MEDICAL PLAN COMPARISON

FY2010 (July 1, 2009 – June 30, 2010)

BENEFIT	CCHMC SELECT – HUMANA	CCHMC ELITE - HUMANA
Out-of-Network Benefits	Only true urgent/emergent care claims	Only true urgent/emergent care claims
Pre-Existing Condition Limits	None	None
Lifetime Maximum Benefits	$5 million per member combined across all CCHMC medical plans. Claims incurred prior to 7/1/2007 and prescription drugs do not count against limit.	
Annual Deductible (January 1 – December 31)	None	None
Out-of-Pocket Maximum (January 1 – December 31)	$1,000 Single $2,000 Family	$1,000 Single $2,000 Family
PROFESSIONAL SERVICES – Your Co-Pay or Co-Insurance Amount		
Office Visit	$20 per visit, referral for Specialists not required	$15 per visit, referral for Specialists not required
Urgent Care	$25 per visit	$25 per visit
Therapy Services - Physical & Speech - Occupational	 $20 per visit (30 visit limit) $20 per visit (20 visit limit)	 $15 per visit (30 visit limit) $15 per visit (20 visit limit)
Maternity	$20 at first visit only and applicable inpatient hospitalization co-pay	$15 at first visit only and applicable inpatient hospitalization co-pay
Infertility Services	20% diagnostic testing and artificial insemination only	20% diagnostic testing and artificial insemination only
Allergy Services	$20 per visit, if office visit charged 20% for testing	$15 per visit, if office visit charged 20% for testing
Hearing & Vision Exams	$20 per visit	$15 per visit
Diagnostic Tests, X-Rays, Routine Labs	None	None
HOSPITAL SERVICES – Your Co-Pay or Co-Insurance Amount		
Ambulance	None	None
Emergency Room	$75 per visit (waived if admitted)	$50 per visit (waived if admitted)
Inpatient Hospital (anesthesia, surgery, semi-private room)	$250 per admission	None
Outpatient Hospital (facility, physician, surgery, anesthesia)	$75 per admission	None
OTHER SERVICES – Your Co-Pay or Co-Insurance Amount		
Mental Health Care (LifeSynch network) - Inpatient - Outpatient	 $250 per admission $20 per visit	 None $15 per visit
Prescription Drugs - Generic - Preferred Brand - Non-Preferred Brand Maintenance Drugs	 $12 per 30-day supply $24 per 30-day supply 50% per 30-day supply ($50 minimum) 2 x 30-day price for 90-day supply	 $10 per 30-day supply $20 per 30-day supply $30 per 30-day supply 2 x 30-day price for 90-day supply

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MEDICAL PLAN COMPARISON

FY2010 (July 1, 2009 – June 30, 2010)

BENEFIT	CCHMC CHOICE – ANTHEM		CCHMC CHOICE PLUS - ANTHEM	
Out-of-Network Benefits	Yes at a reduced level of benefits		Yes at a reduced level of benefits	
Pre-Existing Condition Limits	Yes, if more than 63 day break in coverage		Yes, if more than 63 day break in coverage	
Lifetime Maximum Benefits	$5 million per member combined across all CCHMC medical plans. Claims incurred prior to 7/1/2007 and prescription drugs do not count against limit.			
	Network	Non-Network	Network	Non-Network
Annual Deductible (January 1 – December 31)	$500 Single $1,000 Family	$1,000 Single $2,000 Family	$200 Single $400 Family	$400 Single $700 Family
Out-of-Pocket Maximum (January 1 – December 31)	$3,000 Single $6,000 Family	$6,000 Single $12,000 Family	$1,500 Single $3,000 Family	$4,000 Single $8,000 Family
PROFESSIONAL SERVICES – Your Co-Pay or Co-Insurance Amount				
Office Visit	$25 per visit	Deductible, then 40%	$20 per visit	Deductible, then 30%
Urgent Care	$35 per visit		$35 per visit	
Therapy Services - Physical & Speech (Combined 30 visit limit network/non-network each) - Occupational (Combined 30 visit limit network/non-network)	$25 per visit $25 per visit	Deductible, then 40% Deductible, then 40%	$20 per visit $20 per visit	Deductible, then 30% Deductible, then 30%
Maternity	$25 at first visit only and applicable inpatient hospitalization co-insurance	Deductible, then 40%	$20 at first visit only and applicable inpatient hospitalization co-pay	Deductible, then 30%
Infertility Services	Diagnostic testing only at office visit rate		Diagnostic testing only at office visit rate	
Allergy Services	$25 per visit	Deductible, then 40%	$20 per visit	Deductible, then 30%
Hearing & Vision Exams	$25 per visit	Deductible, then 40%	$20 per visit	Deductible, then 30%
Diagnostic Tests, X-Rays, Routine Labs	Deductible, then 20%	Deductible, then 40%	Deductible, then 10%	Deductible, then 30%
HOSPITAL SERVICES – Your Co-Pay or Co-Insurance Amount				
Ambulance	Deductible, then 20%		Deductible, then 20%	
Emergency Room	$100 per visit (waived if admitted)		$75 per visit (waived if admitted)	
Inpatient Hospital (anesthesia, surgery, semi-private room)	Deductible, then 20%	Deductible, then 40%	$250 per admission	Deductible, then 30%
Outpatient Hospital (facility, physician, surgery, anesthesia)	Deductible, then 20%	Deductible, then 40%	Deductible, then 10%	Deductible, then 30%

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MEDICAL PLAN COMPARISON

FY2010 (July 1, 2009 – June 30, 2010)

OTHER SERVICES – Your Co-Pay or Co-Insurance Amount				
	Network	Non-Network	Network	Non-Network
Mental Health Care (Anthem Behavioral Health network) - Inpatient - Outpatient	 Deductible, then 20% $25 per visit	 Deductible, then 40% Deductible, then 40%	 $250 per admission $20 per visit	 Deductible, then 30% Deductible, then 30%
Prescription Drugs - Generic - Preferred Brand - Non-Preferred Brand ($50 minimum) Maintenance Drugs	 $12 per 30-day supply $24 per 30-day supply 50% per 30-day supply 2 x 30-day price for 90-day supply	 30% 30% 30% N/A	 $12 per 30-day supply $24 per 30-day supply 50% per 30-day supply 2 x 30-day price for 90-day supply	 30% 30% 30% N/A

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MEDICAL PLAN COMPARISON

FY2010 (July 1, 2009 – June 30, 2010)

BENEFIT	CCHMC CHOICE ELITE – ANTHEM	
Out-of-Network Benefits	Yes at a reduced level of benefits	
Pre-Existing Condition Limits	Yes, if more than 63 day break in coverage	
Lifetime Maximum Benefits	$5 million per member combined across all CCHMC medical plans. Claims incurred prior to 7/1/2007 and prescription drugs do not count against limit.	
	Network	Non-Network
Annual Deductible (January 1 – December 31)	None	$300 Single $600 Family
Out-of-Pocket Maximum (January 1 – December 31)	$500 Single $1,000 Family	$1,000 Single $2,000 Family
PROFESSIONAL SERVICES – Your Co-Pay or Co-Insurance Amount		
Office Visit	$15 per visit	Deductible, then 20%
Urgent Care	$35 per visit	
Therapy Services - Physical & Speech (Combined 30 visit limit network/non-network each) - Occupational (Combined with Phys, 60 visit limit network/non-network)	 $15 per visit $15 per visit	 Deductible, then 20% Deductible, then 20%
Maternity	$15 at first visit only and applicable inpatient hospitalization co-insurance	Deductible, then 20%
Infertility Services	Diagnostic testing only at office visit rate	
Allergy Services	$15 per visit	Deductible, then 20%
Hearing & Vision Exams	$15 per visit	Deductible, then 20%
Diagnostic Tests, X-Rays, Routine Labs	None	Deductible, then 20%
HOSPITAL SERVICES – Your Co-Pay or Co-Insurance Amount		
Ambulance	None	
Emergency Room	$50 per visit (waived if admitted)	
Inpatient Hospital (anesthesia, surgery, semi-private room)	None	Deductible, then 20%
Outpatient Hospital (facility, physician, surgery, anesthesia)	None	Deductible, then 20%

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MEDICAL PLAN COMPARISON

FY2010 (July 1, 2009 – June 30, 2010)

OTHER SERVICES – Your Co-Pay or Co-Insurance Amount		
	Network	Non-Network
Mental Health Care (Anthem Behavioral Health network) - Inpatient - Outpatient	 None $15 per visit	 Deductible, then 20% $15 per visit, plus any amount above fee schedule
Prescription Drugs - Generic - Preferred Brand - Non-Preferred Brand Maintenance Drugs	 $10 per 30-day supply $15 per 30-day supply $30 per 30-day supply 2 x 30-day price for 90-day supply	 N/A N/A N/A N/A

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