CDPHP	POS $25	PPO $15
Annual Deduction In-Network:	none	
Annual Deduction Out-of-Network	$500 Individual coverage, $1,000 Family coverage	
Out-of-Network:	30% coinsurance	20% coinsurance
Out of pocket maximum (*In-Network*) **:**	$5,080 Individual maximum, $12,700 family maximum	
Out of pocket maximum *(Out of Network):*	$2,500 Individual maximum, $5,000 family maximum	$2,000 Individual maximum, $4,000 family maximum
Physicians Visits:	$25 Copay	$15 Copay
Specialist Visits:	$25 Copay	$15 Copay
Hospital coverage (Inpatient):	Covered in full	$200 copay ($400 max per member per year)
Mental Health In patient:	Covered in full	$200 copay ($400 max per member per year)
Mental Health Out patient:	Covered in full	**Facility**- Covered in Full; **Physician**- $15 Copayment
Maternity Physician services:	$25 Copay	$15 Copay
Delivery:	Covered in full	$200 copay ($400 max per year)
Diagnostic Testing in network: (*Laboratory services/Radioglogy and Imaging (X-rays, MRIs)* **:**	Covered in full	
Urgent Care in/out network:	$25 Copay - in network; Deductible then 30% co-insurance - out of network	$15 copay -in network and out network
Durable Medical Equipment coverage in network: (Prior authorization required for items over $1000)	20% coinsurance (employee is responsible for 20% of the amount charged)	Covered in full
Vision Eye Exam: **Once every 24 months*	$25 Copay	$15 Copay
Glasses or Contacts	One pair of glasses or contacts every 24 months	not covered
Standard lenses	$15 Copayment	not covered
Lens upgrades/enhancements:	$225 Allowance	not covered
Frames:	$175 Allowance	not covered
Standard Contacts:	$200 Allowance	not covered
ER copay (waived if admitted):	$25 Copay	$150 Copay
Prescription Drug Coverage:	**Retail:** $5 Tier 1/$25 Tier 2/ $50 Tier 3; **Mail Order**: Up to a 90 day supply for two (2) copayments	