	Current		Renewal	
	Humana Choice POS 10		**Humana Choice POS 10**	
	(In/Out of Network)		(In/Out of Network)	
Individual Deductible	$5,000/15,000		$5,000/15,000	
Family Deductible	$10,000/30,000		$10,000/30,000	
Coinsurance	100/70%		100/70%	
Out-Of-Pocket (Inc. Ded.)	$5,000/23,000		$5,000/23,000	
Family OOP (Inc. Ded.)	$10,000/46,000		$10,000/46,000	
In Network Physicians Svcs.	Deductible then Coinsurance		Deductible then Coinsurance	
Specialist Services	Deductible then Coinsurance		Deductible then Coinsurance	
Emergency Room	Deductible then Coinsurance		Deductible then Coinsurance	
Inpatient Hospital Services	Deductible then Coinsurance		Deductible then Coinsurance	
Outpatient Surgery	Deductible then Coinsurance		Deductible then Coinsurance	
Preventative Care	100%		100%	
Rx Copay	$15/30/50		$15/30/50	
EE:	11	$357.52	11	$443.64
EE+Sp:	1	$786.55	1	$976.00
EE+Ch:	0	$679.30	0	$842.91
Family:	2	$1,108.33	2	$1,375.27
Total Monthly	14	$6,935.93	14	$8,606.58
Total Monthly		$6,935.93		$8,606.58
Total Annually		**$83,231.16**		**$103,278.96**
			Vs Inforce	
Annual Difference			**$20,047.80**	
Percent Difference			**24.09%**	

*This spreadsheet is for comparison purposes only. Refer to your contract for actual benefits

	Inforce		Renewal	
	Principal PPO Plan		**Principal PPO Plan**	
	(In/Out of Network)		(In/Out of Network)	
Individual Deductible	$50/100		$50/100	
Family Deductible	$150/300		$150/300	
Waived for preventive?	Yes		Yes	
Preventive	100/100%		100/100%	
Basic	100/80%		100/80%	
Major	60/50%		60/50%	
Orthodontia	N/A		N/A	
Endo/Periodontics	Covered in Major		Covered in Major	
Calendar Year Maximum	$1,000		$1,000	
Orthodontia Maximum	N/A		N/A	
	PPO Plan		**PPO Plan**	
EE:	11	$29.27	11	$30.82
EE+Sp:	1	$60.39	1	$63.59
EE+Ch:	0	$65.93	0	$69.42
Family:	2	$101.44	2	$106.82
Total Monthly	14	$585.24	14	$616.25
Total Monthly		**$585.24**		**$616.25**
Total Annually		**$7,022.88**		**$7,395.00**
			Vs Inforce	
Annual Difference			**$372.12**	
Percent Difference			**5.30%**	

Current/Renewal

	Humana
Life & AD&D	$50,000
Total Employees	12
Life/AD&D Rate	$0.280
Volume	$632,500
Total Monthly	**$177.10**
Total Annually	**$2,125.20**

		Current		*Renewal*	
		Humana Voluntary Vision		**Humana Voluntary Vision**	
Primary Benefits		**(In Network)**	**(Out of Network)**	**(In Network)**	**(Out of Network)**
Eye Exams					
Frequency		12 Months		12 Months	
Benefit		$10 Copay	Reimbursed up to $35	$10 Copay	Reimbursed up to $35
Lenses					
Frequency		12 Months		12 Months	
Benefit					
Single Vision		$15 Copay	Reimbursed up to $25	$15 Copay	Reimbursed up to $25
Bifocal		$15 Copay	Reimbursed up to $25	$15 Copay	Reimbursed up to $25
Trifocal		$15 Copay	Reimbursed up to $25	$15 Copay	Reimbursed up to $25
Contact Lenses					
Frequency		12 Months		12 Months	
Benefit		Covered up to $150	Reimbursed up to $150	Covered up to $150	Reimbursed up to $150
Frames					
Frequency		24 Months		24 Months	
Benefit		Covered up to $50	Reimbursed up to $40	Covered up to $50	Reimbursed up to $40
	EE's	**Rates**		**Rates**	
Employee	11	$5.45		$5.87	
Employee & Spouse	1	$10.90		$11.74	
Employee & Child(ren)	0	$10.36		$11.15	
Family	2	$16.28		$17.53	
Total Monthly		**$103.41**		**$111.37**	
Total Annual		**$1,240.92**		**$1,336.44**	
Annual Difference				**$95.52**	

*This spreadsheet is for comparison purposes only. Refer to your contract for actual benefits

CBIZ has made every effort to supply you with an accurate and comprehensive proposal, however, we will not be bound by any typographical errors or ommissions contained herein.