive**	**Plus**
Dental Care Coverage (provided by CIGNA Healthcare)		
Note: Reasonable and customary (R&C) limits apply to all coverage amounts.		
Calendar year deductible • Individual • Family	 • $25/person • $75/family	 • $50/person • $150/family
Preventive services (e.g., x-rays, cleanings, fluoride treatments, sealants and space maintainers for children under 14 years)	100% of covered expenses (no deductible)	100% of covered expenses (no deductible)
Basic services (e.g., fillings, extractions, oral surgery, periodontal treatment, minor restorations)	80% of covered expenses	80% of covered expenses
Major services (e.g., crowns, onlays, dentures, bridges)	50% of covered expenses	60% of covered expenses
Orthodontics (treatment such as straightening of teeth)	50% of covered expenses	50% of covered expenses
Annual maximum dental benefit (excludes orthodontia, includes oral surgery)	$1,500/person	$2,000/person
Lifetime maximum orthodontics benefit	$1,500/person	$2,000/person
Vision Care Coverage (provided by EyeMed Vision Care)		
Copayment for vision care services	$10 copayment	$10 copayment
Routine exam, frames and lens benefits from an EyeMed provider[1]	Covered up to plan allowance after applicable copayments	Covered up to plan allowance after applicable copayments
Contact lens benefit from an EyeMed provider[2]	Up to $150/calendar year for elective contact lenses[3]; medically necessary contact lenses are covered in full[4]; contact lenses are in lieu of spectacle lenses. **Note:** Only one claim per year — please see footnotes.	
Services from an out-of-network provider: • **Exam** **Spectacle lenses**[5]: • **Single** • **Bifocal** • **Trifocal** • **Lenticular** • **Contact lenses/elective** (in lieu of spectacle lenses) • **Contact lenses/necessary**[3] (in lieu of spectacle lenses) • **Frames**	Reimbursed after copayment up to the following under Comprehensive and Plus options; the contact lens allowance is for CL materials only**:** • $50 • $40 • $60 • $80 • $125 • $105 • $210 • $45	
Laser Vision Correction Discount	When arranged with a participating provider, the discount is 15% off the retail price or 5% off any promotional offer.	

Dental/Vision/Hearing Care Plan Options		
Feature	**Comprehensive**	**Plus**
Plan pays benefits for: • **Exams** • **Spectacle lenses**[5] • **Contact lenses**[6] • **Frames**	Once every: • Calendar year • Calendar year • Calendar year • Two calendar years •	Once every: • Calendar year • Calendar year • Calendar year • Two calendar years •
Hearing Care Coverage (provided by CIGNA Healthcare)		
Eligible expenses (hearing aids and hearing exams)	80% of covered expenses	100% of covered expenses
Maximum benefit every two calendar years	$750	$1,000

[1]The plan allowance is a retail equivalent amount of at least $115. There is full coverage for approved frames. When deciding on a frame, ask the doctor which ones are covered in full. You may choose a frame outside the plan's coverage and pay 80% of the difference in cost.
[2]The contact lens exam is a special exam for ensuring proper fit of your contacts and evaluating your vision with the contacts. Standard fitting costs will not exceed $40, you pay 90% of the premium fitting cost. Your contact lens allowance is applied to the contact lenses (material). You pay for expenses above the allowance.
[3]This is a one-time benefit per year. You must use the $150 allowance at one time during the year — any unused amount will be forfeited.
[4]Medically necessary contact lenses are for patients who cannot wear prescription glasses. Examples of conditions for prescribing medically necessary contact lenses include Keratoconus or to correct extreme visual acuity problems that cannot be corrected with spectacle lenses. Prior authorization is not required but advisable if you're receiving services from an out-of-network provider.
[5]In-network, there are discounts for elective lens options. Out-of-network, expenses for elective lens options are your responsibility. Examples of elective lens options are tinting, polycarbonates, and progressives. If you have any questions, please contact EyeMed.
[6] In lieu of spectacle lenses