



# MEDICAL PLAN COMPARISON

Plan Highlights	Managed Choice HDHP		Balanced Choice PPO		Choice PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Choice of Doctors and Hospitals</b>	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	
<b>Must Select a PCP?</b>	No	No	No	No	No	No
<b>Annual Deductible</b> (Does not include copays)	\$2,000 single/ \$4,000 other levels <sup>1</sup>	\$3,600 single/ \$7,200 other levels <sup>1</sup>	\$1,400 single/ \$4,200 other levels	\$3,600 single/ \$10,800 other levels	\$800 single/ \$3,000 other levels	\$1,800 single/ \$5,400 other levels
<b>Out-of-Pocket Limit</b>	\$3,675 single/ \$7,350 other levels	\$7,200 single/ \$14,400 other levels	\$4,200 single/ \$12,600 other levels	\$10,800 single/ \$32,400 other levels	\$2,400 single/ \$9,000 other levels	\$6,000 single/ \$18,000 other levels
<b>Tax Savings</b>	HRA and FSA		HRA and FSA		FSA only	
<b>Doctor's Office Visits</b>						
Metro Wellness Center	\$5 copay/visit		\$5 copay/visit		\$5 copay/visit	
Primary Care Physician	80% <sup>7</sup>	60% <sup>7</sup>	\$30 copay/visit	60% <sup>7</sup>	\$30 copay/visit	60% <sup>7</sup>
Specialists <sup>3</sup>	80% <sup>7</sup>	60% <sup>7</sup>	\$50 copay/visit	60% <sup>7</sup>	\$50 copay/visit	60% <sup>7</sup>
Inpatient Physician	80% <sup>7</sup>	60% <sup>7</sup>	80% <sup>7</sup>	60% <sup>7</sup>	80% <sup>7</sup>	60% <sup>7</sup>
ER Physician	80% <sup>7</sup>	80% <sup>7</sup>	80% <sup>7</sup>	60% <sup>7</sup>	80% <sup>7</sup>	60% <sup>7</sup>
Diagnostic Tests	80% <sup>7</sup>	60% <sup>7</sup>	80% <sup>7</sup>	60% <sup>7</sup>	80% <sup>7</sup>	60% <sup>7</sup>
Metro Wellness Center	Included in copay		Included in copay		Included in copay	
Inpatient Hospital	80% <sup>7</sup>	60% <sup>7</sup>	80% <sup>7</sup>	60% <sup>7</sup>	80% <sup>7</sup>	60% <sup>7</sup>
Outpatient Hospital	80% <sup>7</sup>	60% <sup>7</sup>	80% <sup>7</sup>	60% <sup>7</sup>	80% <sup>7</sup>	60% <sup>7</sup>
Emergency Room	80% <sup>7</sup>	80% <sup>7</sup>	80% <sup>7</sup>	80% <sup>7</sup>	80% <sup>7</sup>	80% <sup>7</sup>
Urgent Care Center	80% <sup>7</sup>	60% <sup>7</sup>	\$100 copay/visit	60% <sup>7</sup>	\$100 copay/visit	60% <sup>7</sup>
<b>Allergy Services</b>						
Testing	80% <sup>7</sup>	60% <sup>7</sup>	80% <sup>7</sup>	60% <sup>7</sup>	80% <sup>7</sup>	60% <sup>7</sup>
Serum	80% <sup>7</sup>	60% <sup>7</sup>	80% <sup>7</sup>	60% <sup>7</sup>	80% <sup>7</sup>	60% <sup>7</sup>
Injections	80% <sup>7</sup>	60% <sup>7</sup>	80% <sup>7</sup>	60% <sup>7</sup>	80% <sup>7</sup>	60% <sup>7</sup>
Metro Wellness Center	Included in copay		Included in copay		Included in copay	
Ambulance	80% <sup>7</sup>	80% <sup>7</sup>	80% <sup>7</sup>	80% <sup>7</sup>	80% <sup>7</sup>	80% <sup>7</sup>
Skilled Nursing Facility	80% <sup>7</sup>	60% <sup>7</sup>	80% <sup>7</sup>	60% <sup>7</sup>	80% <sup>7</sup>	60% <sup>7</sup>
<b>Behavioral Health/Substance Abuse</b>						
Inpatient	80% <sup>7</sup>	60% <sup>7</sup>	80% <sup>7</sup>	60% <sup>7</sup>	80% <sup>7</sup>	60% <sup>7</sup>
Outpatient	80% <sup>7</sup>	60% <sup>7</sup>	\$50 copay/visit <sup>4</sup>	60% <sup>7</sup>	\$50 copay/visit	60% <sup>7</sup>
Home Health Care	80% <sup>7</sup> (limit 60 visits/year)	60% <sup>7</sup> (limit 60 visits/year)	80% <sup>7</sup> (limit 60 visits/year)	60% <sup>7</sup> (limit 60 visits/year)	80% <sup>7</sup> (limit 60 visits/year)	60% <sup>7</sup> (limit 60 visits/year)
Therapy Services <sup>2,4,5,8</sup>	80% <sup>7</sup>	60% <sup>7</sup>	\$30 copay/visit <sup>4</sup>	60% <sup>7</sup>	\$30 copay/visit	60% <sup>7</sup>
Chiropractic Care (Must be reviewed for medical necessity)	80% <sup>7</sup> (limit 20 visits/year)	60% <sup>7</sup> (limit 20 visits/year)	\$30 copay/visit (limit 60 visits/year)	60% <sup>7</sup> (limit 20 visits/year)	\$30 copay/visit (limit 60 visits/year)	60% <sup>7</sup> (limit 20 visits/year)
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited

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

Please Note: At the time this booklet was printed, 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.