Miami County Plan Comparison | July 2020 - June 2021

MEDICAL PLAN OPTIONS	Humana HDHP - 2000 w/HSA			Humana PPO - 1000		
Participation Level	Total Prem	EE Monthly	EE Annual	Total Prem	EE Monthly	EE Annual
Employee Only	$521.38	$0.00	$0.00	$721.26	$19.48	$233.76
Employee + Spouse or Child(ren)	$1,240.89	$248.18	$2,978.16	$1,702.17	$383.00	$4,596.00
Family	$1,465.08	$293.02	$3,516.24	$1,911.32	$430.06	$5,160.72
Dual Family	$1,465.08	$146.52	$1,758.24	$1,911.32	$238.92	$2,867.04
HSA Employer Contribution		ER Monthly	ER Annual	*Only available w/HDHP*		
Employee Only		$180.42	$2,165.04			
Family		$309.22	$3,710.64			
In Network Benefits*	**Humana Open Access Network**			**Humana Open Access Network**		
Deductible (Single / Family)	$2,000 / $4,000			$1,000 / $2,000		
Out of Pocket Maximum	$3,400 / $6,800 *(aggregate if family)*			$6,500 / $13,000 *(Medical & RX copays apply to OPM)*		
Physician Care						
Primary Care Physician	20% after deductible			$30 office visit copay		
Specialist	20% after deductible			$45 office visit copay		
Physical Therapy / Mental Health						
Primary Care Physician	20% after deductible			$30 office visit copay		
Specialist	20% after deductible			$45 office visit copay		
Hospital / Facility						
Inpatient	20% after deductible			$0 after deductible		
Outpatient	20% after deductible			$0 after deductible		
Emergency Room	20% after deductible			$250 copay		
Urgent Care	20% after deductible			$75 copay		
Diagnostic Lab & X-ray						
Dr. Office / Independent Lab	20% after deductible			$0 (plan pays 100%)		
Outpatient Hospital	20% after deductible			$0 (plan pays 100%)		
Advanced Imaging	20% after deductible			$0 after deductible		
Maternity						
Physician Care - global bill	20% after deductible			$0 copay		
Hospital Care	20% after deductible			$0 after deductible		
Telehealth Services	$0 copay			$0 copay		
Prescription Benefits In Network*	**Humana HDHP - 2000 w/HSA**			**Humana PPO - 1000**		
Retail Pharmacy - 30 days						
Level 1	20% after deductible			$10 (or actual cost if less)		
Level 2	20% after deductible			$40		
Level 3	20% after deductible			$70		
Specialty - Level 4	20% after deductible			25%		
Max out of Pocket	Combined with Medical			Combined with Medical		

Delta Dental Premiums			
Participation Level	Total Prem	EE Monthly	EE Annual
Employee Only	$34.28	$0.00	$0.00
Family	$85.71	$17.14	$205.68
Dual Family	$85.71	$8.58	$102.96

Humana Vision Premiums			
Participation Level	Total Prem	EE Monthly	EE Annual
Employee Only	$5.75	$0.00	$0.00
Employee + Spouse or Child(ren)	$11.50	$0.00	$0.00
Family	$18.61	$0.00	$0.00