

Benefits At-A-Glance

2011-2012 Plan Year

Northwest Region: AK, Northern CA, HI, NV, OR, WA

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 TriNet's plan year October 1, 2011 to September 30, 2012.

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

Questions? Comments?

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

TriNet's benefits give your company a competitive advantage by helping you attract and retain worksite 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 issue with no pre existing condition 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 educational 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.

Insurance coverage 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, any TriNet 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.

PPO Plans

	Aetna PPO 300	Aetna PPO 600	Blue Shield PPO 250	Blue Shield PPO 500
Regional Plan Names	Aetna PPO 300	Aetna PPO 600	Blue Shield PPO 250	Blue Shield PPO 500
Plan Locations	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	CA	CA
Carrier Network	Managed Choice POS Open Access	Managed Choice POS Open Access	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: \$300/person; \$600/family Out-of-Network: \$600/person; \$1,200/family	In-Network: \$600/person; \$1,200/family Out-of-Network: \$1,200/person; \$2,400/family	In-Network: \$250/person; \$500/family Out-of-Network: \$250/person; \$500/family	In-Network: \$500/person; \$1,000/family Out-of-Network: \$500/person; \$1,000/family
Calendar-Year Out-of-Pocket Expense Maximum (Excludes deductible unless otherwise stated)	In-Network: \$600/person; \$1,200/family Out-of-Network: \$1,200/person; \$2,400/family	In-Network: \$1,200/person; \$2,400/family Out-of-Network: \$2,400/person; \$4,800/family	In-Network: \$2,250/person; \$4,500/family Out-of-Network: \$4,500/person; \$9,000/family	In-Network: \$3,000/person; \$6,000/family Out-of-Network: \$6,000/person; \$12,000/family
Lifetime Benefits Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Routine Health Maintenance				
Preventive Care Well-woman Well-baby Well-man (Includes annual Pap smear, routine mammogram, and annual prostate exam)	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: 70% covered after deductible
Vision Testing	Contact Aetna to confirm benefits	Contact Aetna to confirm benefits	Covered under preventive care with applicable copay/visit	Covered under preventive care with applicable copay/visit
Hearing Testing	In-Network: 100% covered Out-of-Network: 70% covered after deductible	In-Network: 100% covered Out-of-Network: 70% covered after deductible	Covered under preventive care with applicable copay/visit	Covered under preventive care with applicable copay/visit
Physician & Hospital Services				
Physician Office Visit	In-Network: \$20/visit Specialist: \$35/visit Out-of-Network: 70% 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: \$25/visit Specialist: \$40/visit Out-of-Network: 70% covered after deductible
Surgery Outpatient	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, 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: 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, 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: 90% covered after deductible Out-of-Network: 90% covered after deductible	In-Network: 90% covered after deductible Out-of-Network: 90% covered after deductible	In-Network: 90% covered after deductible Out-of-Network: 90% covered after deductible	In-Network: 90% covered after deductible Out-of-Network: 90% covered after deductible

PPO Plans

	Aetna PPO 300	Aetna PPO 600	Blue Shield PPO 250	Blue Shield PPO 500
Urgent Care	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	Determined by place of service – contact Blue Shield for details	Determined by place of service – contact Blue Shield for details
Pregnancy & Maternity Care				
Prenatal Care and Inpatient	In-Network: \$35 for initial visit, then 90% covered after deductible Out-of-Network: 70% covered after deductible	In-Network: \$40 for initial visit, then 90% covered after deductible Out-of-Network: 70% covered after deductible	In-Network: 90% covered after deductible Out-of-Network: 70% covered after deductible, up to \$1,500/day	In-Network: 90% covered after deductible Out-of-Network: 70% covered after deductible, up to \$1,500/day
Other Medical Services (Including Alternative Care)				
X-Ray and Lab – Outpatient (Applicable deductibles and copays apply)	In-Network: \$35/visit Out-of-Network: 70% covered after deductible	In-Network: \$40/visit Out-of-Network: 70% covered after deductible	In-Network: \$20/visit Out-of-Network: 70% covered after deductible	In-Network: \$25/visit Out-of-Network: 70% covered after deductible
MRIs (Complex Imaging) Outpatient	In-Network: \$150/visit Out-of-Network: 70% covered after deductible	In-Network: \$150/visit Out-of-Network: 70% covered after deductible	In-Network: 90% covered after deductible Out-of-Network: 70% covered after deductible	In-Network: 90% covered after deductible Out-of-Network: 70% covered after deductible
Chiropractic (Subject to visit limits)	In-Network: \$35/visit Out-of-Network: 70% covered after deductible	In-Network: \$40/visit Out-of-Network: 70% covered after deductible	In-Network: \$25/visit Out-of-Network: 70% covered after deductible (Up to 20 visits/year)	In-Network: \$25/visit Out-of-Network: 70% covered after deductible (Up to 20 visits/year)
Physical Therapy and Speech Therapy (Subject to visit limits)	In-Network: \$35/visit Out-of-Network: 70% covered after deductible (Up to 60 visits/year combined)	In-Network: \$40/visit Out-of-Network: 70% covered after deductible (Up to 60 visits/year combined)	In-Network: Physical therapy: \$35/visit Speech therapy: \$20/visit Out-of-Network: 70% covered after deductible	In-Network: Physical therapy: \$40/visit Speech therapy: \$20/visit Out-of-Network: 70% covered after deductible
Mental Health				
Mental Health – Inpatient	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, up to \$1,500/day	In-Network: 90% covered after deductible Out-of-Network: 70% covered after deductible, up to \$1,500/day
Mental Health – Outpatient	In-Network: 100% covered Out-of-Network: 70% covered after deductible	In-Network: 100% covered Out-of-Network: 70% covered after deductible	In-Network: \$20/visit Out-of-Network: 70% covered after deductible	In-Network: \$25/visit Out-of-Network: 70% covered after deductible
Substance Abuse				
Substance Abuse – Inpatient	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, up to \$1,500/day	In-Network: 90% covered after deductible Out-of-Network: 70% covered after deductible, up to \$1,500/day

PPO Plans

	Aetna PPO 300	Aetna PPO 600	Blue Shield PPO 250	Blue Shield PPO 500
Substance Abuse – Outpatient	In-Network: 100% covered Out-of-Network: 70% covered after deductible	In-Network: 100% covered Out-of-Network: 70% covered after deductible	In-Network: \$20/visit Out-of-Network: 70% covered after deductible	In-Network: \$25/visit Out-of-Network: 70% covered after deductible
Prescription Drugs				
Retail Pharmacy – In-Network (30-day supply if not specified) Dollar amounts listed are generic/formulary brand/non-formulary brand	\$10/\$35/\$50	\$10/\$30/\$50	\$10/\$35/\$50	\$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/\$70/\$100	\$20/\$60/\$100	\$20/\$70/\$100	\$20/\$60/\$100
Self-Injectables (Includes many specialty drugs. Call your carrier for more information.)	30% of prescription cost, up to \$150/prescription, with prior authorization	30% of prescription cost, up to \$150/prescription, with prior authorization	30% of prescription cost, up to \$150/prescription, with prior authorization	30% of prescription cost, up to \$150/prescription, with prior authorization

PPO Plans

Regional Plan Names	Aetna PPO 1000	Blue Shield PPO 700	Aetna PPO 1500	Blue Shield PPO 1500
Regional Plan Names	Aetna PPO 1000	Blue Shield PPO 700	Aetna PPO 1500	Blue Shield PPO 1500
Plan Locations	Nationwide, except AK, CA, HI, ID, ME, MT, NE, SD, WY	CA	Nationwide, except AK, CA, HI, ID, ME, MT, NE, SD, WY	CA
Carrier Network	Managed Choice POS Open Access	Blue Shield of California PPO	Managed Choice POS Open Access	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: \$1,000/person; \$3,000/family Out-of-Network: \$3,000/person; \$9,000/family	In-Network: \$700/person; \$1,400/family Out-of-Network: \$700/person; \$1,400/family	In-Network: \$1,500/person; \$4,500/family Out-of-Network: \$3,000/person; \$9,000/family	In-Network: \$1,500/person; \$3,000/family Out-of-Network: \$1,500/person; \$3,000/family
Calendar-Year Out-of-Pocket Expense Maximum (Excludes deductible unless otherwise stated)	In-Network: \$3,000/person; \$9,000/family Out-of-Network: \$5,000/person; \$15,000/family	In-Network: \$3,300/person; \$6,600/family Out-of-Network: \$6,600/person; \$13,200/family	In-Network: \$1,500/person; \$4,500/family Out-of-Network: \$3,000/person; \$9,000/family	In-Network: \$4,000/person; \$8,000/family Out-of-Network: \$8,000/person; \$16,000/family
Lifetime Benefits Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Routine Health Maintenance				
Preventive Care Well-woman Well-baby Well-man (Includes annual Pap smear, routine mammogram, and annual prostate exam)	In-Network: 100% covered Out-of-Network: 60% covered after deductible	In-Network: 100% covered Out-of-Network: 60% covered after deductible	In-Network: 100% covered Out-of-Network: 50% covered after deductible	In-Network: 100% covered Out-of-Network: 50% covered after deductible
Vision Testing	Contact Aetna to confirm benefits	Covered under preventive care with applicable copay/visit	Contact Aetna to confirm benefits	Covered under preventive care with applicable copay/visit
Hearing Testing	In-Network: 100% covered Out-of-Network: 60% covered after deductible (1 exam per 24 months)	Covered under preventive care with applicable copay/visit	In-Network: 100% covered Out-of-Network: 50% covered after deductible (1 exam per 24 months)	Covered under preventive care with applicable copay/visit
Physician & Hospital Services				
Physician Office Visit	In-Network: \$25/visit Specialist: \$50/visit Out-of-Network: 60% covered after deductible	In-Network: \$30/visit Specialist: \$45/visit Out-of-Network: 60% covered after deductible	In-Network: \$35/visit Specialist: \$50/visit Out-of-Network: 50% covered after deductible	In-Network: \$35/visit Specialist: \$45/visit Out-of-Network: 50% covered after deductible
Surgery Outpatient	In-Network: 80% covered after deductible Out-of-Network: 60% covered after deductible	In-Network: 80% covered after deductible Out-of-Network: 60% covered after deductible, up to \$350/day	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, up to \$350/day
Hospital Inpatient Room and Board Surgery Anesthesia Drugs/Supplies	In-Network: 80% covered after deductible Out-of-Network: 60% covered after deductible	In-Network: 80% covered after deductible Out-of-Network: 60% covered after deductible, up to \$1,500/day	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, up to \$1,500/day
Emergency Room (Copay waived if admitted)	In-Network: \$250/visit Out-of-Network: \$250/visit	In-Network: 80% covered after deductible Out-of-Network: 80% covered after deductible	In-Network: \$250/visit Out-of-Network: \$250/visit	In-Network: 70% covered after deductible Out-of-Network: 70% covered after deductible

PPO Plans

Regional Plan Names	Aetna PPO 1000	Blue Shield PPO 700	Aetna PPO 1500	Blue Shield PPO 1500
Urgent Care	In-Network: \$75/visit Out-of-Network: 60% covered after deductible	Determined by place of service – contact Blue Shield for details	In-Network: \$75/visit Out-of-Network: 50% covered after deductible	Determined by place of service – contact Blue Shield for details
Pregnancy & Maternity Care				
Prenatal Care and Inpatient	In-Network: \$50 for initial visit, then 80% covered after deductible Out-of-Network: 60% covered after deductible	In-Network: 80% covered after deductible Out-of-Network: 60% covered after deductible, up to \$1,500/day	In-Network: \$50 for initial visit, then 70% covered after deductible Out-of-Network: 50% covered after deductible	In-Network: 70% covered after deductible Out-of-Network: 50% covered after deductible, up to \$1,500/day
Other Medical Services (Including Alternative Care)				
X-Ray and Lab – Outpatient (Applicable deductibles and copays apply)	In-Network: 80% covered after deductible Out-of-Network: 60% covered after deductible	In-Network: \$30/visit Out-of-Network: 60% covered after deductible	In-Network: 70% covered after deductible Out-of-Network: 50% covered after deductible	In-Network: \$35/visit Out-of-Network: 50% covered after deductible
MRIs (Complex Imaging) Outpatient	In-Network: 80% covered after deductible Out-of-Network: 60% covered after deductible	In-Network: 80% covered after deductible Out-of-Network: 60% covered after deductible	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
Chiropractic (Subject to visit limits)	In-Network: \$50/visit Out-of-Network: 60% covered after deductible	In-Network: \$25/visit Out-of-Network: 60% covered after deductible (Up to 20 visits/year)	In-Network: \$50/visit Out-of-Network: 50% covered after deductible	In-Network: \$25/visit Out-of-Network: 50% covered after deductible (Up to 20 visits/year)
Physical Therapy and Speech Therapy (Subject to visit limits)	In-Network: 80% covered after deductible Out-of-Network: 60% covered after deductible (Up to 60 visits/year combined)	In-Network: Physical therapy: \$45/visit Speech therapy: \$20/visit Out-of-Network: 60% covered after deductible	In-Network: 70% covered after deductible Out-of-Network: 50% covered after deductible (Up to 60 visits/year combined)	In-Network: Physical therapy: \$35/visit Speech therapy: \$20/visit Out-of-Network: 50% covered after deductible
Mental Health				
Mental Health – Inpatient	In-Network: 80% covered after deductible Out-of-Network: 60% covered after deductible	In-Network: 80% covered after deductible Out-of-Network: 60% covered after deductible, up to \$1,500/day	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, up to \$1,500/day
Mental Health – Outpatient	In-Network: \$50/visit Out-of-Network: 60% covered after deductible	In-Network: \$30/visit Out-of-Network: 60% covered after deductible	In-Network: \$50/visit Out-of-Network: 50% covered after deductible	In-Network: \$35/visit Out-of-Network: 50% covered after deductible
Substance Abuse				
Substance Abuse – Inpatient	In-Network: 80% covered after deductible Out-of-Network: 60% covered after deductible	In-Network: 80% covered after deductible Out-of-Network: 60% covered after deductible, up to \$1,500/day	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, up to \$1,500/day

PPO Plans

Regional Plan Names	Aetna PPO 1000	Blue Shield PPO 700	Aetna PPO 1500	Blue Shield PPO 1500
Substance Abuse – Outpatient	In-Network: \$50/visit Out-of-Network: 60% covered after deductible	In-Network: \$30/visit Out-of-Network: 60% covered after deductible	In-Network: \$50/visit Out-of-Network: 50% covered after deductible	In-Network: \$35 – \$45/visit Out-of-Network: 50% 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/\$50	\$10/\$35/\$60	\$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/\$120	\$20/\$70/\$100	\$20/\$70/\$120	\$20/\$70/\$100
Self-Injectables (Includes many specialty drugs. Call your carrier for more information.)	50% of prescription cost, up to \$250/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	30% of prescription cost, up to \$150/prescription, with prior authorization

PPO Plans

Regional Plan Names	Aetna PPO 2000	Aetna PPO 3000	Aetna HRA 2500	Blue Shield HDHP 2500
Regional Plan Names	Aetna PPO 2000	Aetna PPO 3000	Aetna HRA 2500	Blue Shield HDHP 2500
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	CA
Carrier Network	Managed Choice POS Open Access	Managed Choice POS Open Access	Managed Choice POS Open Access	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: \$2,000/person; \$4,000/family Out-of-Network: \$4,000/person; \$8,000/family	In-Network: \$3,000/person; \$9,000/family Out-of-Network: \$7,500/person; \$22,500/family	In-Network: \$2,500/person; \$5,000/family Out-of-Network: \$4,000/person; \$12,000/family	In-Network: \$2,500/person; \$5,000/family Out-of-Network: \$2,500/person; \$5,000/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: None Out-of-Network: \$2,500/person; \$7,500/family	In-Network: \$1,000/person; \$2,000/family Out-of-Network: \$1,000/person; \$3,000/family	In-Network: \$5,000/person; \$10,000/family Out-of-Network: \$5,000/person; \$10,000/family
Lifetime Benefits Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Routine Health Maintenance				
Preventive Care Well-woman Well-baby Well-man (Includes annual Pap smear, routine mammogram, and annual prostate exam)	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
Vision Testing	Contact Aetna to confirm benefits	Contact Aetna to confirm benefits	Contact Aetna to confirm benefits	Covered under preventive care with applicable coinsurance
Hearing Testing	In-Network: 100% covered Out-of-Network: 50% covered after deductible	In-Network: 100% covered Out-of-Network: 70% covered after deductible (1 exam per 24 months)	In-Network: 100% covered Out-of-Network: 70% covered after deductible (1 exam per 24 months)	Covered under preventive care with applicable coinsurance
Physician & Hospital Services				
Physician Office Visit	In-Network: \$35/visit Specialist: \$50/visit Out-of-Network: 50% 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: 90% covered after deductible Out-of-Network: 70% covered after deductible
Surgery Outpatient	In-Network: 60% covered after deductible Out-of-Network: 50% 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: 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: 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, up to \$1,500/day
Emergency Room (Copay waived if admitted)	In-Network: 60% covered after deductible Out-of-Network: 60% covered after deductible	In-Network: \$250/visit Out-of-Network: \$250/visit	In-Network: 90% covered after deductible Out-of-Network: 90% covered after deductible	In-Network: 90% covered after deductible Out-of-Network: 70% covered after deductible

PPO Plans

Regional Plan Names	Aetna PPO 2000	Aetna PPO 3000	Aetna HRA 2500	Blue Shield HDHP 2500
Urgent Care	In-Network: 60% covered after deductible Out-of-Network: 50% covered after deductible	In-Network: \$75/visit Out-of-Network: 70% covered after deductible	In-Network: 90% covered after deductible Out-of-Network: 70% covered after deductible	Determined by place of service – contact Blue Shield for details
Pregnancy & Maternity Care				
Prenatal Care and Inpatient	In-Network: \$50 for initial visit, then 60% covered after deductible Out-of-Network: 50% covered after deductible	In-Network: \$50 for initial visit, then 100% covered after deductible Out-of-Network: 70% covered after deductible	In-Network: 90% covered after deductible Out-of-Network: 70% covered after deductible	In-Network: 90% covered after deductible Out-of-Network: 70% covered after deductible, up to \$1,500/day
Other Medical Services (Including Alternative Care)				
X-Ray and Lab – Outpatient (Applicable deductibles and copays apply)	In-Network: \$50/visit Out-of-Network: 50% 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: 90% covered after deductible Out-of-Network: 70% covered after deductible
MRIs (Complex Imaging) Outpatient	In-Network: \$200/visit Out-of-Network: 50% 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: 90% covered after deductible Out-of-Network: 70% covered after deductible
Chiropractic (Subject to visit limits)	In-Network: \$50/visit Out-of-Network: 50% covered after deductible	In-Network: \$60/visit Out-of-Network: 70% covered after deductible	In-Network: 90% covered after deductible Out-of-Network: 70% covered after deductible	In-Network: 90% covered after deductible Out-of-Network: 70% covered after deductible
Physical Therapy and Speech Therapy (Subject to visit limits)	In-Network: \$50/visit Out-of-Network: 50% covered after deductible (Up to 60 visits/year combined)	In-Network: 100% covered after deductible Out-of-Network: 70% covered after deductible (Up to 60 visits/year combined)	In-Network: 90% covered after deductible Out-of-Network: 70% covered after deductible	In-Network: 90% covered after deductible Out-of-Network: 70% covered after deductible
Mental Health				
Mental Health – Inpatient	In-Network: 60% covered after deductible Out-of-Network: 50% 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: 90% covered after deductible Out-of-Network: 70% covered after deductible, up to \$1,500/day
Mental Health – Outpatient	In-Network: 100% covered Out-of-Network: 50% covered after deductible	In-Network: \$60/visit Out-of-Network: 70% covered after deductible	In-Network: 90% covered after deductible Out-of-Network: 70% covered after deductible	In-Network: 90% covered after deductible Out-of-Network: 70% covered after deductible

PPO Plans

Regional Plan Names	Aetna PPO 2000	Aetna PPO 3000	Aetna HRA 2500	Blue Shield HDHP 2500
Substance Abuse				
Substance Abuse – Inpatient	In-Network: 60% covered after deductible Out-of-Network: 50% 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: 90% covered after deductible Out-of-Network: 70% covered after deductible, up to \$1,500/day
Substance Abuse – Outpatient	In-Network: 100% covered Out-of-Network: 50% covered after deductible	In-Network: \$60/visit Out-of-Network: 70% covered after deductible	In-Network: 90% covered after deductible Out-of-Network: 70% covered after deductible	In-Network: 90% covered after deductible Out-of-Network: 70% covered after deductible
Prescription Drugs				
Retail Pharmacy – In-Network (30-day supply if not specified) Dollar amounts listed are generic/formulary brand/non-formulary brand	\$10/\$40/\$60	\$10/\$35/\$60	\$10/\$35/\$60 after deductible	\$10/\$35/\$55 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/\$70/\$120	\$20/\$70/\$120 after deductible	\$20/\$70/\$110 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	50% of prescription cost, up to \$250/prescription, with prior authorization	50% of prescription cost, up to \$250/prescription, with prior authorization, after deductible	30% of prescription cost, up to \$150/prescription, with prior authorization, after deductible

PPO Plans

	Aetna HDHP 2000	Aetna HDHP 5000	HMSA PPO	Aetna Indemnity
Regional Plan Names	Aetna HDHP 2000	Aetna HDHP 5000	HMSA PPO	Aetna Indemnity
Plan Locations	Nationwide, except AK, CA, HI, ID, ME, MT, NE, SD, WY	Nationwide, except AK, CA, HI, ID, ME, MT, NE, SD, WY	HI	Nationwide – Limited counties
Carrier Network	Managed Choice POS Open Access	Managed Choice POS Open Access	Plan Name: Preferred Provider Plan	Not applicable
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: \$5,000/person; \$10,000/family Out-of-Network: \$7,000/person; \$14,000/family	In-Network: None Out-of-Network: \$100/person; \$300/family	\$300/person; \$900/family
Calendar-Year Out-of-Pocket Expense Maximum (Excludes deductible unless otherwise stated)	In-Network: \$4,000/person; \$8,000/family Out-of-Network: \$8,000/person; \$16,000/family (includes deductible)	In-Network: \$5,950/person; \$11,900/family Out-of-Network: \$10,000/person; \$20,000/family (includes deductible)	\$2,500/person; \$7,500/family	\$2,000/person; \$6,000/family
Lifetime Benefits Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Routine Health Maintenance				
Preventive Care Well-woman Well-baby Well-man (Includes annual Pap smear, routine mammogram, and annual prostate exam)	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 Prostate specific antigen screening: 80% covered Out-of-Network: 70% covered Contact carrier or refer to your EOC for more details	100% covered
Vision Testing	Contact Aetna to confirm benefits	Contact Aetna to confirm benefits	Not covered	Contact Aetna to confirm benefits
Hearing Testing	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)	Hearing aid evaluation: In-Network: 80% covered Out-of-Network: 70% covered after deductible	100% covered
Physician & Hospital Services				
Physician Office Visit	In-Network: 90% covered after deductible Out-of-Network: 70% covered after deductible	In-Network: 80% covered after deductible Out-of-Network: 60% covered after deductible	In-Network: \$12/visit Out-of-Network: 70% covered after deductible	80% covered after deductible
Surgery Outpatient	In-Network: 90% covered after deductible Out-of-Network: 70% covered after deductible	In-Network: 80% covered after deductible Out-of-Network: 60% covered after deductible	In-Network: 90% covered (cutting); 80% covered (non-cutting) Out-of-Network: 70% covered after deductible	80% covered after deductible
Hospital Inpatient Room and Board Surgery Anesthesia Drugs/Supplies	In-Network: 90% covered after deductible Out-of-Network: 70% covered after deductible	In-Network: 80% covered after deductible Out-of-Network: 60% covered after deductible	In-Network: 90% covered Out-of-Network: 70% covered after deductible	80% covered after deductible

PPO Plans

	Aetna HDHP 2000	Aetna HDHP 5000	HMSA PPO	Aetna Indemnity
Emergency Room (Copay waived if admitted)	In-Network: 90% covered after deductible Out-of-Network: 90% covered after deductible	In-Network: 80% covered after deductible Out-of-Network: 80% covered after deductible	\$75/visit	80% covered after deductible
Urgent Care	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	Regular plan benefits for office visit and/or hospital inpatient	80% covered after deductible
Pregnancy & Maternity Care				
Prenatal Care and Inpatient	In-Network: 90% covered after deductible Out-of-Network: 70% covered after deductible	In-Network: 80% covered after deductible Out-of-Network: 60% covered after deductible	In-Network: Inpatient: 90% covered Outpatient: \$12/visit Out-of-Network: 70% covered after deductible	80% covered after deductible
Other Medical Services (Including Alternative Care)				
X-Ray and Lab – Outpatient (Applicable deductibles and copays apply)	In-Network: 90% covered after deductible Out-of-Network: 70% covered after deductible	In-Network: 80% covered after deductible Out-of-Network: 60% covered after deductible	In-Network: Inpatient: 90% covered Outpatient: 80% covered Out-of-Network: 70% covered after deductible	80% covered after deductible
MRIs (Complex Imaging) Outpatient	In-Network: 90% covered after deductible Out-of-Network: 70% covered after deductible	In-Network: 80% covered after deductible Out-of-Network: 60% covered after deductible	In-Network: 80% covered Out-of-Network: 70% covered after deductible	80% covered after deductible
Chiropractic (Subject to visit limits)	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	Not covered	80% covered after deductible
Physical Therapy and Speech Therapy (Subject to visit limits)	In-Network: 90% covered after deductible Out-of-Network: 70% covered after deductible (Up to 60 visits/year combined)	In-Network: 80% covered after deductible Out-of-Network: 60% covered after deductible (Up to 60 visits/year combined)	In-Network: Inpatient: 90% covered Outpatient: 80% covered Out-of-Network: 70% covered after deductible	80% covered after deductible
Mental Health				
Mental Health – Inpatient	In-Network: 90% covered after deductible Out-of-Network: 70% covered after deductible	In-Network: 80% covered after deductible Out-of-Network: 60% covered after deductible	In-Network: 90% covered Out-of-Network: 70% covered after deductible	80% covered after deductible

PPO Plans

	Aetna HDHP 2000	Aetna HDHP 5000	HMSA PPO	Aetna Indemnity
Mental Health – Outpatient	In-Network: 90% covered after deductible Out-of-Network: 70% covered after deductible	In-Network: 80% covered after deductible Out-of-Network: 60% covered after deductible	In-Network: \$12/visit Out-of-Network: 70% covered after deductible	80% covered after deductible
Substance Abuse				
Substance Abuse – Inpatient	In-Network: 90% covered after deductible Out-of-Network: 70% covered after deductible	In-Network: 80% covered after deductible Out-of-Network: 60% covered after deductible	In-Network: 90% covered Out-of-Network: 70% covered after deductible	80% covered after deductible
Substance Abuse – Outpatient	In-Network: 90% covered after deductible Out-of-Network: 70% covered after deductible	In-Network: 80% covered after deductible Out-of-Network: 60% covered after deductible	In-Network: \$12/visit Out-of-Network: 70% covered after deductible	80% 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 after deductible	\$10/\$35/\$60 after deductible	\$7/\$30/\$65	\$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/\$70/\$120 after deductible	\$20/\$70/\$120 after deductible	\$11/\$65/\$170	\$20/\$60/\$100
Self-Injectables (Includes many specialty drugs. Call your carrier for more information.)	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	Coverage varies according to the drug – contact HMSA for more details	30% of prescription cost, up to \$150/prescription, with prior authorization

PPO Plans

Regional Plan Names	Aetna Out-of Area HDHP	Aetna Out-of-Area PPO
Regional Plan Names	Aetna HDHP 2000	Aetna PPO 1000
Plan Locations	Nationwide – Limited counties	Nationwide – Limited counties
Carrier Network	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: \$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: \$4,000/person; \$8,000/family Out-of-Network: \$8,000/person; \$16,000/family (includes deductible)	In-Network: \$3,000/person; \$9,000/family Out-of-Network: \$5,000/person; \$15,000/family
Lifetime Benefits Maximum	Unlimited	Unlimited
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: 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: 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: 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: 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: 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: 90% covered after deductible Out-of-Network: 90% covered after deductible	In-Network: \$250/visit Out-of-Network: \$250/visit
Urgent Care	In-Network: 90% covered after deductible Out-of-Network: 70% covered after deductible	In-Network: \$75/visit Out-of-Network: 60% covered after deductible

PPO Plans

Regional Plan Names	Aetna Out-of Area HDHP	Aetna Out-of-Area PPO
Pregnancy & Maternity Care		
Prenatal Care and Inpatient	In-Network: 90% covered after deductible Out-of-Network: 70% covered after deductible	In-Network: \$50 for initial visit, then 80% covered after deductible Out-of-Network: 60% covered after deductible
Other Medical Services (Including Alternative Care)		
X-Ray and Lab – Outpatient (Applicable deductibles and copays apply)	In-Network: 90% covered after deductible Out-of-Network: 70% covered after deductible	In-Network: 80% covered after deductible Out-of-Network: 60% covered after deductible
MRIs (Complex Imaging) Outpatient	In-Network: 90% covered after deductible Out-of-Network: 70% covered after deductible	In-Network: 80% covered after deductible Out-of-Network: 60% covered after deductible
Chiropractic (Subject to visit limits)	In-Network: 90% covered after deductible Out-of-Network: 70% covered after deductible	In-Network: \$50/visit Out-of-Network: 60% covered after deductible
Physical Therapy and Speech Therapy (Subject to visit limits)	In-Network: 90% covered after deductible Out-of-Network: 70% covered after deductible (Up to 60 visits/year combined)	In-Network: \$50/visit Out-of-Network: 60% covered after deductible (Up to 60 visits/year combined)
Mental Health		
Mental Health – Inpatient	In-Network: 90% covered after deductible Out-of-Network: 70% covered after deductible	In-Network: 80% covered after deductible Out-of-Network: 60% covered after deductible
Mental Health – Outpatient	In-Network: 90% covered after deductible Out-of-Network: 70% covered after deductible	In-Network: \$50/visit Out-of-Network: 60% covered after deductible
Substance Abuse		
Substance Abuse – Inpatient	In-Network: 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: 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 after deductible	\$10/\$35/\$60
Mail-Order Program – In-Network (90-day supply if not specified; out-of-network not covered) Dollar amounts listed are generic/formulary brand/non-formulary brand	\$20/\$70/\$120 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, after deductible	50% of prescription cost, up to \$250/prescription, with prior authorization

HMO Plans

Regional Plan Names	Blue Shield HMO 30	Blue Shield HMO 20	Kaiser CA HMO 30	Kaiser CA HMO 20
Regional Plan Names	Blue Shield HMO 30	Blue Shield HMO 20	Kaiser CA HMO 30	Kaiser CA HMO 20
Plan Locations	CA	CA	CA	CA
Carrier Network	Access+ HMO	Access+ HMO	Kaiser HMO	Kaiser HMO
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
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
Lifetime Benefits Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Routine Health Maintenance				
Preventive Care Well-woman Well-baby Well-man (Includes annual Pap smear, routine mammogram, and annual prostate exam)	100% covered	100% covered	100% covered	100% covered
Vision Testing	Covered under preventive care with applicable copay/visit	Covered under preventive care with applicable copay/visit	100% covered	100% covered preventive only
Hearing Testing	Covered under preventive care with applicable copay/visit	Covered under preventive care with applicable copay/visit	100% covered	100% covered preventive only
Physician & Hospital Services				
Physician Office Visit	PCP: \$30/visit Specialist: \$45/visit	PCP: \$20/visit Specialist: \$35/visit	\$30/visit Specialist: \$45/visit	\$20/visit Specialist: \$35/visit
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
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
Emergency Room (Copay waived if admitted)	\$150/visit	\$100/visit	80% covered after deductible	\$100/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
Pregnancy & Maternity Care				
Prenatal Care and Inpatient	Prenatal: 100% covered Inpatient: 100% covered after \$500/admission	Prenatal: 100% covered Inpatient: 100% covered after \$350/admission	Visits: 100% covered Inpatient: 80% covered after deductible	Visits: 100% covered Inpatient: 100% covered after \$250/admission
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
MRIs (Complex Imaging) Outpatient	100% covered	100% covered	\$50 per procedure after deductible	100% covered

HMO Plans

Regional Plan Names	Blue Shield HMO 30	Blue Shield HMO 20	Kaiser CA HMO 30	Kaiser CA HMO 20
Chiropractic (Subject to visit limits)	\$45/visit (Up to 30 visits/year)	\$35/visit (Up to 30 visits/year)	\$15/visit (Up to 20 visits/calendar year)	\$15/visit (Up to 20 visits/calendar year)
Physical Therapy and Speech Therapy (Subject to visit limits)	\$30/visit	\$20/visit	\$30/visit after deductible	\$20/visit
Mental Health				
Mental Health – Inpatient	100% covered after \$500/admission	100% covered after \$350/admission	80% covered after deductible	100% covered after \$250/admission
Mental Health – Outpatient	\$30/visit	\$20/visit	Individual session: \$30/visit Group session: \$15/visit	Individual session: \$20/visit Group session: \$10/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
Substance Abuse – Outpatient	\$30/visit	\$20/visit	Individual session: \$30/visit Group session: \$5/visit	Individual session: \$20/visit Group session: \$5/visit
Prescription Drugs				
Retail Pharmacy – In-Network (30-day supply if not specified) Dollar amounts listed are generic/formulary brand/non-formulary brand	\$10/\$35/\$50	\$10/\$35/\$50	Up to 30-day supply: \$10/\$35/full retail 31- to 60-day supply: \$20/\$70/full retail 61- to 100-day supply: \$30/\$105/full retail	\$10/\$35/full retail
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)
Self-Injectables (Includes many specialty drugs. Call your carrier for more information.)	20% of prescription cost, up to \$150/prescription, with prior authorization	20% of prescription cost, up to \$150/prescription, with prior authorization	Coverage varies according to the drug – contact Kaiser for more details	Coverage varies according to the drug – contact Kaiser for more details

HMO Plans

Regional Plan Names	Aetna CO HMO 30	Aetna CO HMO 20	Kaiser CO HMO 30	Kaiser CO HMO 20
Regional Plan Names	Aetna CO HMO 30	Aetna CO HMO 20	Kaiser CO HMO 30	Kaiser CO HMO 20
Plan Locations	CO	CO	CO	CO
Carrier Network	HMO Open Access	HMO Open Access	Kaiser HMO	Kaiser HMO
Plan Features				
Calendar-Year Deductible (Deductible applies where specifically stated; doesn't apply to out-of-pocket expense maximum unless otherwise stated)	\$1,000/person; \$2,000/family	None	\$1,000/person; \$2,000/family	None
Calendar-Year Out-of-Pocket Expense Maximum (Excludes deductible unless otherwise stated)	\$3,000/person; \$6,000/family (Includes deductible)	\$2,000/person; \$4,000/family	\$2,000/person; \$4,000/family	\$2,000/person; \$4,000/family
Lifetime Benefits Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Routine Health Maintenance				
Preventive Care Well-woman Well-baby Well-man (Includes annual Pap smear, routine mammogram, and annual prostate exam)	100% covered	100% covered	100% covered	100% covered
Vision Testing	Not covered	Not covered	\$30/visit Specialist: \$45/visit	\$20/visit Specialist: \$35/visit
Hearing Testing	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)	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
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
Surgery Outpatient	80% covered after deductible	100% covered after \$250/visit	80% covered after deductible	\$100/visit
Hospital Inpatient Room and Board Surgery Anesthesia Drugs/Supplies	80% covered after deductible	100% covered after \$250/admission	80% covered after deductible	100% covered after \$250/admission
Emergency Room (Copay waived if admitted)	\$150/visit	\$100/visit	\$150/visit (Procedure performed in office may be 80% covered after deductible)	\$100/visit
Urgent Care	\$75/visit After hours PCP Visit: \$35/visit	\$50/visit After hours PCP Visit: \$25/visit	\$75/visit	\$50/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% after \$250/admission

HMO Plans

Regional Plan Names	Aetna CO HMO 30	Aetna CO HMO 20	Kaiser CO HMO 30	Kaiser CO HMO 20
Other Medical Services (Including Alternative Care)				
X-Ray and Lab – Outpatient (Applicable deductibles and copays apply)	Diagnostic X-ray and Lab: \$45/visit	Diagnostic X-ray: \$35/visit	80% covered after deductible	Diagnostic: 100% covered Therapeutic: \$35/visit
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)	\$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)	\$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)	\$30/visit (Up to 20 visits/therapy year)	\$20/visit (Up to 20 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	Individual session: \$30/visit Group session: \$15/visit	Individual session: \$20/visit Group session: \$10/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	Individual session: \$30/visit Group session: \$15/visit	Individual session: \$20/visit Group session: \$10/visit
Prescription Drugs				
Retail Pharmacy – In-Network (30-day supply if not specified) Dollar amounts listed are generic/formulary brand/non-formulary brand	\$10/\$30/\$60	\$10/\$30/\$50	\$10/\$30/\$50	\$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/\$120	\$20/\$60/\$100	\$20/\$60/\$100	\$20/\$60/\$100
Self-Injectables (Includes many specialty drugs. Call your carrier for more information.)	Third tier copay applies – refer to your COC for further details	Third tier copay applies – refer to your COC for further details	80% covered, up to \$250/prescription/fill	80% covered, up to \$250/prescription/fill

HMO Plans

	Kaiser HI HMO	Aetna NV HMO 30	Aetna NV HMO 20
Regional Plan Names	Kaiser HI HMO	Aetna NV HMO 30	Aetna NV HMO 20
Plan Locations	HI	NV	NV
Carrier Network	Kaiser HMO	HMO Open Access	HMO Open Access
Plan Features			
Calendar-Year Deductible (Deductible applies where specifically stated; doesn't apply to out-of-pocket expense maximum unless otherwise stated)	None	\$1,000/person; \$2,000/family	None
Calendar-Year Out-of-Pocket Expense Maximum (Excludes deductible unless otherwise stated)	\$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
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
Vision Testing	\$14/visit	Not covered	Not covered
Hearing Testing	\$14/visit	Subject to routine physical exam cost sharing \$30/visit	Subject to routine physical exam cost sharing \$20/visit
Physician & Hospital Services			
Physician Office Visit	\$14/visit	\$30/visit Specialist: \$45/visit	\$20/visit Specialist: \$35/visit
Surgery Outpatient	\$14/visit	\$300/visit	100% covered after \$250/visit
Hospital Inpatient Room and Board Surgery Anesthesia Drugs/Supplies	100% covered	100% covered after \$300/day for first 5 days	100% covered after \$250/visit
Emergency Room (Copay waived if admitted)	\$50/visit	\$150/visit	\$100/visit
Urgent Care	Within service area: \$14/visit Outside service area: 80% covered	\$75/visit	\$50/visit
Pregnancy & Maternity Care			
Prenatal Care and Inpatient	100% covered after confirmation of pregnancy	Visits: \$45 for initial visit; then 100% covered Inpatient: 100% covered after \$300/day for first 5 days	Visits: \$35 for initial visit; then 100% covered Inpatient: 100% covered after \$250/admission
Other Medical Services (Including Alternative Care)			
X-Ray and Lab – Outpatient (Applicable deductibles and copays apply)	90% covered	Diagnostic X-ray: \$45/visit Lab: 100% covered	Diagnostic X-ray: \$35/visit Lab: 100% covered
MRIs (Complex Imaging) Outpatient	90% covered	\$50/visit	\$50/visit
Chiropractic (Subject to visit limits)	Not covered	\$45/visit (Up to 20 visits/calendar year)	\$35/visit (Up to 20 visits/calendar year)

HMO Plans

	Kaiser HI HMO	Aetna NV HMO 30	Aetna NV HMO 20
Physical Therapy and Speech Therapy (Subject to visit limits)	\$14/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)	\$35/visit (Up to a 60-day consecutive period of treatment per incident of illness or injury beginning with the first day of treatment)
Mental Health			
Mental Health – Inpatient	100% covered	100% covered after \$300/day for first 5 days	100% covered after \$250/admission
Mental Health – Outpatient	\$14/visit	\$45/visit	\$35/visit
Substance Abuse			
Substance Abuse – Inpatient	100% covered	100% covered after \$300/day for first 5 days	100% covered after \$250/admission
Substance Abuse – Outpatient	\$14/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/\$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/\$20/full retail	\$20/\$60/\$120	\$20/\$60/\$100
Self-Injectables (Includes many specialty drugs. Call your carrier for more information.)	Coverage varies according to the drug – contact Kaiser for more details	Third tier copay applies – refer to your COC for further details	Third tier copay applies – refer to your COC for further details

HMO Plans

Regional Plan Names	Kaiser HMO 30 – OR/WA	Kaiser HMO 20 – OR/WA	Group Health WA HMO 30	Group Health WA HMO 20
Regional Plan Names	Kaiser HMO 30 – OR/WA	Kaiser HMO 20 – OR/WA	Group Health WA HMO 30	Group Health WA HMO 20
Plan Locations	OR/WA	OR/WA	WA	WA
Carrier Network	Kaiser HMO	Kaiser HMO	Alliant Select	Alliant Select
Plan Features				
Calendar-Year Deductible (Deductible applies where specifically stated; doesn't apply to out-of-pocket expense maximum unless otherwise stated)	\$1,000/person; \$2,000/family	None	\$1,000/person; \$2,000/family	None
Calendar-Year Out-of-Pocket Expense Maximum (Excludes deductible unless otherwise stated)	\$2,000/person; \$4,000/family	\$2,000/person; \$4,000/family	\$2,000/person; \$4,000/family	\$2,000/person; \$4,000/family
Lifetime Benefits Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Routine Health Maintenance				
Preventive Care Well-woman Well-baby Well-man (Includes annual Pap smear, routine mammogram, and annual prostate exam)	100% covered	100% covered	100% covered	100% covered
Vision Testing	\$30/visit	\$20/visit	\$30/visit (deductible and coinsurance apply)	\$20/visit
Hearing Testing	100% covered after \$25 PCP copay	100% covered after \$20 PCP copay	\$30/visit (deductible and coinsurance apply)	\$20/visit
Physician & Hospital Services				
Physician Office Visit	\$30/visit Specialist: \$45/visit	\$20/visit Specialist: \$35/visit	80% covered after deductible and \$30/visit	\$20/visit Specialist: \$40/visit
Surgery Outpatient	80% covered after deductible	\$100/visit	80% covered after deductible and \$50/visit	\$20/visit Specialist: \$40/visit
Hospital Inpatient Room and Board Surgery Anesthesia Drugs/Supplies	80% covered after deductible	100% covered after \$250/admission	80% covered after deductible	100% covered after \$250/admission
Emergency Room (Copay waived if admitted)	\$100/visit	\$100/visit	80% covered after deductible and \$150/visit	\$100/visit
Urgent Care	\$50/visit	\$50/visit	80% covered after deductible and \$30/visit	Primary care provider: \$20/visit Specialist: 40/visit
Pregnancy & Maternity Care				
Prenatal Care and Inpatient	Visits: 100% covered Inpatient: 100% covered after \$250/admission	Visits: 100% covered Inpatient: 100% covered after \$250/admission	Visits: \$30 copay/visit (deductible and coinsurance apply) Inpatient: 80% covered after deductible	Visits: \$20/visit Inpatient: 100% covered after \$250/admission
Other Medical Services (Including Alternative Care)				
X-Ray and Lab – Outpatient (Applicable deductibles and copays apply)	80% covered after deductible	100% covered	80% covered after deductible	Inpatient: 100% covered after \$250/admission Outpatient: 100% covered
MRIs (Complex Imaging) Outpatient	80% covered after deductible	100% covered	80% covered after deductible	100% covered

HMO Plans

Regional Plan Names	Kaiser HMO 30 – OR/WA	Kaiser HMO 20 – OR/WA	Group Health WA HMO 30	Group Health WA HMO 20
Chiropractic (Subject to visit limits)	\$30/visit (Up to 20 visits/calendar year)	\$20/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 20 visits per calendar year)	\$35/visit (Up to 20 visits per calendar year)	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	Individual session: \$30/visit Group session: \$15/visit	Individual session: \$20/visit Group session: \$10/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	Individual session: \$30/visit Group session: \$15/visit	Individual session: \$20/visit Group session: \$10/visit	80% covered after deductible and \$30/visit	\$20/visit
Prescription Drugs				
Retail Pharmacy – In-Network (30-day supply if not specified) Dollar amounts listed are generic/formulary brand/non-formulary brand	\$10/\$30/full retail	\$10/\$30/full retail	\$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/full retail	\$20/\$60/full retail	\$20/\$40/\$80	\$20/\$40/\$80
Self-Injectables (Includes many specialty drugs. Call your carrier for more information.)	Coverage varies according to the drug – contact Kaiser for more details	Coverage varies according to the drug – contact Kaiser for more details	Coverage varies according to the drug – contact Group Health for more details	Coverage varies according to the drug – contact Group Health for more details

Dental Plans

	Aetna Dental 50	Delta Dental 50	MetLife Dental 50	Aetna Dental 100
Regional Plan Names	<ul style="list-style-type: none"> Aetna Dental 50 Group Aetna Dental 50 Optional 	<ul style="list-style-type: none"> Delta Dental 50 Group Delta Dental 50 Optional 	<ul style="list-style-type: none"> MetLife Dental 50 Group MetLife Dental 50 Optional 	<ul style="list-style-type: none"> Aetna Dental 100 Group Aetna Dental 100 Optional
Plan Locations	Nationwide*	Nationwide*	Nationwide, except FL	Nationwide*
Carrier Network	Dental PPO/PDN with PPO II Network	Delta Dental PPO Network	MetLife Preferred Dentist Program (PDP) Network	Dental PPO/PDN with PPO II Network
Plan Features				
Notes on Availability Service areas may not be available in all ZIP codes for DMO/PPO plans	You can use any licensed dentist – you receive a discount when you use a dentist who participates in the PPO network	You can use any licensed dentist – you receive a discount when you use a dentist who participates in the PPO network	You can use any licensed dentist – you receive a discount when you use a dentist who participates in the PPO network	You can use any licensed dentist – you receive a discount when you use a dentist who participates in the PPO network
Calendar-Year Deductible (Required before plan pays benefits)	In-Network: \$50/person; \$150/family Out-of-Network: \$100/person; \$300/family	In-Network: \$50/person; \$150/family Out-of-Network: \$100/person; \$300/family	In-Network: \$50/person; \$150/family Out-of-Network: \$150/person; \$300/family	In-Network: \$100/person; \$300/family Out-of-Network: \$150/person; \$450/family
Calendar-Year Benefit Maximum	\$1,500/person	\$1,500/person	\$1,500/person	\$1,000/person
Diagnostic & Preventive				
Routine Checkups, Cleanings, X-rays, and Diagnostic Visits	In-Network: 100% covered Out-of-Network: 100% covered	In-Network: 100% covered Out-of-Network: 100% covered	In-Network: 100% covered Out-of-Network: 100% covered	In-Network: 100% covered Out-of-Network: 100% covered
Basic Services				
Fillings and Oral Surgery	In-Network: 90% covered after deductible Out-of-Network: 80% covered after deductible	In-Network: 90% covered after deductible Out-of-Network: 80% covered after deductible	In-Network: 90% covered after deductible Out-of-Network: 80% covered after deductible	In-Network: 70% covered after deductible Out-of-Network: 50% covered after deductible
Periodontics	In-Network: 90% covered after deductible Out-of-Network: 80% covered after deductible	In-Network: 90% covered after deductible Out-of-Network: 80% covered after deductible	In-Network: 90% covered after deductible Out-of-Network: 80% covered after deductible	In-Network: 70% covered after deductible Out-of-Network: 50% covered after deductible
Endodontics	In-Network: 90% covered after deductible Out-of-Network: 80% covered after deductible	In-Network: 90% covered after deductible Out-of-Network: 80% covered after deductible	In-Network: 90% covered after deductible Out-of-Network: 80% covered after deductible	In-Network: 70% covered after deductible Out-of-Network: 50% covered after deductible
Crowns & Cast Restorations				
Crowns, Inlays, Onlays, and Bridges	In-Network: 65% covered after deductible Out-of-Network: 50% covered after deductible	In-Network: 65% covered after deductible Out-of-Network: 50% covered after deductible	In-Network: 65% covered after deductible Out-of-Network: 50% covered after deductible	In-Network: 50% covered after deductible Out-of-Network: 50% covered after deductible
Prosthetics				
Dentures	In-Network: 65% covered after deductible Out-of-Network: 50% covered after deductible	In-Network: 65% covered after deductible Out-of-Network: 50% covered after deductible	In-Network: 65% covered after deductible Out-of-Network: 50% covered after deductible	In-Network: 50% covered after deductible Out-of-Network: 50% covered after deductible
Orthodontics				
Orthodontics	In-Network: 50% covered after \$50 orthodontia deductible Out-of-Network: 50% covered after \$50 orthodontia deductible (Up to \$1,500/person/lifetime)	In-Network: 50% covered after \$50 orthodontia deductible Out-of-Network: 50% covered after \$50 orthodontia deductible (Up to \$1,500/person/lifetime)	In-Network: 50% covered after \$50 orthodontia deductible Out-of-Network: 50% covered after \$50 orthodontia deductible (Up to \$1,500/person/lifetime)	Not available

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

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

Dental Plans

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

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

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

Vision Plans

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