

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	\$1,600 \$3,200 Single Family	\$2,500 \$5,000 Single Family	
Global In-Network Annual Out-of-Pocket Maximum	\$9,450 \$18,900 per indiv. per family (combined pharmacy and medical)	\$9,450 \$18,900 per indiv per family (combined pharmacy and medical)	N/A	\$4,600 \$9,200 \$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
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)		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	
	\$14 \$60 \$100 Mail Order or Participating 90-Day Retail (up to 90-day supply)					
Monthly Premiums:	We Deduct Your Premium a Month in Advance (e.g., December 2020 for January 1, 2021, 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)	\$813.46 Each			\$736.80 Each		
COBRA	\$829.73 Single		\$1,867.70 Family	\$751.54 Single		\$1,664.69 Family
Retiree < Age 65	\$813.46 Single		\$1,813.08 Family	\$736.80 Single		\$1,632.05 Family
Medicare Tiers ² :	Medicare I	Medicare II	Medicare III	Med I	Med II	Med III
Retiree ≥ Age 65 or on SSI Disability	\$430.18	\$1,243.63	\$860.35	\$324.26	\$1,061.06	\$648.52
Capital Health Plan	\$282.62	\$1,054.31	\$565.24	\$257.23	\$950.54	\$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.