

MEDICAL PLANS COMPARISON CHART

Benefit/Feature	Humana Managed Choice (HDHP) with HRA and FSA		Humana Balanced Choice (PPO) with HRA and FSA		Humana Choice (PPO) with FSA only	
	In-Network	Out of Network	In-Network	Out of Network	In-Network	Out of Network
Choice of doctors and hospitals	Use any doctor but better coverage in-network; must use network hospitals except in emergency		Use any doctor but better coverage in-network; must use network hospitals except in emergency		Use any doctor but better coverage in-network; must use network hospitals except in emergency	
Need to select primary care physician?	No	No	No	No	No	No
Annual deductible	\$1,800/single	\$3,600/single	\$1,200/person	\$3,600/person	\$600/person	\$1,800/person
(does not include copays)	\$3,600/other levels ¹	\$7,200/other levels ¹	\$3,600/other levels	\$10,800/other levels	\$1,800/other levels	\$5,400/other levels
Annual out-of-pocket expense limit	\$3,600/person	\$7,200/person	\$3,600/person	\$10,800/person	\$2,000/person	\$6,000/person
(includes deductible and in-network copays)	\$7,200/other levels	\$14,400/other levels	\$10,800/other levels	\$32,400/other levels	\$6,000/other levels	\$18,000/other levels
Doctor's office visits						
Metro Employee Wellness Center	\$5 copay/visit		\$5 copay/visit		\$5 copay/visit	
Primary care	80% ⁷	60% ⁷	\$30 copay/visit	60% ⁷	\$30 copay/visit	60% ⁷
Specialists ³	80% ⁷	60% ⁷	\$50 copay/visit	60% ⁷	\$50 copay/visit	60% ⁷
Inpatient physician care	80% ⁷	60% ⁷	80% ⁷	60% ⁷	80% ⁷	60% ⁷
ER physician care	80% ⁷	80% ⁷	80% ⁷	60% ⁷	80% ⁷	60% ⁷
Diagnostic tests	80% ⁷	60% ⁷	80% ⁷	60% ⁷	80% ⁷	60% ⁷
Metro Employee Wellness Center	included in \$5 copay/visit		included in \$5 copay/visit		included in \$5 copay/visit	
Inpatient hospital	80% ⁷	60% ⁷	80% ⁷	60% ⁷	80% ⁷	60% ⁷
Outpatient hospital	80% ⁷	60% ⁷	80% ⁷	60% ⁷	80% ⁷	60% ⁷
Emergency Room	80% ⁷	80% ⁷	80% ⁷	80% ⁷	80% ⁷	80% ⁷
Urgent care Centers	80% ⁷	60% ⁷	\$100 copay/visit	60% ⁷	\$100 copay/visit	60% ⁷
Prescription Drugs						
Metro Employee Wellness Center	\$0 generic (Tier 1)		\$0 generic (Tier 1)		\$0 generic (Tier 1)	
Retail Pharmacies	80% ⁷	60% ⁷	\$20 generic (Tier 1)	Not covered	\$20 generic (Tier 1)	Not covered
(30-day supply)			\$35 brand name (Tier 2) ⁶ \$60 non-formulary (Tier 3) ⁶		\$35 brand name (Tier 2) ⁶ \$60 non-formulary (Tier 3) ⁶	
Mail order (90-day supply)	80% ⁷	60% ⁷	2x retail copay	Not covered	2x retail copay	Not covered
Allergy services						
Testing	80% ⁷	60% ⁷	80% ⁷	60% ⁷	80% ⁷	60% ⁷
Serum	80% ⁷	60% ⁷	80% ⁷	60% ⁷	80% ⁷	60% ⁷
Injections	80% ⁷	60% ⁷	80% ⁷	60% ⁷	80% ⁷	60% ⁷
Metro Employee Wellness Center	included in \$5 copay/visit		included in \$5 copay/visit		included in \$5 copay/visit	
Ambulance	80% ⁷	80% ⁷	80% ⁷	80% ⁷	80% ⁷	80% ⁷
Skilled Nursing Facility	80% ⁷	60% ⁷	80% ⁷	60% ⁷	80% ⁷	60% ⁷
Behavioral Health/Substance Abuse						
Inpatient	80% ⁷	60% ⁷	80% ⁷	60% ⁷	80% ⁷	60% ⁷
Outpatient	80% ⁷	60% ⁷	\$50 copay/visit ⁴	60% ⁷	\$50 copay/visit ⁴	60% ⁷
Home Health Care	80% ⁷ (limit 60 visits/year)	60% ⁷ (limit 60 visits/year)	80% ⁷ (limit 60 visits/year)	60% ⁷ (limit 60 visits/year)	80% ⁷ (limit 60 visits/year)	60% ⁷ (limit 60 visits/year)
Therapy services^{2, 4, 5, 8}	80% ⁷	60% ⁷	\$30 copay/visit	60% ⁷	\$30 copay/visit	60% ⁷
Chiropractic care (must be reviewed for medical necessity)	80% ⁷ (limit 20 visits/year)	60% ⁷ (limit 20 visits/year)	\$30 copay/visit (limit 20 visits/year)	60% ⁷ (limit 20 visits/year)	\$30 copay/visit (limit 20 visits/year)	60% ⁷ (limit 20 visits/year)
Lifetime maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited

¹If you choose a coverage other than Employee Only, you must satisfy the whole deductible. The whole deductible may be satisfied by one person or any combination of enrolled eligible person. ²Therapy services are limited to 25 visits/year each for speech, physical, occupational therapy and pediatric vision therapy. Maximum of 50 visits/year for all types of therapy combined. ³Does not apply to pediatrician or OB/GYN annual exams. ⁴Psychiatrist is considered a specialist and copay is \$50 per visit. ⁵Any therapy claims with an autism diagnosis are not counted against the therapy limits. They are in addition to the mental health autism benefits. ⁶Member pays applicable copays plus difference when a generic is available. ⁷After annual deductible. ⁸The initial visit may be billed as a specialty office visit due to evaluation by therapist.

Please Note: Under health care reform, preventive care is covered at 100%. Claims must be submitted as preventive or routine without a diagnosis. Examples of routine medical procedures include annual physical exam, immunizations, pap smear, annual mammogram, preventive colonoscopy, etc. Also included are breast feeding counseling, breast feeding support and supplies, and prescribed contraceptive methods. For more information, please refer to your Summary Plan Description.