Real benefits begin here.



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 a 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.

Disclaimer: This proprietary communication has been prepared for eductional and informational purposes only. The content does not provide legal or tax advice or legal opinion on any specific matters. Transmission of this information is not intended to create, and receipt does not constitute, an attorney-client relationship between TriNet and you. TriNet is not an insurance company, but rather is the single-employer sponsor of all its health and welfare plans. Nothing contained herein constitutes an offer to sell, buy, or procure insurance.

TriNet is the single employer sponsor of all its benefit plans. TriNet makes these plans available to qualifying worksite employees ("WSEs"), with whom TriNet has established an employment relationship, and who perform services for customers of TriNet in a Professional Employer Organization ("PEO") or service model. Under this model, TriNet incurs all expenses associated with its plan sponsorship and maintenance, and TriNet bills the Customer for its services. Customer has no other financial obligation to TriNet, its other customers, or any of its insurance carriers for benefit plans sponsorship or provision. TriNet's carriers have no recourse against TriNet customers. Other than compliance with TriNet's contract terms, Customers have no legal responsibilities to TriNet or the WSEs or any other TriNet customer for plan sponsorship or compliance.

Any references to "your benefit programs or plans" are not legal terms or terms of art, and should not be confused with legal plan sponsorship, participation, or fiduciary compliance. These terms and others, such as "your employees" or "your selections, plan, or investments," are used solely as lay terms of convenience so that you understand we are referring only to the decisions made and TriNet plans available in a specific worksite or to a specific group of WSEs.

Exclusions and limitations apply. In the event there is a conflict between any of the information contained in any benefits guidance materials provided by TriNet (including but not limited to information contained in any TriNet website, the Benefits Confirmation Statement, any written or electronic pamphlets, letters, emails, text messages, and statements made by TriNet employees) and TriNet's Plan document, the Plan document will control. Also, if there is a conflict between an official certificate provided by TriNet's insurance carrier(s) (the "Carrier Certificate") and either TriNet's Plan document, the forthcoming Summary Plan Description, statements made by a TriNet employee, or any other benefits guidance materials provided by TriNet (including but not limited to those described above), the Carrier Certificate will control.

Please note: Information contained in this summary may be updated at any time based on additional clarifications due to recent health care reform legislation and state mandates.

	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			
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			
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	In-Network: 100% covered Out-of-Network: 60% covered after deductible
	لنب زيداد إليا			(1 exam per 24 months)	(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	In-Network: 90% covered after deductible	In-Network: 90% covered after deductible	In-Network: 90% covered after deductible	In-Network: 80% covered after deductible
	Out-of-Network:	Out-of-Network:	Out-of-Network:	Out-of-Network:	Out-of-Network:
	60% covered after	90% covered after	90% covered after	90% covered after	80% covered after
	deductible	deductible	deductible	deductible	deductible
Jrgent Care	In-Network:	In-Network:	In-Network:	In-Network:	In-Network:
	60% covered after	90% covered after	90% covered after	90% covered after	80% covered after
	deductible	deductible	deductible	deductible	deductible
	Out-of-Network:	Out-of-Network:	Out-of-Network:	Out-of-Network:	Out-of-Network:
	50% covered after	70% covered after	70% covered after	70% covered after	60% covered after
	deductible	deductible	deductible	deductible	deductible
Pregnancy & Maternity Care					
Prenatal Care and Inpatient	In-Network: \$50 for initial visit, then 60% covered after deductible	In-Network: \$40 for initial visit, then 90% covered after deductible	In-Network: \$35 for initial visit, then 90% covered after deductible	In-Network: 90% covered after deductible	In-Network: 80% covered after deductible
	Out-of-Network:	Out-of-Network:	Out-of-Network:	Out-of-Network:	Out-of-Network:
	50% covered after	70% covered after	70% covered after	70% covered after	60% covered after
	deductible	deductible	deductible	deductible	deductible
Other Medical Services (Includin	g Alternative Care)				
X-Ray and Lab - Outpatient (Applicable deductibles and copays apply)	In-Network: \$50/visit	In-Network: \$40/visit	In-Network: \$35/visit	In-Network: 90% covered after deductible	In-Network: 80% covered after deductible
1	Out-of-Network:	Out-of-Network:	Out-of-Network:	Out-of-Network:	Out-of-Network:
	50% covered after	70% covered after	70% covered after	70% covered after	60% covered after
	deductible	deductible	deductible	deductible	deductible
MRIs (Complex Imaging) Outpatient	In-Network: \$200/visit	In-Network: \$150/visit	In-Network: \$150/visit	In-Network: 90% covered after deductible	In-Network: 80% covered after deductible
5.	Out-of-Network:	Out-of-Network:	Out-of-Network:	Out-of-Network:	Out-of-Network:
	50% covered after	70% covered after	70% covered after	70% covered after	60% covered after
	deductible	deductible	deductible	deductible	deductible
Chiropractic (Subject to visit limits)	In-Network: \$50/visit	In-Network: \$40/visit	In-Network: \$35/visit	In-Network: 90% covered after deductible	In-Network: 80% covered after deductible
	Out-of-Network:	Out-of-Network:	Out-of-Network:	Out-of-Network:	Out-of-Network:
	50% covered after	70% covered after	70% covered after	70% covered after	60% covered after
	deductible	deductible	deductible	deductible	deductible
Physical Therapy and Speech Therapy (Subject to visit limits)	In-Network: \$50/visit	In-Network: \$40/visit	In-Network: \$35/visit	In-Network: 90% covered after deductible	In-Network: 80% covered after deductible
	Out-of-Network:	Out-of-Network:	Out-of-Network:	Out-of-Network:	Out-of-Network:
	50% covered after	70% covered after	70% covered after	70% covered after	60% covered after
	deductible	deductible	deductible	deductible	deductible
	(Up to 60 visits/year combined)	(Up to 60 visits/year combined)	(Up to 60 visits/year combined)	(Up to 60 visits/year combined)	(Up to 60 visits/year combined)
Mental Health	1 0 1 0 7				
Mental Health – Inpatient	In-Network:	In-Network:	In-Network:	In-Network:	In-Network:
	60% covered after	90% covered after	90% covered after	90% covered after	80% covered after
	deductible	deductible	deductible	deductible	deductible
	Out-of-Network:	Out-of-Network:	Out-of-Network:	Out-of-Network:	Out-of-Network:
	50% covered after	70% covered after	70% covered after	70% covered after	60% covered after
	deductible	deductible	deductible	deductible	deductible
Mental Health – Outpatient	In-Network: 100% covered	In-Network: 100% covered	In-Network: 100% covered	In-Network: 90% covered after deductible	In-Network: 80% covered after deductible
	Out-of-Network:	Out-of-Network:	Out-of-Network:	Out-of-Network:	Out-of-Network:
	50% covered after	70% covered after	70% covered after	70% covered after	60% covered after
	deductible	deductible	deductible	deductible	deductible

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

	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/lamily Out-of-Network: \$8,000/person; \$16,000/lamily (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			
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	In-Network: \$250/visit	In-Network: \$250/visit	In-Network: 90% covered after deductible	In-Network: \$250/visit
	Out-of-Network: \$250/visit	Out-of-Network: \$250/visit	Out-of-Network: \$250/visit	Out-of-Network: 90% covered after deductible	Out-of-Network: \$250/visit
Jrgent Care	In-Network: \$75/visit	In-Network: \$75/visit	In-Network: \$75/visit	In-Network: 90% covered after deductible	In-Network: \$75/visit
	Out-of-Network: 50% covered after deductible	Out-of-Network: 60% covered after deductible	Out-of-Network: 70% covered after deductible	Out-of-Network: 70% covered after deductible	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	In-Network: \$50 for initial visit, then 80% covered after deductible	In-Network: \$50 for initial visit, then 100% covered after deductible	In-Network: 90% covered after deductible	In-Network: \$50 for initial visit, ther 80% covered after deductible
	Out-of-Network: 50% covered after deductible	Out-of-Network: 60% covered after deductible	Out-of-Network: 70% covered after deductible	Out-of-Network: 70% covered after deductible	Out-of-Network: 60% covered after deductible
Other Medical Services (Includin	g Alternative Care)				
X-Ray and Lab – Outpatient (Applicable deductibles and copays apply)	In-Network: 70% covered after deductible	In-Network: 80% covered after deductible	In-Network: 100% covered after deductible	In-Network: 90% covered after deductible	In-Network: 80% covered after deductible
	Out-of-Network: 50% covered after deductible	Out-of-Network: 60% covered after deductible	Out-of-Network: 70% covered after deductible	Out-of-Network: 70% covered after deductible	Out-of-Network: 60% covered after deductible
MRIs (Complex Imaging) Outpatient	In-Network: 70% covered after deductible	In-Network: 80% covered after deductible	In-Network: 100% covered after deductible	In-Network: 90% covered after deductible	In-Network: 80% covered after deductible
	Out-of-Network: 50% covered after deductible	Out-of-Network: 60% covered after deductible	Out-of-Network: 70% covered after deductible	Out-of-Network: 70% covered after deductible	Out-of-Network: 60% covered after deductible
Chiropractic (Subject to visit limits)	In-Network: \$50/visit	In-Network: \$50/visit	In-Network: \$60/visit	In-Network: 90% covered after deductible	In-Network: \$50/visit
	Out-of-Network: 50% covered after deductible	Out-of-Network: 60% covered after deductible	Out-of-Network: 70% covered after deductible	Out-of-Network: 70% covered after deductible	Out-of-Network: 60% covered after deductible
Physical Therapy and Speech Therapy (Subject to visit limits)	In-Network: 70% covered after deductible	In-Network: 80% covered after deductible	In-Network: 100% covered after deductible	In-Network: 90% covered after deductible	In-Network: \$50/visit
	Out-of-Network: 50% covered after deductible	Out-of-Network: 60% covered after deductible	Out-of-Network: 70% covered after deductible	Out-of-Network: 70% covered after deductible	Out-of-Network: 60% covered after deductible
	(Up to 60 visits/year combined)	(Up to 60 visits/year combined)	(Up to 60 visits/year combined)	(Up to 60 visits/year combined)	(Up to 60 visits/year combined)
Mental Health					
Mental Health – Inpatient	In-Network: 70% covered after deductible	In-Network: 80% covered after deductible	In-Network: 100% covered after deductible	In-Network: 90% covered after deductible	In-Network: 80% covered after deductible
	Out-of-Network: 50% covered after deductible	Out-of-Network: 60% covered after deductible	Out-of-Network: 70% covered after deductible	Out-of-Network: 70% covered after deductible	Out-of-Network: 60% covered after deductible
Mental Health – Outpatient	In-Network: \$50/visit	In-Network: \$50/visit	In-Network: \$60/visit	In-Network: 90% covered after deductible	In-Network: \$50/visit
	Out-of-Network: 50% covered after deductible	Out-of-Network: 60% covered after deductible	Out-of-Network: 70% covered after deductible	Out-of-Network: 70% covered after deductible	Out-of-Network: 60% covered after deductible

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
Mall-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

	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 \$pecialist: \$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	In-Network: 90% covered after deductible	In-Network: 80% covered after deductible	In-Network: 90% covered after deductible	In-Network: 90% covered after deductible
	Out-of-Network:	Out-of-Network:	Out-of-Network:	Out-of-Network:	Out-of-Network:
	70% covered after	90% covered after	80% covered after	90% covered after	90% covered after
	deductible	deductible	deductible	deductible	deductible
Urgent Care	Determined by place of				
	service – contact Blue	service – contact Blue	service - contact Blue	service – contact Blue	service – contact Blue
	Shield for details				
Pregnancy & Maternity Care					
Prenatal Care and Inpatient	In-Network:	In-Network:	In-Network:	In-Network:	In-Network:
	70% covered after	90% covered after	80% covered after	90% covered after	90% covered after
	deductible	deductible	deductible	deductible	deductible
	Out-of-Network:	Out-of-Network:	Out-of-Network:	Out-of-Network:	Out-of-Network:
	50% covered after	70% covered after	60% covered after	70% covered after	70% covered after
	deductible, up to				
	\$1,500/day	\$1,500/day	\$1,500/day	\$1,500/day	\$1,500/day
Other Medical Services (Includin	g Alternative Care)				
X-Ray and Lab – Outpatient (Applicable deductibles and copays apply)	In-Network: \$35/visit	In-Network: 90% covered after deductible	In-Network: \$30/visit	In-Network: \$25/visit	In-Network: \$20/visit
	Out-of-Network:	Out-of-Network:	Out-of-Network:	Out-of-Network:	Out-of-Network:
	50% covered after	70% covered after	60% covered after	70% covered after	70% covered after
	deductible	deductible	deductible	deductible	deductible
MRIs (Complex Imaging) Outpatient	In-Network: 70% covered after deductible	In-Network: 90% covered after deductible	In-Network: 80% covered after deductible	In-Network: 90% covered after deductible	In-Network: 90% covered after deductible
	Out-of-Network:	Out-of-Network:	Out-of-Network:	Out-of-Network:	Out-of-Network:
	50% covered after	70% covered after	60% covered after	70% covered after	70% covered after
	deductible	deductible	deductible	deductible	deductible
Chiropractic (Subject to visit limits)	In-Network: \$25/visit	In-Network: 90% covered after deductible	In-Network: \$25/visit	In-Network: \$25/visit	In-Network: \$25/visit
	Out-of-Network:	Out-of-Network:	Out-of-Network:	Out-of-Network:	Out-of-Network:
	50% covered after	70% covered after	60% covered after	70% covered after	70% covered after
	deductible	deductible	deductible	deductible	deductible
	(Up to 20 visits/year)		(Up to 20 visits/year)	(Up to 20 visits/year)	(Up to 20 visits/year)
Physical Therapy and Speech	In-Network:	In-Network:	In-Network:	In-Network:	In-Network:
Therapy	Physical therapy:	90% covered after	Physical therapy:	Physical therapy:	Physical therapy:
(Subject to visit limits)	\$35/visit	deductible	\$45/visit	\$40/visit	\$35/visit
	Speech therapy: \$20/visit	Out-of-Network: 70% covered after deductible	Speech therapy: \$20/visit	Speech therapy: \$20/visit	Speech therapy: \$20/visit
	Out-of-Network: 50% covered after deductible		Out-of-Network: 60% covered after deductible	Out-of-Network: 70% covered after deductible	Out-of-Network: 70% covered after deductible
Mental Health				1911 - 11	
Mental Health – Inpatient	In-Network:	In-Network:	In-Network:	In-Network:	In-Network:
	70% covered after	90% covered after	80% covered after	90% covered after	90% covered after
	deductible	deductible	deductible	deductible	deductible
	Out-of-Network:	Out-of-Network:	Out-of-Network:	Out-of-Network:	Out-of-Network:
	50% covered after	70% covered after	60% covered after	70% covered after	70% covered after
	deductible, up to				
	\$1,500/day	\$1,500/day	\$1,500/day	\$1,500/day	\$1,500/day
Mental Health – Outpatient	In-Network: \$35/visit	In-Network: 90% covered after deductible	In-Network: \$30/visit	In-Network: \$25/visit	In-Network: \$20/visit
	Out-of-Network:	Out-of-Network:	Out-of-Network:	Out-of-Network:	Out-of-Network:
	50% covered after	70% covered after	60% covered after	70% covered after	70% covered after
	deductible	deductible	deductible	deductible	deductible

Substance Abuse – Inpatient	In-Network: 70% covered after deductible	In-Network: 90% covered after deductible	In-Network: 80% covered after deductible	In-Network: 90% covered after deductible	In-Network: 90% covered after deductible
	Out-of-Network: 50% covered after deductible, up to \$1,500/day	Out-of-Network: 70% covered after deductible, up to \$1,500/day	Out-of-Network: 60% covered after deductible, up to \$1,500/day	Out-of-Network: 70% covered after deductible, up to \$1,500/day	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		7-3			
Retall 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 specially 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

	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/lamily Out-of-Network: \$16,000/person; \$32,000/lamily (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	In-Network: 70% covered after deductible	In-Network: 80% covered after deductible	In-Network: 90% covered after deductible	In-Network: 90% covered after deductible
	Out-of-Network: 50% covered after deductible	Out-of-Network: 50% covered after deductible	Out-of-Network: 60% covered after deductible	Out-of-Network: 70% 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 (Includin	g 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	In-Network: 70% covered after deductible Out-of-Network: 50% covered after	In-Network: 80% covered after deductible Out-of-Network: 60% covered after	In-Network: 90% covered after deductible Out-of-Network: 70% covered after	In-Network: 90% covered after deductible Out-of-Network: 60% covered after
Mental Health – Outpatient	In-Network: \$50/visit Out-of-Network: 50% covered	deductible In-Network: \$50/visit Out-of-Network: 50% covered	In-Network: \$45/visit Out-of-Network: 60% covered	fn-Network: \$40/visit Out-of-Network: 70% covered	In-Network: 90% covered after deductible Out-of-Network: 60% covered after deductible

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
Mall-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

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	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/lamily Out-of-Network: \$10,000/person; \$20,000/lamily	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			Kinik je ha Kri	******	
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-cuttling) 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 (Includi	ing 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	Not covered	In-Network: 80% covered after	In-Network: 90% covered after	\$10/visit \$7/manipulation
	deductible Out-of-Network: 80% covered after		deductible Out-of-Network: 60% covered after	deductible Out-of-Network: 70% covered after	(Up to 20 visits/year; combined with therapy benefits)
	deductible (Up to combined \$2,500 outpatient therapy maximum; up to 26 spinal manipulations)		deductible (Up to 12 visits/year; combined in- and out-of- network)	deductible (Up to 12 visits/year; combined in- and out-of- network)	
Physical Therapy and Speech Therapy (Subject to visit limits)	In-Network: 100% covered after deductible	In-Network: Inpatient: 90% covered	In-Network: 80% covered after deductible	In-Network: 90% covered after deductible	\$7/visit (Up to 20 visits/year; combined with chiropractic
	Out-of-Network: 80% covered after deductible	Outpatient: 80% covered	Out-of-Network: 60% covered after deductible	Out-of-Network: 70% covered after deductible	benefits)
	(Up to combined \$2,500 outpatient therapy maximum)	Out-of-Network: 70% covered after deductible	(Physical therapy: 30 visits/year; speech therapy: no limit)	(Physical therapy: 30 visits/year; speech therapy: no limit)	
Mental Health					. 7
Mental Health – Inpatient	In-Network: 100% covered after deductible	In-Network: 90% covered	In-Network: 80% covered after deductible	In-Network: 90% covered after deductible	100% after \$50/admission
	Out-of-Network: 80% covered after deductible	Out-of-Network: 70% covered after deductible	Out-of-Network: 60% covered after deductible	Out-of-Network: 70% covered after deductible	
Mental Health – Outpatient	In-Network: 100% covered after deductible	In-Network: \$12/visit	In-Network: \$30/visit*	In-Network: \$20/visit*	Individual therapy: \$10/visit
	Out-of-Network: 80% covered after	Out-of-Network: 70% covered after deductible	Out-of-Network: 80% covered after deductible	Out-of-Network: 80% covered after deductible	Group therapy: \$5/visit
	deductible		*Some services performed during a routine office visit may be subject to the deductible	*Some services performed during a routine office visit may be subject to the deductible	(Group therapy: up to 5 visits/policy year)
Substance Abuse			7 1 5 1 5		
Substance Abuse – Inpatient	In-Network: 100% covered after deductible	In-Network: 90% covered Out-of-Network:	In-Network: 80% covered after deductible	In-Network: 90% covered after deductible	100% after \$50/admission (Maximum 30 days/policy
	Out-of-Network: 80% covered after deductible	70% covered after deductible	Out-of-Network: 60% covered after deductible	Out-of-Network: 70% covered after deductible	year)
Substance Abuse - Outpatient	In-Network: 100% covered after deductible	In-Network: \$12/visit	In-Network: \$30/visit*	In-Network: \$20/visit*	Individual therapy: \$10/visit
	Out-of-Network: 80% covered after	Out-of-Network: 70% covered after deductible	Out-of-Network: 80% covered after deductible	Out-of-Network: 80% covered after deductible	Group therapy: \$5/visit
	deductible		*Some services performed during a routine office visit may be subject to the deductible	'Some services performed during a routine office visit may be subject to the deductible	(Group therapy: up to 5 visits/policy year)
Prescription Drugs	7. II				
Retail Pharmacy – In-Network (30-day supply if not specified) Dollar amounts listed are generic/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
non-formulary brand 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	acute prescriptions) \$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

	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		1 - 1 - 1			
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/tamily (Includes deductible)	\$2,000/person; \$4,000/family
Lifetime Benefits Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Routine Health Maintenance					and the state of t
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	In-Network: 100% covered	Subject to routine physical exam cost sharing	Subject to routine physica exam cost sharing
*		Out-of-Network: 70% covered after deductible	Out-of-Network: 70% covered after deductible	Hearing Ald: Not covered	Hearing Aid: Not covered
			(1 exam per 24 months)		
Physician & Hospital Services					Carlo See a Mil
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 walved if admitted)	80% covered after deductible	In-Network: \$75/visit Out-of-Network:	In-Network: 90% covered after deductible	\$150/visit	\$100/visit
		\$75/visit	Out-of-Network: 90% covered after deductible		
Urgent Care	80% covered after deductible	In-Network: \$25/visit	In-Network: 90% covered after deductible	\$75/visit	\$50/visit
		Out-of-Network: 70% covered after deductible	Out-of-Network: 70% covered after deductible		
Pregnancy & Maternity Care	\				
Prenatal Care and Inpatient	80% covered after deductible	In-Network: \$30 for initial visit, then \$250 copay/confinement; delivery charges covered	In-Network: 90% covered after deductible	Visits: \$45 for initial visit, then 100% covered	Visits: \$35 for initial visit, then 100% covered
		90% Out-of-Network: 70% covered after deductible	Out-of-Network: 70% covered after deductible	Inpatient: 80% covered after deductible	Inpatient: 100% covered after \$250/admission
Other Medical Services (Including	Alternative Care)		LX-14-1-FI		
X-Ray and Lab - Outpatient (Applicable deductibles and copays apply)	80% covered after deductible	In-Network: \$30/visit	In-Network: 90% covered after deductible	Diagnostic X-ray: \$45/visit	Diagnostic X-ray: \$35/visit
ши сорије цррју	ė.	Out-of-Network: 70% covered after deductible	Out-of-Network: 70% covered after deductible	Lab: 100% covered	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)	(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 – 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				F-1:1-1:-	
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 specially 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

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	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		d and group			
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

Prenatal Care and Inpatient	Prenatal: 100% covered Inpatient: 100% covered after	Prenatal: 100% covered Inpatient: 100% covered after	Visits: 100% covered Inpatient: 80% covered after	Visits: 100% covered Inpatient: 100% covered after	Visits: \$45 for initial visit, then 100% covered Inpatient:
	\$500/admission	\$350/admission	deductible	\$250/admission	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) Outpatlent	100% covered	100% covered	\$50 per procedure after deductible	100% covered	\$150/visit
Chiropractic	\$45/visit	\$35/visit	\$15/visit	\$15/visit	\$45/visit
(Subject to visit limits)	(Up to 30 visits/year)	(Up to 30 visits/year)	(Up to 20 visits/calendar year)	(Up to 20 visits/calendar year)	(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		10 10 10 1	18		
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 specially 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 Kalser for more details	Third tier copay applies – refer to your COC for further details

	Aetna CO HMO 20	Kalser 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	со	со	со	СТ	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 o 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	Untimited
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 Ald: 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

Prenatal Care and Inpatient	Visite:	Visite	Visits:	Visits:	Visits:
Prenatar Care and Impatient	Visits: \$35 for initial visit, then 100% covered	Visits: 100% covered	100% covered	\$45 for initial visit, then 100% covered	\$35 for initial visit, then 100% covered
	Inpatient: 100% covered after \$250/admission	Inpatient: 80% covered after deductible	Inpatient: 100% after \$250/admission	Inpatient: 100% covered after deductible and \$400/day for first 5 days	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	Diagnostic X-ray: \$35/visit
and copays apply)				Lab: 100% covered	Lab: 100% covered
MRIs (Complex Imaging) Outpatient	\$150/visit	80% covered after deductible	100% covered	\$75/visit	\$75/visit
Chiropractic	\$35/visit	\$45/visit	\$35/visit	\$45/visit	\$35/visit
(Subject to visit limits)	(Up to 20 visits/calendar year)	(Up to 20 visits/calendar year)	(Up to 20 visits/calendar year)	(Up to 20 visits/calendar year)	(Up to 20 visits/calendar year)
Physical Therapy and Speech	\$35/visit	\$30/visit	\$20/visit	\$45/visit	\$35/visit
Therapy (Subject to visit limits)	(Up to a 60-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)	(Up to 20 visits/therapy year)	(Up to 20 visits/therapy year)	(Up to a 60-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)	(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:	Individual session: \$20/visit Group session:	\$45/visit	\$35/visit
		\$15/visit	\$10/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 – Outpatlent	\$35/visit	Individual session: \$30/visit	Individual session: \$20/visit	\$45/visit	\$35/visit
		Group session: \$15/visit	Group session: \$10/visit		
Prescription Drugs					
Retall 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 specially 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

	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				P. W. T. T.	
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			- X- y		
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)			And the state	
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					
Retall 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

	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 ald: 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 ald: Not covered
Physician & Hospital Services				X	
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	\$45/visit	\$35/visit	\$45/visit	\$35/visit (Up to 20 visits/calendar
	(Up to 20 visits/calendar year)	(Authorization required)	(Authorization required)	(Up to 20 visits/calendar year)	year)
Physical Therapy and Speech Therapy	\$35/visit	\$45/visit	\$35/visit	\$45/visit	\$35/visit
(Subject to visit limits)	(Up to a 60-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)	(Authorization required)	(Authorization required)	(Up to a 60-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)	(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	1,				
Retall 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
Mall-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

	Kaiser GA HMO 30	Kaiser GA HMO 20	Kaiser HI HMO	Aetna IL HMO 30	Aetna IL HMO 20
Regional Plan Names	Kalser GA HMO 30	Kaiser GA HMO 20	Kaiser HI HMO	Aetna IL HMO 30	Aetna IL HMO 20
Plan Locations	GA	GA	н	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			En Harman Taxas	- S	
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		1 1 1 2 1 1 1			1 5 7 8
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			A STATE OF THE STATE OF		
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:	In office: 100% covered Hospital:	90% covered	Diagnostic X-ray: \$45/visit Lab:	Diagnostic X-ray: \$35/visit Lab:
	80% covered after deductible	\$250/procedure		100% covered	100% covered

MRIs (Complex Imaging) Outpatient	80% covered after deductible	\$250/procedure/nospital \$35 in doctor'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/calendaryear)	\$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				- 1,	10 10 10 10 10 10 10 10 10 10 10 10 10 1
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		THE THE		-1.4	
Retail Pharmacy – In-Network (30-day supply if not specified) Dollar amounts listed are generic/formulary brand/ non-formulary brand	Kalser 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 specially 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

	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/lamily (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	Subject to routine physical exam cost sharing	Subject to routine physical exam cost sharing
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)				, and the second
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	\$35/visit	\$45/visit	\$35/visit	\$45/visit
	(Up to 20 visits/calendar year)	(Up to 20 visits/calendar year)	(Up to 20 visits/calendar year)	(Up to 20 visits/calendar year)	(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		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			
Retall 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
Mall-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 specially 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

	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	МА	MA, NH, and RI	MA, NH, and RI	МО	МО
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	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					THE WAY TELEVISION
Physician Office Visit	\$20/visit Specialist: \$35/visit	PCP: \$30/visit \$pecialist: \$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 deductible Outpatient:	Inpatient: \$250/visit Outpatient: \$20/visit for up to 10 visits,	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
	100% covered after \$250/admission	\$30/visit for up to 10 visits, then 100% covered	then 100% covered		

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					TE TO STEWARD
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			90 - 0 - N		
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

	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/(amily (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				8 1 1 1 1 1 1 1 1 1	
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	Subject to routine physical exam cost sharing	Subject to routine physical exam cost sharing	Subject to routine physical exam cost sharing	Subject to routine physical exam cost sharing
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				1	
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)	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			
X-Ray and Lab – Outpatient (Applicable deductibles and copays apply)	Diagnostic X-ray: \$45/visit	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

(Subject to visit limits)	\$25/visit	\$25/visit	\$45/visit	\$35/visit	\$45/visit
	(Up to 20 visits/calendar year)	(Up to 20 visits/calendar year)	(Up to 20 visits/calendar year)	(Up to 20 visits/calendar year)	(Up to 20 visits/calendar year)
Physical Therapy and Speech Therapy	\$45/visit	\$35/visit	\$45/visit	\$35/visit	\$45/visit
(Subject to visit limits)	(Up to a 60-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)	(Up to a 60-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)	(Up to a 60-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)	(Up to a 60-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)	(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	\$20/visit	\$45/visit
			(Up to 20 visits/year for family members for rehabilitation)	(Up to 20 visits/year for family members for rehabilitation)	
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
Mall-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 specially 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

	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	ОН	ОН
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	1000		ET, I VIII		
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	Subject to routine physical exam cost sharing \$30/visit	Subject to routine physical exam cost sharing	Subject to routine physical exam cost sharing	Subject to routine physical exam cost sharing
Physician & Hospital Services		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			
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					
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	\$45/visit	\$35/visit	\$45/visit	\$35/visit
	(Up to 20 visits/calendar year)			(Up to 20 visits/calendar year)	(Up to 20 visits/calendar year)
Physical Therapy and Speech Therapy	\$35/visit	\$45/visit	\$35/visit	\$45/visit	\$35/visit
Subject to visit limits)	(Up to a 60-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)	(Up to a 60-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)	(Up to a 60-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)	(Up to a 60-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)	(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	The state of				
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					
Retall 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 specially 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

	Kalser 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				W. 1 - 1 - 1	
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	Subject to routine physical exam cost sharing	Subject to routine physical exam cost sharing
Physician & Hospital Services		- 11. 11.			
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	\$15 <mark>0/visit</mark>	\$100/visit	\$75/visit
Pregnancy & Maternity Care					Estile Sin 1
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)			Y i w 'w' -wi	
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	\$20/visit	\$45/visit	\$35/visit	\$45/visit
(Subject to visit mints)	(Up to 20 visits/calendar year)	(Up to 20 visits/calendar year)	(Up to 20 visits/calendar year)	(Up to 20 visits/calendar year)	
Physical Therapy and Speech Therapy (Subject to visit limits) Mental Health Mental Health – Inpatient	\$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) 80% covered after deductible
Mental Health — Outpatient	deductible Individual session: \$30/visit Group session: \$15/visit	\$250/admission Individual session: \$20/visit Group session: \$10/visit	deductible \$45/visit	\$250/admission \$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 Kalser 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	Subject to routine physical exam cost sharing	Subject to routine physical exam cost sharing	Subject to routine physical exam cost sharing \$30/visit	Subject to routine physical exam cost sharing
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	Visits: \$45 for initial visit; then 100% covered	Visits: \$35 for initial visit; then 100% covered	Visits: \$45 for initial visit; then 100% covered	Visits: \$35 for initial visit; then 100% covered
	Inpatient: 100% covered after \$250/admission	Inpatient: 80% covered after deductible	Inpatient: 100% covered after \$250/admission	Inpatient: 80% covered after deductible	Inpatient: 100% covered after \$250/admission
Other Medical Services (Including	Alternative Care)		1 d 2 1 1 - 1	Of the same	
X-Ray and Lab – Outpatient (Applicable deductibles and copays apply)	Diagnostic X-ray: \$35/visit Lab:	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	100% covered \$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	\$35/visit (Up to 20 visits/calendar
				year)	year)
Physical Therapy and Speech Therapy	\$35/visit	\$45/visit	\$35/visit	\$45/visit	\$35/visit
(Subject to visit limits)	(Up to a 60-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)	(Up to a 60-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)	(Up to a 60-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)	(Up to a 60-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)	(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	_U *** 2E		ta tiva je ijit sile i		
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

		The state of the s	the state of the s
Aetna VA HMO 30	Aetna VA HMO 20	Group Health WA HMO 30	Group Health WA HMO 20
VA	VA	WA	WA
HMO Open Access	HMO Open Access	Alliant Select	Alliant Select
\$1,000/person; \$2,000/family	None	\$1,000/person; \$2,000/family	None
\$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
Unlimited	Unlimited	Unlimited	Unlimited
	wen 'en n' file		
100% covered	100% covered	100% covered	100% covered
Not covered	Not covered	\$30/visit (deductible and coinsurance apply)	\$20/visit
Subject to routine physical exam cost sharing	Subject to routine physical exam cost sharing	\$30/visit (deductible and coinsurance apply)	\$20/visit
100% covered	100% covered		
\$30/visit Specialist: \$45/visit	\$20/visit Specialist: \$35/visit	80% covered after deductible and \$30/visit	\$20/visit Specialist: \$40/visit
80% covered after deductible	100% covered after \$250/visit	80% covered after deductible and \$50/visit	\$20/visit Specialist: \$40/visit
80% covered after deductible	100% covered after \$250/admission	80% covered after deductible	100% covered after \$250/admission
\$150/visit	\$100/visit	80% covered after deductible and \$150/visit	\$100/visit
\$75/visit	\$50/visit	80% covered after deductible and \$30/visit	Primary care provider: \$20/visit Specialist: 40/visit
	-, "-,", lg,, ','', -l.,-	Latina Paga	
Visits: \$45 for initial visit; then 100% covered Inpatient:	Visits: \$35 for initial visit; then 100% covered Inpatient:	Visits: \$30 copay/visit (deductible and coinsurance apply) Inpatient:	Visits: \$20/visit Inpatient: 100% covered after \$250/admission
	HMO Open Access \$1,000/person; \$2,000/family \$3,000/person; \$6,000/family (Includes deductible) Unlimited 100% covered Subject to routine physical exam cost sharing 100% covered \$30/visit \$pecialist: \$45/visit 80% covered after deductible \$150/visit \$75/visit Visits: \$45 for initial visit; then 100% covered	WA HMO Open Access HMO Open Access \$1,000/person; \$2,000/family \$3,000/person; \$4,000/family Unlimited Unlimited Unlimited 100% covered Not covered Not covered Subject to routine physical exam cost sharing 100% covered \$20/visit \$20/visit \$20/visit \$20/visit \$pecialist: \$35/visit \$35/visit \$35/visit	WA HMO Open Access HMO Open Access Alliant Select S1,000/person; S2,000/family S3,000/person; S2,000/family S3,000/person; S4,000/family S3,000/person; S4,000/family S5,000/family S5,

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	و و المحالي والمحالية			THE WASHINGTON
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 specially 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	In-Network: \$50/person; \$150/family	In-Network: \$50/person; \$150/family	In-Network: \$100/person; \$300/family
	Out-of-Network: \$100/person; \$300/family	Out-of-Network: \$100/person; \$300/family	Out-of-Network: \$150/person; \$300/family	Out-of-Network: \$150/person; \$450/lamily
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	In-Network: 100% covered	In-Network: 100% covered	In-Network: 100% covered
	Out-of-Network: 100% covered	Out-of-Network: 100% covered	Out-of-Network: 100% covered	Out-of-Network: 100% covered
Basic Services				
Fillings and Oral Surgery	In-Network: 90% covered after deductible	In-Network: 90% covered after deductible	In-Network: 90% covered after deductible	In-Network: 70% covered after deductible
	Out-of-Network: 80% covered after deductible	Out-of-Network: 80% covered after deductible	Out-of-Network: 80% covered after deductible	Out-of-Network: 50% covered after deductible
Periodontics	In-Network: 90% covered after deductible	In-Network: 90% covered after deductible	In-Network: 90% covered after deductible	In-Network: 70% covered after deductible
	Out-of-Network: 80% covered after deductible	Out-of-Network: 80% covered after deductible	Out-of-Network: 80% covered after deductible	Out-of-Network: 50% covered after deductible
Endodontics	In-Network: 90% covered after deductible	In-Network: 90% covered after deductible	In-Network: 90% covered after deductible	In-Network: 70% covered after deductible
	Out-of-Network: 80% covered after deductible	Out-of-Network: 80% covered after deductible	Out-of-Network: 80% covered after deductible	Out-of-Network: 50% covered after deductible
Crowns & Cast Restorations				
Crowns, Inlays, Onlays, and Bridges	In-Network: 65% covered after deductible	In-Network: 65% covered after deductible	In-Network: 65% covered after deductible	In-Network: 50% covered after deductible
	Out-of-Network: 50% covered after deductible			
Prosthodontics				
Dentures	In-Network: 65% covered after deductible	In-Network: 65% covered after deductible	In-Network: 65% 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	In-Network: 50% covered after \$50 orthodontia deductible	In-Network: 50% covered after \$50 orthodontia deductible	Not available
	Out-of-Network: 50% covered after \$50 orthodontia deductible	Out-of-Network: 50% covered after \$50 orthodontia deductible	Out-of-Network: 50% covered after \$50 orthodontia deductible	
	(Up to \$1,500/person/lifetime)	(Up to \$1,500/person/lifetime)	(Up to \$1,500/person/lifetime)	

- 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	BW II Y			
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:	In-Network: \$100/person; \$300/family Out-of-Network:	None	None
	\$150/person; \$450/family	\$150/person; \$450/family		
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
Basic Services				the EOC booklet for details)
Fillings and Oral Surgery	In-Network: 70% covered after deductible	In-Network: 70% covered after deductible	Fillings: \$0 – \$85/visit depending on the services rendered	\$0 – \$75/visit depending on the services rendered
	Out-of-Network: 50% covered after deductible	Out-of-Network: 50% covered after deductible	Oral Surgery: \$0 – \$280/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:	In-Network: 50% covered after deductible Out-of-Network:	\$20 - \$240/visit depending on the services rendered	\$10 - \$320/visit depending on the services rendered
200	50% covered after deductible	50% covered after deductible		
Orthodontics	West Market		Tank transfer	Tana
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, construction, placement, and adjustments to retainers and office visits students. Some state rutes may differ.	24 months of active treatment, debar s for a maximum of 24 months. Eligibl	nding, and the retention phase of treatmen le children are dependent, unmarried child	t. The treatment phase includes the initial ren up to age 19, or 25 if full-time
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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	Aelna through EyeMed	VSP Signature Network	VSP Signature Network
Plan Features				
Copay Schedule	In-Network:	In-Network:	In-Network:	In-Network:
	Exam: \$10	Exam: \$10	Exam: \$10	Exam: \$10
	Materials: \$25	Materials: \$25	Materials: \$25	Materials: \$25
			Out-of-Network:	Out-of-Network:
	D 40 10 10 10 10 10 10 10 10 10 10 10 10 10		Exam: \$10	Exam: \$10
			Materials: \$25	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:	In-Network:	In-Network:	In-Network:
	100% covered after copay	100% covered after copay	100% covered after copay	100% covered after copay
المستوسي	Out-of-Network: Up to \$50 covered	Out-of-Network: Up to \$45 covered	Out-of-Network: Up to \$50 covered after copay	Out-of-Network: Up to \$45 covered after copay
Lenses				
Single Vision Lenses (Depends on prescription and addons)	In-Network: 100% covered after copay	In-Network: 100% covered after copay	In-Network: 100% covered after copay	In-Network: 100% covered after copay
	Out-of-Network: Up to \$50 covered	Out-of-Network: Up to \$45 covered	Out-of-Network: Up to \$50 covered after copay	Out-of-Network: Up to \$45 covered after copay
Bifocal Lenses (Depends on prescription and addons)	In-Network: 100% covered after copay	In-Network: 100% covered after copay	In-Network: 100% covered after copay	In-Network: 100% covered after copay
	Out-of-Network: Up to \$75 covered	Out-of-Network: Up to \$65 covered	Out-of-Network: Up to \$75 covered after copay	Out-of-Network: Up to \$65 covered after copay
Trifocal Lenses (Depends on prescription and addons)	In-Network: 100% covered after copay	In-Network: 100% covered after copay	In-Network: 100% covered after copay	In-Network: 100% covered after copay
	Out-of-Network: Up to \$100 covered	Out-of-Network: Up to \$85 covered	Out-of-Network: Up to \$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	In-Network: Up to \$130 covered, then 20% discount	In-Network: Up to \$150 covered then 20% discount	In-Network: Up to \$130 covered after copay, then 20% discount
	Out-of-Network: Up to \$75 covered	Out-of-Network: Up to \$47 covered	Out-of-Network: Up to \$75 covered after copay	Out-of-Network: Up to \$47 covered after copay
			Costco: Up to \$100 covered after copay	Costco: Up to \$70 covered after copay
Contact Lenses	i de mario Paristo s	Wester & William	ita jila ja	Arige - Will Large
Contact Lenses (Depends on prescription and addons)	In-Network: 100% covered if medically necessary; up to \$200 covered if elective, then 15% discount for conventional contacts	In-Network: 100% covered if medically necessary; up to \$120 covered if elective, then 15% discount for conventional contacts	In-Network: 100% covered after copay 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 \$210 covered if medically necessary; up to \$200 covered if elective	Out-of-Network: Up to \$150 covered if medically necessary; up to \$105 covered if elective	Out-of-Network: Up to \$210 after copay covered if medically necessary; up to \$200 covered if elective	Out-of-Network: Up to \$150 covered after copay if medically necessary; up to \$105 covered if elective