MEDICAL PLAN COMPARISON

FY2014 (July 1, 2013 – June 30, 2014)

BENEFIT	HSA Advantage		Select		Elite	
Lifetime Maximum Benefits	No limit					
CCHMC Facility Discount	**40% OFF BILLED CHARGES FOR CCHMC FACILITY BASED SERVICES FOR COVERED MEMBERS**					
Provider Network	Humana NPOS-Open Access		Humana NPOS-Open Access		Humana NPOS-Open Access	
	Network	**Non-Network**	**Network**	**Non-Network**	**Network**	**Non-Network**
Annual Deductible (Ded) Single: Family:	 $1,500 $3,000	 $2,000 $4,000	 $300 $600	 $600 $1,200	 $0 $0	 $300 $600
Out-of-Pocket Maximum Single: Family:	 $2,500 $5,000	 $5,000 $10,000	 $1,750 $3,500	 $3,500 $7,000	 $750 $1,500	 $1,500 $3,000
HSA Contributions by CCHMC Single: Family:	*Made in 4 even quarterly deposits* $1,000 $2,000		N/A		N/A	
CCHMC Co-Insurance	85%	60%	90%	70%	100%	80%
WHAT YOU PAY … Flat $ Copay *or* Deductible + Co-Insurance %						
Preventive Services	$0	Ded + 40%	$0	Ded + 30%	$0	Ded + 20%
Office Visit	Ded + 15%	Ded + 40%	$20	Ded + 30%	$20	Ded + 20%
Specialist Visit	Ded + 15%	Ded + 40%	$40	Ded + 30%	$40	Ded + 20%
Urgent Care	Ded + 15%	Ded + 40%	$50		$50	
Emergency Room	Ded + 15%		$150		$150	
Inpatient Hospital	Ded + 15%	Ded + 40%	Ded + 10%	Ded + 30%	$0	Ded + 20%
Outpatient Hospital	Ded + 15%	Ded + 40%	Ded + 10%	Ded + 30%	$0	Ded + 20%
Maternity Services Prenatal Visits Delivery	 Ded + 15% Ded + 15%	 Ded + 40% Ded + 40%	 $20 Ded + 10%	 Ded + 30% Ded + 30%	 $20 $0	 Ded + 20% Ded + 20%
Occupation, Physical, and Speech Therapy Services	Ded + 15%	Ded + 40%	$40	Ded + 30%	$40	Ded + 20%
	60 visits combined		*60 visits combined*		*90 visits combined*	
Prescription Drugs (30 days) Generic Formulary Brand Non-Formulary Brand Maintenance Drugs (90 days)	 Ded + 15% Ded + 15% Ded + 15% Ded + 15%	 Ded + 40% Ded + 40% Ded + 40% Ded + 40%	 $10 30% ($40 max) 50% ($80 max) 2x30 day cost	 30% 30% 30% 2x30 day cost	 $10 30% ($40 max) 50% ($80 max) 2x30 day cost	 30% 30% 30% 2x30 day cost
Generic Preventive Prescription Drugs	$0	Ded + 40%	$0	30%	$0	30%

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MEDICAL PLAN COMPARISON

FY2014 (July 1, 2013 – June 30, 2014)

BENEFIT	HSA Advantage		Select		Elite	
	Network	Non-Network	Network	Non-Network	Network	Non-Network
WHAT YOU PAY … Flat $ Copay *or* Deductible + Co-Insurance %						
Mental Health Outpatient	Ded + 15%	Ded + 40%	$20	Ded + 30%	$20	Ded + 20%
Mental Health Inpatient	Ded + 15%	Ded + 40%	Ded + 10%	Ded + 30%	$0	Ded + 20%
Infertility Services *All plans cover diagnostic testing, counseling, and artificial insemination*	Ded + 15% *After deductible, plan covers IVF medical services up to $3,000 annual maximum benefit – drugs NOT covered $15,000 lifetime maximum benefit*	Ded + 40%	Ded + 10%	Ded + 30%	$0	Ded + 20%
Diagnostic Tests, X-Rays, and Labs: In-Office	Ded + 15%	Ded + 40%	$0	Ded + 30%	$0	Ded + 20%
Diagnostic Tests, X-Rays, and Labs: Outpatient Hospital	Ded + 15%	Ded + 40%	Ded + 10%	Ded + 30%	$0	Ded + 20%
MRI, MRA, PET, CAT, SPECT scans	Ded + 15%	Ded + 40%	Ded + 10%	Ded + 30%	$0	Ded + 20%
Durable Medical Equipment	Ded + 15%	Ded + 40%	Ded + 10%	Ded + 30%	$0	Ded + 20%
Diabetic Supplies	$0	Ded + 40%	Ded + 10%	Ded + 30%	$0	Ded + 20%
Hearing Aids *$1,000 per ear maximum benefit every three plan years*	Ded + 15%	Ded + 40%	Ded + 10%	Ded + 30%	$0	Ded + 20%

DEFINITIONS

CCHMC Co-Insurance: The portion of charges that CCHMC will pay once you have met the deductible.
Co-Insurance: The portion of charges that you will pay once you have met the deductible up to the stated Out-of-Pocket Maximum.
Copay: A flat dollar amount that you pay for a service without needing to first meet a deductible.
Deductible: An amount of money that the member must pay out of pocket before the medical plan begins paying for a service. Network and non-network expenses accumulate separately to the different deductibles. Prescription drugs *do not* count towards the deductible *except* under the HSA Advantage plan.
Diabetic Supplies: Common supplies used to treat and monitor diabetes such as lancets, syringes, swabs, test strips, etc.
Diagnostic Tests, X-Rays, and Labs: In-Office: These services generally are covered as stated above unless a separate charge is billed for the office visit. The services billed are determined by the individual provider.
Diagnostic Tests, X-Rays, and Labs: Outpatient Hospital: These services generally are covered like any other inpatient or outpatient hospital procedure.
Office Visit: Care in an outpatient setting from a primary care provider defined as: family care provider, pediatrician, internal medicine, general practitioner, physician assistant, registered nurse, retail/minute clinic, and OB/Gyn.
Out-of-Pocket Maximum: The maximum dollar amount you will pay in deductibles, co-insurance, and/or copays before CCHMC begins paying 100% for covered services. Network and non-network expenses accumulate separately to the different maximums. Prescription drugs *do not* count towards the maximum *except* under the HSA Advantage plan.
Preventive Prescription Drugs: A collection of drugs used to treat chronic medical conditions (such as high blood pressure, diabetes, depression, etc.) covered 100% by CCHMC under the HSA Advantage plan.
Preventive Services: Screenings, tests, and routine care, as recommended by the U.S. Preventive Services Task Force, that are covered 100% by CCHMC and not subject to the deductible or co-pay when in-network.
Specialist Visit: Care in an outpatient setting from a medical provider other than a primary care provider.

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