Real benefits begin here. | TriNet

Benefits At-A-Glance

2011-2012 Plan Year

Benefit plan: AL, AK, AR, AZ, CA, CO, CT, DE, DC, FL, GA, HI, ID, IL, IN, IA, KS, KY, LA, ME, MD, MA, MI, MN, MS, MO, MT, NE, NH, NJ, NM, NY, NV, NC, ND, OH, OK, OR, PA, PR, RI, SC, SD, TN, TX, UT, VT, VA, WA, WV, WI, WY

How to Benefit from Your Benefits Selections

We know how hard it is to make sense of health care plans. Which is why we put together this comparison summary for the benefit year October 1, 2011 to September 30, 2012.

Everything here is also available online at www.hrpassport.com.

Questions? Comments?

Call us toll-free any time at 800-638-0461.

TriNet's benefits give your company a competitive advantage by helping you attract and retain employees. They are designed to cover worksite employees and their families at every stage of life; they provide greater security, tax saving opportunities, and important financial protection.

TriNet's benefits are comparable to the benefits the largest US businesses select — and, they package the right products, management tools, and support to help you make the most of every benefits dollar.

TriNet's health plans are different because we offer guaranteed issues with no pre existing limitations and same-day coverage. Included in TriNet's offering is a broad range of plans, from affordable higher-deductible plans to more costly low-deductible plans. TriNet also offers regional plans and HMOs in select states to provide a greater level of choice to many worksite employees.

Medical

	Aetna PPO 2000	Aetna PPO 600	Aetna PPO 300	Aetna HDHP 2000	Aetna HDHP 5000
Regional Plan Names	Aetna PPO 2000	Aetna PPO 600	Aetna PPO 300	Aetna HDHP 2000	Aetna HDHP 5000
Plan Locations	Nationwide, except AK, CA, HI, ID, ME, MT, NE, SD, WY	Nationwide, except AK, CA, HI, ID, ME, MT, NE, SD, WY	Nationwide, except AK, CA, CT, DC, DE, HI, ID, MD, ME, MT, NE, NJ, NY, PA, SD, VA, WV, WY	Nationwide, except AK, CA, HI, ID, ME, MT, NE, SD, WY	Nationwide, except AK, CA, HI, ID, ME, MT, NE, SD, WY
Carrier Network	Managed Choice POS Open Access	Managed Choice POS Open Access	Managed Choice POS Open Access	Managed Choice POS Open Access	Managed Choice POS Open Access
Plan Features					
Calendar-Year Deductible (Deductible applies where specifically stated; doesn't apply to out-of-pocket expense maximum unless otherwise stated)	**In-Network:** $2,000/person; $4,000/family **Out-of-Network:** $4,000/person; $8,000/family	**In-Network:** $600/person; $1,200/family **Out-of-Network:** $1,200/person; $2,400/family	**In-Network:** $300/person; $600/family **Out-of-Network:** $600/person; $1,200/family	**In-Network:** $2,000/person; $4,000/family **Out-of-Network:** $4,000/person; $8,000/family	**In-Network:** $5,000/person; $10,000/family **Out-of-Network:** $7,000/person; $14,000/family
Calendar-Year Out-of-Pocket Expense Maximum (Excludes deductible unless otherwise stated)	**In-Network:** $8,000/person; $16,000/family **Out-of-Network:** $16,000/person; $32,000/family	**In-Network:** $1,200/person; $2,400/family **Out-of-Network:** $2,400/person; $4,800/family	**In-Network:** $600/person; $1,200/family **Out-of-Network:** $1,200/person; $2,400/family	**In-Network:** $4,000/person; $8,000/family **Out-of-Network:** $8,000/person; $16,000/family (includes deductible)	**In-Network:** $5,950/person; $11,900/family **Out-of-Network:** $10,000/person; $20,000/family (inclues deductible)
Lifetime Benefits Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Routine Health Maintenance					
Preventive Care Well-woman Well-baby Well-man (Includes annual Pap smear, routine mammogram, and annual prostate exam)	**In-Network:** 100% covered **Out-of-Network:** 50% covered after deductible	**In-Network:** 100% covered **Out-of-Network:** 70% covered after deductible	**In-Network:** 100% covered **Out-of-Network:** 70% covered after deductible	**In-Network:** 100% covered **Out-of-Network:** 70% covered after deductible	**In-Network:** 100% covered **Out-of-Network:** 60% covered after deductible
Vision Testing	Contact Aetna to confirm benefits	Contact Aetna to confirm benefits	Contact Aetna to confirm benefits	Contact Aetna to confirm benefits	Contact Aetna to confirm benefits
Hearing Testing	**In-Network:** 100% covered **Out-of-Network:** 50% covered after deductible	**In-Network:** 100% covered **Out-of-Network:** 70% covered after deductible	**In-Network:** 100% covered **Out-of-Network:** 70% covered after deductible	**In-Network:** 100% covered **Out-of-Network:** 70% covered after deductible (1 exam per 24 months)	**In-Network:** 100% covered **Out-of-Network:** 60% covered after deductible (1 exam per 24 months)
Physician & Hospital Services					
Physician Office Visit	**In-Network:** $35/visit Specialist: $50/visit **Out-of-Network:** 50% covered after deductible	**In-Network:** $25/visit Specialist: $40/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** $20/visit Specialist: $35/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible
Surgery Outpatient	**In-Network:** 60% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible
Hospital Inpatient Room and Board Surgery Anesthesia Drugs/Supplies	**In-Network:** 60% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible

Emergency Room (Copay waived if admitted)	**In-Network:** 60% covered after deductible **Out-of-Network:** 60% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 90% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 90% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 90% covered after deductible	**In-Network:** 80% covered after deductible **Out-of-Network:** 80% covered after deductible
Urgent Care	**In-Network:** 60% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible
Pregnancy & Maternity Care					
Prenatal Care and Inpatient	**In-Network:** $50 for initial visit, then 60% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** $40 for initial visit, then 90% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** $35 for initial visit, then 90% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible
Other Medical Services (Including Alternative Care)					
X-Ray and Lab – Outpatient (Applicable deductibles and copays apply)	**In-Network:** $50/visit **Out-of-Network:** 50% covered after deductible	**In-Network:** $40/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** $35/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible
MRIs (Complex Imaging) Outpatient	**In-Network:** $200/visit **Out-of-Network:** 50% covered after deductible	**In-Network:** $150/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** $150/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible
Chiropractic (Subject to visit limits)	**In-Network:** $50/visit **Out-of-Network:** 50% covered after deductible	**In-Network:** $40/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** $35/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible
Physical Therapy and Speech Therapy (Subject to visit limits)	**In-Network:** $50/visit **Out-of-Network:** 50% covered after deductible (Up to 60 visits/year combined)	**In-Network:** $40/visit **Out-of-Network:** 70% covered after deductible (Up to 60 visits/year combined)	**In-Network:** $35/visit **Out-of-Network:** 70% covered after deductible (Up to 60 visits/year combined)	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible (Up to 60 visits/year combined)	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible (Up to 60 visits/year combined)
Mental Health					
Mental Health – Inpatient	**In-Network:** 60% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible
Mental Health – Outpatient	**In-Network:** 100% covered **Out-of-Network:** 50% covered after deductible	**In-Network:** 100% covered **Out-of-Network:** 70% covered after deductible	**In-Network:** 100% covered **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible
Substance Abuse					

Substance Abuse – Inpatient	**In-Network:** 60% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible
Substance Abuse – Outpatient	**In-Network:** 100% covered **Out-of-Network:** 50% covered after deductible	**In-Network:** 100% covered **Out-of-Network:** 70% covered after deductible	**In-Network:** 100% covered **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible
Prescription Drugs					
Retail Pharmacy – In-Network (30-day supply if not specified) Dollar amounts listed are generic/formulary brand/ non-formulary brand	$10/$40/$60	$10/$30/$50	$10/$35/$50	$10/$35/$60 after deductible	$10/$35/$60 after deductible
Mail-Order Program – In-Network (90-day supply if not specified; out-of-network not covered) Dollar amounts listed are generic/formulary brand/ non-formulary brand	$20/$80/$120	$20/$60/$100	$20/$70/$100	$20/$70/$120 after deductible	$20/$70/$120 after deductible
Self-Injectables (Includes many specialty drugs. Call your carrier for more information.)	30% of prescription cost, up to $150/prescription, with prior authorization	30% of prescription cost, up to $150/prescription, with prior authorization	30% of prescription cost, up to $150/prescription, with prior authorization	50% of prescription cost, up to $250/prescription, with prior authorization, after deductible	50% of prescription cost, up to $250/prescription, with prior authorization, after deductible

Medical

	Aetna PPO 1500	Aetna PPO 1000	Aetna PPO 3000	Aetna Out-of-Area HDHP	Aetna Out-of-Area PPO
Regional Plan Names	Aetna PPO 1500	Aetna PPO 1000	Aetna PPO 3000	Aetna HDHP	Aetna PPO 1000
Plan Locations	Nationwide, except AK, CA, HI, ID, ME, MT, NE, SD, WY	Nationwide, except AK, CA, HI, ID, ME, MT, NE, SD, WY	Nationwide, except AK, CA, HI, ID, ME, MT, NE, SD, WY	Nationwide - Limited counties	Nationwide - Limited counties
Carrier Network	Managed Choice POS Open Access	Managed Choice POS Open Access	Managed Choice POS Open Access	Open Choice PPO	Open Choice PPO
Plan Features					
Calendar-Year Deductible (Deductible applies where specifically stated; doesn't apply to out-of-pocket expense maximum unless otherwise stated)	**In-Network:** $1,500/person; $4,500/family **Out-of-Network:** $3,000/person; $9,000/family	**In-Network:** $1,000/person; $3,000/family **Out-of-Network:** $3,000/person; $9,000/family	**In-Network:** $3,000/person; $9,000/family **Out-of-Network:** $7,500/person; $22,500/family	**In-Network:** $2,000/person; $4,000/family **Out-of-Network:** $4,000/person; $8,000/family	**In-Network:** $1,000/person; $3,000/family **Out-of-Network:** $3,000/person; $9,000/family
Calendar-Year Out-of-Pocket Expense Maximum (Excludes deductible unless otherwise stated)	**In-Network:** $1,500/person; $4,500/family **Out-of-Network:** $3,000/person; $9,000/family	**In-Network:** $3,000/person; $9,000/family **Out-of-Network:** $5,000/person; $15,000/family	**In-Network:** None **Out-of-Network:** $2,500/person; $7,500/family	**In-Network:** $4,000/person; $8,000/family **Out-of-Network:** $8,000/person; $16,000/family (includes deductible)	**In-Network:** $3,000/person; $9,000/family **Out-of-Network:** $5,000/person; $15,000/family
Lifetime Benefits Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Routine Health Maintenance					
Preventive Care Well-woman Well-baby Well-man (Includes annual Pap smear, routine mammogram, and annual prostate exam)	**In-Network:** 100% covered **Out-of-Network:** 50% covered after deductible	**In-Network:** 100% covered **Out-of-Network:** 60% covered after deductible	**In-Network:** 100% covered **Out-of-Network:** 70% covered after deductible	**In-Network:** 100% covered **Out-of-Network:** 70% covered after deductible	**In-Network:** 100% covered **Out-of-Network:** 60% covered after deductible
Vision Testing	Contact Aetna to confirm benefits	Contact Aetna to confirm benefits	Contact Aetna to confirm benefits	Contact Aetna to confirm benefits	Contact Aetna to confirm benefits
Hearing Testing	**In-Network:** 100% covered **Out-of-Network:** 50% covered after deductible (1 exam per 24 months)	**In-Network:** 100% covered **Out-of-Network:** 60% covered after deductible (1 exam per 24 months)	**In-Network:** 100% covered **Out-of-Network:** 70% covered after deductible (1 exam per 24 months)	**In-Network:** 100% covered **Out-of-Network:** 70% covered after deductible (1 exam per 24 months)	**In-Network:** 100% covered **Out-of-Network:** 60% covered after deductible (1 exam per 24 months)
Physician & Hospital Services					
Physician Office Visit	**In-Network:** $35/visit Specialist: $50/visit **Out-of-Network:** 50% covered after deductible	**In-Network:** $25/visit Specialist: $50/visit **Out-of-Network:** 60% covered after deductible	**In-Network:** $30/visit Specialist: $60/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** $25/visit Specialist: $50/visit **Out-of-Network:** 60% covered after deductible
Surgery Outpatient	**In-Network:** 70% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible	**In-Network:** 100% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible
Hospital Inpatient Room and Board Surgery Anesthesia Drugs/Supplies	**In-Network:** 70% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible	**In-Network:** 100% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible

Emergency Room (Copay waived if admitted)	**In-Network:** $250/visit **Out-of-Network:** $250/visit	**In-Network:** $250/visit **Out-of-Network:** $250/visit	**In-Network:** $250/visit **Out-of-Network:** $250/visit	**In-Network:** 90% covered after deductible **Out-of-Network:** 90% covered after deductible	**In-Network:** $250/visit **Out-of-Network:** $250/visit
Urgent Care	**In-Network:** $75/visit **Out-of-Network:** 50% covered after deductible	**In-Network:** $75/visit **Out-of-Network:** 60% covered after deductible	**In-Network:** $75/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** $75/visit **Out-of-Network:** 60% covered after deductible
Pregnancy & Maternity Care					
Prenatal Care and Inpatient	**In-Network:** $50 for initial visit, then 70% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** $50 for initial visit, then 80% covered after deductible **Out-of-Network:** 60% covered after deductible	**In-Network:** $50 for initial visit, then 100% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** $50 for initial visit, then 80% covered after deductible **Out-of-Network:** 60% covered after deductible
Other Medical Services (Including Alternative Care)					
X-Ray and Lab – Outpatient (Applicable deductibles and copays apply)	**In-Network:** 70% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible	**In-Network:** 100% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible
MRIs (Complex Imaging) Outpatient	**In-Network:** 70% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible	**In-Network:** 100% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible
Chiropractic (Subject to visit limits)	**In-Network:** $50/visit **Out-of-Network:** 50% covered after deductible	**In-Network:** $50/visit **Out-of-Network:** 60% covered after deductible	**In-Network:** $60/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** $50/visit **Out-of-Network:** 60% covered after deductible
Physical Therapy and Speech Therapy (Subject to visit limits)	**In-Network:** 70% covered after deductible **Out-of-Network:** 50% covered after deductible (Up to 60 visits/year combined)	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible (Up to 60 visits/year combined)	**In-Network:** 100% covered after deductible **Out-of-Network:** 70% covered after deductible (Up to 60 visits/year combined)	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible (Up to 60 visits/year combined)	**In-Network:** $50/visit **Out-of-Network:** 60% covered after deductible (Up to 60 visits/year combined)
Mental Health					
Mental Health – Inpatient	**In-Network:** 70% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible	**In-Network:** 100% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible
Mental Health – Outpatient	**In-Network:** $50/visit **Out-of-Network:** 50% covered after deductible	**In-Network:** $50/visit **Out-of-Network:** 60% covered after deductible	**In-Network:** $60/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** $50/visit **Out-of-Network:** 60% covered after deductible
Substance Abuse					

Substance Abuse – Inpatient	**In-Network:** 70% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible	**In-Network:** 100% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible
Substance Abuse – Outpatient	**In-Network:** $50/visit **Out-of-Network:** 50% covered after deductible	**In-Network:** $50/visit **Out-of-Network:** 60% covered after deductible	**In-Network:** $60/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** 100% covered **Out-of-Network:** 70% covered after deductible	**In-Network:** $50/visit **Out-of-Network:** 60% covered after deductible
Prescription Drugs					
Retail Pharmacy – In-Network (30-day supply if not specified) Dollar amounts listed are generic/formulary brand/ non-formulary brand	$10/$35/$60	$10/$35/$60	$10/$35/$60	$10/$35/$60 after deductible	$10/$35/$60
Mail-Order Program – In-Network (90-day supply if not specified; out-of-network not covered) Dollar amounts listed are generic/formulary brand/ non-formulary brand	$20/$70/$120	$20/$70/$120	$20/$70/$120	$20/$70/$120 after deductible	$20/$70/$120
Self-Injectables (Includes many specialty drugs. Call your carrier for more information.)	50% of prescription cost, up to $250/prescription, with prior authorization	50% of prescription cost, up to $250/prescription, with prior authorization	50% of prescription cost, up to $250/prescription, with prior authorization	50% of prescription cost, up to $250/prescription, with prior authorization, after deductible	50% of prescription cost, up to $250/prescription, with prior authorization

Medical

	Blue Shield PPO 1500	Blue Shield HDHP 2500	Blue Shield PPO 700	Blue Shield PPO 500	Blue Shield PPO 250
Regional Plan Names	Blue Shield PPO 1500	Blue Shield HDHP 2500	Blue Shield PPO 700	Blue Shield PPO 500	Blue Shield PPO 250
Plan Locations	CA	CA	CA	CA	CA
Carrier Network	Blue Shield of California PPO	Blue Shield of California PPO	Blue Shield of California PPO	Blue Shield of California PPO	Blue Shield of California PPO
Plan Features					
Calendar-Year Deductible (Deductible applies where specifically stated; doesn't apply to out-of-pocket expense maximum unless otherwise stated)	**In-Network:** $1,500/person; $3,000/family **Out-of-Network:** $1,500/person; $3,000/family	**In-Network:** $2,500/person; $5,000/family **Out-of-Network:** $2,500/person; $5,000/family	**In-Network:** $700/person; $1,400/family **Out-of-Network:** $700/person; $1,400/family	**In-Network:** $500/person; $1,000/family **Out-of-Network:** $500/person; $1,000/family	**In-Network:** $250/person; $500/family **Out-of-Network:** $250/person; $500/family
Calendar-Year Out-of-Pocket Expense Maximum (Excludes deductible unless otherwise stated)	**In-Network:** $4,000/person; $8,000/family **Out-of-Network:** $8,000person; $16,000/family	**In-Network:** $5,000/person; $10,000/family **Out-of-Network:** $5,000/person; $10,000/family (Includes deductible)	**In-Network:** $3,300/person; $6,600/family **Out-of-Network:** $6,600person; $13,200/family	**In-Network:** $3,000/person; $6,000/family **Out-of-Network:** $6,000/person; $12,000family	**In-Network:** $2,250/person; $4,500/family **Out-of-Network:** $4,500/person; $9,000/family
Lifetime Benefits Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Routine Health Maintenance					
Preventive Care Well-woman Well-baby Well-man (Includes annual Pap smear, routine mammogram, and annual prostate exam)	**In-Network:** 100% covered **Out-of-Network:** 50% covered after deductible	**In-Network:** 100% covered **Out-of-Network:** 70% covered after deductible	**In-Network:** 100% covered **Out-of-Network:** 60% covered after deductible	**In-Network:** 100% covered **Out-of-Network:** 70% covered after deductible	**In-Network:** 100% covered **Out-of-Network:** 70% covered after deductible
Vision Testing	Covered under preventive care with applicable copay/visit	Covered under preventive care with applicable coinsurance	Covered under preventive care with applicable copay/visit	Covered under preventive care with applicable copay/visit	Covered under preventive care with applicable copay/visit
Hearing Testing	Covered under preventive care with applicable copay/visit	Covered under preventive care with applicable coinsurance	Covered under preventive care with applicable copay/visit	Covered under preventive care with applicable copay/visit	Covered under preventive care with applicable copay/visit
Physician & Hospital Services					
Physician Office Visit	**In-Network:** $35/visit Specialist: $45/visit **Out-of-Network:** 50% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** $30/visit Specialist: $45/visit **Out-of-Network:** 60% covered after deductible	**In-Network:** $25/visit Specialist: $40/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** $20/visit Specialist: $35/visit **Out-of-Network:** 70% covered after deductible
Surgery Outpatient	**In-Network:** 70% covered after deductible **Out-of-Network:** 50% covered after deductible, up to $350/day	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible, up to $350/day	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible, up to $350/day	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible, up to $350/day	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible, up to $350/day
Hospital Inpatient Room and Board Surgery Anesthesia Drugs/Supplies	**In-Network:** 70% covered after deductible **Out-of-Network:** 50% covered after deductible, up to $1,500/day	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible, up to $1,500/day	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible, up to $1,500/day	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible, up to $1,500/day	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible, up to $1,500/day

Emergency Room (Copay waived if admitted)	**In-Network:** 70% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 90% covered after deductible	**In-Network:** 80% covered after deductible **Out-of-Network:** 80% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 90% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 90% covered after deductible
Urgent Care	Determined by place of service – contact Blue Shield for details	Determined by place of service – contact Blue Shield for details	Determined by place of service – contact Blue Shield for details	Determined by place of service – contact Blue Shield for details	Determined by place of service – contact Blue Shield for details
Pregnancy & Maternity Care					
Prenatal Care and Inpatient	**In-Network:** 70% covered after deductible **Out-of-Network:** 50% covered after deductible, up to $1,500/day	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible, up to $1,500/day	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible, up to $1,500/day	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible, up to $1,500/day	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible, up to $1,500/day
Other Medical Services (Including Alternative Care)					
X-Ray and Lab – Outpatient (Applicable deductibles and copays apply)	**In-Network:** $35/visit **Out-of-Network:** 50% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** $30/visit **Out-of-Network:** 60% covered after deductible	**In-Network:** $25/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** $20/visit **Out-of-Network:** 70% covered after deductible
MRIs (Complex Imaging) Outpatient	**In-Network:** 70% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible
Chiropractic (Subject to visit limits)	**In-Network:** $25/visit **Out-of-Network:** 50% covered after deductible (Up to 20 visits/year)	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** $25/visit **Out-of-Network:** 60% covered after deductible (Up to 20 visits/year)	**In-Network:** $25/visit **Out-of-Network:** 70% covered after deductible (Up to 20 visits/year)	**In-Network:** $25/visit **Out-of-Network:** 70% covered after deductible (Up to 20 visits/year)
Physical Therapy and Speech Therapy (Subject to visit limits)	**In-Network:** Physical therapy: $35/visit Speech therapy: $20/visit **Out-of-Network:** 50% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** Physical therapy: $45/visit Speech therapy: $20/visit **Out-of-Network:** 60% covered after deductible	**In-Network:** Physical therapy: $40/visit Speech therapy: $20/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** Physical therapy: $35/visit Speech therapy: $20/visit **Out-of-Network:** 70% covered after deductible
Mental Health					
Mental Health – Inpatient	**In-Network:** 70% covered after deductible **Out-of-Network:** 50% covered after deductible, up to $1,500/day	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible, up to $1,500/day	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible, up to $1,500/day	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible, up to $1,500/day	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible, up to $1,500/day
Mental Health – Outpatient	**In-Network:** $35/visit **Out-of-Network:** 50% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** $30/visit **Out-of-Network:** 60% covered after deductible	**In-Network:** $25/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** $20/visit **Out-of-Network:** 70% covered after deductible
Substance Abuse					

Substance Abuse – Inpatient	**In-Network:** 70% covered after deductible **Out-of-Network:** 50% covered after deductible, up to $1,500/day	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible, up to $1,500/day	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible, up to $1,500/day	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible, up to $1,500/day	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible, up to $1,500/day
Substance Abuse – Outpatient	**In-Network:** $35 – $45/visit **Out-of-Network:** 50% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** $30/visit **Out-of-Network:** 60% covered after deductible	**In-Network:** $25/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** $20/visit **Out-of-Network:** 70% covered after deductible
Prescription Drugs					
Retail Pharmacy – In-Network (30-day supply if not specified) Dollar amounts listed are generic/formulary brand/ non-formulary brand	$10/$35/$50	$10/$35/$55 after deductible	$10/$35/$50	$10/$30/$50	$10/$35/$50
Mail-Order Program – In-Network (90-day supply if not specified; out-of-network not covered) Dollar amounts listed are generic/formulary brand/ non-formulary brand	$20/$70/$100	$20/$70/$110 after deductible	$20/$70/$100	$20/$60/$100	$20/$70/$100
Self-Injectables (Includes many specialty drugs. Call your carrier for more information.)	30% of prescription cost, up to $150/prescription, with prior authorization	30% of prescription cost, up to $150/prescription, with prior authorization, after deductible	30% of prescription cost, up to $150/prescription, with prior authorization	30% of prescription cost, up to $150/prescription, with prior authorization	30% of prescription cost, up to $150/prescription, with prior authorization

Medical

	BCBS PPO 2000	BCBS PPO 1500	BCBS PPO 1000	BCBS PPO 500	BCBS HDHP 2000
Regional Plan Names	BCBS PPO 2000	BCBS PPO 1500	BCBS PPO 1000	BCBS PPO 500	BCBS HDHP 2000
Plan Locations	FL; nationally with the Blue Card for employers based in FL	FL; nationally with the Blue Card for employers based in FL	FL; nationally with the Blue Card for employers based in FL	FL; nationally with the Blue Card for employers based in FL	FL; nationally with the Blue Card for employers based in FL
Carrier Network	FL: Blue Options; nationally through Blue Card	FL: Blue Options; nationally through Blue Card	FL: Blue Options; nationally through Blue Card	FL: Blue Options; nationally through Blue Card	FL: Blue Options; nationally through Blue Card
Plan Features					
Calendar-Year Deductible (Deductible applies where specifically stated; doesn't apply to out-of-pocket expense maximum unless otherwise stated)	**In-Network:** $2,000/person; $4,000/family **Out-of-Network:** $4,000/person; $8,000/family	**In-Network:** $1,500/person; $3,000/family **Out-of-Network:** $3,000/person; $6,000/family	**In-Network:** $1,000/person; $2,000/family **Out-of-Network:** $2,000/person; $4,000/family	**In-Network:** $500/person; $1,000/family **Out-of-Network:** $1,200/person; $2,400/family	**In-Network:** $2,000/person; $5,000/family **Out-of-Network:** $5,000/person; $10,000/family
Calendar-Year Out-of-Pocket Expense Maximum (Excludes deductible unless otherwise stated)	**In-Network:** $6,000/person; $12,000/family **Out-of-Network:** $16,000/person; $32,000/family (Includes deductible)	**In-Network:** $4,500/person; $9,000/family **Out-of-Network:** $6,000/person; $12,000/family (Includes deductible)	**In-Network:** $3,000/person; $6,000/family **Out-of-Network:** $4,000/person; $8,000/family (Includes deductible)	**In-Network:** $1,500/person; $2,000/family **Out-of-Network:** $3,000/person; $4,000/family (Includes deductible)	**In-Network:** $3,000/person; $6,000/family **Out-of-Network:** $10,000/person; $20,000/family (Includes deductible)
Lifetime Benefits Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Routine Health Maintenance					
Preventive Care Well-woman Well-baby Well-man (Includes annual Pap smear, routine mammogram, and annual prostate exam)	**In-Network:** 100% covered **Out-of-Network:** 50% covered	**In-Network:** 100% covered **Out-of-Network:** 50% covered	**In-Network:** 100% covered **Out-of-Network:** 60% covered	**In-Network:** 100% covered **Out-of-Network:** 70% covered	**In-Network:** 100% covered **Out-of-Network:** 60% covered after deductible
Vision Testing	Not covered	Not covered	Not covered	Not covered	Not covered
Hearing Testing	Not covered	Not covered	Discount only	Discount only	Discount only
Physician & Hospital Services					
Physician Office Visit	**In-Network:** $35/visit Specialist: $50/visit **Out-of-Network:** 50% covered after deductible	**In-Network:** $35/visit Specialist: $50/visit **Out-of-Network:** 50% covered after deductible	**In-Network:** $30/visit Specialist: $45/visit **Out-of-Network:** 60% covered after deductible	**In-Network:** $25/visit Specialist: $40/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 60% covered after deductible
Surgery Outpatient	**In-Network:** Option 1: $200 copay Option 2: $300 copay **Out-of-Network:** 50% covered after deductible	**In-Network:** 70% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** Option 1: $200 copay Option 2: $300 copay **Out-of-Network:** 60% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 60% covered after deductible
Hospital Inpatient Room and Board Surgery Anesthesia Drugs/Supplies	**In-Network:** 70% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 70% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 60% covered after deductible
Emergency Room (Copay waived if admitted)	**In-Network:** 70% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 70% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 80% covered after deductible **Out-of-Network:** 80% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 90% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 90% covered after deductible

Urgent Care	**In-Network:** 70% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 70% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 60% covered after deductible
Pregnancy & Maternity Care					
Prenatal Care and Inpatient	**In-Network:** Initial visit: $50 Inpatient: 70% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** Initial visit: $50 Inpatient: 70% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** Initial visit: $45 Inpatient: 80% covered after deductible **Out-of-Network:** 60% covered after deductible	**In-Network:** Initial visit: $40 Inpatient: 90% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 60% covered after deductible
Other Medical Services (Including Alternative Care)					
X-Ray and Lab – Outpatient (Applicable deductibles and copays apply)	**In-Network:** Lab: $0/visit X-ray: $50/visit **Out-of-Network:** 50% covered after deductible	**In-Network:** Lab: $0/visit X-ray: $50/visit **Out-of-Network:** 50% covered after deductible	**In-Network:** Lab: $0/visit X-ray: $50/visit **Out-of-Network:** 60% covered after deductible	**In-Network:** Lab: $0/visit X-ray: $50/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 60% covered after deductible
MRIs (Complex Imaging) Outpatient	**In-Network:** $200/visit **Out-of-Network:** 50% covered after deductible	**In-Network:** $200/visit **Out-of-Network:** 50% covered after deductible	**In-Network:** $200/visit **Out-of-Network:** 60% covered after deductible	**In-Network:** $125/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 60% covered after deductible
Chiropractic (Subject to visit limits)	**In-Network:** $50/visit **Out-of-Network:** 50% covered after deductible (Up to combined $2,500 outpatient therapy maximum; up to 26 spinal manipulations)	**In-Network:** $50/visit **Out-of-Network:** 50% covered after deductible (Up to combined $2,500 outpatient therapy maximum; up to 26 spinal manipulations)	**In-Network:** $45/visit **Out-of-Network:** 60% covered after deductible (Up to combined $2,500 outpatient therapy maximum; up to 26 spinal manipulations)	**In-Network:** $40/visit **Out-of-Network:** 70% covered after deductible (Up to combined $2,500 outpatient therapy maximum; up to 26 spinal manipulations)	**In-Network:** 90% covered after deductible **Out-of-Network:** 60% covered after deductible (Up to combined $2,500 outpatient therapy maximum; up to 26 spinal manipulations)
Physical Therapy and Speech Therapy (Subject to visit limits)	**In-Network:** $50/visit **Out-of-Network:** 50% covered after deductible (Up to combined $2,500 outpatient therapy maximum)	**In-Network:** $50/visit **Out-of-Network:** 50% covered after deductible (Up to combined $2,500 outpatient therapy maximum)	**In-Network:** $45/visit **Out-of-Network:** 60% covered after deductible (Up to combined $2,500 outpatient therapy maximum)	**In-Network:** $40/visit **Out-of-Network:** 70% covered after deductible (Up to combined $2,500 outpatient therapy maximum)	**In-Network:** 90% covered after deductible **Out-of-Network:** 60% covered after deductible (Up to combined $2,500 outpatient therapy maximum)
Mental Health					
Mental Health – Inpatient	**In-Network:** 70% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 70% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 60% covered after deductible
Mental Health – Outpatient	**In-Network:** $50/visit **Out-of-Network:** 50% covered	**In-Network:** $50/visit **Out-of-Network:** 50% covered	**In-Network:** $45/visit **Out-of-Network:** 60% covered	**In-Network:** $40/visit **Out-of-Network:** 70% covered	**In-Network:** 90% covered after deductible **Out-of-Network:** 60% covered after deductible
Substance Abuse					

Substance Abuse – Inpatient	**In-Network:** 70% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 70% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 60% covered after deductible
Substance Abuse – Outpatient	**In-Network:** $50/visit **Out-of-Network:** 50% covered	**In-Network:** $50/visit **Out-of-Network:** 50% covered	**In-Network:** $45/visit **Out-of-Network:** 60% covered	**In-Network:** $40/visit **Out-of-Network:** 70% covered	**In-Network:** 90% covered after deductible **Out-of-Network:** 60% covered after deductible
Prescription Drugs					
Retail Pharmacy – In-Network (30-day supply if not specified) Dollar amounts listed are generic/formulary brand/ non-formulary brand	$10/$40/$60	$10/$40/$60	$10/$40/$60	$10/$35/$50	$10/$40/$60 after deductible; 100% after deductible and out-of-pocket maximum
Mail-Order Program – In-Network (90-day supply if not specified; out-of-network not covered) Dollar amounts listed are generic/formulary brand/ non-formulary brand	$20/$80/$120	$20/$80/$120	$20/$80/$120	$20/$70/$100	80% covered after deductible; 100% after deductible and out-of-pocket maximum
Self-Injectables (Includes many specialty drugs. Call your carrier for more information.)	30% of prescription cost, up to $150	30% of prescription cost, up to $150	30% of prescription cost, up to $150	30% of prescription cost, up to $150	30% of prescription cost, up to $150, after deductible; 100% after deductible and out-of-pocket maximum

Medical

	BCBS HDHP 5000	HMSA PPO	Tufts PPO 1000	Tufts PPO 500	Triple S PPO
Regional Plan Names	BCBS HDHP 5000	HMSA PPO	Tufts PPO 1000	Tufts PPO 500	Triple S PPO 100 PR
Plan Locations	FL; nationally with the Blue Card for employers based in FL	HI	MA, NH, and RI	MA, NH, and RI	Puerto Rico
Carrier Network	FL: Blue Options; nationally through Blue Card	Plan Name: Preferred Provider Plan	Tufts Standard PPO Network	Tufts Standard PPO Network	Triple S Network
Plan Features					
Calendar-Year Deductible (Deductible applies where specifically stated; doesn't apply to out-of-pocket expense maximum unless otherwise stated)	**In-Network:** $5,000/person; $10,000/family **Out-of-Network:** $10,000/person; $20,000/family	**In-Network:** None **Out-of-Network:** $100/person; $300/family	**In-Network:** $1,000/person; $2,000/family **Out-of-Network:** $1,000/person; $2,000/family	**In-Network:** $500/person; $1,000/family **Out-of-Network:** $500/person; $1,000/family	None
Calendar-Year Out-of-Pocket Expense Maximum (Excludes deductible unless otherwise stated)	**In-Network:** $5,000/person; $10,000/family **Out-of-Network:** $10,000/person; $20,000/family (Includes deductible)	$2,500/person; $7,500/family	**In-Network:** $2,000/person; $4,000/family **Out-of-Network:** $2,000/person; $4,000/family (includes deductible and coinsurance)	**In-Network:** $1,500/person; $3,000/family **Out-of-Network:** $1,500/person; $3,000/family (includes deductible and coinsurance)	None
Lifetime Benefits Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Routine Health Maintenance					
Preventive Care Well-woman Well-baby Well-man (Includes annual Pap smear, routine mammogram, and annual prostate exam)	**In-Network:** 100% covered **Out-of-Network:** 80% covered after deductible	**In-Network:** 100% covered **Prostate specific antigen screening:** 80% covered **Out-of-Network:** 70% covered Contact carrier or refer to your EOC for more details	**In-Network:** 100% covered **Out-of-Network:** 80% covered after deductible	**In-Network:** 100% covered **Out-of-Network:** 80% covered after deductible	$5/visit Specialist/subspecialist: $10/visit
Vision Testing	Not covered	Not covered	**In-Network** (through EyeMed Vision care provider): $30/visit* **Out-of-Network:** 80% covered after deductible (1 visit every 24 months) *Some services performed during a routine office visit may be subject to the deductible	**In-Network** (through EyeMed Vision care provider): $20/visit* **Out-of-Network:** 80% covered after deductible (1 visit every 24 months) *Some services performed during a routine office visit may be subject to the deductible	$10/visit
Hearing Testing	Discount only	Hearing aid evaluation: **In-Network:** 80% covered **Out-of-Network:** 70% covered after deductible	Covered at PCP copay	Covered at PCP copay	75% covered (1 exam/policy year)
Physician & Hospital Services					
Physician Office Visit	**In-Network:** 100% covered after deductible **Out-of-Network:** 80% covered after deductible	**In-Network:** $12/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** $30/visit **Out-of-Network:** 80% covered after deductible	**In-Network:** $20/visit **Out-of-Network:** 80% covered after deductible	$5/visit Specialist/subspecialist: $10/visit

Surgery Outpatient	**In-Network:** 100% covered after deductible **Out-of-Network:** 80% covered after deductible	**In-Network:** 90% covered (cutting); 80% covered (non-cutting) **Out-of-Network:** 70% covered after deductible	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	100% covered after deductible
Hospital Inpatient Room and Board Surgery Anesthesia Drugs/Supplies	**In-Network:** 100% covered after deductible **Out-of-Network:** 80% covered after deductible	**In-Network:** 90% covered **Out-of-Network:** 70% covered after deductible	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	100% covered after $50/admission
Emergency Room (Copay waived if admitted)	**In-Network:** 100% covered after deductible **Out-of-Network:** 100% covered after deductible	$75/visit	**In-Network:** $100/visit **Out-of-Network:** $100/visit	**In-Network:** $100/visit **Out-of-Network:** $100/visit	$50/visit; $25/visit if recommended by Teleconsulta
Urgent Care	**In-Network:** 100% covered after deductible **Out-of-Network:** 80% covered after deductible	Regular plan benefits for office visit and/or hospital inpatient	Refer to specific Evidence of Coverage for benefit	Refer to specific Evidence of Coverage for benefit	During office hours: $5/visit Specialist/subspecialist: $10/visit After hours: $20/visit
Pregnancy & Maternity Care					
Prenatal Care and Inpatient	**In-Network:** 100% covered after deductible **Out-of-Network:** 80% covered after deductible	**In-Network:** **Inpatient:** 90% covered **Outpatient:** $12/visit **Out-of-Network:** 70% covered after deductible	Inpatient: **In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible Outpatient: **In-Network:** $30/visit* for up to 10 visits, then 100% covered **Out-of-Network:** 80% covered after deductible *Some services performed during a routine office visit may be subject to the deductible	Inpatient: **In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible Outpatient: **In-Network:** $20/visit* for up to 10 visits, then 100% covered **Out-of-Network:** 80% covered after deductible *Some services performed during a routine office visit may be subject to the deductible	Visits: $10 Inpatient: 100% after $50/admission
Other Medical Services (Including Alternative Care)					
X-Ray and Lab – Outpatient (Applicable deductibles and copays apply)	**In-Network:** 100% covered after deductible **Out-of-Network:** 80% covered after deductible	**In-Network:** Inpatient: 90% covered Outpatient: 80% covered **Out-of-Network:** 70% covered after deductible	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	75% covered
MRIs (Complex Imaging) Outpatient	**In-Network:** 100% covered after deductible **Out-of-Network:** 80% covered after deductible	**In-Network:** 80% covered **Out-of-Network:** 70% covered after deductible	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	75% covered (1 per anatomic region/policy year)

Chiropractic (Subject to visit limits)	**In-Network:** 100% covered after deductible **Out-of-Network:** 80% covered after deductible (Up to combined $2,500 outpatient therapy maximum; up to 26 spinal manipulations)	Not covered	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible (Up to 12 visits/year; combined in- and out-of-network)	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible (Up to 12 visits/year; combined in- and out-of-network)	$10/visit $7/manipulation (Up to 20 visits/year; combined with therapy benefits)
Physical Therapy and Speech Therapy (Subject to visit limits)	**In-Network:** 100% covered after deductible **Out-of-Network:** 80% covered after deductible (Up to combined $2,500 outpatient therapy maximum)	**In-Network:** Inpatient: 90% covered Outpatient: 80% covered **Out-of-Network:** 70% covered after deductible	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible (Physical therapy: 30 visits/year; speech therapy: no limit)	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible (Physical therapy: 30 visits/year; speech therapy: no limit)	$7/visit (Up to 20 visits/year; combined with chiropractic benefits)
Mental Health					
Mental Health – Inpatient	**In-Network:** 100% covered after deductible **Out-of-Network:** 80% covered after deductible	**In-Network:** 90% covered **Out-of-Network:** 70% covered after deductible	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	100% after $50/admission
Mental Health – Outpatient	**In-Network:** 100% covered after deductible **Out-of-Network:** 80% covered after deductible	**In-Network:** $12/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** $30/visit* **Out-of-Network:** 80% covered after deductible *Some services performed during a routine office visit may be subject to the deductible	**In-Network:** $20/visit* **Out-of-Network:** 80% covered after deductible *Some services performed during a routine office visit may be subject to the deductible	Individual therapy: $10/visit Group therapy: $5/visit (Group therapy: up to 5 visits/policy year)
Substance Abuse					
Substance Abuse – Inpatient	**In-Network:** 100% covered after deductible **Out-of-Network:** 80% covered after deductible	**In-Network:** 90% covered **Out-of-Network:** 70% covered after deductible	**In-Network:** 80% covered after deductible **Out-of-Network:** 60% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	100% after $50/admission (Maximum 30 days/policy year)
Substance Abuse – Outpatient	**In-Network:** 100% covered after deductible **Out-of-Network:** 80% covered after deductible	**In-Network:** $12/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** $30/visit* **Out-of-Network:** 80% covered after deductible *Some services performed during a routine office visit may be subject to the deductible	**In-Network:** $20/visit* **Out-of-Network:** 80% covered after deductible *Some services performed during a routine office visit may be subject to the deductible	Individual therapy: $10/visit Group therapy: $5/visit (Group therapy: up to 5 visits/policy year)
Prescription Drugs					
Retail Pharmacy – In-Network (30-day supply if not specified) Dollar amounts listed are generic/formulary brand/ non-formulary brand	100% after deductible	$7/$30/$65	$15/$30/$50	$15/$30/$50	$5/$15/20% of prescription cost; $20 minimum (Up to a 15-day supply for acute prescriptions)
Mail-Order Program – In-Network (90-day supply if not specified; out-of-network not covered) Dollar amounts listed are generic/formulary brand/ non-formulary brand	100% after deductible	$11/$65/$170	$30/$60/$100	$30/$60/$100	$10/$30/20% of prescription cost; $40 minimum
Self-Injectables (Includes many specialty drugs. Call your carrier for more information.)	100% after deductible	Coverage varies according to the drug – contact HMSA for more details	Cost varies depending on injectable – refer to specific Evidence of Coverage for benefit	Cost varies depending on injectable – refer to specific Evidence of Coverage for benefit	20% of prescription cost, up to $100/prescription with prior authorization

Medical

	Aetna Indemnity	Aetna POS East	Aetna HRA 2500	Aetna AZ HMO 30	Aetna AZ HMO 20
Regional Plan Names	Aetna Indemnity	Northeast and Mid-Atlantic	Aetna HRA 2500	Aetna AZ HMO 30	Aetna AZ HMO 20
Plan Locations	Nationwide - Limited counties	CT, DC, DE, MD, NY, NJ, PA, VA, WV	Nationwide, except AK, CA, HI, ID, ME, MT, NE, SD, WY	AZ	AZ
Carrier Network	Not applicable	Managed Choice POS Open Access	Managed Choice POS Open Access	HMO Open Access	HMO Open Access
Plan Features					
Calendar-Year Deductible (Deductible applies where specifically stated; doesn't apply to out-of-pocket expense maximum unless otherwise stated)	$300/person; $900/family	**In-Network:** None **Out-of-Network:** $300/person; $600/family	**In-Network:** $2,500/person; $5,000/family **Out-of-Network:** $4,000/person; $12,000/family	$1,000/person; $2,000/family	None
Calendar-Year Out-of-Pocket Expense Maximum (Excludes deductible unless otherwise stated)	$2,000/person; $6,000/family	**In-Network:** $1,000/person; $2,000/family **Out-of-Network:** $3,000/person; $6,000/family	**In-Network:** $1,000/person; $2,000/family **Out-of-Network:** $1,000/person; $3,000/family	$3,000/person; $6,000/family (Includes deductible)	$2,000/person; $4,000/family
Lifetime Benefits Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Routine Health Maintenance					
Preventive Care Well-woman Well-baby Well-man (Includes annual Pap smear, routine mammogram, and annual prostate exam)	100% covered	**In-Network:** 100% covered **Out-of-Network:** 70% covered after deductible	**In-Network:** 100% covered **Out-of-Network:** 70% covered after deductible	100% covered	100% covered
Vision Testing	Contact Aetna to confirm benefits	Contact Aetna to confirm benefits	Contact Aetna to confirm benefits	Not covered	Not covered
Hearing Testing	100% covered	**In-Network:** 100% covered **Out-of-Network:** 70% covered after deductible	**In-Network:** 100% covered **Out-of-Network:** 70% covered after deductible (1 exam per 24 months)	Subject to routine physical exam cost sharing Hearing Aid: Not covered	Subject to routine physical exam cost sharing Hearing Aid: Not covered
Physician & Hospital Services					
Physician Office Visit	80% covered after deductible	**In-Network:** $15/visit Specialist: $30/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	$30/visit Specialist: $45/visit	$20/visit Specialist: $35/visit
Surgery Outpatient	80% covered after deductible	**In-Network:** 90% covered **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	80% covered after deductible	100% after $250/visit
Hospital Inpatient Room and Board Surgery Anesthesia Drugs/Supplies	80% covered after deductible	**In-Network:** 100% covered after $250/confinement **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	80% covered after deductible	100% covered after $250/admission

Emergency Room (Copay waived if admitted)	80% covered after deductible	**In-Network:** $75/visit **Out-of-Network:** $75/visit	**In-Network:** 90% covered after deductible **Out-of-Network:** 90% covered after deductible	$150/visit	$100/visit
Urgent Care	80% covered after deductible	**In-Network:** $25/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	$75/visit	$50/visit
Pregnancy & Maternity Care					
Prenatal Care and Inpatient	80% covered after deductible	**In-Network:** $30 for initial visit, then $250 copay/confinement; delivery charges covered 90% **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	Visits: $45 for initial visit, then 100% covered Inpatient: 80% covered after deductible	Visits: $35 for initial visit, then 100% covered Inpatient: 100% covered after $250/admission
Other Medical Services (Including Alternative Care)					
X-Ray and Lab – Outpatient (Applicable deductibles and copays apply)	80% covered after deductible	**In-Network:** $30/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	Diagnostic X-ray: $45/visit Lab: 100% covered	Diagnostic X-ray: $35/visit Lab: 100% covered
MRIs (Complex Imaging) Outpatient	80% covered after deductible	**In-Network:** $30/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	$150/visit	$150/visit
Chiropractic (Subject to visit limits)	80% covered after deductible	**In-Network:** $30/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	$45/visit (Up to 20 visits/calendar year)	$35/visit (Up to 20 visits/calendar year)
Physical Therapy and Speech Therapy (Subject to visit limits)	80% covered after deductible	**In-Network:** $30/visit **Out-of-Network:** 70% covered after deductible (Up to 60 visits/year)	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	$45/visit (Up to a 60-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)	$35/visit (Up to a 60-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)
Mental Health					
Mental Health – Inpatient	80% covered after deductible	**In-Network:** 90% covered **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	80% covered after deductible	100% covered after $250/admission
Mental Health – Outpatient	80% covered after deductible	**In-Network:** 100% covered **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	$45/visit	$35/visit
Substance Abuse					

Substance Abuse – Inpatient	80% covered after deductible	**In-Network:** 90% covered **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	80% covered after deductible	100% covered after $250/admission
Substance Abuse – Outpatient	80% covered after deductible	**In-Network:** 100% covered **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible	$45/visit	$35/visit
Prescription Drugs					
Retail Pharmacy – In-Network (30-day supply if not specified) Dollar amounts listed are generic/formulary brand/ non-formulary brand	$10/$30/$50	$15/$25/$40	$10/$35/$60 after deductible	$10/$30/$60	$10/$30/$50
Mail-Order Program – In-Network (90-day supply if not specified; out-of-network not covered) Dollar amounts listed are generic/formulary brand/ non-formulary brand	$20/$60/$100	$30/$50/$80	$20/$70/$120 after deductible	$20/$60/$120	$20/$60/$100
Self-Injectables (Includes many specialty drugs. Call your carrier for more information.)	30% of prescription cost, up to $150/prescription, with prior authorization	30% of prescription cost, up to $150/prescription, with prior authorization	50% of prescription cost, up to $250/prescription, with prior authorization, after deductible	Third tier copay applies – refer to your COC for further details	Third tier copay applies – refer to your COC for further details

Medical

	Blue Shield HMO 30	Blue Shield HMO 20	Kaiser CA HMO 30	Kaiser CA HMO 20	Aetna CO HMO 30
Regional Plan Names	Blue Shield HMO 30	Blue Shield HMO 20	Kaiser CA HMO 30	Kaiser CA HMO 20	Aetna CO HMO 30
Plan Locations	CA	CA	CA	CA	CO
Carrier Network	Access+ HMO	Access+ HMO	Kaiser HMO	Kaiser HMO	HMO Open Access
Plan Features					
Calendar-Year Deductible (Deductible applies where specifically stated; doesn't apply to out-of-pocket expense maximum unless otherwise stated)	None	None	$1,000/person; $2,000/family	None	$1,000/person; $2,000/family
Calendar-Year Out-of-Pocket Expense Maximum (Excludes deductible unless otherwise stated)	$2,000/person; $4,000/family	$2,000/person; $4,000/family	$2,000/person; $4,000/family (includes deductible)	$1,500/person; $3,000/family	$3,000/person; $6,000/family (Includes deductible)
Lifetime Benefits Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Routine Health Maintenance					
Preventive Care Well-woman Well-baby Well-man (Includes annual Pap smear, routine mammogram, and annual prostate exam)	100% covered	100% covered	100% covered	100% covered	100% covered
Vision Testing	Covered under preventive care with applicable copay/visit	Covered under preventive care with applicable copay/visit	100% covered	100% covered preventive only	Not covered
Hearing Testing	Covered under preventive care with applicable copay/visit	Covered under preventive care with applicable copay/visit	100% covered	100% covered preventive only	Subject to routine physical exam cost sharing Hearing Aid: $45/visit (Up to age 18; initial and replacement aids not covered more frequently than every five years)
Physician & Hospital Services					
Physician Office Visit	PCP: $30/visit Specialist: $45/visit	PCP: $20/visit Specialist: $35/visit	$30/visit Specialist: $45/visit	$20/visit Specialist: $35/visit	$30/visit Specialist: $45/visit
Surgery Outpatient	Hospital: 100% covered after $300/surgery Ambulatory center: 100% covered after $150/surgery	Hospital: 100% covered after $150/surgery Ambulatory center: 100% covered after $100/surgery	80% covered after deductible	$35/procedure	80% covered after deductible
Hospital Inpatient Room and Board Surgery Anesthesia Drugs/Supplies	100% covered after $500/admission	100% covered after $350/admission	80% covered after deductible	100% covered after $250/admission	80% covered after deductible
Emergency Room (Copay waived if admitted)	$150/visit	$100/visit	80% covered after deductible	$100/visit	$150/visit
Urgent Care	Within service area: $30/visit Outside of service area: $50/visit	Within service area: $20/visit Outside of service area: $50/visit	$30/visit	$20/visit	$75/visit After hours PCP Visit: $35/visit
Pregnancy & Maternity Care					

Prenatal Care and Inpatient	Prenatal: 100% covered Inpatient: 100% covered after $500/admission	Prenatal: 100% covered Inpatient: 100% covered after $350/admission	Visits: 100% covered Inpatient: 80% covered after deductible	Visits: 100% covered Inpatient: 100% covered after $250/admission	Visits: $45 for initial visit, then 100% covered Inpatient: 80% covered after deductible
Other Medical Services (Including Alternative Care)					
X-Ray and Lab – Outpatient (Applicable deductibles and copays apply)	100% covered	100% covered	$10/encounter after deductible	100% covered	Diagnostic X-ray and Lab: $45/visit
MRIs (Complex Imaging) Outpatient	100% covered	100% covered	$50 per procedure after deductible	100% covered	$150/visit
Chiropractic (Subject to visit limits)	$45/visit (Up to 30 visits/year)	$35/visit (Up to 30 visits/year)	$15/visit (Up to 20 visits/calendar year)	$15/visit (Up to 20 visits/calendar year)	$45/visit (Up to 20 visits/calendar year)
Physical Therapy and Speech Therapy (Subject to visit limits)	$30/visit	$20/visit	$30/visit after deductible	$20/visit	$45/visit (Up to a 60-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)
Mental Health					
Mental Health – Inpatient	100% covered after $500/admission	100% covered after $350/admission	80% covered after deductible	100% covered after $250/admission	80% covered after deductible
Mental Health – Outpatient	$30/visit	$20/visit	Individual session: $30/visit Group session: $15/visit	Individual session: $20/visit Group session: $10/visit	$45/visit
Substance Abuse					
Substance Abuse – Inpatient	100% covered after $500/admission	100% covered after $350/admission	80% covered after deductible	100% covered after $250/admission	80% covered after deductible
Substance Abuse – Outpatient	$30/visit	$20/visit	Individual session: $30/visit Group session: $5/visit	Individual session: $20/visit Group session: $5/visit	$45/visit
Prescription Drugs					
Retail Pharmacy – In-Network (30-day supply if not specified) Dollar amounts listed are generic/formulary brand/ non-formulary brand	$10/$35/$50	$10/$35/$50	Up to 30-day supply: $10/$35/full retail 31- to 60-day supply: $20/$70/full retail 61- to 100-day supply: $30/$105/full retail	$10/$35/full retail	$10/$30/$60
Mail-Order Program – In-Network (90-day supply if not specified; out-of-network not covered) Dollar amounts listed are generic/formulary brand/ non-formulary brand	$20/$70/$100	$20/$70/$100	Up to a 30-day supply: $10/$35/full retail 31- to 100-day supply: $20/$70/full retail	$20/$70/full retail (Up to 100-day supply)	$20/$60/$120
Self-Injectables (Includes many specialty drugs. Call your carrier for more information.)	20% of prescription cost, up to $150/prescription, with prior authorization	20% of prescription cost, up to $150/prescription, with prior authorization	Coverage varies according to the drug – contact Kaiser for more details	Coverage varies according to the drug – contact Kaiser for more details	Third tier copay applies – refer to your COC for further details

Medical

	Aetna CO HMO 20	Kaiser CO HMO 30	Kaiser CO HMO 20	Aetna CT HMO 30	Aetna CT HMO 20
Regional Plan Names	Aetna CO HMO 20	Kaiser CO HMO 30	Kaiser CO HMO 20	Aetna CT HMO 30	Aetna CT HMO 20
Plan Locations	CO	CO	CO	CT	CT
Carrier Network	HMO Open Access	Kaiser HMO	Kaiser HMO	HMO Open Access	HMO Open Access
Plan Features					
Calendar-Year Deductible (Deductible applies where specifically stated; doesn't apply to out-of-pocket expense maximum unless otherwise stated)	None	$1,000/person; $2,000/family	None	$1,500/person; $3,000/family	None
Calendar-Year Out-of-Pocket Expense Maximum (Excludes deductible unless otherwise stated)	$2,000/person; $4,000/family	$2,000/person; $4,000/family	$2,000/person; $4,000/family	$3,000/person; $6,000/family (Includes deductible)	$2,000/person; $4,000/family
Lifetime Benefits Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Routine Health Maintenance					
Preventive Care Well-woman Well-baby Well-man (Includes annual Pap smear, routine mammogram, and annual prostate exam)	100% covered	100% covered	100% covered	100% covered	100% covered
Vision Testing	Not covered	$30/visit Specialist: $45/visit	$20/visit Specialist: $35/visit	Not covered	Not covered
Hearing Testing	Subject to routine physical exam cost sharing Hearing Aid: $35 (Up to age 18; initial and replacement aids not covered more frequently than every five years)	$30/visit	$20/visit	Subject to routine physical exam cost sharing Hearing Aid: Up to $1,000 within 24-month period, for those under 12 years of age	Subject to routine physical exam cost sharing Hearing Aid: Up to $1,000 within 24-month period, for those under 12 years of age
Physician & Hospital Services					
Physician Office Visit	$20/visit Specialist: $35/visit	$30/visit Specialist: $45/visit	$20/visit Specialist: $35/visit	$30/visit Specialist: $45/visit	$20/visit Specialist: $35/visit
Surgery Outpatient	100% covered after $250/visit	80% covered after deductible	$100/visit	100% covered after deductible and $400/viist	100% covered after $250/visit
Hospital Inpatient Room and Board Surgery Anesthesia Drugs/Supplies	100% covered after $250/admission	80% covered after deductible	100% covered after $250/admission	100% covered after deductible and $400/day for first 5 days	100% covered after $250/admission
Emergency Room (Copay waived if admitted)	$100/visit	$150/visit (Procedure performed in office may be 80% covered after deductible)	$100/visit	$150/visit	$100/visit
Urgent Care	$50/visit After hours PCP Visit: $25/visit	$75/visit	$50/visit	$75/visit	$50/visit
Pregnancy & Maternity Care					

Prenatal Care and Inpatient	Visits: $35 for initial visit, then 100% covered Inpatient: 100% covered after $250/admission	Visits: 100% covered Inpatient: 80% covered after deductible	Visits: 100% covered Inpatient: 100% after $250/admission	Visits: $45 for initial visit, then 100% covered Inpatient: 100% covered after deductible and $400/day for first 5 days	Visits: $35 for initial visit, then 100% covered Inpatient: 100% covered after $250/admission
Other Medical Services (Including Alternative Care)					
X-Ray and Lab – Outpatient (Applicable deductibles and copays apply)	Diagnostic X-ray: $35/visit	80% covered after deductible	Diagnostic: 100% covered Therapeutic: $35/visit	Diagnostic X-ray: $45/visit Lab: 100% covered	Diagnostic X-ray: $35/visit Lab: 100% covered
MRIs (Complex Imaging) Outpatient	$150/visit	80% covered after deductible	100% covered	$75/visit	$75/visit
Chiropractic (Subject to visit limits)	$35/visit (Up to 20 visits/calendar year)	$45/visit (Up to 20 visits/calendar year)	$35/visit (Up to 20 visits/calendar year)	$45/visit (Up to 20 visits/calendar year)	$35/visit (Up to 20 visits/calendar year)
Physical Therapy and Speech Therapy (Subject to visit limits)	$35/visit (Up to a 60-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)	$30/visit (Up to 20 visits/therapy year)	$20/visit (Up to 20 visits/therapy year)	$45/visit (Up to a 60-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)	$35/visit (Up to a 60-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)
Mental Health					
Mental Health – Inpatient	100% covered after $250/admission	80% covered after deductible	100% covered after $250/admission	100% covered after deductible and $400/day for first 5 days	100% covered after $250/admission
Mental Health – Outpatient	$35/visit	Individual session: $30/visit Group session: $15/visit	Individual session: $20/visit Group session: $10/visit	$45/visit	$35/visit
Substance Abuse					
Substance Abuse – Inpatient	100% covered after $250/admission	80% covered after deductible	100% covered after $250/admission	100% covered after deductible and $400/day for first 5 days	100% covered after $250/admission
Substance Abuse – Outpatient	$35/visit	Individual session: $30/visit Group session: $15/visit	Individual session: $20/visit Group session: $10/visit	$45/visit	$35/visit
Prescription Drugs					
Retail Pharmacy – In-Network (30-day supply if not specified) Dollar amounts listed are generic/formulary brand/ non-formulary brand	$10/$30/$50	$10/$30/$50	$10/$30/$50	$10/$20/$40	$10/$20/$35
Mail-Order Program – In-Network (90-day supply if not specified; out-of-network not covered) Dollar amounts listed are generic/formulary brand/ non-formulary brand	$20/$60/$100	$20/$60/$100	$20/$60/$100	$20/$40/$80	$20/$40/$70
Self-Injectables (Includes many specialty drugs. Call your carrier for more information.)	Third tier copay applies – refer to your COC for further details	80% covered, up to $250/prescription/fill	80% covered, up to $250/prescription/fill	Third tier copay applies – refer to your COC for further details	Third tier copay applies – refer to your COC for further details

Medical

	Aetna DC HMO 30	Aetna DC HMO 20	Kaiser HMO 25 – DC/MD/VA	Kaiser HMO 20 – DC/MD/VA	Aetna FL HMO 30
Regional Plan Names	Aetna DC HMO 30	Aetna DC HMO 20	Kaiser HMO 25 – DC/MD/VA	Kaiser HMO 20 – DC/MD/VA	Aetna FL HMO 30
Plan Locations	DC	DC	DC/MD/VA	DC/MD/VA	FL
Carrier Network	HMO Open Access	HMO Open Access	Kaiser HMO	Kaiser HMO	HMO Open Access
Plan Features					
Calendar-Year Deductible (Deductible applies where specifically stated; doesn't apply to out-of-pocket expense maximum unless otherwise stated)	$1,000/person; $2,000/family	None	$1,000/person; $2,000/family	None	$1,000/person; $2,000/family
Calendar-Year Out-of-Pocket Expense Maximum (Excludes deductible unless otherwise stated)	$3,000/person; $6,000/family (Includes deductible)	$2,000/person; $4,000/family	$3,000/person; $6,000/family	$2,000/person; $4,000/family	$3,000/person; $6,000/family (Includes deductible)
Lifetime Benefits Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Routine Health Maintenance					
Preventive Care Well-woman Well-baby Well-man (Includes annual Pap smear, routine mammogram, and annual prostate exam)	100% covered	100% covered	100% covered	100% covered	100% covered
Vision Testing	$45/visit	$35/visit	$25/visit Specialist: $35/visit	$20/visit Specialist: $35/visit	Not covered
Hearing Testing	Subject to routine physical exam cost sharing Hearing Aid: Not covered	Subject to routine physical exam cost sharing Hearing Aid: Not covered	$25/visit Specialist: $35/visit	$20/visit Specialist: $35/visit	Subject to routine physical exam cost sharing Hearing aid: Not covered
Physician & Hospital Services					
Physician Office Visit	$30/visit Specialist: $45/visit	$20/visit Specialist: $35/visit	$25/visit Specialist: $35/visit	$20/visit Specialist: $35/visit	$30/visit Specialist: $45/visit
Surgery Outpatient	80% covered after deductible	100% covered after $250/visit	80% covered after deductible	$35/procedure	80% covered after deductible
Hospital Inpatient Room and Board Surgery Anesthesia Drugs/Supplies	80% covered after deductible	100% covered after $250/admission	80% covered after deductible	100% covered after $250/admission	80% covered after deductible
Emergency Room (Copay waived if admitted)	$150/visit	$100/visit	$75/visit	$50/visit	$150/visit
Urgent Care	$75/visit	$50/visit	$35/visit	$35/visit	$75/visit
Pregnancy & Maternity Care					
Prenatal Care and Inpatient	Visits: $45 for initial visit, then 100% covered Inpatient: 80% covered after deductible	Visits: $35 for initial visit, then 100% covered Inpatient: 100% covered after $250/admission	Visits: 100% covered Inpatient: 80% covered after deductible	Visits: 100% covered Inpatient: 100% covered after $250/admission	Visits: $45 for initial visit, then 100% covered Inpatient: 80% covered after deductible
Other Medical Services (Including Alternative Care)					
X-Ray and Lab – Outpatient (Applicable deductibles and copays apply)	Diagnostic X-ray: $45/visit Lab: 100% covered	Diagnostic X-ray: $35/visit Lab: 100% covered	80% covered after deductible	100% covered	Diagnostic X-ray: $45/visit Lab: 100% covered

MRIs (Complex Imaging) Outpatient	$75/visit	$75/visit	80% covered after deductible	100% covered	$150/visit
Chiropractic (Subject to visit limits)	$45/visit (Up to 20 visits/calendar year)	$35/visit (Up to 20 visits/calendar year)	Not covered	Not covered	$45/visit (Up to 20 visits/calendar year)
Physical Therapy and Speech Therapy (Subject to visit limits)	$45/visit (Up to a 60-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)	$35/visit (Up to a 60-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)	$35/visit	$35/visit	$45/visit (Up to a 60-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)
Mental Health					
Mental Health – Inpatient	80% covered after deductible	100% covered after $250/admission	80% covered after deductible	100% covered after $250/admission	80% covered after deductible
Mental Health – Outpatient	Visits 1-40: $25/visit Visits 41+: $40/visit	Visits 1-40: $25/visit Visits 41+: $35/visit	Individual session: $25/visit Group session: $12/visit	Individual session: $20/visit Group session: $10/visit	$45/visit
Substance Abuse					
Substance Abuse – Inpatient	80% covered after deductible	100% covered after $250/admission	80% covered after deductible	100% covered after $250/admission	80% covered after deductible
Substance Abuse – Outpatient	Visits 1-40: $25/visit Visits 41+: $40/visit	Visits 1-40: $25/visit Visits 41+: $35/visit	Individual session: $25/visit Group session: $12/visit	Individual session: $20/visit Group session: $10/visit	$45/visit
Prescription Drugs					
Retail Pharmacy – In-Network (30-day supply if not specified) Dollar amounts listed are generic/formulary brand/ non-formulary brand	$10/$30/$60	$10/$30/$50	Plan pharmacy: $20/$30/$45 Participating network pharmacy: $30/$50/$65	Plan pharmacy: $10/$30/$50 Network pharmacy: $30/$50/$75	$10/$30/$60
Mail-Order Program – In-Network (90-day supply if not specified; out-of-network not covered) Dollar amounts listed are generic/formulary brand/ non-formulary brand	$20/$60/$120	$20/$60/$100	$18/$28/$43 90 day supply $36/$56/$86	$8/$28/$48 90 day supply $16/$56/$96	$20/$60/$120
Self-Injectables (Includes many specialty drugs. Call your carrier for more information.)	Third tier copay applies – refer to your COC for further details	Third tier copay applies – refer to your COC for further details	Coverage varies according to the drug – contact Kaiser for more details	Coverage varies according to the drug – contact Kaiser for more details	Third tier copay applies – refer to your COC for further details

Medical

	Aetna FL HMO 20	BCBS HMO 30	BCBS HMO 20	Aetna GA HMO 30	Aetna GA HMO 20
Regional Plan Names	Aetna FL HMO 20	BCBS HMO 30	BCBS HMO 20	Aetna GA HMO 30	Aetna GA HMO 20
Plan Locations	FL	FL; nationally with the Blue Card for employers based in FL	FL; nationally with the Blue Card for employers based in FL	GA	GA
Carrier Network	HMO Open Access	Blue Care	Blue Care	HMO Open Access	HMO Open Access
Plan Features					
Calendar-Year Deductible (Deductible applies where specifically stated; doesn't apply to out-of-pocket expense maximum unless otherwise stated)	None	$1,000/person; $2,000/family	None	$1,000/person; $2,000/family	None
Calendar-Year Out-of-Pocket Expense Maximum (Excludes deductible unless otherwise stated)	$2,000/person; $4,000/family	$3,000/person; $6,000/family (Includes deductible)	$2,000/person; $4,000/family	$3,000/person; $6,000/family (Includes deductible)	$2,000/person; $4,000/family
Lifetime Benefits Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Routine Health Maintenance					
Preventive Care Well-woman Well-baby Well-man (Includes annual Pap smear, routine mammogram, and annual prostate exam)	100% covered	100% covered	100% covered	100% covered	100% covered
Vision Testing	Not covered	Not covered	Not covered	Not covered	Not covered
Hearing Testing	Subject to routine physical exam cost sharing Hearing aid: Not covered	Discount only	Discount only	Subject to routine physical exam cost sharing Hearing aid: Not covered	Subject to routine physical exam cost sharing Hearing aid: Not covered
Physician & Hospital Services					
Physician Office Visit	$20/visit Specialist: $35/visit	$30/visit Specialist: $45/visit	$20/visit Specialist: $35/visit	$30/visit Specialist: $45/visit	$20/visit Specialist: $35/visit
Surgery Outpatient	100% covered after $250/visit	80% covered after deductible	$100/visit	80% covered after deductible	100% covered after $250/visit
Hospital Inpatient Room and Board Surgery Anesthesia Drugs/Supplies	100% covered after $250/admission	80% covered after deductible	100% covered after $250/admission	80% covered after deductible	100% covered after $250/admission
Emergency Room (Copay waived if admitted)	$100/visit	$150/visit	$100/visit	$150/visit	$100/visit
Urgent Care	$50/visit	$75/visit	$50/visit	$75/visit	$50/visit
Pregnancy & Maternity Care					
Prenatal Care and Inpatient	Visits: $35 for initial visit, then 100% covered Inpatient: 100% covered after $250/admission	Initial visit: $45 Inpatient: 80% covered after deductible	Initial visit: $35 Inpatient: 100% covered after $250/admission	Visits: $45 for initial visit, then 100% covered Inpatient: 80% covered after deductible	Visits: $35 for initial visit, then 100% covered Inpatient: 100% covered after $250/admission
Other Medical Services (Including Alternative Care)					
X-Ray and Lab – Outpatient (Applicable deductibles and copays apply)	Diagnostic X-ray: $35/visit Lab: 100% covered	100% covered	100% covered	Diagnostic X-ray: $45/visit Lab: 100% covered	Diagnostic X-ray: $35/visit Lab: 100% covered
MRIs (Complex Imaging) Outpatient	$150/visit	80% covered after deductible	$100/visit	$150/visit	$150/visit

Chiropractic (Subject to visit limits)	$35/visit (Up to 20 visits/calendar year)	$45/visit (Authorization required)	$35/visit (Authorization required)	$45/visit (Up to 20 visits/calendar year)	$35/visit (Up to 20 visits/calendar year)
Physical Therapy and Speech Therapy (Subject to visit limits)	$35/visit (Up to a 60-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)	$45/visit (Authorization required)	$35/visit (Authorization required)	$45/visit (Up to a 60-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)	$35/visit (Up to a 60-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)
Mental Health					
Mental Health – Inpatient	100% covered after $250/admission	80% covered after deductible	100% covered after $250/admission	80% covered after deductible	100% covered after $250/admission
Mental Health – Outpatient	$35/visit	$45/visit	$35/visit	$45/visit	$35/visit
Substance Abuse					
Substance Abuse – Inpatient	100% covered after $250/admission	80% covered after deductible	100% covered after $250/admission	80% covered after deductible	100% covered after $250/admission
Substance Abuse – Outpatient	$35/visit	$45/visit	$35/visit	$45/visit	$35/visit
Prescription Drugs					
Retail Pharmacy – In-Network (30-day supply if not specified) Dollar amounts listed are generic/formulary brand/ non-formulary brand	$10/$30/$50	$10/$40/$60	$10/$35/$50	$10/$30/$60	$10/$30/$50
Mail-Order Program – In-Network (90-day supply if not specified; out-of-network not covered) Dollar amounts listed are generic/formulary brand/ non-formulary brand	$20/$60/$100	$20/$80/$120	$20/$70/$100	$20/$60/$120	$20/$60/$100
Self-Injectables (Includes many specialty drugs. Call your carrier for more information.)	Third tier copay applies – refer to your COC for further details	20% of prescription cost, up to $150	20% of prescription cost, up to $150	Third tier copay applies – refer to your COC for further details	Third tier copay applies – refer to your COC for further details

Medical

	Kaiser GA HMO 30	Kaiser GA HMO 20	Kaiser HI HMO	Aetna IL HMO 30	Aetna IL HMO 20
Regional Plan Names	Kaiser GA HMO 30	Kaiser GA HMO 20	Kaiser HI HMO	Aetna IL HMO 30	Aetna IL HMO 20
Plan Locations	GA	GA	HI	IL	IL
Carrier Network	Kaiser HMO	Kaiser HMO	Kaiser HMO	HMO Open Access	HMO Open Access
Plan Features					
Calendar-Year Deductible (Deductible applies where specifically stated; doesn't apply to out-of-pocket expense maximum unless otherwise stated)	$1,000/person; $2,000/family	None	None	$1,000/person; $2,000/family	None
Calendar-Year Out-of-Pocket Expense Maximum (Excludes deductible unless otherwise stated)	$2,000/person; $4,000/family	None	$2,000/person; $6,000/family	$3,000/person; $6,000/family (Includes deductible)	$2,000/person; $4,000/family
Lifetime Benefits Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Routine Health Maintenance					
Preventive Care Well-woman Well-baby Well-man (Includes annual Pap smear, routine mammogram, and annual prostate exam)	100% covered	100% covered	100% covered	100% covered	100% covered
Vision Testing	$45/visit	$35/visit	$14/visit	Not covered	Not covered
Hearing Testing	$45/visit	$35/visit	$14/visit	Subject to routine physical exam cost sharing Hearing Aid: Not covered	Subject to routine physical exam cost sharing Hearing Aid: Not covered
Physician & Hospital Services					
Physician Office Visit	$30/visit Specialist: $45/visit	$20/visit Specialist: $35/visit	$14/visit	$30/visit Specialist: $45/visit	$20/visit Specialist: $35/visit
Surgery Outpatient	80% covered after deductible	$250/visit	$14/visit	80% covered after deductible	100% covered after $250/visit
Hospital Inpatient Room and Board Surgery Anesthesia Drugs/Supplies	80% covered after deductible	100% covered after $250/admission	100% covered	80% covered after deductible	100% covered after $250/admission
Emergency Room (Copay waived if admitted)	$150/visit	$100/visit	$50/visit	$150/visit	$100/visit
Urgent Care	$75/visit	$50/visit	Within service area: $14/visit Outside service area: 80% covered	$75/visit	$50/visit
Pregnancy & Maternity Care					
Prenatal Care and Inpatient	Visits: 100% covered Inpatient: 80% covered after deductible	Visits: 100% covered Inpatient: 100% covered	100% covered after confirmation of pregnancy	Visits: $45 for initial visit, then 100% covered Inpatient: 80% covered after deductible	Visits: $35 for initial visit, then 100% covered Inpatient: 100% covered after $250/admission
Other Medical Services (Including Alternative Care)					
X-Ray and Lab – Outpatient (Applicable deductibles and copays apply)	In office: 100% covered Hospital: 80% covered after deductible	In office: 100% covered Hospital: $250/procedure	90% covered	Diagnostic X-ray: $45/visit Lab: 100% covered	Diagnostic X-ray: $35/visit Lab: 100% covered

MRIs (Complex Imaging) Outpatient	80% covered after deductible	$250/procedure/hospital $35 in doctorâ€™s office	90% covered	$150/visit	$150/visit
Chiropractic (Subject to visit limits)	$45/visit (Up to 20 visits/calendar year)	$35/visit (Up to 20 visits/calendar year)	Not covered	$45/visit (Up to 20 visits/calendar year)	$35/visit (Up to 20 visits/calendar year)
Physical Therapy and Speech Therapy (Subject to visit limits)	80% covered after deductible (Physical therapy: up to 20 visits/year; speech therapy: up to 20 visits/year)	$35/visit (Physical therapy: up to 20 visits/year; speech therapy: up to 20 visits/year)	$14/visit	$45/visit (Up to 60 visits/calendar year, plus additional 20 visits for pervasive developmental disorders)	$35/visit (Up to 60 visits/calendar year, plus additional 20 visits for pervasive developmental disorders)
Mental Health					
Mental Health – Inpatient	80% covered after deductible	100% covered after $250/admission	100% covered	80% covered after deductible	100% covered after $250/admission
Mental Health – Outpatient	Individual session: $30/visit Group session: $15/visit	Individual session: $20/visit Group session: $10/visit	$14/visit	100% covered	$35/visit
Substance Abuse					
Substance Abuse – Inpatient	Not covered	Not covered	100% covered	80% covered after deductible	100% covered after $250/admission
Substance Abuse – Outpatient	Not covered	Not covered	$14/visit	100% covered	$35/visit
Prescription Drugs					
Retail Pharmacy – In-Network (30-day supply if not specified) Dollar amounts listed are generic/formulary brand/ non-formulary brand	Kaiser pharmacy: $10/$40/full retail Network pharmacy: $16/$46/full retail	Kaiser pharmacy: $10/$35/full retail Network pharmacy: $16/$41/ full retail	$10/$10/full retail	$10/$30/$60	$10/$30/$50
Mail-Order Program – In-Network (90-day supply if not specified; out-of-network not covered) Dollar amounts listed are generic/formulary brand/ non-formulary brand	$20/$80/full retail	$20/$70/ full retail	$20/$20/full retail	$20/$60/$120	$20/$60/$100
Self-Injectables (Includes many specialty drugs. Call your carrier for more information.)	Coverage varies according to the drug – contact Kaiser for more details	Coverage varies according to the drug – contact Kaiser for more details	Coverage varies according to the drug – contact Kaiser for more details	Third tier copay applies – refer to your COC for further details	Third tier copay applies – refer to your COC for further details

Medical

	Aetna IN HMO 30	Aetna IN HMO 20	Aetna MD HMO 30	Aetna MD HMO 20	Aetna MA HMO 30
Regional Plan Names	Aetna IN HMO 30	Aetna IN HMO 20	Aetna MD HMO 30	Aetna MD HMO 20	Aetna MA HMO 30
Plan Locations	IN	IN	MD	MD	MA
Carrier Network	HMO Open Access	HMO Open Access	HMO Open Access	HMO Open Access	HMO Open Access
Plan Features					
Calendar-Year Deductible (Deductible applies where specifically stated; doesn't apply to out-of-pocket expense maximum unless otherwise stated)	$1,000/person; $2,000/family	None	$1,000/person; $2,000/family	None	None
Calendar-Year Out-of-Pocket Expense Maximum (Excludes deductible unless otherwise stated)	$3,000/person; $6,000/family (Includes deductible)	$2,000/person; $4,000/family	$3,000/person; $6,000/family (Includes deductible)	$2,000/person; $4,000/family	$3,000/person; $6,000/family (Includes deductible)
Lifetime Benefits Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Routine Health Maintenance					
Preventive Care Well-woman Well-baby Well-man (Includes annual Pap smear, routine mammogram, and annual prostate exam)	100% covered	100% covered	100% covered	100% covered	100% covered
Vision Testing	Not covered	Not covered	$45/visit (deductible waived)	$35/visit	Not covered
Hearing Testing	Subject to routine physical exam cost sharing Hearing Aid: Not covered	Subject to routine physical exam cost sharing Hearing Aid: Not covered	Subject to routine physical exam cost sharing 100% covered	Subject to routine physical exam cost sharing 100% covered	Subject to routine physical exam cost sharing 100% covered
Physician & Hospital Services					
Physician Office Visit	$30/visit Specialist: $45/visit	$20/visit Specialist: $35/visit	$30/visit Specialist: $45/visit	$20/visit Specialist: $35/visit	$30/visit Specialist: $45/visit
Surgery Outpatient	80% covered after deductible	100% covered after $250/visit	80% covered after deductible	100% covered after $250/visit	100% covered after $200/visit
Hospital Inpatient Room and Board Surgery Anesthesia Drugs/Supplies	80% covered after deductible	100% covered after $250/admission	80% covered after deductible	100% covered after $250/admission	100% covered after $200/day for first 5 days
Emergency Room (Copay waived if admitted)	$150/visit	$100/visit	$150/visit	$100/visit	$150/visit
Urgent Care	$75/visit	$50/visit	$75/visit	$50/visit	$150/visit
Pregnancy & Maternity Care					
Prenatal Care and Inpatient	Visits: $45 for initial visit, then 100% covered Inpatient: 80% covered after deductible	Visits: $35 for initial visit, then 100% covered Inpatient: 100% covered after $250/admission	Visits: $45 for initial visit; then 100% covered Inpatient: 80% covered after deductible	Visits: $35 for initial visit; then 100% covered Inpatient: 100% covered after $250/admission	Visits: $45 for initial visit; then 100% covered Inpatient: 100% covered after $200/day for first 5 days
Other Medical Services (Including Alternative Care)					
X-Ray and Lab – Outpatient (Applicable deductibles and copays apply)	Diagnostic X-ray: $45/visit, then 100% covered Lab: 100% covered	Diagnostic X-ray: $35/visit Lab: 100% covered	Diagnostic X-ray: $45/visit Lab: 100% covered	Diagnostic X-ray: $35/visit Lab: 100% covered	Diagnostic X-ray: $45/visit Lab: 100% covered
MRIs (Complex Imaging) Outpatient	$50/visit	$50/visit	$75/visit	$75/visit	$45/visit

Chiropractic (Subject to visit limits)	$45/visit (Up to 20 visits/calendar year)	$35/visit (Up to 20 visits/calendar year)	$45/visit (Up to 20 visits/calendar year)	$35/visit (Up to 20 visits/calendar year)	$45/visit (Up to 20 visits/calendar year)
Physical Therapy and Speech Therapy (Subject to visit limits)	$45/visit (Up to 60 visits/calendar year, plus additional 20 visits for pervasive developmental disorders)	$35/visit (Up to 60 visits/calendar year, plus additional 20 visits for pervasive developmental disorders)	$45/visit (Up to a 60-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)	$35/visit (Up to a 60-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)	$45/visit (Physical therapy: Up to 30 visits/year)
Mental Health					
Mental Health – Inpatient	80% covered after deductible	100% covered after $250/admission	80% covered after deductible	100% covered after $250/admission	100% covered after $200/day for first 5 days
Mental Health – Outpatient	$45/visit	$35/visit	$45/visit	$35/visit	$30/visit
Substance Abuse					
Substance Abuse – Inpatient	80% covered after deductible	100% covered after $250/admission	80% covered after deductible	100% covered after $250/admission	100% covered after $200/day for first 5 days
Substance Abuse – Outpatient	$45/visit	$35/visit	$45/visit	$35/visit	$30/visit
Prescription Drugs					
Retail Pharmacy – In-Network (30-day supply if not specified) Dollar amounts listed are generic/formulary brand/ non-formulary brand	$10/$30/$60	$10/$30/$50	$10/$30/$60	$10/$30/$50	$10/$30/$60
Mail-Order Program – In-Network (90-day supply if not specified; out-of-network not covered) Dollar amounts listed are generic/formulary brand/ non-formulary brand	$20/$60/$120	$20/$60/$100	$20/$60/$120	$20/$60/$100	$20/$60/$120
Self-Injectables (Includes many specialty drugs. Call your carrier for more information.)	Third tier copay applies – refer to your COC for further details	Third tier copay applies – refer to your COC for further details	Third tier copay applies – refer to your COC for further details	Third tier copay applies – refer to your COC for further details	Third tier copay applies – refer to your COC for further details

Medical

	Aetna MA HMO 20	Tufts Health Plan HMO 30	Tufts Health Plan HMO 20	Aetna MO HMO 30	Aetna MO HMO 20
Regional Plan Names	Aetna MA HMO 20	Tufts Health Plan HMO 30	Tufts Health Plan HMO 20	Aetna MO HMO 30	Aetna MO HMO 20
Plan Locations	MA	MA, NH, and RI	MA, NH, and RI	MO	MO
Carrier Network	HMO Open Access	Tufts Standard HMO Network	Tufts Standard HMO Network	HMO Open Access	HMO Open Access
Plan Features					
Calendar-Year Deductible (Deductible applies where specifically stated; doesn't apply to out-of-pocket expense maximum unless otherwise stated)	None	$1,000/person; $2,000/family	None	None	None
Calendar-Year Out-of-Pocket Expense Maximum (Excludes deductible unless otherwise stated)	$2,000/person; $4,000/family	$3,000/person; $6,000/family (includes deductible and coinsurance)	$1,000/person; $2,000/family	$3,000/person; $6,000/family (Includes deductible)	$2,000/person; $4,000/family
Lifetime Benefits Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Routine Health Maintenance					
Preventive Care Well-woman Well-baby Well-man (Includes annual Pap smear, routine mammogram, and annual prostate exam)	100% covered	100% covered	100% covered	100% covered	100% covered
Vision Testing	Not covered	$30/visit (through EyeMed Vision Care provider) (1 visit every 24 months)	$20/visit (through EyeMed Vision Care provider) (1 visit every 24 months)	Not covered	Not covered
Hearing Testing	Subject to routine physical exam cost sharing 100% covered	Covered at PCP copay	Covered at PCP copay	Subject to routine physical exam cost sharing Hearing Aid: Not covered	Subject to routine physical exam cost sharing Hearing Aid: Not covered
Physician & Hospital Services					
Physician Office Visit	$20/visit Specialist: $35/visit	PCP: $30/visit Specialist: $45/visit	PCP: $20/visit Specialist: $35/visit	$30/visit Specialist: $45/visit	$20/visit Specialist: $35/visit
Surgery Outpatient	100% covered after $250/visit	100% covered after deductible	100% covered	80% covered after deductible	100% covered after $250/visit
Hospital Inpatient Room and Board Surgery Anesthesia Drugs/Supplies	100% covered after $250/admission	100% covered after deductible	$250/visit	80% covered after deductible	100% covered after $250/admission
Emergency Room (Copay waived if admitted)	$100/visit	$150/visit	$100/visit	$150/visit	$100/visit
Urgent Care	$100/visit	Refer to specific Evidence of Coverage for benefit	Refer to specific Evidence of Coverage for benefit	$75/visit	$50/visit
Pregnancy & Maternity Care					
Prenatal Care and Inpatient	Visits: $35 for initial visit; then 100% covered Inpatient: 100% covered after $250/admission	Inpatient: 100% covered after deductible Outpatient: $30/visit for up to 10 visits, then 100% covered	Inpatient: $250/visit Outpatient: $20/visit for up to 10 visits, then 100% covered	Visits: $45 for initial visit, then 100% covered Inpatient: 80% covered after deductible	Visits: $35 for initial visit, then 100% covered Inpatient: 100% covered after $250/admission
Other Medical Services (Including Alternative Care)					

X-Ray and Lab – Outpatient (Applicable deductibles and copays apply)	Diagnostic X-ray: $35/visit Lab: 100% covered	100% covered after deductible	100% covered	Diagnostic X-ray: $45/visit Lab: 100% covered	Diagnostic X-ray: $35/visit Lab: 100% covered
MRIs (Complex Imaging) Outpatient	$35/visit	100% covered after deductible	$50/visit	$150/visit	$150/visit
Chiropractic (Subject to visit limits)	$35/visit (Up to 20 visits/calendar year)	100% covered after deductible (Up to 12 visits/year; combined in- and out-of-network)	PCP: $20/visit Specialist: $35/visit (Up to 12 visits/year; combined in- and out-of-network)	$45/visit (Up to 20 visits/calendar year)	$35/visit (Up to 20 visits/calendar year)
Physical Therapy and Speech Therapy (Subject to visit limits)	$35/visit (Physical therapy: Up to 30 visits/year)	100% covered after deductible (Physical therapy: 30 visits/year; speech therapy: no limits)	PCP: $20/visit Specialist: $35/visit (Physical therapy: 30 visits/year; speech therapy: no limits)	$45/visit (limited to treatment over a 60-day consecutive period per incident of illness or injury beginning with the first day of treatment)	$35/visit (limited to treatment over a 60-day consecutive period per incident of illness or injury beginning with the first day of treatment)
Mental Health					
Mental Health – Inpatient	100% covered after $250/admission	100% covered after deductible	$250/admission	80% covered after deductible	100% covered after $250/admission
Mental Health – Outpatient	$20/visit	$30/visit	$20/visit	$45/visit	$35/visit
Substance Abuse					
Substance Abuse – Inpatient	100% covered after $250/admission	100% covered after deductible	$250/admission	80% covered after deductible	100% covered after $250/admission
Substance Abuse – Outpatient	$20/visit	$30/visit	$20/visit	$45/visit	$35/visit
Prescription Drugs					
Retail Pharmacy – In-Network (30-day supply if not specified) Dollar amounts listed are generic/formulary brand/ non-formulary brand	$10/$30/$50	$20/$30/$45	$10/$30/$45	$10/$30/$60	$10/$30/$50
Mail-Order Program – In-Network (90-day supply if not specified; out-of-network not covered) Dollar amounts listed are generic/formulary brand/ non-formulary brand	$20/$60/$100	$40/$60/$90	$20/$60/$90	$20/$60/$120	$20/$60/$100
Self-Injectables (Includes many specialty drugs. Call your carrier for more information.)	Third tier copay applies – refer to your COC for further details	Cost varies depending on injectable – refer to specific Evidence of Coverage for benefit	Cost varies depending on injectable – refer to specific Evidence of Coverage for benefit	Third tier copay applies – refer to your COC for further details	Third tier copay applies – refer to your COC for further details

Medical

	Aetna NJ HMO 30	Aetna NJ HMO 20	Aetna NY HMO 30	Aetna NY HMO 20	Aetna NV HMO 30
Regional Plan Names	Aetna NJ HMO 30	Aetna NJ HMO 20	Aetna NY HMO 30	Aetna NY HMO 20	Aetna NV HMO 30
Plan Locations	NJ	NJ	NY	NY	NV
Carrier Network	HMO Open Access	HMO Open Access	HMO Open Access	HMO Open Access	HMO Open Access
Plan Features					
Calendar-Year Deductible (Deductible applies where specifically stated; doesn't apply to out-of-pocket expense maximum unless otherwise stated)	$1,000/person; $2,000/family	None	None	None	$1,000/person; $2,000/family
Calendar-Year Out-of-Pocket Expense Maximum (Excludes deductible unless otherwise stated)	$3,000/person; $6,000/family (Includes deductible)	$2,000/person; $4,000/family	$3,000/person; $6,000/family	$2,000/person; $4,000/family	$3,000/person; $6,000/family (Includes deductible)
Lifetime Benefits Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Routine Health Maintenance					
Preventive Care Well-woman Well-baby Well-man (Includes annual Pap smear, routine mammogram, and annual prostate exam)	100% covered	100% covered	100% covered	100% covered	100% covered
Vision Testing	Not covered	Not covered	Not covered	Not covered	Not covered
Hearing Testing	Subject to routine physical exam cost sharing 100% covered	Subject to routine physical exam cost sharing 100% covered	Subject to routine physical exam cost sharing 100% covered	Subject to routine physical exam cost sharing 100% covered	Subject to routine physical exam cost sharing $30/visit
Physician & Hospital Services					
Physician Office Visit	$30/visit Specialist: $45/visit)	$20/visit Specialist: $35/visit	$30/visit Specialist: $45/visit	$20/visit Specialist: $35/visit	$30/visit Specialist: $45/visit
Surgery Outpatient	80% covered after deductible	100% covered after $250/visit	$100/visit	100% covered after $150/visit	$300/visit
Hospital Inpatient Room and Board Surgery Anesthesia Drugs/Supplies	80% covered after deductible	100% covered after $250/admission	100% covered after $100/day for first 5 days	100% covered after $250/visit	100% covered after $300/day for first 5 days
Emergency Room (Copay waived if admitted)	$100/visit	$100/visit	$150/visit	$100/visit	$150/visit
Urgent Care	$100/visit	$100/visit	$35/visit	$35/visit	$75/visit
Pregnancy & Maternity Care					
Prenatal Care and Inpatient	Visits: $45 for initial visit; then 100% covered Inpatient: 80% covered after deductible	Visits: $35 for initial visit; then 100% covered Inpatient: 100% covered after $250/admission	Visits: $30 for initial visit; then 100% covered Inpatient: 100% covered after $100/day for first 5 days	Visits: $20 for initial visit; then 100% covered Inpatient: 100% covered after $250/admission	Visits: $45 for initial visit; then 100% covered Inpatient: 100% covered after $300/day for first 5 days
Other Medical Services (Including Alternative Care)					
X-Ray and Lab – Outpatient (Applicable deductibles and copays apply)	Diagnostic X-ray: $45/visit Lab: 100% covered	Diagnostic X-ray: $35/visit Lab: 100% covered	Diagnostic X-ray: $45/visit Lab: 100% covered	Diagnostic X-ray: $35/visit Lab: 100% covered	Diagnostic X-ray: $45/visit Lab: 100% covered
MRIs (Complex Imaging) Outpatient	$50/visit	$50/visit	$45/visit	$35/visit	$50/visit

Chiropractic (Subject to visit limits)	$25/visit (Up to 20 visits/calendar year)	$25/visit (Up to 20 visits/calendar year)	$45/visit (Up to 20 visits/calendar year)	$35/visit (Up to 20 visits/calendar year)	$45/visit (Up to 20 visits/calendar year)
Physical Therapy and Speech Therapy (Subject to visit limits)	$45/visit (Up to a 60-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)	$35/visit (Up to a 60-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)	$45/visit (Up to a 60-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)	$35/visit (Up to a 60-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)	$45/visit (Up to a 60-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)
Mental Health					
Mental Health – Inpatient	80% covered after deductible	100% covered after $250/admission	100% covered after $100/day for first 5 days	100% covered after $250/admission	100% covered after $300/day for first 5 days
Mental Health – Outpatient	100% covered	$35/visit	$30/visit	$20/visit	$45/visit
Substance Abuse					
Substance Abuse – Inpatient	80% covered after deductible	100% covered after $250/admission	100% covered after $100/day for first 5 days	100% covered after $250/admission	100% covered after $300/day for first 5 days
Substance Abuse – Outpatient	100% covered	$35/visit	$30/visit (Up to 20 visits/year for family members for rehabilitation)	$20/visit (Up to 20 visits/year for family members for rehabilitation)	$45/visit
Prescription Drugs					
Retail Pharmacy – In-Network (30-day supply if not specified) Dollar amounts listed are generic/formulary brand/ non-formulary brand	$10/$30/$60	$10/$30/$50	$10/$30/$60	$10/$30/$50	$10/$30/$60
Mail-Order Program – In-Network (90-day supply if not specified; out-of-network not covered) Dollar amounts listed are generic/formulary brand/ non-formulary brand	$20/$60/$120	$20/$60/$100	$20/$60/$120	$20/$60/$100	$20/$60/$120
Self-Injectables (Includes many specialty drugs. Call your carrier for more information.)	Third tier copay applies – refer to your COC for further details	Third tier copay applies – refer to your COC for further details	Third tier copay applies – refer to your COC for further details	Third tier copay applies – refer to your COC for further details	Third tier copay applies – refer to your COC for further details

Medical

	Aetna NV HMO 20	Aetna NC HMO 30	Aetna NC HMO 20	Aetna OH HMO 30	Aetna OH HMO 20
Regional Plan Names	Aetna NV HMO 20	Aetna NC HMO 30	Aetna NC HMO 20	Aetna OH HMO 30	Aetna OH HMO 20
Plan Locations	NV	NC	NC	OH	OH
Carrier Network	HMO Open Access	HMO Open Access	HMO Open Access	HMO Open Access	HMO Open Access
Plan Features					
Calendar-Year Deductible (Deductible applies where specifically stated; doesn't apply to out-of-pocket expense maximum unless otherwise stated)	None	$1,000/person; $2,000/family	None	$1,000/person; $2,000/family	None
Calendar-Year Out-of-Pocket Expense Maximum (Excludes deductible unless otherwise stated)	$2,000/person; $4,000/family	$3,000/person; $6,000/family (Includes deductible)	$2,000/person; $4,000/family	$3,000/person; $6,000/family (Includes deductible)	$2,000/person; $4,000/family
Lifetime Benefits Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Routine Health Maintenance					
Preventive Care Well-woman Well-baby Well-man (Includes annual Pap smear, routine mammogram, and annual prostate exam)	100% covered	100% covered	100% covered	100% covered	100% covered
Vision Testing	Not covered	Not covered	Not covered	Not covered	Not covered
Hearing Testing	Subject to routine physical exam cost sharing $20/visit	Subject to routine physical exam cost sharing $30/visit	Subject to routine physical exam cost sharing $20/visit	Subject to routine physical exam cost sharing 100% covered	Subject to routine physical exam cost sharing 100% covered
Physician & Hospital Services					
Physician Office Visit	$20/visit Specialist: $35/visit	$30/visit Specialist: $45/visit	$20/visit Specialist: $35/visit	$30/visit Specialist: $45/visit	$20/visit Specialist: $35/visit
Surgery Outpatient	100% covered after $250/visit	80% covered after deductible	100% covered after $250/visit	80% covered after deductible	100% covered after $250/visit
Hospital Inpatient Room and Board Surgery Anesthesia Drugs/Supplies	100% covered after $250/visit	80% covered after deductible	100% covered after $250/visit	80% covered after deductible	100% covered after $250/admission
Emergency Room (Copay waived if admitted)	$100/visit	$150/visit	$100/visit	$150/visit	$100/visit
Urgent Care	$50/visit	$75/visit	$50/visit	$60/visit	$50/visit
Pregnancy & Maternity Care					
Prenatal Care and Inpatient	Visits: $35 for initial visit; then 100% covered Inpatient: 100% covered after $250/admission	Visits: $45 for initial visit; then 100% covered Inpatient: 80% covered after deductible	Visits: $35 for initial visit; then 100% covered Inpatient: 100% covered after $250/admission	Visits: $30 for initial visit; then 100% covered Inpatient: 80% covered after deductible	Visits: $20 for initial visit; then 100% covered Inpatient: 100% covered after $250/admission
Other Medical Services (Including Alternative Care)					
X-Ray and Lab – Outpatient (Applicable deductibles and copays apply)	Diagnostic X-ray: $35/visit Lab: 100% covered	Diagnostic X-ray: $45/visit Lab: 100% covered	Diagnostic X-ray: $35/visit Lab: 100% covered	Diagnostic X-ray: $45/visit Lab: 100% covered	Diagnostic X-ray: $35/visit Lab: 100% covered
MRIs (Complex Imaging) Outpatient	$50/visit	$125/visit	$125/visit	$100/visit	$100/visit

Chiropractic (Subject to visit limits)	$35/visit (Up to 20 visits/calendar year)	$45/visit	$35/visit	$45/visit (Up to 20 visits/calendar year)	$35/visit (Up to 20 visits/calendar year)
Physical Therapy and Speech Therapy (Subject to visit limits)	$35/visit (Up to a 60-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)	$45/visit (Up to a 60-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)	$35/visit (Up to a 60-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)	$45/visit (Up to a 60-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)	$35/visit (Up to a 60-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)
Mental Health					
Mental Health – Inpatient	100% covered after $250/admission	80% covered after deductible	100% covered after $250/admission	80% covered after deductible	100% covered after $250/admission
Mental Health – Outpatient	$35/visit	$45/visit	$35/visit	$45/visit	$35/visit
Substance Abuse					
Substance Abuse – Inpatient	100% covered after $250/admission	80% covered after deductible	100% covered after $250/admission	80% covered after deductible	100% covered after $250/admission
Substance Abuse – Outpatient	$35/visit	$45/visit	$35/visit	$45/visit	$35/visit
Prescription Drugs					
Retail Pharmacy – In-Network (30-day supply if not specified) Dollar amounts listed are generic/formulary brand/ non-formulary brand	$10/$30/$50	$10/$30/$60	$10/$30/$50	$10/$30/$60	$10/$30/$50
Mail-Order Program – In-Network (90-day supply if not specified; out-of-network not covered) Dollar amounts listed are generic/formulary brand/ non-formulary brand	$20/$60/$100	$20/$60/$120	$20/$60/$100	$20/$60/$120	$20/$60/$100
Self-Injectables (Includes many specialty drugs. Call your carrier for more information.)	Third tier copay applies – refer to your COC for further details	Third tier copay applies – refer to your COC for further details	Third tier copay applies – refer to your COC for further details	Third tier copay applies – refer to your COC for further details	Third tier copay applies – refer to your COC for further details

Medical

	Kaiser HMO 30 – OR/WA	Kaiser HMO 20 – OR/WA	Aetna PA HMO 30	Aetna PA HMO 20	Aetna SC HMO 30
Regional Plan Names	Kaiser HMO 30 – OR/WA	Kaiser HMO 20 – OR/WA	Aetna PA HMO 30	Aetna PA HMO 20	Aetna SC HMO 30
Plan Locations	OR/WA	OR/WA	PA	PA	SC
Carrier Network	Kaiser HMO	Kaiser HMO	HMO Open Access	HMO Open Access	HMO Open Access
Plan Features					
Calendar-Year Deductible (Deductible applies where specifically stated; doesn't apply to out-of-pocket expense maximum unless otherwise stated)	$1,000/person; $2,000/family	None	$1,000/person; $2,000/family	None	$1,000/person; $2,000/family
Calendar-Year Out-of-Pocket Expense Maximum (Excludes deductible unless otherwise stated)	$2,000/person; $4,000/family	$2,000/person; $4,000/family	$3,000/person; $6,000/family (Includes deductible)	$2,000/person; $4,000/family	$3,000/person; $6,000/family (Includes deductible)
Lifetime Benefits Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Routine Health Maintenance					
Preventive Care Well-woman Well-baby Well-man (Includes annual Pap smear, routine mammogram, and annual prostate exam)	100% covered	100% covered	100% covered	100% covered	100% covered
Vision Testing	$30/visit	$20/visit	Not covered	Not covered	Not covered
Hearing Testing	100% covered after $25 PCP copay	100% covered after $20 PCP copay	Subject to routine physical exam cost sharing 100% covered	Subject to routine physical exam cost sharing 100% covered	Subject to routine physical exam cost sharing $30/visit
Physician & Hospital Services					
Physician Office Visit	$30/visit Specialist: $45/visit	$20/visit Specialist: $35/visit	$30/visit Specialist: $45/visit	$20/visit Specialist: $35/visit	$30/visit Specialist: $45/visit
Surgery Outpatient	80% covered after deductible	$100/visit	80% covered after deductible	100% covered after $250/visit	80% covered after deductible
Hospital Inpatient Room and Board Surgery Anesthesia Drugs/Supplies	80% covered after deductible	100% covered after $250/admission	80% covered after deductible	100% covered after $250/admission	80% covered after deductible
Emergency Room (Copay waived if admitted)	$100/visit	$100/visit	$150/visit	$100/visit	$150/visit
Urgent Care	$50/visit	$50/visit	$150/visit	$100/visit	$75/visit
Pregnancy & Maternity Care					
Prenatal Care and Inpatient	Visits: 100% covered Inpatient: 100% covered after $250/admission	Visits: 100% covered Inpatient: 100% covered after $250/admission	Visits: $45 for initial visit; then 100% covered Inpatient: 80% covered after deductible	Visits: $35 for initial visit; then 100% covered Inpatient: 100% covered after $250/admission	Visits: $45 for initial visit; then 100% covered Inpatient: 80% covered after deductible
Other Medical Services (Including Alternative Care)					
X-Ray and Lab – Outpatient (Applicable deductibles and copays apply)	80% covered after deductible	100% covered	Diagnostic X-ray: $45/visit Lab: 100% covered	Diagnostic X-ray: $35/visit Lab: 100% covered	Diagnostic X-ray: $45/visit Lab: 100% covered
MRIs (Complex Imaging) Outpatient	80% covered after deductible	100% covered	$50/visit	$50/visit	$125/visit

Chiropractic (Subject to visit limits)	$30/visit (Up to 20 visits/calendar year)	$20/visit (Up to 20 visits/calendar year)	$45/visit (Up to 20 visits/calendar year)	$35/visit (Up to 20 visits/calendar year)	$45/visit
Physical Therapy and Speech Therapy (Subject to visit limits)	$45/visit (Up to 20 visits per calendar year)	$35/visit (Up to 20 visits per calendar year)	$45/visit (Up to a 60-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)	$35/visit (Up to a 60-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)	$45/visit (Up to a 60-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)
Mental Health					
Mental Health – Inpatient	80% covered after deductible	100% covered after $250/admission	80% covered after deductible	100% covered after $250/admission	80% covered after deductible
Mental Health – Outpatient	Individual session: $30/visit Group session: $15/visit	Individual session: $20/visit Group session: $10/visit	$45/visit	$35/visit	$45/visit
Substance Abuse					
Substance Abuse – Inpatient	80% covered after deductible	100% covered after $250/admission	80% covered after deductible	100% covered after $250/admission	80% covered after deductible
Substance Abuse – Outpatient	Individual session: $30/visit Group session: $15/visit	Individual session: $20/visit Group session: $10/visit	$45/visit	$35/visit	$45/visit
Prescription Drugs					
Retail Pharmacy – In-Network (30-day supply if not specified) Dollar amounts listed are generic/formulary brand/ non-formulary brand	$10/$30/full retail	$10/$30/full retail	$10/$30/$60	$10/$30/$50	$10/$30/$60
Mail-Order Program – In-Network (90-day supply if not specified; out-of-network not covered) Dollar amounts listed are generic/formulary brand/ non-formulary brand	$20/$60/full retail	$20/$60/full retail	$20/$60/$120	$20/$60/$100	$20/$60/$120
Self-Injectables (Includes many specialty drugs. Call your carrier for more information.)	Coverage varies according to the drug – contact Kaiser for more details	Coverage varies according to the drug – contact Kaiser for more details	Third tier copay applies – refer to your COC for further details	Third tier copay applies – refer to your COC for further details	Third tier copay applies – refer to your EOC for further details

Medical

	Aetna SC HMO 20	Aetna TN HMO 30	Aetna TN HMO 20	Aetna TX HMO 30	Aetna TX HMO 20
Regional Plan Names	Aetna SC HMO 20	Aetna TN HMO 30	Aetna TN HMO 20	Aetna TX HMO 30	Aetna TX HMO 20
Plan Locations	SC	TN	TN	TX	TX
Carrier Network	HMO Open Access	HMO Open Access	HMO Open Access	HMO Open Access	HMO Open Access
Plan Features					
Calendar-Year Deductible (Deductible applies where specifically stated; doesn't apply to out-of-pocket expense maximum unless otherwise stated)	None	$1,000/person; $2,000/family	None	$1,000/person; $2,000/family	None
Calendar-Year Out-of-Pocket Expense Maximum (Excludes deductible unless otherwise stated)	$2,000/person; $4,000/family	$3,000/person; $6,000/family (Includes deductible)	$2,000/person; $4,000/family	$2,000/person; $4,000/family	$2,000/person; $4,000/family
Lifetime Benefits Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Routine Health Maintenance					
Preventive Care Well-woman Well-baby Well-man (Includes annual Pap smear, routine mammogram, and annual prostate exam)	100% covered	100% covered	100% covered	100% covered	100% covered
Vision Testing	Not covered	Not covered	Not covered	Not covered	Not covered
Hearing Testing	Subject to routine physical exam cost sharing $20/visit	Subject to routine physical exam cost sharing $30/visit	Subject to routine physical exam cost sharing $20/visit	Subject to routine physical exam cost sharing $30/visit	Subject to routine physical exam cost sharing $20/visit
Physician & Hospital Services					
Physician Office Visit	$20/visit Specialist: $35/visit	$30/visit Specialist: $45/visit	$20/visit Specialist: $35/visit	$30/visit Specialist: $45/visit	$20/visit Specialist: $35/visit
Surgery Outpatient	100% covered after $250/visit	80% covered after deductible	100% covered after $250/visit	80% covered after deductible	100% covered after $250/visit
Hospital Inpatient Room and Board Surgery Anesthesia Drugs/Supplies	100% covered after $250/admission	80% covered after deductible	100% covered after $250/admission	80% covered after deductible	100% covered after $250/admission
Emergency Room (Copay waived if admitted)	$100/visit	$150/visit	$100/visit	$150/visit	$100/visit
Urgent Care	$50/visit	$75/visit	$50/visit	$75/visit	$50/visit
Pregnancy & Maternity Care					
Prenatal Care and Inpatient	Visits: $35 for initial visit; then 100% covered Inpatient: 100% covered after $250/admission	Visits: $45 for initial visit; then 100% covered Inpatient: 80% covered after deductible	Visits: $35 for initial visit; then 100% covered Inpatient: 100% covered after $250/admission	Visits: $45 for initial visit; then 100% covered Inpatient: 80% covered after deductible	Visits: $35 for initial visit; then 100% covered Inpatient: 100% covered after $250/admission
Other Medical Services (Including Alternative Care)					
X-Ray and Lab – Outpatient (Applicable deductibles and copays apply)	Diagnostic X-ray: $35/visit Lab: 100% covered	Diagnostic X-ray: $45/visit Lab: 100% covered	Diagnostic X-ray: $35/visit Lab: 100% covered	Diagnostic X-ray: $45/visit Lab: 100% covered	Diagnostic X-ray: $35/visit Lab: 100% covered
MRIs (Complex Imaging) Outpatient	$125/visit	$150/visit	$150/visit	$150/visit	$150/visit

Chiropractic (Subject to visit limits)	$35/visit	$45/visit	$35/visit	$45/visit (Up to 20 visits/calendar year)	$35/visit (Up to 20 visits/calendar year)
Physical Therapy and Speech Therapy (Subject to visit limits)	$35/visit (Up to a 60-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)	$45/visit (Up to a 60-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)	$35/visit (Up to a 60-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)	$45/visit (Up to a 60-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)	$35/visit (Up to a 60-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)
Mental Health					
Mental Health – Inpatient	100% covered after $250/admission	80% covered after deductible	100% covered after $250/admission	80% covered after deductible	100% covered after $250/admission
Mental Health – Outpatient	$35/visit	$45/visit	$35/visit	$45/visit	$35/visit
Substance Abuse					
Substance Abuse – Inpatient	100% covered after $250/admission	80% covered after deductible	100% covered after $250/admission	80% covered after deductible	100% covered after $250/admission
Substance Abuse – Outpatient	$35/visit	$45/visit	$35/visit	$45/visit	$35/visit
Prescription Drugs					
Retail Pharmacy – In-Network (30-day supply if not specified) Dollar amounts listed are generic/formulary brand/ non-formulary brand	$10/$30/$50	$10/$30/$60	$10/$30/$50	$10/$30/$60	$10/$30/$50
Mail-Order Program – In-Network (90-day supply if not specified; out-of-network not covered) Dollar amounts listed are generic/formulary brand/ non-formulary brand	$20/$60/$100	$20/$60/$120	$20/$60/$100	$20/$60/$120	$20/$60/$100
Self-Injectables (Includes many specialty drugs. Call your carrier for more information.)	Third tier copay applies – refer to your EOC for further details	Third tier copay applies – refer to your COC for further details	Third tier copay applies – refer to your COC for further details	Third tier copay applies – refer to your COC for further details	Third tier copay applies – refer to your COC for further details

Medical

	Aetna VA HMO 30	Aetna VA HMO 20	Group Health WA HMO 30	Group Health WA HMO 20
Regional Plan Names	Aetna VA HMO 30	Aetna VA HMO 20	Group Health WA HMO 30	Group Health WA HMO 20
Plan Locations	VA	VA	WA	WA
Carrier Network	HMO Open Access	HMO Open Access	Alliant Select	Alliant Select
Plan Features				
Calendar-Year Deductible (Deductible applies where specifically stated; doesn't apply to out-of-pocket expense maximum unless otherwise stated)	$1,000/person; $2,000/family	None	$1,000/person; $2,000/family	None
Calendar-Year Out-of-Pocket Expense Maximum (Excludes deductible unless otherwise stated)	$3,000/person; $6,000/family (Includes deductible)	$2,000/person; $4,000/family	$2,000/person; $4,000/family	$2,000/person; $4,000/family
Lifetime Benefits Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Routine Health Maintenance				
Preventive Care Well-woman Well-baby Well-man (Includes annual Pap smear, routine mammogram, and annual prostate exam)	100% covered	100% covered	100% covered	100% covered
Vision Testing	Not covered	Not covered	$30/visit (deductible and coinsurance apply)	$20/visit
Hearing Testing	Subject to routine physical exam cost sharing 100% covered	Subject to routine physical exam cost sharing 100% covered	$30/visit (deductible and coinsurance apply)	$20/visit
Physician & Hospital Services				
Physician Office Visit	$30/visit Specialist: $45/visit	$20/visit Specialist: $35/visit	80% covered after deductible and $30/visit	$20/visit Specialist: $40/visit
Surgery Outpatient	80% covered after deductible	100% covered after $250/visit	80% covered after deductible and $50/visit	$20/visit Specialist: $40/visit
Hospital Inpatient Room and Board Surgery Anesthesia Drugs/Supplies	80% covered after deductible	100% covered after $250/admission	80% covered after deductible	100% covered after $250/admission
Emergency Room (Copay waived if admitted)	$150/visit	$100/visit	80% covered after deductible and $150/visit	$100/visit
Urgent Care	$75/visit	$50/visit	80% covered after deductible and $30/visit	Primary care provider: $20/visit Specialist: 40/visit
Pregnancy & Maternity Care				
Prenatal Care and Inpatient	Visits: $45 for initial visit; then 100% covered Inpatient: 80% covered after deductible	Visits: $35 for initial visit; then 100% covered Inpatient: 100% covered after $250/admission	Visits: $30 copay/visit (deductible and coinsurance apply) Inpatient: 80% covered after deductible	Visits: $20/visit Inpatient: 100% covered after $250/admission
Other Medical Services (Including Alternative Care)				

X-Ray and Lab – Outpatient (Applicable deductibles and copays apply)	Diagnostic X-ray: $45/visit Lab: 100% covered	Diagnostic X-ray: $35/visit Lab: 100% covered	80% covered after deductible	Inpatient: 100% covered after $250/admission Outpatient: 100% covered
MRIs (Complex Imaging) Outpatient	$150/visit	$150/visit	80% covered after deductible	100% covered
Chiropractic (Subject to visit limits)	$45/visit (Up to 20 visits/calendar year)	$35/visit (Up to 20 visits/calendar year)	80% covered after deductible and $30/visit (Up to 10 visits/calendar year)	$20/visit (Up to 10 visits/calendar year)
Physical Therapy and Speech Therapy (Subject to visit limits)	$45/visit (Up to a 90-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)	$35/visit (Up to a 90-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)	Inpatient: 80% covered after deductible Outpatient: 80% covered after deductible and $30/visit (Up to 60 visits/therapy year)	Inpatient: 100% covered after $250/admission Outpatient: $20/visit (Up to 60 visits/therapy year)
Mental Health				
Mental Health – Inpatient	80% covered after deductible	100% covered after $250/admission	80% covered after deductible	100% covered after $250/admission
Mental Health – Outpatient	$45/visit	$35/visit	80% covered after deductible and $30/visit	$20/visit
Substance Abuse				
Substance Abuse – Inpatient	80% covered after deductible	100% covered after $250/admission	80% covered after deductible	100% covered after $250/admission
Substance Abuse – Outpatient	$45/visit	$35/visit	80% covered after deductible and $30/visit	$20/visit
Prescription Drugs				
Retail Pharmacy – In-Network (30-day supply if not specified) Dollar amounts listed are generic/formulary brand/ non-formulary brand	$10/$30/$60	$10/$30/$50	$10/$20/$40	$10/$20/$40
Mail-Order Program – In-Network (90-day supply if not specified; out-of-network not covered) Dollar amounts listed are generic/formulary brand/ non-formulary brand	$20/$60/$120	$20/$60/$100	$20/$40/$80	$20/$40/$80
Self-Injectables (Includes many specialty drugs. Call your carrier for more information.)	Third tier copay applies – refer to your COC for further details	Third tier copay applies – refer to your COC for further details	Coverage varies according to the drug – contact Group Health for more details	Coverage varies according to the drug – contact Group Health for more details

Dental

	Aetna Dental 50	Delta Dental 50	MetLife Dental 50	Aetna Dental 100
Regional Plan Names	• Aetna Dental 50 Group • Aetna Dental 50 Optional	• Delta Dental 50 Group • Delta Dental 50 Optional	• MetLife Dental 50 Group • MetLife Dental 50 Optional	• Aetna Dental 100 Group • Aetna Dental 100 Optional
Plan Locations	Nationwide*	Nationwide*	Nationwide, except FL	Nationwide*
Carrier Network	Dental PPO/PDN with PPO II Network	Delta Dental PPO Network	MetLife Preferred Dentist Program (PDP) Network	Dental PPO/PDN with PPO II Network
Plan Features				
Notes on Availability Service areas may not be available in all ZIP codes for DMO/PPO plans	You can use any licensed dentist – you receive a discount when you use a dentist who participates in the PPO network	You can use any licensed dentist – you receive a discount when you use a dentist who participates in the PPO network	You can use any licensed dentist – you receive a discount when you use a dentist who participates in the PPO network	You can use any licensed dentist – you receive a discount when you use a dentist who participates in the PPO network
Calendar-Year Deductible (Required before plan pays benefits)	**In-Network:** $50/person; $150/family **Out-of-Network:** $100/person; $300/family	**In-Network:** $50/person; $150/family **Out-of-Network:** $100/person; $300/family	**In-Network:** $50/person; $150/family **Out-of-Network:** $150/person; $300/family	**In-Network:** $100/person; $300/family **Out-of-Network:** $150/person; $450/family
Calendar-Year Benefit Maximum	$1,500/person	$1,500/person	$1,500/person	$1,000/person
Diagnostic & Preventive				
Routine Checkups, Cleanings, X-rays, and Diagnostic Visits	**In-Network:** 100% covered **Out-of-Network:** 100% covered	**In-Network:** 100% covered **Out-of-Network:** 100% covered	**In-Network:** 100% covered **Out-of-Network:** 100% covered	**In-Network:** 100% covered **Out-of-Network:** 100% covered
Basic Services				
Fillings and Oral Surgery	**In-Network:** 90% covered after deductible **Out-of-Network:** 80% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 80% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 80% covered after deductible	**In-Network:** 70% covered after deductible **Out-of-Network:** 50% covered after deductible
Periodontics	**In-Network:** 90% covered after deductible **Out-of-Network:** 80% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 80% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 80% covered after deductible	**In-Network:** 70% covered after deductible **Out-of-Network:** 50% covered after deductible
Endodontics	**In-Network:** 90% covered after deductible **Out-of-Network:** 80% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 80% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 80% covered after deductible	**In-Network:** 70% covered after deductible **Out-of-Network:** 50% covered after deductible
Crowns & Cast Restorations				
Crowns, Inlays, Onlays, and Bridges	**In-Network:** 65% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 65% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 65% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 50% covered after deductible **Out-of-Network:** 50% covered after deductible
Prosthodontics				
Dentures	**In-Network:** 65% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 65% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 65% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 50% covered after deductible **Out-of-Network:** 50% covered after deductible
Orthodontics				
Orthodontics	**In-Network:** 50% covered after $50 orthodontia deductible **Out-of-Network:** 50% covered after $50 orthodontia deductible (Up to $1,500/person/lifetime)	**In-Network:** 50% covered after $50 orthodontia deductible **Out-of-Network:** 50% covered after $50 orthodontia deductible (Up to $1,500/person/lifetime)	**In-Network:** 50% covered after $50 orthodontia deductible **Out-of-Network:** 50% covered after $50 orthodontia deductible (Up to $1,500/person/lifetime)	Not available

* In Texas, the coverage level for out-of-network benefits is the same as for in-network benefits for the Aetna and MetLife dental plans due to state regulations.
** Includes initial examination, diagnosis, consultation, initial banding, 24 months of active treatment, debanding, and the retention phase of treatment. The treatment phase includes the initial construction, placement, and adjustments to retainers and office visits for a maximum of 24 months. Eligible children are dependent, unmarried children up to age 19, or 25 if full-time students. Some state rules may differ.

Dental

	Delta Dental 100	MetLife Dental 100	Delta Dental DMO	Aetna DMO
Regional Plan Names	• Delta Dental 100 Group • Delta Dental 100 Optional	• MetLife Dental 100 Group • MetLife Dental 100 Optional	• Delta Dental DMO Group • Delta Dental DMO Optional	• Aetna DMO Group • Aetna DMO Optional
Plan Locations	Nationwide*	Nationwide, except FL	Nationwide*	Nationwide, except AL, AK, AR, LA, ME, MS, MT, ND, NH, SC, SD, VT, WY
Carrier Network	Delta Dental PPO Network	MetLife Preferred Dentist Program (PDP) Network	DeltaCare USA	Dental Maintenance Organization
Plan Features				
Notes on Availability Service areas may not be available in all ZIP codes for DMO/PPO plans	You can use any licensed dentist – you receive a discount when you use a dentist who participates in the PPO network	You can use any licensed dentist – you receive a discount when you use a dentist who participates in the PPO network	No benefits are available outside the DMO network of providers	No benefits are available outside the DMO network of providers
Calendar-Year Deductible (Required before plan pays benefits)	**In-Network:** $100/person; $300/family **Out-of-Network:** $150/person; $450/family	**In-Network:** $100/person; $300/family **Out-of-Network:** $150/person; $450/family	None	None
Calendar-Year Benefit Maximum	$1,000/person	$1,000/person	None	None
Diagnostic & Preventive				
Routine Checkups, Cleanings, X-rays, and Diagnostic Visits	**In-Network:** 100% covered **Out-of-Network:** 100% covered	**In-Network:** 100% covered **Out-of-Network:** 100% covered	**In-Network:** 100% covered **Out-of-Network:** Not covered	**In-Network:** 100% covered **Out-of-Network:** Not covered (Limitations may apply – refer to the EOC booklet for details)
Basic Services				
Fillings and Oral Surgery	**In-Network:** 70% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 70% covered after deductible **Out-of-Network:** 50% covered after deductible	Fillings: $0 – $85/visit depending on the services rendered Oral Surgery: $0 – $280/visit depending on the services rendered	$0 – $75/visit depending on the services rendered
Periodontics	**In-Network:** 70% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 70% covered after deductible **Out-of-Network:** 50% covered after deductible	$15 – $280/visit depending on the services rendered	$10 – $285/visit depending on the services rendered
Endodontics	**In-Network:** 70% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 70% covered after deductible **Out-of-Network:** 50% covered after deductible	$0 – $280/visit depending on the services rendered	$0 – $246/visit depending on the services rendered
Crowns & Cast Restorations				
Crowns, Inlays, Onlays, and Bridges	**In-Network:** 50% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 50% covered after deductible **Out-of-Network:** 50% covered after deductible	$0 – $250/visit depending on the services rendered	$0 – $220/visit depending on the services rendered
Prosthodontics				
Dentures	**In-Network:** 50% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 50% covered after deductible **Out-of-Network:** 50% covered after deductible	$20 – $240/visit depending on the services rendered	$10 – $320/visit depending on the services rendered
Orthodontics				
Orthodontics	Not available	Not available	$25 – $1,900 for 24-month treatment plan**	$30 – $1,545 for 24-month treatment plan**

* In Texas, the coverage level for out-of-network benefits is the same as for in-network benefits for the Aetna and MetLife dental plans due to state regulations.

** Includes initial examination, diagnosis, consultation, initial banding, 24 months of active treatment, debanding, and the retention phase of treatment. The treatment phase includes the initial construction, placement, and adjustments to retainers and office visits for a maximum of 24 months. Eligible children are dependent, unmarried children up to age 19, or 25 if full-time students. Some state rules may differ.

Vision

	Aetna Vision Plus Plan	Aetna Vision Plan	VSP: Vision Plus Plan	VSP: Vision Plan
Regional Plan Names	• Aetna Vision Plus Plan	• Aetna Vision Plan	• VSP: Vision Plus Plan	• VSP: Vision Plan
Plan Locations	Nationwide	Nationwide	Nationwide	Nationwide
Carrier Network	Aetna through EyeMed	Aetna through EyeMed	VSP Signature Network	VSP Signature Network
Plan Features				
Copay Schedule	**In-Network:** Exam: $10 Materials: $25	**In-Network:** Exam: $10 Materials: $25	**In-Network:** Exam: $10 Materials: $25 **Out-of-Network:** Exam: $10 Materials: $25	**In-Network:** Exam: $10 Materials: $25 **Out-of-Network:** Exam: $10 Materials: $25
Frequency of Services				
Eye Examinations	Every 12 months	Every 12 months	Every 12 months	Every 12 months
Replacement Lenses	Every 12 months	Every 12 months	Every 12 months	Every 12 months
Frames	Every 12 months	Every 24 months	Every 12 months	Every 24 months
Exam				
Diagnostic Eye Exam	**In-Network:** 100% covered after copay **Out-of-Network:** Up to $50 covered	**In-Network:** 100% covered after copay **Out-of-Network:** Up to $45 covered	**In-Network:** 100% covered after copay **Out-of-Network:** Up to $50 covered after copay	**In-Network:** 100% covered after copay **Out-of-Network:** Up to $45 covered after copay
Lenses				
Single Vision Lenses (Depends on prescription and add-ons)	**In-Network:** 100% covered after copay **Out-of-Network:** Up to $50 covered	**In-Network:** 100% covered after copay **Out-of-Network:** Up to $45 covered	**In-Network:** 100% covered after copay **Out-of-Network:** Up to $50 covered after copay	**In-Network:** 100% covered after copay **Out-of-Network:** Up to $45 covered after copay
Bifocal Lenses (Depends on prescription and add-ons)	**In-Network:** 100% covered after copay **Out-of-Network:** Up to $75 covered	**In-Network:** 100% covered after copay **Out-of-Network:** Up to $65 covered	**In-Network:** 100% covered after copay **Out-of-Network:** Up to $75 covered after copay	**In-Network:** 100% covered after copay **Out-of-Network:** Up to $65 covered after copay
Trifocal Lenses (Depends on prescription and add-ons)	**In-Network:** 100% covered after copay **Out-of-Network:** Up to $100 covered	**In-Network:** 100% covered after copay **Out-of-Network:** Up to $85 covered	**In-Network:** 100% covered after copay **Out-of-Network:** Up to $100 covered after copay	**In-Network:** 100% covered after copay **Out-of-Network:** Up to $85 covered after copay
Frames				
Moderate Frames (Depends on style and brand)	**In-Network:** Up to $150 covered, then 20% discount **Out-of-Network:** Up to $75 covered	**In-Network:** Up to $130 covered, then 20% discount **Out-of-Network:** Up to $47 covered	**In-Network:** Up to $150 covered then 20% discount **Out-of-Network:** Up to $75 covered after copay Costco: Up to $100 covered after copay	**In-Network:** Up to $130 covered after copay, then 20% discount **Out-of-Network:** Up to $47 covered after copay **Costco:** Up to $70 covered after copay
Contact Lenses				
Contact Lenses (Depends on prescription and add-ons)	**In-Network:** 100% covered if medically necessary; up to $200 covered if elective, then 15% discount for conventional contacts **Out-of-Network:** Up to $210 covered if medically necessary; up to $200 covered if elective	**In-Network:** 100% covered if medically necessary; up to $120 covered if elective, then 15% discount for conventional contacts **Out-of-Network:** Up to $150 covered if medically necessary; up to $105 covered if elective	**In-Network:** 100% covered after copay if medically necessary; up to $200 covered if elective **Out-of-Network:** Up to $210 after copay covered if medically necessary; up to $200 covered if elective	**In-Network:** 100% covered after copay if medically necessary; up to $120 covered if elective **Out-of-Network:** Up to $150 covered after copay if medically necessary; up to $105 covered if elective