
SHRM[®] HEALTH CARE CUSTOMIZED BENCHMARKING REPORT



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**** Fictitious Data ****

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SHRM 2011-2012 CUSTOMIZED
HEALTH CARE BENCHMARKING REPORT**

Your report is based on the following criteria:

SELECTION CRITERIA

Industry: Your Industry

Staff Size: Your Staff Size

SHRM Customized Human Capital,
Retirement and Welfare Benchmarking,
Employee Benefits Prevalence, and Employee
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A GUIDE TO YOUR SHRM® CUSTOMIZED BENCHMARKING REPORT

Understanding the Data

As you compare your own data against the other organizations, please keep the following in mind:

1. This report is based on data derived from the SHRM Customized Benchmarking Database, which contains data from a random collection of U.S. companies of all sizes and types. The report is designed to target companies that closely match the selected criteria to allow for a more focused and comparable analysis and interpretation. Therefore, any interpretations of these data should be kept within this context.

2. A deviation between your figure for any health care measure and the comparative figure is not necessarily favorable or unfavorable; it is merely an indication that additional analyses may be needed. Health care measures that relate more closely to the context of your organization's industry and employee size are more descriptive and meaningful than information that is more generic in nature, such as all industries combined. The larger the discrepancy

between your figure and those found in this report, the greater the need for additional scrutiny.

3. In cases where you determine that potentially serious deviations do exist, it may be helpful to go back and calculate the same health care measure for your organization over the past several years to identify any existing trends.

4. The information in this report should be used as a tool for decision-making rather than an absolute standard. Because companies differ in their total rewards strategy, location, size and other factors, any two companies can be well managed, yet some of their health care measures may differ greatly. No decision should be made solely based on the results of any one study.

Working With the Data

The information in this report is designed to be a tool to help you evaluate decisions and activities that affect your organization's employee health care benefits. When reviewing these data, it is important to

realize that business strategy, organizational culture, benefit philosophies and industry pressures are just a few of the many factors that drive various benefit measures. For example, an industry that generally hires nonskilled labor, such as manufacturing, may have less costly benefits packages than the high-tech industry, which hires specialized knowledge workers. This is because organizations in the high-tech industry may need to have richer, more attractive benefits plans to make themselves more enticing in order to attract “hard-to-find” knowledge workers.

Absolute measures are not meaningful in isolation—they should be compared with one or more measures to determine whether a satisfactory level exists. Other measures, for example, might be your organization’s past results in this area or comparatives based on organizational size, industry or geographic location.

Each page in the custom tables contains customized health care benchmarks in aggregated form. There may be discrepancies between your organization’s

health care benchmarks and the average or median numbers for a particular category. It is particularly helpful to communicate to line managers and other executives that just because your organization has benchmarks that are different from the average or median, it does not mean they are favorable or unfavorable. Rather, this difference may be the result of your organization’s particular total rewards strategy, special circumstances or other business initiatives.

Notes

The data in this report were collected in the spring of 2011 and reflect plan year 2010. The number of respondents, indicated by “n,” is composed of the organizations that responded to the specific benchmark for which it is listed. Therefore, the number of peer organizations may vary from benchmark to benchmark. Some benchmarks are less frequently collected by organizations or may be more difficult to obtain. Therefore, some benchmarks show a smaller “n” than others. Some data are not displayed when there are fewer than five organizations for a specific metric.

SHRM CUSTOMIZED HEALTH CARE BENCHMARKING REPORT

HEALTH CARE COVERAGE AND STOP LOSS COVERAGE PREVALENCE

	n	Percentage
Percentage of organizations providing employee health care coverage	111	100%
Percentage of organizations providing spouse health care coverage	103	94%
Percentage of organizations providing same-sex domestic partner health care coverage	29	32%
Percentage of organizations providing opposite-sex domestic partner health care coverage	25	29%
Percentage of organizations with self-funded health care	14	38%
Percentage of organizations with stop loss coverage	7	76%

SHRM CUSTOMIZED HEALTH CARE BENCHMARKING REPORT

EMPLOYEE PARTICIPATION AND PLANS OFFERED

	Percentage of Employees Enrolled	Percentage of Organizations Offering Plan
n	93	112
HMO	49%	37%
EPO	47%	6%
PPO	65%	81%
POS	45%	17%
Indemnity	26%	3%
CDHP	38%	16%

	Number of Health Care Plans Offered
n	113
1 plan	56%
2 plans	32%
3 or more plans	12%

SHRM CUSTOMIZED HEALTH CARE BENCHMARKING REPORT

HEALTH CARE COST, WAITING PERIOD AND STOP LOSS COVERAGE AMOUNT

	n	25th Percentile	Median	75th Percentile	Average
Total annual health care cost per covered employee	75	\$4,047	\$5,743	\$7,174	\$6,013
Waiting period, in months, for coverage for new employees	109	1	2	3	2
Amount of stop loss coverage	8	\$75,000	\$150,000	\$225,000	\$182,426

* To ensure that the data are seen as credible, data for metrics with an “n” of less than 5 are not displayed.

SHRM CUSTOMIZED HEALTH CARE BENCHMARKING REPORT

HEALTH CARE COSTS FOR ALL PLANS COMBINED

	n	25th Percentile	Median	75th Percentile	Average
Employer contribution to monthly health care premium for employee-only coverage	48	\$170	\$335	\$455	\$298
Percentage of premium employer pays for employee-only coverage	87	70%	80%	90%	78%
Percentage of premium employer pays for spouse or domestic partner coverage	76	50%	75%	80%	63%
Annual in-network deductible for employee-only coverage	72	\$100	\$280	\$800	\$638
Annual out-of-network deductible for employee-only coverage	65	\$350	\$780	\$1,600	\$1,276
Co-pay for in-network primary care office visits for employee-only coverage	29	\$0	\$1,400,000	\$5,500,000	\$3,385,889

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SHRM CUSTOMIZED HEALTH CARE BENCHMARKING REPORT

HEALTH MAINTENANCE ORGANIZATION

	n	25th Percentile	Median	75th Percentile	Average
Employer contribution to monthly health care premium for employee-only coverage	12	\$185	\$320	\$395	\$470
Percentage of premium employer pays for employee-only coverage	24	70%	80%	95%	77%
Percentage of premium employer pays for spouse or domestic partner coverage	25	45%	65%	80%	54%
Annual in-network deductible for employee-only coverage	28	\$0	\$100	\$350	\$300
Annual out-of-network deductible for employee-only coverage	28	\$0	\$250	\$500	\$425
Co-pay for in-network primary care office visits for employee-only coverage	15	\$15	\$20	\$25	\$17

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SHRM CUSTOMIZED HEALTH CARE BENCHMARKING REPORT

EXCLUSIVE PROVIDER ORGANIZATION

	n	25th Percentile	Median	75th Percentile	Average
Employer contribution to monthly health care premium for employee-only coverage	27	\$78	\$266	\$346	\$254
Percentage of premium employer pays for employee-only coverage	72	75%	80%	95%	77%
Percentage of premium employer pays for spouse or domestic partner coverage	68	50%	75%	85%	62%
Annual in-network deductible for employee-only coverage	38	\$0	\$95	\$225	\$126
Annual out-of-network deductible for employee-only coverage	38	\$150	\$205	\$367	\$267
Co-pay for in-network primary care office visits for employee-only coverage	59	\$15	\$20	\$25	\$21

* To ensure that the data are seen as credible, data for metrics with an “n” of less than 5 are not displayed.

SHRM CUSTOMIZED HEALTH CARE BENCHMARKING REPORT

PREFERRED PROVIDER ORGANIZATION

	n	25th Percentile	Median	75th Percentile	Average
Employer contribution to monthly health care premium for employee-only coverage	58	\$188	\$320	\$431	\$339
Percentage of premium employer pays for employee-only coverage	63	70%	80%	93%	77%
Percentage of premium employer pays for spouse or domestic partner coverage	40	48%	70%	80%	60%
Annual in-network deductible for employee-only coverage	47	\$185	\$325	\$695	\$470
Annual out-of-network deductible for employee-only coverage	49	\$350	\$600	\$1,500	\$1,098
Co-pay for in-network primary care office visits for employee-only coverage	47	\$15	\$20	\$25	\$21

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SHRM CUSTOMIZED HEALTH CARE BENCHMARKING REPORT

POINT OF SERVICE

	n	25th Percentile	Median	75th Percentile	Average
Employer contribution to monthly health care premium for employee-only coverage	7	\$167	\$308	\$421	\$286
Percentage of premium employer pays for employee-only coverage	11	70%	79%	92%	76%
Percentage of premium employer pays for spouse or domestic partner coverage	8	45%	70%	85%	59%
Annual in-network deductible for employee-only coverage	8	\$0	\$210	\$500	\$497
Annual out-of-network deductible for employee-only coverage	7	\$300	\$500	\$1,500	\$1,166
Co-pay for in-network primary care office visits for employee-only coverage	8	\$15	\$20	\$25	\$23

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SHRM CUSTOMIZED HEALTH CARE BENCHMARKING REPORT

INDEMNITY

	n	25th Percentile	Median	75th Percentile	Average
Employer contribution to monthly health care premium for employee-only coverage	23	\$101	\$356	\$454	\$378
Percentage of premium employer pays for employee-only coverage	31	74%	84%	94%	79%
Percentage of premium employer pays for spouse or domestic partner coverage	28	40%	77%	89%	67%
Annual in-network deductible for employee-only coverage	19	\$100	\$530	\$850	\$774
Annual out-of-network deductible for employee-only coverage	24	\$150	\$580	\$1,100	\$932
Co-pay for in-network primary care office visits for employee-only coverage	26	\$5	\$15	\$20	\$16

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SHRM CUSTOMIZED HEALTH CARE BENCHMARKING REPORT

CONSUMER-DRIVEN HEALTH PLAN: HIGH DEDUCTIBLE HEALTH PLAN

	n	25th Percentile	Median	75th Percentile	Average
Employer contribution to monthly health care premium for employee-only coverage	6	\$156	\$252	\$358	\$279
Percentage of premium employer pays for employee-only coverage	14	75%	88%	98%	83%
Percentage of premium employer pays for spouse or domestic partner coverage	12	57%	75%	88%	64%
Annual in-network deductible for employee-only coverage	15	\$1,050	\$1,250	\$2,500	\$1,999
Annual out-of-network deductible for employee-only coverage	13	\$1,550	\$2,250	\$3,500	\$2,788
Co-pay for in-network primary care office visits for employee-only coverage	18	\$0	\$10	\$15	\$6

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SHRM CUSTOMIZED HEALTH CARE BENCHMARKING REPORT

CONSUMER-DRIVEN HEALTH PLAN: HEALTH SAVINGS ACCOUNT AND HEALTH REIMBURSEMENT ACCOUNT

	n	25th Percentile	Median	75th Percentile	Average
Employer contribution to health savings account	23	\$45	\$450	\$1,100	\$743
Maximum allowable employee contribution to health savings account	15	\$2,500	\$2,750	\$3,000	\$2,452
Employer contribution to health reimbursement account	12	\$500	\$750	\$1,125	\$1,581

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SHRM CUSTOMIZED HEALTH CARE BENCHMARKING REPORT

PRESCRIPTION DRUG COVERAGE

	n	25th Percentile	Median	75th Percentile	Average
Employee co-pay for generic medication	75	\$10	\$15	\$18	\$13
Employee co-pay for formulary brand medication	78	\$20	\$25	\$35	\$26
Employee co-pay for non-formulary brand medication	\$81	\$35	\$50	\$70	\$47
Employee co-pay for generic medication 90-day mail order supply	72	\$15	\$20	\$25	\$26
Employee co-pay for formulary brand medication 90-day mail order supply	69	\$40	\$50	\$75	\$59
Employee co-pay for non-formulary brand medication 90-day mail order supply	71	\$65	\$95	\$125	\$98

* To ensure that the data are seen as credible, data for metrics with an “n” of less than 5 are not displayed.

HEALTH CARE GLOSSARY OF METRIC TERMS, DEFINITIONS AND CALCULATIONS

Statistical Definitions

“ n ”

The letter “n” in tables and figures indicates the number of respondents to each question. In other words, when it is noted that n = 25, it indicates that the number of respondents was 25.

Percentile

The percentile is the percentage of responses in a group that have values less than or equal to that particular value. For example, when data are arranged from lowest to highest, the 25th percentile is the point at which 75% of the data are above and 25% are below it. Conversely, the 75th percentile is the point at which 25% of the data are above and 75% are below it.

Median (50th percentile)

The median is the midpoint of the set of numbers or values arranged in ascending order. It is recommended that the median is used as a basis for all interpretations of the data when the average and median are discrepant.

Average

The average is the sum of the responses divided by the total number of responses. It is also known as the mean. This measure is affected more than the median by the occurrence of outliers (extreme values). For this reason, the average reported may be greater than the 75th percentile or less than the 25th percentile.

Health Care Coverage and Stop Loss Coverage Prevalence

Percentage of Organizations Providing Employee Health Care Coverage

This percentage represents those organizations that offer health care coverage as a benefit to their employees. It is calculated by dividing the number of organizations that offer health care benefits by the total number of organizations, regardless of whether they offer health care coverage.

Percentage of Organizations Providing Spouse Health Care Coverage

This percentage represents those organizations that offer spouse health care coverage as a benefit to their employees. It is calculated by dividing the number of organizations that offer spouse health care benefits by the total number of organizations, regardless of whether they offer spouse health care coverage.

Percentage of Organizations Providing Same-Sex Domestic Partner Health Care Coverage

This percentage represents those organizations that offer same-sex domestic partner health care coverage as a benefit to their employees. This benefit recognizes the family as the intimate, committed relationship of two unrelated people of the same sex that is the approximate equivalent of marriage but does not involve formal marriage. It is calculated by dividing the number of organizations that offer same-sex domestic partner health care benefits by the total number of organizations, regardless of whether they offer same-sex domestic partner health care coverage.

Percentage of Organizations Providing Opposite-Sex Domestic Partner Health Care Coverage

This percentage represents those organizations that offer opposite-sex domestic partner health care coverage as a benefit to their employees. This benefit recognizes the family as the intimate, committed relationship of two unrelated people of the opposite sex that is the approximate equivalent of marriage but

does not involve formal marriage. It is calculated by dividing the number of organizations that offer opposite-sex domestic partner health care benefits by the total number of organizations, regardless of whether they offer opposite-sex domestic partner health care coverage.

Percentage of Organizations With Self-Funded Health Care

This percentage represents those organizations whose health care is self-funded by the organization. A self-funded health care plan is one in which no insurance company or service plan collects premiums and assumes risk. In a sense, the employer is acting as its own insurance company, paying the medical claims submitted by its employees. This percentage is calculated by dividing the number of organizations with self-funded health care by the total number of organizations, regardless of whether their health care is self-funded.

Percentage of Organizations With Stop Loss Coverage

This percentage represents those organizations that contract with a third-party insurance provider to cover medical claims if they exceed a specified dollar amount over a set period of time. It is calculated by dividing the number of organizations that have stop loss coverage by the total number of organizations, regardless of whether they have stop loss coverage.

Employee Participation and Plans Offered

Percentage of Employees Enrolled

This percentage represents the number of employees in an organization that have elected to sign up for an organization's health care plan. It is calculated by dividing the number of employees who enroll in an organization's health care plan by the total number of employees in the organization, regardless of whether they have elected health care coverage from the organization.

Percentage of Organizations Offering Plan

This percentage represents the number of organizations offering at least one of the following health care plans: health maintenance organization (HMO), exclusive provider organization (EPO), preferred provider organization (PPO), point of service (POS), indemnity and consumer-driven health plan (CDHP). It is calculated by dividing the number of organizations offering a specific plan by the total number of organizations, regardless of whether they offer a specific plan.

Number of Health Care Plans Offered

Organizations may offer a number of different health care plans to meet the needs of their employee population. This percentage represents the number of organizations that offer one or more health care plans from which their employees can choose.

Health Care Cost, Waiting Period and Stop Loss Coverage Amount

Total Annual Health Care Cost per Covered Employee

Health care expense per covered employee is calculated by taking the total health care expenses paid by the organization in a given year and dividing it by the number of employees who are enrolled in a health care plan.

Waiting Period (in Months) for Coverage for New Employees

This category of data represents the period of time between an employee's first day of employment and the date when the employee becomes eligible for health care coverage.

Amount of Stop Loss Coverage

Organizations often contract with a third-party insurance provider to cover medical claims if they exceed a specified dollar amount over a set period of time. This benchmark represents the dollar amount at which the stop loss coverage begins.

Health Care Costs for All Plans Combined

Employer Contribution to Monthly Health Care Premium for Employee-Only Coverage

This benchmark is the monthly dollar amount that the employer pays for health care to cover an employee who is enrolled in an organization's health care plan.

Percentage of Premium Employer Pays for Employee-Only Coverage

The percentage of premium the organization pays for employee-only coverage is calculated by dividing the monthly dollar amount the organization pays for employee-only coverage premiums by the total monthly premium dollar amount.

Percentage of Premium Employer Pays for Spouse or Domestic Partner Coverage

The percentage of premium the organization pays for spouse or domestic partner coverage is calculated by dividing the dollar amount the organization pays for spouse or domestic partner coverage premiums by the total premium dollar amount.

Annual In-Network Deductible for Employee-Only Coverage

This benchmark is the annual amount of out-of-pocket expenses that the employee pays for health care services when the provider participates in the employee's health care plan.

Annual Out-of-Network Deductible for Employee-Only Coverage

This benchmark is the annual amount of out-of-pocket expenses that the employee pays for health care services when the provider does not participate in the employee's health care plan.

Co-Pay for In-Network Primary Care Office Visits for Employee-Only Coverage

This benchmark represents the payment due at the time of service to a provider that participates with the employee's health

plan. Co-pays are made in addition to deductibles.

Health Maintenance Organization

Health maintenance organizations (HMOs), typically referred to as managed care plans, are pre-paid medical group practice plans that provide comprehensive predetermined medical care benefits for pre-negotiated amounts. Some HMO plans utilize gatekeepers to ensure that certain medical services are used only when absolutely necessary.

Exclusive Provider Organization

Exclusive provider organizations (EPOs) are self-funded medical plans that combine aspects of a PPO and an HMO. EPOs provide specific benefit levels if care is provided by a specific network of service providers, otherwise no payment will be made.

Preferred Provider Organization

Preferred provider organizations (PPOs) are formed by an insurance company, an employer or a group of employers who negotiate discounted fees with networks of health care providers. In return, the employers guarantee a certain volume of patients and prompt payment. PPO participants' out-of-pocket costs are usually lower than under a fee-for-service plan.

Point of Service

Point of service (POS) plans allow employees to use both in-network and out-of-network providers, although benefits are greater if in-network providers are used. Often combining aspects of a PPO and an

HMO, some POS plans utilize gatekeepers to ensure that certain medical services are used only when absolutely necessary.

Indemnity

Indemnity plans are full-choice health care plans that allow covered employees to go to any qualified physician or hospital they choose, as there is no incentive or requirement to use a particular network of providers. Medical claims are then submitted to the insurance company for payment. Indemnity plans are also known as fee-for-service health care plans.

Consumer-Driven Health Plan: High-Deductible Health Plan

A consumer-driven health care plan (CDHP) is a high-deductible health care plan that is presented along with a tax-advantaged spending account. Presently, two types of plans meet these criteria—health savings accounts (HSAs) and health reimbursement accounts (HRAs).

Consumer-Driven Health Plan: Health Savings Accounts and Health Reimbursement Accounts

Employer Contribution to Health Savings Accounts

Health savings accounts, a component of consumer-driven health care plans, allow employers and employees to contribute to tax-deductible accounts for the benefit of employees covered under high-deductible health plans. This benchmark indicates the amount employers contribute to health savings accounts.

Maximum Allowable Employee Contribution to Health Savings Accounts

Health savings accounts, a component of consumer-driven health care plans, allow employers and employees to contribute to tax-deductible accounts for the benefit of employees covered under high-deductible health plans. This benchmark indicates the maximum amount that an employee may contribute to health savings accounts.

Employer Contribution to Health Reimbursement Accounts

Health reimbursement accounts, a component of consumer-driven health care plans, are tax-free accounts funded by employers. Any benefit dollars that are left in the account at year-end can roll over and be used to cover future medical expenses.

Prescription Drug Coverage

Employee Co-Pay for Generic Medication

This benchmark represents the payment made at the time of purchase for generic prescription drug medication. Generic medication is equal in therapeutic dose to brand-name original drugs and is typically cost-effective. Co-pays are made in addition to deductibles.

Employee Co-Pay for Formulary Brand Medication

This benchmark represents the payment made at the time of purchase for formulary prescription drug medication. Formulary brand medications are a list of preferred drugs that will be covered by a plan at a discount, and they differ from plan to plan.

Drugs are selected to be included in this list because they are cost-effective or have a generic substitution available. Co-pays are made in addition to deductibles.

Employee Co-Pay for Non-Formulary Brand Medication

This benchmark represents the payment made at the time of purchase for non-formulary prescription drug medication. Non-formulary brand medications are not on the formulary list of drugs, and therefore, no discount is usually offered. Some plans may refuse to cover a non-formulary drug if a physician has prescribed a generic substitution. Co-pays are made in addition to deductibles.

Employee Co-Pay for Generic Medication 90-Day Mail-Order Supply

This benchmark represents the payment made at the time of purchase for a 90-day supply of generic prescription drug medication when the prescription is ordered through the mail. Generic medication is equal in therapeutic dose to brand-name original drugs and is typically cost-effective. Co-pays are made in addition to deductibles.

Employee Co-Pay for Formulary Brand Medication 90-Day Mail-Order Supply

This benchmark represents the payment made at the time of purchase for a 90-day supply of formulary prescription drug medication when the prescription is ordered through the mail. Formulary brand medications are a list of preferred drugs that will be covered by a plan at a discount, and they differ from plan to plan. Drugs are

selected to be included in this list because they are cost-effective or have a generic substitution available. Co-pays are made in addition to deductibles.

Employee Co-Pay for Non-Formulary Brand Medication 90-Day Mail-Order Supply

This benchmark represents the payment made at the time of purchase for a 90-day supply of non-formulary prescription drug medication when the prescription is ordered through the mail. Non-formulary brand medications are not on the formulary list of drugs, and therefore, no discount is usually offered. Some plans may refuse to cover a non-formulary drug if a physician has prescribed a generic substitution. Co-pays are made in addition to deductibles.