Woods Hole Oceanographic Institution

PLAN DESIGN COMPARISON

Medical Plan Features	High Deductible Health Plan with Health Reimbursement Account (HDHP-HRA)	High Deductible Health Plan with Health Savings Account (HDHP-HSA)	Low Deductible Health Plan (LDHP)
Annual Deductible Individual Coverage Family Coverage * *includes EE + child(ren), EE+ spouse, and family coverage	$2,000 $4,000	$1,500 $3,000	$500 $1,000
	The *deductible* applies to in-network and out-of-network benefits combined.	The *deductible* applies to in-network and out-of-network benefits combined.	Coverage is provided for in-network benefits only, except for Emergency services
	The *deductible* applies to all covered services except in-network preventive health services, prescription drugs and supplies, and certain other covered services as noted in this chart.	The *deductible* applies to all *covered services* except preventive health services	The Deductible applies to covered services as noted in this chart
	The family *deductible* can be met by eligible costs incurred by any combination of members enrolled under the same family plan. But, no one member will have to pay more than the $2,000 per member *deductible*.	The family *deductible* can be met by amounts paid by one family *member* or any combination of family *members* enrolled under the same family plan. Under a plan that includes the *subscriber* and eligible dependents, the entire amount of the family *deductible* must be met before benefits will be provided for any one *member*.	The family *deductible* can be met by eligible costs incurred by any combination of members enrolled under the same family plan. But, no one member will have to pay more than the $500 per member *deductible*.
Annual Out-of-Pocket Max Individual Coverage Family Coverage * *includes EE + child(ren), EE+ spouse, and family coverage	$5,000 $10,000	$5,000 $10,000	$5,000 $10,000
	The *out-of-pocket maximum* applies to in-network and out-of-network benefits combined. **Effective 1/1/2015:** **Member Prescription Drug cost share will now apply towards the Out of Pocket Max**	The *out-of-pocket maximum* applies to in-network and out-of-network benefits combined. **No Change From Current:** **Includes member prescription drug cost share**	The *out-of-pocket maximum* applies to all covered benefits. **Effective 1/1/2015:** **Member Prescription Drug cost share will now apply towards the Out of Pocket Max**
	The *out-of-pocket maximum* is a total of your deductible expenses, co-insurance, and all co-payments	The *out-of-pocket maximum* is a total of your deductible, copayments, and coinsurance	The *out-of-pocket maximum* is a total of your deductible expenses, co-insurance, and all co-payments
	The family *out-of-pocket maximum* can be met by eligible costs incurred by any combination of members enrolled under the same family plan. But, no one member will have to pay more than the $5,000 per member *out-of-pocket maximum*.	The family *out-of-pocket maximum* can be met by amounts paid by one family *member* or any combination of family *members* enrolled under the same family plan. Under a plan that includes the *subscriber* and eligible dependents, the entire amount of the family *out-of-pocket maximum* must be met before full benefits will be provided for any one *member*.	The family *out-of-pocket maximum* can be met by eligible costs incurred by any combination of members enrolled under the same family plan. But, no one member will have to pay more than the $5,000 per member *out-of-pocket maximum*.
Overall Benefit Maximum	No dollar limit	No dollar limit	No dollar limit

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	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only
	Your Cost is:	Your Cost is:	Your Cost is:	Your Cost is:	Your Cost is:
Admissions for Inpatient Medical and Surgical Care					
In a General Hospital	$0 AD	20% co-insurance AD	$0 AD	20% co-insurance AD	$0 AD
In a Chronic Disease Hospital	$0 AD	20% co-insurance AD	$0 AD	20% co-insurance AD	$0 AD
In a Rehabilitation Hospital (60-day benefit limit per member per year)	$0 AD	20% co-insurance AD	$0 AD	20% co-insurance AD	$0 AD
In a Skilled Nursing Facility (100-day benefit limit per member per year)	$0 AD	20% co-insurance AD	$0 AD	20% co-insurance AD	$0 AD
Ambulance Services (ground or air ambulance transport)					
Emergency Ambulance	$0 AD	$0 AD	$0 AD	$0 AD	No charge
Other Ambulance	$0 AD	20% co-insurance AD	$0 AD	20% co-insurance AD	No charge
Cardiac Rehabilitation (Outpatient Services)	$0 AD	20% co-insurance AD	$0 AD	20% co-insurance AD	$35 co-pay per visit
Chiropractor Services (Outpatient Services, including spinal manipulation)	$0 AD	20% co-insurance AD	$0 AD	20% co-insurance AD	$35 co-pay per visit
Dialysis Services (Outpatient Services and home dialysis)	$0 AD	20% co-insurance AD	$0 AD	20% co-insurance AD	$0 AD
Durable Medical Equipment	$0 AD	20% co-insurance AD	$0 AD	20% co-insurance AD	20% co-insurance AD
Early Intervention Services (for an eligible child through age two)	No charge	No charge	$0 AD	$0 AD	No charge
Emergency Room Services	$0 AD	$0 AD	$0 AD	$0 AD	$150 co-pay per visit
Home Health Care	$0 AD	20% co-insurance AD	$0 AD	20% co-insurance AD	No charge
Hospice Services (Inpatient or Outpatient Services)	$0 AD	20% co-insurance AD	$0 AD	20% co-insurance AD	No charge
Lab Tests, X-Rays, Other Tests (Diagnostic Services not part of routine preventive visit)	$0 AD	20% co-insurance AD	$0 AD	20% co-insurance AD	$0 AD

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	Your Cost is:	Your Cost is:	Your Cost is:	Your Cost is:	Your Cost is:	
Maternity Services and Well Newborn Inpatient Care						
Maternity Services (includes delivery and postnatal care)	$0 AD	20% co-insurance AD	$0 AD	20% co-insurance AD	$0 AD	
Prenatal Care	No charge	20% co-insurance AD	No charge	20% co-insurance AD	No charge	
Well Newborn Care during enrolled mother's maternity admission	No charge	20% co-insurance (deductible does not apply)	No charge	20% co-insurance (deductible does not apply)	No charge	
In a Skilled Nursing Facility (100-day benefit limit per member per year)	$0 AD	20% co-insurance AD	$0 AD	20% co-insurance AD	$0 AD	
Medical Care Outpatient Visits (includes syringes and needles dispensed during a visit)	$0 AD	20% co-insurance AD	$0 AD	20% co-insurance AD	For services performed by a family or general practitioner, internist, nurse practitioner, nurse midwife, pediatrician, geriatric specialist, licensed dietitian nutritionist, and multi-specialty provider group services	$20 co-pay per visit
					For services performed by other *covered providers* through a non-hospital or health center	$35 co-pay per visit

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	Your Cost is:	Your Cost is:	Your Cost is:	Your Cost is:	Your Cost is:
Mental Health & Substance Abuse Treatment					
Inpatient Services	$0 AD	20% co-insurance AD	$0 AD	20% co-insurance AD	No charge
Outpatient Services	$0 AD	20% co-insurance AD	$0 AD	20% co-insurance AD	$20 co-pay per visit, no deductible
Oxygen & Respiratory Therapy					
Oxygen & Equipment for its administration	$0 AD	20% co-insurance AD	$0 AD	20% co-insurance AD	$0 AD
Outpatient Respiratory Therapy	$0 AD	20% co-insurance AD	$0 AD	20% co-insurance AD	For services performed by a family or general practitioner, internist, nurse practitioner, nurse midwife, pediatrician, geriatric specialist, licensed dietitian nutritionist, and multi-specialty provider group services $20 co-pay per visit
					For services performed by other *covered providers* through a non-hospital or health center $35 co-pay per visit
Prescriptions Drugs (Rx co-pay based on tier/brand) **Rx Retail Pharmacy** Tier 1 Tier 2 Tier 3	 $15 $30 $50	N/A, not covered	 $10 AD $25 AD $45 AD	 $20 AD $50 AD $90 AD	 $15 $30 $50

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	Your Cost is:	Your Cost is:	Your Cost is:	Your Cost is:	Your Cost is:
Rx Mail Order Tier 1 Tier 2 Tier 3	$30 $60 $150	N/A, not covered	$20 AD $50 AD $135 AD	N/A, not covered	$30 $60 $150
Preventive Health Services					
Routine Pediatric Care	$0	20% co-insurance AD	$0	20% co-insurance AD	$0
Routine Adult Exams & Tests (includes one routine exam per member per year, immunizations, routine lab tests and x-rays, routine mammograms once between age 35-39 and once per year for age 40+, blood tests to screen for lead poisoning, and routine colonoscopies)	$0	20% co-insurance AD	$0	20% co-insurance AD	$0
Routine GYN exams (once per member per year)	$0	20% co-insurance AD	$0	20% co-insurance AD	$0
Family Planning	$0	20% co-insurance AD	$0	20% co-insurance AD	$0
Routine Hearing Exams & Tests	$0	20% co-insurance AD	$0	20% co-insurance AD	$0
Routine Vision Exams (one exam per member every 24 months)	$0	20% co-insurance AD	$0	20% co-insurance AD	$0
Prosthetic Devices	$0 AD	20% co-insurance AD	$0 AD	20% co-insurance AD	20% coinsurance AD
Radiation Therapy and Chemotherapy (Outpatient Services)	$0 AD	20% co-insurance AD	$0 AD	20% co-insurance AD	$0 AD
Short-Term Rehabilitation Therapy Outpatient Services for physical, occupational, and speech therapy (100-visit benefit limit per member per year)	$0 AD	20% co-insurance AD	$0 AD	20% co-insurance AD	$35 co-pay per visit
Surgery as an Outpatient	$0 AD	20% co-insurance AD	$0 AD	20% co-insurance AD	$0 AD