# Medical Plan Comparison Tool

Create a side-by-side comparison of plan details.

Tip: You may find it easier to select a few Plan Provisions at a time rather than all at once.

## Plan A (Traditional Plan) vs. Plan B (Consumer Plan)

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Plan Information</th>
<th>Type of Benefit</th>
<th>Dependent Age Limit</th>
<th>Deductibles / Maximums</th>
<th>Coinsurance Limit</th>
<th>Out of Pocket Maximum</th>
<th>Health Saving Account (HSA)</th>
<th>Employer Funded Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Network</td>
<td>PPO</td>
<td>End of month in which they turn 26</td>
<td>$300 (Deductible incurred for a network provider will only apply to the network limits)</td>
<td>85%</td>
<td>$950</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Non-Network</td>
<td>PPO HSA</td>
<td>End of month in which they turn 26</td>
<td>$600 (Deductible incurred for a non-network provider will only apply to the non-network coinsurance limits)</td>
<td>60%</td>
<td>$1,350</td>
<td>$2,550 (Excludes deductible and copays)</td>
<td>$500</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CMM</td>
<td>End of month in which they turn 26</td>
<td>$2,000 (Deductible incurred for a network provider will only apply to the network limits)</td>
<td>90%</td>
<td>$4,000</td>
<td>$8,550 (Excludes deductible and copays)</td>
<td>$500</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CMM</td>
<td>End of month in which they turn 26</td>
<td>$4,000 (Deductible incurred for a non-network provider will only apply to the non-network coinsurance limits)</td>
<td>60%</td>
<td>$8,000</td>
<td>$16,000 (For family ($6,750 per covered member)</td>
<td>$1,000</td>
</tr>
</tbody>
</table>

### Deductibles / Maximums

- **Individual**: $300 (Deductible incurred for a network provider will only apply to the network limits)
- **Family**: $700 (Deductible incurred for a network provider will only apply to the network limits)
- **Individual**: $950 (Deductible incurred for a network provider will only apply to the network limits)
- **Family**: $2,550 (Deductible incurred for a network provider will only apply to the network limits)
- **Individual**: $2,000 (Separate - Coinsurance incurred for a non-network provider will only apply to the non-network coinsurance limits)
- **Family**: $4,000 (Separate - Coinsurance incurred for a non-network provider will only apply to the non-network coinsurance limits)

### Coinsurance Limit

- **Individual**: 85%
- **Family**: 60%
- **Individual**: 90%
- **Family**: 60%

### Out of Pocket Maximum

- **Individual**: $950 (Excludes deductible and copays)
- **Family**: $2,550 (Excludes deductible and copays)
- **Individual**: $3,150 (Excludes deductible and copays)
- **Family**: $8,350 (Excludes deductible and copays)
- **Individual**: $4,000 (Separate - Coinsurance incurred for a non-network provider will only apply to the non-network coinsurance limits)
- **Family**: $8,000 (Separate - Coinsurance incurred for a non-network provider will only apply to the non-network coinsurance limits)

### Health Saving Account (HSA)

- **Employee Funded Amount**
  - **Individual**: $500
  - **Family**: $1,000

### Preventive Care

- **Routine Preventive Services**: 100%
- **Well Child Care**: 100% (under age 21)
- **Immunizations**: 100%
- **Well Woman Care**: 100% (under age 21)
- **Dependent Care**: 100% (under age 21)
- **Well Child Care**: 100% (under age 21)
- **Immunizations**: 100%
- **Well Woman Care**: 100% (under age 21)
- **Dependent Care**: 100% (under age 21)

### Endoscopic Services

- **Colonoscopy and Sigmoidoscopy only**: 100%
- **All other Endoscopic Services**: Not Covered

### Lab

- **Routine Lab Tests**: 100%
- **Critical Lab Tests**: 100%
- **Special Lab Tests**: 100%

### Mammogram

- **Routine Mammogram**: 100% (Limited to one per rolling 12 months with no age limitations)
- **Non-Routine Mammogram**: Not Covered

### Medical Tests

- **Routine Medical Tests**: 100% (Limited to one per rolling 12 months with no age limitations)
- **Non-Routine Medical Tests**: Not Covered

### Pap Test

- **Routine Pap Test**: 100% (Limited to one per rolling 12 months with no age limitations)
- **Non-Routine Pap Test**: Not Covered

### X-rays

- **Routine X-rays**: 100% (Limited to one per rolling 12 months with no age limitations)
- **Non-Routine X-rays**: Not Covered
<table>
<thead>
<tr>
<th>Services</th>
<th>Benefits paid based on corresponding medical benefits</th>
<th>Benefits paid based on corresponding medical benefits</th>
<th>Benefits paid based on corresponding medical benefits</th>
<th>Benefits paid based on corresponding medical benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSA Tests</td>
<td>100% (age 40 and over, 1 per rolling 12 months)</td>
<td>60% after deductible</td>
<td>100% (age 40 and over, 1 per rolling 12 months)</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Inpatient Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech Therapy</td>
<td>85% after deductible</td>
<td>60% after deductible</td>
<td>90% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Professional Services</td>
<td>85% after deductible</td>
<td>60% after deductible</td>
<td>90% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Institutional Services</td>
<td>85% after deductible</td>
<td>60% after deductible</td>
<td>90% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Chemical Therapy</td>
<td>85% after deductible</td>
<td>60% after deductible</td>
<td>90% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>85% after deductible</td>
<td>60% after deductible</td>
<td>90% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Other Benefits</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice Care</td>
<td>85% after deductible</td>
<td>60% after deductible</td>
<td>90% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>100% (Physician Office); 85% after deductible (All other Places of Service)</td>
<td>60% after deductible</td>
<td>90% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>100% (Physician Office); 85% after deductible (All other Places of Service)</td>
<td>60% after deductible</td>
<td>90% after deductible</td>
<td>60% after deductible</td>
</tr>
</tbody>
</table>

Important Note on Printing: While we encourage you to print the results from the Estimator to help you decide which plan is best for you, please remember that the amounts provided are only estimates. They are intended to give you a general idea of your costs, based on your usage and the coverage levels of the available plans.