

November Open Enrollment for January 1st coverage.

	CO-PAY PLANS		TRANSITIONAL DEDUCTIBLE PLANS			HSA QUALIFIED HIGH DEDUCTIBLE PLANS				
	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6		Option 7	Option 8	
	HA6S12	ED9S12	EPH1S12	EPOS2712	EPOS2812	QPPOS0212		QEPOS1812	QEPOS2212	
	HMO	EPO	Transitional EPO	Transitional EPO	Transitional EPO	HDPPQ		HDEPOQ	HDEPOQ	
	In-Network	In-Network	In-Network	In-Network	In-Network	In-Network	Out-of-Network	In-Network	In-Network	
	2+ Employer Groups	2+ Employer Groups	2+ Employer Groups	2+ Employer Groups	2+ Employer Groups	2+ Employer Groups		2+ Employer Groups	2+ Employer Groups	
Individual	456.97	391.98	398.52	352.69	287.37	347.91		202.26	105.79	
2-Person	913.93	783.96	797.05	705.39	574.75	692.73		390.36	207.66	
Family	1,210.97	1,038.76	1,056.10	934.66	761.57	917.87		517.23	275.15	
	Sole Proprietors	Sole Proprietors	Sole Proprietors	Sole Proprietors	Sole Proprietors	Sole Proprietors		Sole Proprietors	Sole Proprietors	
Individual	520.95	446.86	454.31	402.06	327.61	396.61		230.56	120.60	
2-Person	1,041.89	893.71	908.64	804.15	655.22	789.71		445.02	236.74	
Family	1,380.50	1,184.18	1,203.95	1,065.50	868.18	1,046.37		589.64	313.67	
Deductible (Single/Family)	Not Applicable	Not Applicable	\$250/\$500	\$1,250/\$3,125	\$1,250/\$3,125	\$1,500/\$3,000		\$4,000/\$8,000	\$3,500/\$7,000	\$5,000/\$10,000
Coinsurance	Not Applicable	Not Applicable	20%	20%	20%	Not Applicable		Not Applicable	Not Applicable	Not Applicable
Out of Pocket/Coinsurance Maximum	Not Applicable	Not Applicable	\$2,000/\$4,000	\$4,000/\$10,000	\$4,000/\$10,000	\$5,000/\$10,000		\$10,000/\$20,000	\$4,500/\$8,000	\$5,000/\$10,000
Annual Benefit Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited		Unlimited	Unlimited	Unlimited
PCP/OBGYN	\$25 Copayment	\$30 Copayment	\$30 Copayment	\$30 Copayment	\$50 Copayment	Deductible Then \$30 Copayment		Deductible Then Covered in Full	Deductible Then Covered in Full	Deductible Then Covered in Full
Specialist	\$25 Copayment	\$50 Copayment	\$30 Copayment	\$30 Copayment	\$50 Copayment	Deductible Then \$30 Copayment		Deductible Then Covered in Full	Deductible Then Covered in Full	Deductible Then Covered in Full
Inpatient Hospitalization	\$500 Copayment	\$1,000 Copayment	Deductible Then 20% Coinsurance	Deductible Then 20% Coinsurance	Deductible Then 20% Coinsurance	Deductible Then \$500 Copayment		Deductible Then Covered in Full	Deductible Then Covered in Full	Deductible Then Covered in Full
Emergency Room	\$100 Copayment	\$100 Copayment	Deductible Then 20% Coinsurance	Deductible Then 20% Coinsurance	Deductible Then 20% Coinsurance	Deductible Then \$50 Copayment		All Emergency Care Is Considered In Network	Deductible Then Covered in Full	Deductible Then Covered in Full
Ambulance	\$100 Copayment	\$100 Copayment	Deductible Then 20% Coinsurance	Deductible Then 20% Coinsurance	Deductible Then 20% Coinsurance	Deductible Then \$50 Copayment		All Emergency Care Is Considered In Network	Deductible Then Covered in Full	Deductible Then Covered in Full
Outpatient Surgery	\$100 Copayment	\$200 Copayment	Deductible then 20% Coinsurance	Deductible Then 20% Coinsurance	Deductible Then 20% Coinsurance	Deductible Then \$75 Copayment		Deductible Then Covered in Full	Deductible Then Covered in Full	Deductible Then Covered in Full
Pharmacy Coverage Rider	Pharmacy Copay is 50% Open Formulary.	Pharmacy Copay is \$10 copay Tier 1 only.	\$250 Deductible then \$10/\$50/50%.	\$250 Deductible, then \$10/\$50/\$80 (Tier-1 and MO Carved Out of the Deductible)	Pharmacy Copay is \$10 copay Tier 1 only.	Deductible** Then \$4/50%.		Deductible** Then Pharmacy Copay is \$4/50%.	Deductible** Then Pharmacy Copay is \$10 copay Tier 1 only.	
Domestic Partner Rider	Domestic Partner, Same or Opposite Sex	Domestic Partner, Same or Opposite Sex	Domestic Partner, Same or Opposite Sex	Domestic Partner, Same or Opposite Sex	Domestic Partner, Same or Opposite Sex	Domestic Partner, Same or Opposite Sex		Domestic Partner, Same or Opposite Sex	Domestic Partner, Same or Opposite Sex	
Skilled Nursing Facility Rider	N / A	Extends SNF Coverage to 365 Days	Extends SNF Coverage to 365 Days	Extends SNF Coverage to 365 Days	Extends SNF Coverage to 365 Days	Extends SNF Coverage to 365 Days		Extends SNF Coverage to 365 Days	Extends SNF Coverage to 365 Days	
Mental Health Rider	Removes Limits for Mental Health Benefits for BBMI and Adds 30 Day IP Chemical Abuse Rehab	N / A	N / A	N / A	N / A	N / A		N / A	N / A	
Vision Coverage Rider	N / A	Routine Eye Exam Every 24 Months commencing on the group effective date	Routine Eye Exam Every 24 Months commencing on the group effective date	Routine Eye Exam Every 24 Months commencing on the group effective date	Routine Eye Exam Every 24 Months commencing on the group effective date	N / A		N / A	N / A	

This comparison has been prepared as a guide to assist you in evaluating the program. This is not a complete comparison or contract and in no way details all the benefits,

* Rates do not include \$7 monthly administrative fee

** Medications on the CDPHP Preventive Drug List are no longer subject to the deductible in High Deductible plans.