

Xavier University

Medical Plan Analysis

Effective January 1, 2009

	\$500 Deductible PPO		\$250 Deductible PPO		PPO Copay - no deductible	
Employee Contributions (Monthly)						
Single	\$62.00		\$88.00		\$105.00	
Double	\$131.00		\$185.00		\$218.00	
Family	\$204.00		\$285.00		\$336.00	
Employee Contributions (Per Pay Period)						
Single	\$31.00		\$44.00		\$52.50	
Double	\$65.50		\$92.50		\$109.00	
Family	\$102.00		\$142.50		\$168.00	
Benefits	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible						
Individual/Family	\$500/\$1,000	\$1,000/\$2,000	\$250/\$500	\$500/\$1,000	None	\$400/\$800
Coinsurance	80/20%	60/40%	90/10%	70/30%	100%	70/30%
Out-of-Pocket Maximum						
Deductible included?	Yes	Yes	Yes	Yes	N/A	Yes
Individual/Family	\$3,000/\$6,000	\$6,000/\$12,000	\$2,500/\$5,000	\$5,000/\$10,000	\$1,500/\$3,000	\$5,000/\$10,000
Lifetime Maximum	\$5,000,000		\$5,000,000		\$5,000,000	
Inpatient Hospital						
Facility	Ded., then 80/20%	Ded., then 60/40%	Ded., then 90/10%	Ded., then 70/30%	\$300 copay	Ded., then 70/30%
Physician	Ded., then 80/20%	Ded., then 60/40%	Ded., then 90/10%	Ded., then 70/30%	Covered at 100%	Ded., then 70/30%
Outpatient						
Facility	Ded., then 80/20%	Ded., then 60/40%	Ded., then 90/10%	Ded., then 70/30%	\$100 copay	Ded., then 70/30%
Physician	Ded., then 80/20%	Ded., then 60/40%	Ded., then 90/10%	Ded., then 70/30%	Covered at 100%	Ded., then 70/30%
Labs						
Routine Lab	Ded., then 80/20%	Ded., then 60/40%	Ded., then 90/10%	Ded., then 70/30%	20% copay	Ded., then 70/30%
Diagnostic Lab	Ded., then 80/20%	Ded., then 60/40%	Ded., then 90/10%	Ded., then 70/30%	20% copay	Ded., then 70/30%
Emergency Room	\$150 copay		\$150 copay		\$100 copay	
Urgent Care	\$35 copay		\$35 copay		\$25 copay	
Office Visit						
Primary Care/Specialist Visit	\$25/\$45 copay	Ded., then 60/40%	\$25/\$45 copay	Ded., then 70/30%	\$20/\$40 copay	Ded., then 70/30%
Wellness	\$25 copay	Ded., then 60/40%	\$25 copay	Ded., then 70/30%	\$20 copay	Ded., then 70/30%
Vision	\$45 copay	Ded., then 60/40%	\$45 copay	Ded., then 70/30%	\$40 copay	Ded., then 70/30%
Prescription Drugs						
Tier 1/Tier 2/Tier 3	\$15/\$40/\$60	50%, min \$50	\$15/\$40/\$60	50%, min \$50	\$15/\$40/\$60	50%, min \$50
Mail-Order	\$30/\$100/\$150	Not covered	\$30/\$100/\$150	Not covered	\$30/\$100/\$150	Not covered

This benefit summary is intended to describe the highlights of the plan(s). Please note that it does not include all of the benefits, nor does it describe all benefit exclusions. Please reference the Certificates of Coverage for complete details. In the event of a discrepancy between these summaries and the Certificates of Coverage, the terms of the Certificates of Coverage will prevail.