HEALTH PLAN SUMMARY COMPARISON CHART (EXCLUDING MA-PD PLANS)

	Standard			High Deductible (Pair with Health Savings Account)	
	HMO	PPO		HMO and PPO	PPO Only
Your Costs:	Network Only	Network	Out of Network	Network	Out of Network
Annual Deductible (You pay this amount first before the plan pays anything, except for preventive care.)	None	$250 | $500 Single | Family	$750 | $1,500 Single | Family	$1,400 | $2,800 Single | Family	$2,500 | $5,000 Single | Family
Global In-Network Annual Out-of-Pocket Maximum	$8,550 | $17,100 per indiv. | per family (combined pharmacy and medical)	$8,550 | $17,100 per indiv | per family (combined pharmacy and medical)	N/A	$4,400 | $8,800 (PPO) $3,000 | $6,000 (HMO) per indiv. | per family (combined pharmacy and medical)	N/A
Preventive Care[1]	No charge	No charge; no deductible	Amount between charge and out-of-network allowance; no deductible	No charge; no deductible	Amount between charge and out-of-network allowance; no deductible
Primary Care	$20 copayment	$15 copayment	40% of out-of-network allowance plus the amount between the charge and the out-of-network allowance	Deductible then 20% of network allowed amount	Deductible then 40% of out-of-network allowance plus amount between charge and out-of-network allowance
Specialist	$40 copayment	$25 copayment			
Urgent Care	$25 copayment	$25 copayment	$25 copayment		Deductible then 20% of out-of-network allowance
Emergency Room	$100 copayment	$100 copayment	$100 copayment		
Hospital Stay	$250 copayment	20% after $250 copayment	40% after $500 copayment plus the amount between charge and out-of-network allowance	Deductible then 20% of network allowed amount	Deductible, $1,000 copay, then 40% of out-of-network allowance plus the amount between charge and out-of-network allowance
Generic Drugs | Preferred Brand | Non-Preferred Brand	$7 | $30 | $50 Network Retail (up to 30-day supply) $14 | $60 | $100 Mail Order or Participating 90-Day Retail (up to 90-day supply)		Pay in full; file claim for reimbursement	After paying deductible, 30% | 30% | 50% Network Retail and Mail Oder	Pay in full; file claim for reimbursement
Monthly Premiums:	We Deduct Your Premium a Month in Advance (e.g., December 2019 for January 1, 2020, coverage)				
Career Service/OPS	$50.00 Single	$180.00 Family		$15.00 Single	$64.30 Family
Select Exempt Service/ Sr. Management Service	$8.34 Single	$30.00 Family		$8.34 Single	$30.00 Family
Spouse Program	$30.00 ($15 each employee)			$30.00 ($15 each employee)	
Over-age Dependents (age 26- 30)	$763.80 Each			$687.14 Each	
COBRA	$779.08 Single	$1,753.71 Family		$700.88 Single	$1,550.70 Family
Retiree < Age 65	$763.80 Single	$1,719.32 Family		$687.14 Single	$1,520.29 Family
Medicare Tiers[2]:	Medicare I	Medicare II	Medicare III	Med I	Med II	Med III
Retiree ≥ Age 65 or on SSI Disability	$403.92	$1,167.71	$807.83	$304.47	$991.61	$608.94
Capital Health Plan	$282.62	$1,000.47	$565.24	$257.23	$902.17	$514.46

[1] Preventive care based on age and gender.

[2] Medicare I = single coverage for retired participant eligible for Medicare. Medicare II = family coverage for two or more and at least one is Medicare eligible. Medicare III = family coverage for retiree and one dependent, and both are Medicare eligible.