Benefit Comparison

Current Plans	Aetna Choice POS II – POS 1 Plan	Aetna Choice POS II – POS 2 Plan	Aetna Select - HMO Plan
	Employee Pays	Employee Pays	Employee Pays
In-Network			
Plan Year Deductible	None	$300/$600	$1,250/$2,500
Medical Out-of-Pocket Maximum	$2,000/$4,000	$3,500/$7,000	$4,500/$9,000
Hospital Benefits			
Inpatient	$400 copay	20% after deductible	30% after deductible
Outpatient Surgery	$150 copay	20% after deductible	30% after deductible
Emergency Room	$200 copay	$200 copay – no deductible	$200 copay after deductible
Diagnostic X-ray, Lab, and Therapeutic Services	$0	20% - no deductible	30% after deductible
Physician			
Referral Required	No	No	No
PCP/Specialist Office Visit	$20 copay/$30 copay	$25 copay/$40 copay	$30 copay after deductible/$45 copay after deductible
Diagnostic X-ray, Lab, and Therapeutic Services (in the office)	Covered under Office Visit copay	Covered under Office Visit copay	Covered under the applicable physician's office visit member cost sharing
Urgent Care	$50 copay	$50 copay – no deductible	$50 copay after deductible
Chiropractic Care (10 visits per plan year)	$30 copay	$40 copay after deductible	$45 copay after deductible
Physical, Occupational, and Speech Therapy (30 visits per plan year)	$30 copay	$40 copay – no deductible	$45 copay after deductible
Preventive Care			
Well Baby/Child Care	$0 - no deductible	$0 - no deductible	$0 - no deductible
Well Adult Care	$0 - no deductible	$0 - no deductible	$0 - no deductible
Mental Health/ Substance Abuse			
Inpatient	$400 copay	20% after deductible	30% after deductible
Outpatient Visit	$15 copay	$15 copay	$15 copay after deductible

Please refer to Summary of Benefit Comparison (SBC) for further details.

Benefit Comparison

Current Plans	Aetna Choice POS II – POS 1 Plan	Aetna Choice POS II – POS 2 Plan	Aetna Select – HMO Plan
	Employee Pays	Employee Pays	Employee Pays
In-Network			
Other			
Dependent Age	Age 26, end of the month	Age 26, end of the month	Age 26, end of the month
Routine Eye Exam	$0, annual exam	$0, annual exam	$0, annual exam
Home Health Care (90 visits per plan year)	$0	$40 copay after deductible	$45 copay after deductible
Durable Medical Equipment	$0	20% after deductible	$0 after deductible
Hospice	$0	20% after deductible	30% after deductible
Skilled Nursing Facility (100 days per plan year)	$0	20% after deductible	30% after deductible
Ambulance	$200 copay	$200 copay after deductible	$200 after deductible
Prescription Drugs			
Calendar Year Deductible	None	None	None
Pharmacy Out-of-Pocket Maximum	$4,350/$8,700	$2,850/$5,700	$1,850/$3,700
Generic/Preferred/Non Preferred	$10/$30/$55	$10/$30/$55	$10/$30/$55
Mail Order copays (90 day supply)	$20/$60/$110	$20/$60/$110	$20/$60/$110
Out-of-Network			
CY Deductible	$100/$200	$300/$600	N/A
Out-Of -Pocket Max	$2,000/$4,000	$3,500/$7,000	N/A
Coinsurance	20%	30%	N/A

Please refer to Summary of Benefit Comparison (SBC) for further details