

2016 COBRA Insurance Coverage & Premium Chart



The chart below provides a side-by-side comparison of your medical plan options, including key provisions and cost information. Review it to help determine which option will best suit your needs.

PLANS	United Healthcare (UHC) Choice Plus HSA		United Healthcare (UHC) Choice Plus POS	
	Network	Out-of-Network	Network	Out-of-Network
Optional Health Care Accounts				
Health Care Account Type	Health Savings Account (HSA) High deductible health plan		Traditional health plan	
County Health Care Account Contribution	\$400 Employee ¹ / \$1,200 Family ¹ to HSA		None	
Maximum Health Care Account Contribution	HSA: \$3,350 ² Employee / \$6,750 ² Family			
Coinsurance (after meeting deductible)	20%	40%	20%	40%
Out-of-Pocket Responsibility				
Primary Care Office Visit	Deductible/Coinsurance	Deductible/Coinsurance	\$20 copay	Deductible/Coinsurance
Specialist Office Visit	Deductible/Coinsurance	Deductible/Coinsurance	\$30 copay	Deductible/Coinsurance
Preventive Care Visit	\$0	\$0	\$0	\$0
Preventive Lab/X-Ray	\$0	\$0	\$0	\$0
Emergency Room Visit	Deductible/Coinsurance	Deductible/Coinsurance	\$100 copay	\$100 copay
Annual Deductible				
Employee	\$1,300	\$2,600	\$600	\$1,200
Family (2 or more)	\$2,600 ³	\$5,200 ³	\$1,200	\$2,400
Out-of-Pocket Maximum (includes deductible) once Out-of-Pocket maximum is reached, plans pay 100% for the year				
Employee	\$3,000	\$4,200	\$2,600	\$5,200
Employee + Spouse	\$4,000	\$5,600	\$5,200	\$10,400
Employee + Child(ren)	\$4,000	\$5,600	\$5,200	\$10,400
Family	\$6,000	\$8,400	\$5,200	\$10,400
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Prescription with Express Scripts	Up to 30 Days Retail	Up to 90 Days Retail	Up to 30 Days Retail	Up to 90 Days Retail
Preventive	\$0	\$0	Varies per drug class	2x 30 day cost
Generic	Deductible/Coinsurance	Deductible/Coinsurance	\$15 copay	2x 30 day cost
Preferred	Deductible/Coinsurance	Deductible/Coinsurance	20% coinsurance \$30-\$60	2x 30 day cost
Non-Preferred	Deductible/Coinsurance	Deductible/Coinsurance	40% coinsurance \$45-\$90	2x 30 day cost
Specialty-Preferred	Deductible/Coinsurance	Deductible/Coinsurance	20% coinsurance \$60-\$120	20% coinsurance \$60-\$120
Specialty-Non-Preferred	Deductible/Coinsurance	Deductible/Coinsurance	40% coinsurance \$90-\$180	40% coinsurance \$90-\$180
Mental Health with ComPsych				
Mental Health Office Visits	Deductible/20% Coinsurance		\$10 copay	
In-patient Care	Deductible/20% Coinsurance		\$100 deductible/10% Coinsurance	
Participant Monthly Premiums (includes 2% administration fee)				
Participant	\$724.01		\$724.01	
Participant + Child(ren)	\$1359.11		\$1359.11	
Participant + Spouse/DP	\$1445.50		\$1445.50	
Family	\$2080.83		\$2080.83	

1. You must open an Optum Bank account and you may contribute additional funds to the account. Employees 55+ may contribute an additional \$1,000.
2. Maximum contribution includes Pinellas County's contribution.
3. If two (2) or more people are covered, Family Deductible must be met before benefits are paid for any covered family member.

Vision Insurance with EyeMed

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| <ul style="list-style-type: none"> • No additional cost; cost of coverage is included in the health insurance premium. • Basic Exam - \$10 copay • Basic Lenses - \$20 copay | <ul style="list-style-type: none"> • Frames - \$110 Allowance; 20% off balance over \$110 • Contact Lenses - \$100 Allowance • Lasik - \$562.50 Reimbursement per eye |
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2016 Pinellas County Group Dental Plan

METLIFE DENTAL PLAN	MONTHLY CONTRIBUTIONS (includes 2% administration fee)						
<ul style="list-style-type: none"> • Network benefits only. Required to choose a dentist from the provider network. • Annual exams, X-rays, cleanings and most preventative services are free at your network general dentist. • No maximum annual benefit. • Copayments apply based on procedure performed and established fee schedule. • Network specialist services provide 25% discount. • ID cards are issued. 	<table> <tr> <td>Participant</td><td style="text-align: right;">\$7.31</td></tr> <tr> <td>Participant + 1</td><td style="text-align: right;">\$10.47</td></tr> <tr> <td>Participant + 2 or more</td><td style="text-align: right;">\$14.67</td></tr> </table>	Participant	\$7.31	Participant + 1	\$10.47	Participant + 2 or more	\$14.67
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Participant + 1	\$10.47						
Participant + 2 or more	\$14.67						
CIGNA DENTAL PLAN							
<ul style="list-style-type: none"> • Use any dentist, specialist, or a CIGNA Radius Network provider for additional savings. • No deductibles or pre-existing condition limitations; some frequency limitations apply. • Plan reimburses 100% of first \$150 of covered expenses and 50% of next \$2,700 per calendar year. Maximum reimbursement is \$1,500 per person per calendar year, of which \$1,500 may be for orthodontics. • No ID cards are issued. 	<table> <tr> <td>Participant</td><td style="text-align: right;">\$42.99</td></tr> <tr> <td>Participant + 1</td><td style="text-align: right;">\$83.18</td></tr> <tr> <td>Participant + 2 or more</td><td style="text-align: right;">\$131.47</td></tr> </table>	Participant	\$42.99	Participant + 1	\$83.18	Participant + 2 or more	\$131.47
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