

# Health Plan Summary Comparison Chart (excluding MA-PD plans)

Your Costs:	Standard			High Deductible (Pair with Health Savings Account)				
	HMO	PPO		HMO and PPO	PPO Only			
	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 <sup>1</sup>	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	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)		Pay in full; file claim for reimbursement	After paying deductible, 30%   30%   50% Network Retail and Mail Order		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 <sup>2</sup> :	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.