

Xavier University

Humana Benefit Outline and Employee Monthly Contributions

January 1, 2012 Renewal

Effective January 1, 2012							
	Humana \$0 Deductible Plan		Humana \$500 Deductible Plan		Humana \$2500 Deductible HDHP (Embedded)		
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	
Tier							
Single		\$122.00		\$72.00		\$32.00	
EE + Spouse		\$260.00		\$158.00		\$74.00	
EE + Child(ren)		\$250.00		\$148.00		\$66.00	
Family		\$400.00		\$245.00		\$122.00	
Benefits							
Network	NPOS		NPOS		NPOS		
Deductible							
Calendar Year or Policy Year?	Calendar	Calendar	Calendar	Calendar	Calendar	Calendar	
Individual/Family	None	\$400/\$800	\$500/\$1,000	\$1,000/\$2,000	\$2,500/\$5,000	\$2,500/\$5,000	
Coinsurance	100%	70/30%	80/20%	60/40%	100%	70/30%	
Out-of-Pocket Maximum							
Deductible Included?	Yes	Yes	Yes	Yes	Yes	Yes	
Individual/Family	\$1,500/\$3,000	\$5,000/\$10,000	\$3,000/\$6,000	\$6,000/\$12,000	\$2,500/\$5,000	\$5,000/\$10,000	
Lifetime Maximum	Unlimited		Unlimited		Unlimited		
Inpatient Hospital							
Facility	\$300 copay	Ded, 70/30	Ded, 80/20	Ded, 60/40	Ded, 100%	Ded, 70/30	
Physician	Covered in full	Ded, 70/30	Ded, 80/20	Ded, 60/40	Ded, 100%	Ded, 70/30	
Outpatient							
Facility	\$100 copay	Ded, 70/30	Ded, 80/20	Ded, 60/40	Ded, 100%	Ded, 70/30	
Physician	Covered in full	Ded, 70/30	Ded, 80/20	Ded, 60/40	Ded, 100%	Ded, 70/30	
Labs							
Routine Lab	Covered in full	Ded, 70/30	Covered in full	Ded, 60/40	Covered in full	Ded, 70/30	
Diagnostic Lab	20% copay	Ded, 70/30	Ded, 80/20	Ded, 60/40	Ded, 100%	Ded, 70/30	
Emergency Room	\$100 copay	\$100 copay	\$150 copay	\$150 copay	Ded, 100%	Ded, 100%	
Urgent Care	\$25 copay	Ded, 70/30	\$35 copay	Ded, 60/40	Ded, 100%	Ded, 70/30	
Office Visit							
Primary Care/Specialist Visit	\$20/\$40 copay	Ded, 70/30	\$20/\$45 copay	Ded, 60/40	Ded, 100%	Ded, 70/30	
Wellness	Covered in full	Ded, 70/30	Covered in full	Ded, 60/40	Covered in full	Ded, 70/30	
Vision Screening	Part of Office Visit Copay	Ded, 70/30	Part of Office Visit Copay	Ded, 60/40	If preventative covered in full	Ded, 70/30	
Prescription Drugs							
Tier 1/Tier 2/Tier 3	\$15/\$40/\$60	Wholesale Rate Less Copays & Less 30%	\$15/\$40/\$60	Wholesale Rate Less Copays & Less 30%	Ded, 100%	Ded, 70/30	
Mail-Order	\$30/\$100/\$150	Not covered	\$30/\$100/\$150	Not covered	Ded, 100%	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.