

HILLSBOROUGH COUNTY EMPLOYEE GROUP HEALTH PLAN OPTIONS

Plan Year: October 1, 2010 - September 30, 2011

Plan Benefits	EPO Open Access with Deductible		EPO Open Access without In Network Deductible		CoverageFirst SM				High Deductible Health Plan (HDHP)			
	In Network ⁽¹⁾	Out of Network	In Network ⁽¹⁾	Out of Network	In Network ⁽¹⁾		Out of Network		In Network ⁽¹⁾		Out of Network	
Annual Deductible (Single/Family)	Single \$250 Family \$750	Single \$400 Family \$800	None	Single \$400 Family \$800	Individual \$1,000 After \$1,000 benefit allowance per member paid by plan.	Family \$3,000	Single \$2,000 Family \$6,000		Single \$2,500 ⁽³⁾ Family \$5,000 ⁽³⁾⁽⁴⁾		Single \$5,000 ⁽³⁾ Family \$10,000 ⁽³⁾⁽⁴⁾	
Annual Medical Out-of-Pocket Maximum	Single \$2,000 Family \$4,000	Single \$4,000 Family \$8,000	Single \$2,000 Family \$4,000	Single \$4,000 Family \$8,000	Single None	Family None	Single \$4,000	Family \$8,000	Single \$3,500	Family \$7,000	Single \$7,500	Family \$15,000
	In and Out of Network Benefits the Same for Both EPO Plans											
	In Network		Out of Network									
Doctor Visit -- Primary: General, Pediatric, Family, Internal Med Providers Specialist: All Other Providers	\$25 copay		30% of charges ⁽²⁾		\$25 copay		30% of charges ⁽²⁾		10% after deductible		30% of charges ⁽²⁾	
	\$40 copay				\$40 copay							
Inpatient Hospital	\$150 per day (3 day max = \$450)		30% of charges ⁽²⁾		100% after deductible		30% of charges ⁽²⁾		10% after deductible		30% of charges ⁽²⁾	
Outpatient Surgical Facility	Hospital Based: \$200 copay Free Standing: \$100 copay		30% of charges ⁽²⁾ 30% of charges ⁽²⁾		Hospital Facility: \$200 copay Free Standing: \$100 copay		30% of charges ⁽²⁾ 30% of charges ⁽²⁾		10% after deductible		30% of charges ⁽²⁾	
X-Ray and Lab	No charge		30% of charges ⁽²⁾		100% after deductible		30% of charges ⁽²⁾		10% after deductible		30% of charges ⁽²⁾	
Emergency/Urgent Care (ER copay waived if admitted)	Hospital ER: \$200 per visit Urgent Care Center: \$75 per visit		Hospital ER: \$200 per visit ⁽²⁾ Urgent Care Center: \$75 per visit ⁽²⁾		Hospital ER \$200 copay per visit. Urgent Care Center: \$75 copay per visit.		Hospital ER \$200 copay per visit ⁽²⁾ Urgent Care Center: \$75 copay per visit ⁽²⁾		10% after deductible		30% of charges	
Skilled Nursing Facility	\$150 per day (3 day max = \$450)		30% of charges ⁽²⁾		100% after deductible		30% of charges ⁽²⁾		10% after deductible		30% of charges ⁽²⁾	
Physical, Speech and Occupational Therapy, Chiropractic Care (60 visit annual maximum aggregated)	\$40 copay		30% of charges ⁽²⁾		100% after deductible Chiropractic Care: \$40 copay per visit.		30% of charges ⁽²⁾		10% after deductible		30% of charges ⁽²⁾	
Pharmacy Copays	<u>Retail</u>	<u>3-Mo Supply</u>			<u>Retail</u>	<u>3-Mo Supply</u>						
Level 1 - Generic	\$10	\$20			\$10	\$20						
Level 2 - Brand	\$30	\$60			\$30	\$60						
Level 3 - Preferred	\$50	\$100			\$50	\$100						
Level 4 - Specialty	25%	25%			25%	25%						
Mail Order Pharmacy Copays	<u>3-Month Mail Order Supply</u>				<u>3-Month Mail Order Supply</u>							
Level 1 - Generic		\$15				\$15						
Level 2 - Brand		\$50				\$50						
Level 3 - Preferred		\$80				\$80						
Annual Pharmacy Maximum	Single \$2,500	Family \$5,000	Single \$2,500	Family \$5,000	Single \$2,500	Family \$5,000	Single \$2,500	Family \$5,000	Included in \$3,500	Included in \$7,000	Included in \$7,500	Included in \$15,000

(1) In-Network Benefits Paid to Any Provider listed in the Humana NPOS Directory

(2) Subject to annual deductible

(3) All copays or coinsurance continue after the Plan Deductible has been met.

(4) No benefits payable until full Family deductible is met