# Quick Comparison: BlueChoice PPO plan and the HDHP + HSA Plan

This is a general overview of plan features. Please refer to the policy for actual terms and conditions.

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<th>BlueChoice PPO</th>
<th>HDHP + HSA</th>
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<tbody>
<tr>
<td>What are my medical plan choices?</td>
<td>The BlueChoice plan is a Preferred Provider Organization (PPO) plan.</td>
<td>The High Deductible Health Plan (HDHP) with Health Savings Account (HSA) is a specially designed high-deductible Preferred Provider Organization (PPO) plan. When you enroll in this type of plan, you have the option to contribute to a personal, tax-free Health Savings Account (HSA).</td>
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<tr>
<td>Will Baylor contribute to my HSA?</td>
<td>No. This plan is not eligible for an HSA.</td>
<td>Yes. For the individual plan, the contribution is $500. For the family plan, the contribution is $1,000. Baylor contributes the annual amount to your HSA in January of each year.</td>
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<td>How much can I contribute to my HSA?</td>
<td>Not applicable. You may contribute to a healthcare Flexible Spending account (FSA). In 2015, the limit is $2,500.</td>
<td>In 2015, the individual HSA plan limit is $3,350. The family plan limit is $6,650. Personal contribution limits are $2,850 and $5,650, respectively. If over age 55, personal contribution limits are $3,850 and $6,650, respectively.</td>
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<td>What happens to my HSA if I retire or separate service from Baylor?</td>
<td>Not applicable.</td>
<td>The HSA is a bank account owned by you. Should you retire or leave Baylor University, the account funds continue to be available to you to use for qualifying out of pocket expenses.</td>
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<td>Will I be charged a fee for the HSA bank account?</td>
<td>Not applicable.</td>
<td>Yes, most banks charge certain fees. Until your HSA total reaches $3,000, you will be charged a monthly fee of $2.25. Review the fee schedule available on the HR, Benefits, Health Saving Account web page.</td>
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<td>What’s the deductible?</td>
<td>The individual deductible is $400. The maximum family deductible is $1,200. There is also a $300 per admission deductible for in-patient hospitalization. Deductibles listed are for participating providers; there is a separate deductible for nonparticipating providers.</td>
<td>The individual deductible is $1,500. The family deductible is $3,000. For qualified medical expenses, you may use tax-free HSA funds to meet your deductible. Deductibles listed are for participating providers; there is a separate deductible for nonparticipating providers.</td>
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<td>For family coverage, is there a separate deductible for each individual?</td>
<td>Yes, each family member has a separate deductible. However, the family deductible is three times the individual deductible – so if four or more family members are covered, only three may have to meet the separate individual deductible to satisfy the family deductible, too.</td>
<td>No, the family deductible applies to all covered family members, so one person’s covered expenses could satisfy the deductible for the entire family.</td>
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<tr>
<td>What happens after I meet the deductible?</td>
<td>The plan pays coinsurance for covered medical expenses as shown on the Summary of Benefits Coverage. The coinsurance percentage may vary depending on the service you receive but is generally 80%. In-network Preventive Services as defined by the Summary of Benefits Coverage are covered at 100%.</td>
<td>The plan pays coinsurance for covered medical expenses as shown on the Summary of Benefits Coverage. The coinsurance percentage may vary depending on the service you receive but is generally 80%. In-network Preventive Services as defined by the Summary of Benefits Coverage are covered at 100%. You can use HSA funds to pay your coinsurance share, if any.</td>
</tr>
</tbody>
</table>
**Do I have copayments?**

Yes, some services require copayments. For in-network providers: consultative primary care office visits - $20; consultative specialist visits - $40; Hospital Emergency facility - $100.

No, this plan doesn’t have copayments. Instead of a copay, you will be paying the full cost of a doctor’s visit or service until you satisfy the deductible. After the annual deductible is met, co-insurance begins.

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**Do copayments help reduce my deductible?**

No, medical and prescription drug copayments do not apply to your deductible.

Not applicable.

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**Is there a limit on how much I’d pay in a year?**

Yes, the plan has separate out-of-pocket expense limits for participating and nonparticipating providers. In-network, the individual plan out-of-pocket limit is $2,900 ($2,500 coinsurance + $400 deductible). For family, the out-of-pocket limit is $6,200 ($5,000 coinsurance + $1,200 deductible). Once you reach the limit for participating providers, the plan pays 100 percent for covered services.

Yes, the plan has separate out-of-pocket expense limits for participating and nonparticipating providers. In-network, the individual plan out-of-pocket limit is $5,000. For family, the out-of-pocket limit is $10,000. Once you reach the limit for participating providers, the plan pays 100 percent for covered services.

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**How are prescription drugs covered? (CVS Caremark manages your prescription benefit. Its network of 57,000 pharmacies includes for example, HEB, Target, CVS, Walgreens and virtually most pharmacies.)**

You pay a copayment for covered drugs. Drugs are assigned to one of three levels, and the copayment varies by level. For 30 day supply at retail: generic, $10; formulary name brand (preferred) $30; non-formulary name brand (non-preferred) $50. For 90-day supply mail service prescriptions require 2 copays. Affordable Care Act (ACA) preventive prescriptions are covered at 100%.

Prescription costs apply to annual deductible. Participants receive the network cost by providing their prescription ID card. Once you meet the deductible with any combination of medical and prescription drug costs, you and your plan pays coinsurance. For generics, you will pay 20% of the cost. For covered name brands, you will pay 30% of the cost. Affordable Care Act (ACA) preventive prescriptions are covered at 100%. Certain generic only maintenance prescriptions are also covered at 100%.

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**Are dental expenses covered?**

No, unless the service is related to an injury.

No, unless the service is related to an injury.

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**HSA eligibility requirements:**

- Must be enrolled in the HDHP
- May not have other medical coverage (spouse, parent, etc.)
- May not be claimed on another person’s tax return
- May not be enrolled in Medicare, Tricare
- May not be receiving Veteran’s Administration services within 90 days of enrollment and thereafter

**For some, the High Deductible Health Plan (HDHP) with Health Savings Account (HSA) will be their plan of choice....**

- The premiums are lower
- Prescription drug costs count toward the medical deductible
- The out-of-pocket maximum includes the medical deductible
- Contributing the difference in premiums and the amount that you may have been contributing to your FSA will increase your available HSA funds to offset your out of pocket expenses that are applying to the deductible.
- The HSA is triple tax advantaged: no taxes incurred with payroll deduction; no taxes paid on earnings if HSA funds are invested; no taxes taken upon distribution for qualified expenses.
- Some participants may choose to continue to pay minor out of pocket expenses without drawing from their HSA funds.
- If your medical expenses are generally limited to preventive care, you should definitely consider an HDHP, especially since you also have the ability to make additional voluntary contributions to your HSA to accelerate the accumulation of funds for future medical expenses.

**For others, the BlueChoice PPO Plan will be their plan of choice.....**

- Premiums are higher
- Level of benefits is higher
- Lower deductible to meet
- Copayments for prescription coverage
- High utilization of medical services
Still not sure which plan is right for you? Some simple math might help with your decision. When projecting your total out of pocket health expenses, everyone’s personal circumstances will vary, so be sure to look at the whole picture to include your costs for medical, prescriptions, dental, vision care needs (contacts, frames) and family size.

Gathering health cost information:

- What you will spend on premiums during the new year
  - Compare premiums for the PPO with the HDHP + HSA
  - Subtract the difference and multiply x 12 to determine your premium savings
- View your Blue Cross-Blue Shield explanation of benefits in Blue Access for Members (BAM) for you and family (if applicable) to determine your total out of pocket medical expense for the previous year.
  - Download 18 months of claims data to an Excel spreadsheet. Subtract BCBS Discount from Billed Amount to see how much you might pay out of pocket and compare to HSA contributions.
- What you spent on prescription drug costs
  - Review your prescription expense from the previous year with your local pharmacist or with CVS/Caremark mail service for you and your family (if applicable) to determine your total out of pocket expense for the previous year.
- What you spent on dental needs not covered by the dental benefit
- What you spent on other unreimbursed medical related expenses such prescription glasses or contacts.

Utilizing the plan selector tool…

- Plan Selector Tool
  - The plan selector tool is provided by our Health Savings Account vendor, BenefitWallet, with The Bank of New York Mellon (BNY Mellon) as custodian.
  - This tool is populated with generic information. You should enter the correct amounts specific to the 2 plans.
  - Step 3, you should edit the HSA qualified plan to include specific information about the HDHP + HSA plan and add an additional plan for the BlueChoice- PPO plan. You can choose basic or enhanced PPO and enter the specific information for the BlueChoice PPO plan.
  - Remember, this is a tool to estimate cost savings and to determine which plan may be best for you and your family and is not a final determination of your annual out of pocket medical/and/or prescription expense.

Choosing a health insurance plan is a big decision. The right plan has to be the ideal balance of cost and coverage.