MEDICAL PLAN COMPARISON

FY2013 (July 1, 2012 – June 30, 2013)



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:	\$2,500	\$3,000	\$300	\$600	\$0	\$300		
Family:	\$5,000	\$6,000	\$600	\$1,200	\$0	\$600		
Out-of-Pocket Maximum	#0.500	# F 000	04.750	00.500	0750	#4.500		
Single:	\$2,500 \$5,000	\$5,000	\$1,750 \$3,500	\$3,500	\$750 \$4.500	\$1,500		
Family: HSA Contributions by	\$5,000	\$10,000	\$3,500	\$7,000	\$1,500	\$3,000		
CCHMC	Made in 4 even quarterly deposits							
Single:	\$1.000		N/A		N/A			
Family:	\$2,0							
CCHMC Co-Insurance	100%	60%	90%	70%	100%	80%		
WHAT YOU PAY Flat \$ Copay <u>or</u> Deductible + Co-Insurance %								
Preventive Services	\$0	Ded + 40%	\$0	Ded + 30%	\$0	Ded + 20%		
Office Visit	Ded only	Ded + 40%	\$20	Ded + 30%	\$20	Ded + 20%		
Specialist Visit	Ded only	Ded + 40%	\$40	Ded + 30%	\$40	Ded + 20%		
Urgent Care	Ded only	Ded + 40%	\$50		\$50			
Emergency Room	Ded only		\$150		\$150			
Inpatient Hospital	Ded only	Ded + 40%	Ded + 10%	Ded + 30%	\$0	Ded + 20%		
Outpatient Hospital	Ded only	Ded + 40%	Ded + 10%	Ded + 30%	\$0	Ded + 20%		
Maternity Services								
Prenatal Visits	Ded only	Ded + 40%	\$20	Ded + 30%	\$20	Ded + 20%		
Delivery	Ded only	Ded + 40%	Ded + 10%	Ded + 30%	\$0	Ded + 20%		
Occupation, Physical, and Speech Therapy Services	Ded only	Ded + 40%	\$40	Ded + 30%	\$40	Ded + 20%		
,	60 visits combined		60 visits combined		90 visits combined			
Prescription Drugs (30								
days)	Ded only	Ded + 40%	\$10	30%	\$10	30%		
Generic	Ded only	Ded + 40%	30% (\$40 max)	30%	30% (\$40 max)	30%		
Formulary Brand	Ded only	Ded + 40%	50% (\$80 max)	30%	50% (\$80 max)	30%		
Non-Formulary Brand	Ded only	Ded + 40%	2x30 day cost	2x30 day cost	2x30 day cost	2x30 day cost		
Maintenance Drugs (90 days)								
Preventive Prescription Drugs	\$0	Ded + 40%	According to above tiers		According to above tiers			
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MEDICAL PLAN COMPARISON

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BENEFIT	HSA Advantage		Select		Elite					
	Network	Non-Network	Network	Non-Network	Network	Non-Network				
WHAT YOU PAY Flat \$ Copay <u>or</u> Deductible + Co-Insurance %										
Mental Health Outpatient	Ded only	Ded + 40%	\$20	Ded + 30%	\$20	Ded + 20%				
Mental Health Inpatient	Ded only	Ded + 40%	Ded + 10%	Ded + 30%	\$0	Ded + 20%				
Infertility Services All plans cover diagnostic testing, counseling, and artificial insemination	Ded only	Ded + 40%	Ded + 10%	Ded + 30%	\$0	Ded + 20%				
	After deductible, plan covers IVF medical services up to \$3,000 annual maximum benefit – drugs <u>NOT</u> covered \$15,000 lifetime maximum benefit									
Diagnostic Tests, X-Rays, and Labs: In-Office	Ded only	Ded + 40%	\$0	Ded + 30%	\$0	Ded + 20%				
Diagnostic Tests, X-Rays, and Labs: Outpatient Hospital	Ded only	Ded + 40%	Ded + 10%	Ded + 30%	\$0	Ded + 20%				
MRI, MRA, PET, CAT, SPECT scans	Ded only	Ded + 40%	Ded + 10%	Ded + 30%	\$0	Ded + 20%				
Durable Medical Equipment	Ded only	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 only	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 <u>do not</u> count towards the deductible <u>except</u> 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 <u>do not</u> count towards the maximum <u>except</u> 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.

