CDPHP	POS $30/$40	PPO $30/$40
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:	$30 Copay	
Specialist Visits:	$40 Copay	
Hospital coverage (Inpatient):	Covered in full	$200 copay ($400 max per year)
Mental Health In patient:	Covered in full	$200 copay ($400 max per year)
Mental Health Out patient:	Covered in full	**Facility**- Covered in Full; **Physician**- $15 Copayment
Maternity Physician services:	$40 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:	20% coinsurance (employee is responsible for 20% of the amount charged)	Covered in full
Vision Eye Exam: **Once every 24 months*	$40 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):	$200 Copay	$250 Copay
Prescription Drug Coverage:	**Retail:** $10 Tier 1/$40 Tier 2/ $60 Tier 3; **Mail Order**: Up to a 90 day supply for two (2) copayments	