Managed care plans*

Managed care plans are based on networks of providers that have agreed to charge negotiated rates for health care. The discounted rates are then passed on to you in the form of lower out-of-pocket expenses when you use in-network providers. There are three types of managed care plans:

- consumer-driven health care plans (CDHP);
- preferred provider organization (PPO); and
- health maintenance organization (HMO).

Consumer-driven health care plans (CDHP)*

Consumer-driven health care plans are an innovative approach to health care. These plans give you flexibility in how your health care dollars are spent. Two CDHPs are available:

- the high deductible health plan (HDHP)*; and
- the health reimbursement account (HRA)* plan.

Health reimbursement account (HRA) plan*

Under this plan, Vectren pays 100 percent of medical claims up to a certain dollar amount through the HRA. Vectren contributes money to the HRA, which provides first-dollar coverage for eligible medical services.

After your medical claims exceed the funds available in your HRA, then you are responsible for paying 100 percent of additional claims up to a certain dollar amount. The portion of the plan in which you pay 100 percent is called the "bridge" because you are bridging the gap between what Vectren pays at 100 percent through the HRA and traditional health coverage, i.e. 80 percent coverage.

After your HRA has been exhausted and you have paid the bridge, then traditional health coverage begins for medical claims. This means that medical claims are paid at 80 percent of eligible expenses when you see in-network providers and 60 percent of eligible expenses when you see out-of-network providers. Out-of-network providers are also subject to reasonable and customary (R&C) provisions.

For many people, the HRA will cover the majority of your annual health care expenses. Any unused benefit dollars in your account at the end of the year automatically roll over for use in subsequent years under the assumption that you remain enrolled in the HRA plan.

Preventive care expenses, such as physicals, immunizations and health screenings, are covered at 100 percent when you see in-network providers and are not applied toward your HRA, bridge or health coverage.
High deductible health plan (HDHP)*

An HDHP carries a higher deductible than other plans and is designed, so you pay 100 percent of medical and prescription drug expenses until the deductible is met. Once the deductible is met, the health insurance company pays a percentage of your medical and prescription drug expenses.

Preventive care expenses, such as physicals, immunizations and health screenings, are always covered at 100 percent when you see in-network providers and are not applied toward your deductible.

Although the HDHP has a higher deductible, it costs less (amount taken out of your paycheck) in employee premiums.

Due to its potentially high out-of-pocket expenses, the HDHP features a health savings account (HSA), which is a tax-free savings account. You can make contributions to your HSA through payroll deductions to pay for qualified medical expenses. Also, Vectren deposits money into this account, "seed money," to help offset the deductible or to accumulate in your account.

Money is available for use once it has been deposited into the account. Unused HSA money rolls over year-after-year. HSAs are advantageous because of tax-deductible contributions, tax-free investment earnings, tax-free distribution for medical expenses and access to the funds at all times.

To maximize your contributions to the HSA, you can contribute up to the Internal Revenue Service maximum of $2,900 for employee coverage and $5,800 for family coverage in 2008.

Preferred provider organization (PPO)*

A PPO gives you the freedom to use any doctor or hospital you choose any time you need care.

When you use a provider in the PPO network, you have a lower annual deductible to satisfy and the plan pays a higher percentage of your covered expenses than when you go out-of-network to any other provider. Vectren PPOs offer national networks, which means you have access to in-network providers throughout the country. This becomes especially important when you are away from home (for example, when you are on vacation) and need to see a health care provider.

Health maintenance organizations (HMO)*

An HMO requires you to select a primary care physician from the HMO network to coordinate all your health care needs. To receive benefits, your care must be coordinated by your primary care physician. If you enroll in an HMO, you will generally pay a flat fee or co-pay for office visits, and most other services are covered at 100 percent. If you go to any provider without a referral from your primary care physician, the plan will generally not pay any benefits – even if the provider is in the HMO network.
Glossary

Co-pay
A fixed amount that the employee pays with each visit to the doctor, prescription or other health care services.

Co-insurance
The portion of medical costs that are shared by both the employee and the insurance company. If you are on a plan and the health insurance company is responsible for 80 percent of the medical expenses, then you are responsible for 20 percent.

Deductible
Dollar amount that the employee and/or family must pay each year before the health insurance company will pay for health care services. The deductible is higher if the procedures are performed by out-of-network providers.

In-network
Physicians, hospitals and other providers who have agreed to charge discounted rates to plan participants for health care services.

Out-of-network
Physicians, hospitals and other providers who have not agreed to charge discounted rates to plan participants for health care services.

Generic drugs
A drug that is exactly the same as a brand name drug and cost significantly less than the brand name drug and is identical in terms of efficacy, safety, side effect profile and dosing.

Formulary (brand)
An approved list of selected prescription drugs and their dosages determined to be the most useful and cost effective for patient care.

Non-formulary
A list of prescription drugs that are brand name medications, are not listed on the formulary list and are typically much more expensive.

Maximum out-of-pocket
The maximum amount that an employee would be expected to pay out of his/her pocket on an annual basis. This includes combining the deductibles and co-insurance that the employee would pay.