



MEDICAL PLAN COMPARISON

	Clear Choice 2000	Real Choices (RC) Plans
Lifetime Maximum	\$8 million, \$5 million or \$2 million	No lifetime maximum
Family Deductible	3X individual deductibles of \$250 and \$500 All others 2X individual deductible	2X individual deductible
Family Deductible Accumulation	Individual/Family – All claims apply to the family deductible. If one covered person satisfies the individual deductible, additional claims will be paid for that family member.	Choice of Individual/Family Deductible or One Deductible. Ind/Fam – All claims apply to the family deductible. If one covered person satisfies the individual deductible, additional claims will be paid for that family member. One Deductible – All claims apply to the family deductible. No benefits are paid until the entire deductible has been satisfied.
Prescription Drug Coverage	3 Tier Generic/preferred brand/nonpreferred brand	3 Tier Generic/preferred brand/nonpreferred brand
Choices	Deductibles: \$0, \$100, \$250, \$500 Copays: \$15/45/60 \$15/35 +20%/50 + 20%	\$0/35/55 (RC I) \$0/50/75 with \$500 brand ded (RC II) \$15/50/75 (RC I) \$15/35/55 (RC I, RC II) \$15/45/60 (RC I, RC II) \$15/35/55 with \$250 brand ded (RC II) \$20/50/75 (RC II) Deductible/coinsurance* (RC I, RC II) Preferred Pricing Card only (RC I, RC II) <i>* Includes Preferred Pricing Card</i>
Mail Order	3 month supply for 2X copay	10% discount for 3 month supply rounded down to nearest \$5
On the Job Coverage	Coverage for officer/owner or sole proprietor only Employees not covered for this type of expense even if group has Worker’s Comp coverage	Coverage for officer/owner or sole proprietor only Employees not covered for this type of expense even if group has Worker’s Comp coverage

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PPO Provision (OON – Out-of-Network) (OOP – Out-of-Pocket)	Separate network and OON deductible and OOP limits. OON charges subject to usual and customary	Separate network and OON deductible and OOP limits. OON charges either subject to SCH (Scheduled Network Option) or UCR (Usual, Customary and Reasonable)
Penalty for Failure to Preauthorize	25% of charge up to \$1,000 HSA plans only – no preauth penalty after OOP is met	30% of charge up to \$1,000 HSA plans only – no preauth penalty after OOP is met
Emergency Room	Covered \$50 access fee – waived if admitted	RCI copayment plans include \$250 ER copay RCII optional \$500 ER copay After ER copay changes paid at 100% Noncopay plans – subject to plan benefits Nonemergency use of facility results in 30% penalty
Allergy Shots	Subject to selected plan benefits	Subject to deductible and coinsurance If copay plan, covered at 100%
Preventive Care Services	Unlimited benefit for routine physical exams, well-child care through age 16 and immunizations, subject to selected plan benefits on PPO and Copay plans; Up to \$300 wellness maximum for Hospital-Only and Indemnity plans EKGs, treadmill and proctosigmoidoscopy covered at 100% but subject to contract schedule on PPO and Copay plans; subject to \$300 maximum for Hospital-Only and Indemnity Plans Outpatient preventive x-ray and lab tests covered at 100% but subject to contract schedule on Copay plans; subject to deductible and rate of payment on all other plans	Preventive care recommended by the United States Preventive Services Task Force. Many services such as routine physicals, mammograms, well-child exams and immunizations are covered at 100% Benefits available from network and out-of-network providers
Outpatient X-ray and Lab Tests	Covered If copay plan and a visit is billed under office, services are covered by the copay except MRIs and CAT Scans.	Covered RC I includes a \$500 first-dollar benefit, then plan benefits. Optional first-dollar benefit can be added to RC II plans. See DXL option on page 4

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Well-Baby Nursery Charges	Subject to baby's own deductible and rate of payment	Must enroll baby within 31 days after birth to be covered
Sterilization	\$500 lifetime maximum, 365 day waiting period	No limit or waiting period
Mental Disorders / Substance Abuse	Inpatient treatment is covered at 50% up to \$5,000 Outpatient treatment is covered at 50% up to \$1,000 Combined maximum of \$5,000 Expenses not applied to OOP limit	Inpatient treatment is covered up to 21 (RC II) or 28 (RC I) days Outpatient treatment has no limit but covered at 50% coinsurance No limit on Rx benefits
Durable Medical Equipment	Oxygen, whole blood and blood components, casts, splints, trusses, crutches, orthopedic braces, prosthetic devices, non-motorized wheelchair	Lifetime maximum of \$50,000
Home Health Care	160 hours	30 (RC II) or 50 (RC I) visits (1 visit = 2 hours)
Hospice	Not subject to deductible, covered at 100% HSA plans covered at 100% after deductible	Not subject to deductible, covered at 100% HSA Plans only – covered at 100% after deductible
Organ Transplants	Covered to lifetime maximum benefit at designated provider	Covered at designated provider \$10,000 is available for travel expenses for the covered person and a companion at designated provider
	\$100,000 limit per organ at nondesignated providers	\$100,000 limit per organ at nondesignated provider
	Kidney, cornea, & skin transplants covered same as any other illness	Kidney, cornea, & skin transplants covered same as any other illness
	Up to \$10,000 for donor related charges	\$10,000 for donor related charges

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Outpatient Physical Medicine	Inpatient services covered up to 30 days Outpatient services covered up to 60 visits Back/Spine/Neck services covered up to 20 visits	No limit for PT, OT, Speech Therapy, cardiac and pulmonary rehab, chiropractic care and developmental delay
Skilled Nursing Facility	31 days	90 days
TMJ / CMJ	\$1,000 lifetime maximum benefit	No lifetime maximum
Waiver of Premium Survivorship	Included	Not included
Dependent Life	Coverage up to \$2,500 for spouse and \$1,000 for dependent children ages 6 months and older	Coverage available through the optional life benefit
Accident Medical Expense Option*	Choice of \$300, \$500, \$1,000, \$2,000 or \$5,000 benefit	Choice of \$500 or \$1,000 benefit
Maternity Option*	Deductible/ rate of payment	Choice of deductible/ coinsurance or separate \$7,500 maternity deductible and 100% coverage thereafter
Diagnostic X-ray and Lab Services (DXL) Option*	\$500 benefit available on PPO copay plans	\$500 benefit automatically included on RC I plans \$200 benefit option on RC II plans
Employee Choice	6 or more employees — 4 plan options	3-24 employees — 2 plan options 25+ employees — 3 plan options

* Available at an additional cost.

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