Benefits At-A-Glance

2017 Plan Year

choices that matter

This report shows TriNet 2017 benefit year plan options available in: CT, NJ, NY

When your business' success depends on your smart decisions, having accurate, easy-to-read information is critical. After all, your decisions can only be as smart as the data behind them.

TriNet is here to help you make the right decisions about worksite employee benefits with experienced guidance and best-in-class tools, including this Benefits-At-A-Glance (BAAG) plan comparison summary. And that's important, because making the right decisions about benefits can give you a competitive advantage, helping you recruit, retain, and engage the talent that powers your company.

TriNet benefit offerings give you the benefit choices you need to engage a high-performing workforce—as well as the information you need to make smart decisions about those benefits.

Questions? Contact your TriNet representative.

Disclaimer: *TriNet is the single-employer sponsor of all its benefit plans. This communication is for informational purposes only; is not legal, tax or accounting advice; and is not an offer to sell, buy or procure insurance. Insurance coverage exclusions and limitations apply. TriNet plan documents and/or the insurance carrier's certificates shall govern in the event a conflict arises between such documents and these benefit materials.*

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Medical Plans

	Aetna NY Tri-State EPO 25	Aetna NY Tri-State EPO 30	Aetna NY Tri-State EPO 45	Aetna HDHP 2600 NY Tri-State
Plan Basics				
Regional Plan Names	Aetna NY Tri-State EPO 25 - Gold	Aetna NY Tri-State EPO 30 - Platinum	Aetna NY Tri-State EPO 45 - Platinum	Aetna HDHP 2600 NY Tri-State - Silver
Plan Locations	CT, NJ, NY	CT, NJ, NY	CT, NJ, NY	CT, NJ, NY
Carrier Network	Aetna Open Access Elect Choice	Aetna Open Access Elect Choice	Aetna Open Access Elect Choice	Aetna Managed Choice POS Open Access
Plan Features				
Calendar-Year Deductible (Deductible applies where specifically stated) * (does not apply if the employee and any family members are enrolled in the plan)	$1,000/person; $2,500/family	None	None	**In-Network:** $2,600/person; $5,200/family **Out-of-Network:** $4,000/person; $8,000/family
Deductible Carryover (Any covered expenses incurred in the last 3 months of a Calendar Year that apply toward that year's network/out-of-network Calendar Year deductible will also count toward the following year's network/out-of-network Calendar Year deductible.)	Yes	NA	NA	No
Calendar-Year Out-of-Pocket Expense Maximum (Includes deductible, coinsurance and medical/Rx copays unless otherwise stated)	$4,000/person; $10,000/family	$3,500/person; $8,750/family	$4,000/person; $10,000/family	**In-Network:** $4,500/person; $9,000/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)	100% covered	100% covered	100% covered	**In-Network:** 100% covered **Out-of-Network:** 70% covered after deductible
Vision Testing	Not covered	Not covered	Not covered	Not Covered

	Aetna NY Tri-State EPO 25	Aetna NY Tri-State EPO 30	Aetna NY Tri-State EPO 45	Aetna HDHP 2600 NY Tri-State
Routine Health Maintenance				
Hearing Testing	100% covered	100% covered	100% covered	**In-Network:** 100% covered **Out-of-Network:** 70% covered after deductible (1 exam per 24 months)
Physician & Hospital Services				
Physician Office Visit	$25/visit Specialist: $40/visit	$30/visit Specialist: $50/visit	$45/visit Specialist: $65/visit	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible
Surgery Outpatient	80% after deductible	100% covered	100% covered	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible
Hospital Inpatient Room and Board Surgery Anesthesia Drugs/Supplies	80% after deductible	100% covered after $750/admission	$500/day for the first 5 days	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible
Emergency Room (Copay waived if admitted)	$200/visit	$200/visit	$200/visit	**In-Network:** 90% covered after deductible **Out-of-Network:** 90% covered after deductible
Urgent Care	$75/visit	$75/visit	$75/visit	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible
Pregnancy & Maternity Care				
Prenatal Care and Inpatient	Visits: 100% covered Inpatient: 80% covered after deductible	Visits: 100% covered Inpatient: 100% covered after $750/admission	Visits: 100% covered Inpatient: $500/day for the first 5 days	**In-Network:** Visits: 100% covered Inpatient: 90% covered after deductible **Out-of-Network:** 70% covered after deductible
Other Medical Services (Including Alternative Care)				
X-Ray and Lab - Outpatient (Applicable deductibles and copays apply)	80% after deductible	100% covered	100% covered	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible

	Aetna NY Tri-State EPO 25	Aetna NY Tri-State EPO 30	Aetna NY Tri-State EPO 45	Aetna HDHP 2600 NY Tri-State
Other Medical Services (Including Alternative Care)				
MRIs (Complex Imaging) Outpatient	80% after deductible	100% covered	100% covered	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible
Chiropractic	$40/visit	$50/visit	$65/visit	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible
Physical, Occupational, and Speech Therapy (Subject to visit limits)	80% after deductible (limited to combined 60 visits per calendar year)	100% covered (limited to combined 60 visits per calendar year)	100% covered (limited to combined 60 visits per calendar year)	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible (Up to 60 visits/year combined)
Mental Health				
Mental Health - Inpatient	80% after deductible	100% covered after $750/admission	$500/day for the first 5 days	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible
Mental Health - Outpatient	$40/visit	$50/visit	$65/visit	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible
Substance Abuse				
Substance Abuse - Inpatient	80% after deductible	100% covered after $750/admission	$500/day for the first 5 days	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible
Substance Abuse - Outpatient	$40/visit	$50/visit	$65/visit	**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) Member cost share amounts listed are generally generic/formulary brand/ non-formulary brand. Contact carrier for additional information	$10/$30/$50 Prescription drug plan year deductible: $100 individual/$300 family Must be met before any drug benefits are paid	$10/$30/$50 Prescription drug plan year deductible: $100 individual/$300 family Must be met before any drug benefits are paid	$10/$30/$50 Prescription drug plan year deductible: $100 individual/$300 family Must be met before any drug benefits are paid	$10/$30/$50 after deductible

	Aetna NY Tri-State EPO 25	Aetna NY Tri-State EPO 30	Aetna NY Tri-State EPO 45	Aetna HDHP 2600 NY Tri-State
Prescription Drugs				
Mail-Order Program - In-Network (90-day supply if not specified; out-of-network not covered) Member cost share amounts listed are generally generic/formulary brand/ non-formulary brand. Contact the carrier for additional information	$20/$60/$100 Prescription drug plan year deductible: $100 individual/$300 family Must be met before any drug benefits are paid. Mandatory mail order for all maintenance drugs. Refer to COC for further details.	$20/$60/$100 Prescription drug plan year deductible: $100 individual/$300 family Must be met before any drug benefits are paid. Mandatory mail order for all maintenance drugs. Refer to COC for further details.	$20/$60/$100 Prescription drug plan year deductible: $100 individual/$300 family Must be met before any drug benefits are paid. Mandatory mail order for all maintenance drugs. Refer to COC for further details.	$20/$60/$100 after deductible
Specialty Pharmacy (Includes many specialty drugs. Call your carrier for more information.)	Refer to your COC or contact Aetna for further details Must use Aetna's specialty pharmacy after 1st purchase from retail pharmacy	Refer to your COC or contact Aetna for further details Must use Aetna's specialty pharmacy after 1st purchase from retail pharmacy.	Refer to your COC or contact Aetna for further details Must use Aetna's specialty pharmacy after 1st purchase from retail pharmacy.	Refer to your COC or contact Aetna for further details

	Aetna HDHP 6350 Tri-State	UHC HDHP 2600	UHC HDHP 5500	UHC Indemnity 500
Plan Basics				
Regional Plan Names	Aetna HDHP 6350 Tri-State - Bronze	UHC HDHP 2600 - Silver	UHC HDHP 5500 - Bronze	UHC Indemnity 500 - Gold
Plan Locations	CT, NJ, NY	Nationwide, except for employees residing in HI & NV	Nationwide, except for employees residing in HI & NV	Nationwide, except for employees residing in HI
Carrier Network	Aetna Managed Choice POS Open Access	Choice Plus	Choice Plus	Options PPO
Plan Features				
Calendar-Year Deductible (Deductible applies where specifically stated) * (does not apply if the employee and any family members are enrolled in the plan)	**In-Network:** $6,350/person; $12,700/family **Out-of-Network:** $10,000/person; $20,000/family	**In-Network:** $2,600/person; $5,200/family **Out-of-Network:** $5,000/person; $10,000/family	**In-Network:** $5,500/person; $11,000/family **Out-of-Network:** $15,000/person; $30,000/family	$500/person; $1,000/family
Deductible Carryover (Any covered expenses incurred in the last 3 months of a Calendar Year that apply toward that year's network/out-of-network Calendar Year deductible will also count toward the following year's network/out-of-network Calendar Year deductible.)	No	No	No	Yes
Calendar-Year Out-of-Pocket Expense Maximum (Includes deductible, coinsurance and medical/Rx copays unless otherwise stated)	**In-Network:** $6,350/person; $12,700/family **Out-of-Network:** $15,000/person; $30,000/family	**In-Network:** $4,000/person; $8,000/family **Out-of-Network:** $10,000/person; $20,000/family	**In-Network:** $6,400/person; $12,800/family **Out-of-Network:** $20,000/person; $40,000/family	$3,000/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:** Not covered	**In-Network:** 100% covered **Out-of-Network:** Not covered	100% covered
Vision Testing	Not Covered	Not covered; except for preventive screening to age 5	Not covered; except for preventive screening to age 5	Not covered; except for preventive screening to age 5

	Aetna HDHP 6350 Tri-State	UHC HDHP 2600	UHC HDHP 5500	UHC Indemnity 500
Routine Health Maintenance				
Hearing Testing	**In-Network:** 100% covered **Out-of-Network:** 70% covered after deductible (1 exam per 24 months)	Preventive screening to age 21	Preventive screening to age 21	Preventive screening to age 21
Physician & Hospital Services				
Physician Office Visit	**In-Network:** 100% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 100% covered after deductible **Out-of-Network:** 70% covered after deductible	80% covered after deductible
Surgery Outpatient	**In-Network:** 100% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 100% covered after deductible **Out-of-Network:** 70% covered after deductible	80% covered after deductible
Hospital Inpatient Room and Board Surgery Anesthesia Drugs/Supplies	**In-Network:** 100% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 100% covered after deductible **Out-of-Network:** 70% covered after deductible	80% covered after deductible
Emergency Room (Copay waived if admitted)	**In-Network:** 100% covered after deductible **Out-of-Network:** 100% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 90% covered after deductible	**In-Network:** 100% covered after deductible **Out-of-Network:** 100% covered after deductible	80% covered after deductible
Urgent Care	**In-Network:** 100% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 100% covered after deductible **Out-of-Network:** 70% covered after deductible	80% covered after deductible
Pregnancy & Maternity Care				
Prenatal Care and Inpatient	**In-Network:** 100% covered Inpatient: 100% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 100% covered after deductible **Out-of-Network:** 70% covered after deductible	80% covered after deductible
Other Medical Services (Including Alternative Care)				

	Aetna HDHP 6350 Tri-State	UHC HDHP 2600	UHC HDHP 5500	UHC Indemnity 500
Other Medical Services (Including Alternative Care)				
X-Ray and Lab - Outpatient (Applicable deductibles and copays apply)	**In-Network:** 100% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 100% covered after deductible **Out-of-Network:** 70% covered after deductible	80% covered after deductible
MRIs (Complex Imaging) Outpatient	**In-Network:** 100% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 100% covered after deductible **Out-of-Network:** 70% covered after deductible	80% covered after deductible
Chiropractic	**In-Network:** 100% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 50% covered after deductible (Up to 20 visits)	**In-Network:** 100% covered after deductible **Out-of-Network:** 70% covered after deductible (Up to 20 visits)	80% covered after deductible (up to 20 visits)
Physical, Occupational, and Speech Therapy (Subject to visit limits)	**In-Network:** 100% covered after deductible **Out-of-Network:** 70% covered after deductible (Up to 60 visits, combined per calendar year)	**In-Network:** 90% covered after deductible **Out-of-Network:** 50% covered after deductible (up to 20 visits each physical, occupational, and speech therapies)	**In-Network:** 100% covered after deductible **Out-of-Network:** 70% covered after deductible (up to 20 visits each physical, occupational, and speech therapies)	80% covered after deductible (up to 20 visits each physical, occupational, and speech therapies)
Mental Health				
Mental Health - Inpatient	**In-Network:** 100% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 100% covered after deductible **Out-of-Network:** 70% covered after deductible	80% covered after deductible
Mental Health - Outpatient	**In-Network:** 100% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 100% covered after deductible **Out-of-Network:** 70% covered after deductible	80% covered after deductible
Substance Abuse				
Substance Abuse - Inpatient	**In-Network:** 100% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 100% covered after deductible **Out-of-Network:** 70% covered after deductible	80% covered after deductible

	Aetna HDHP 6350 Tri-State	UHC HDHP 2600	UHC HDHP 5500	UHC Indemnity 500
Substance Abuse				
Substance Abuse - Outpatient	**In-Network:** 100% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 100% covered after deductible **Out-of-Network:** 70% covered after deductible	80% covered after deductible
Prescription Drugs				
Retail Pharmacy - In-Network (30-day supply if not specified) Member cost share amounts listed are generally generic/formulary brand/ non-formulary brand. Contact carrier for additional information	$10/$30/$50 after deductible	$15/$50/$75/$125 after deductible	$15/$50/$75/$125 after deductible	$15/$45/$65
Mail-Order Program - In-Network (90-day supply if not specified; out-of-network not covered) Member cost share amounts listed are generally generic/formulary brand/ non-formulary brand. Contact the carrier for additional information	$20/$60/$100 after deductible	$37.50/$125/$187.50/$312.50 after deductible	$37.50/$125/$187.50/$312.50 after deductible	$37.50/$112.50/$162.50
Specialty Pharmacy (Includes many specialty drugs. Call your carrier for more information.)	Refer to your COC or contact Aetna for further details	$125 after deductible (30-day supply)	$125 after deductible (30-day supply)	$15/$125/$250 (30-day supply)

	Aetna POS 15 NY Tri-State	Aetna POS 20 NY Tri-State	Aetna POS 30 NY Tri-State	UHC POS 500
Plan Basics				
Regional Plan Names	Aetna POS 15 NY Tri-State - Platinum	Aetna POS 20 NY Tri-State - Platinum	Aetna POS 30 NY Tri-State - Platinum	UHC POS 500 - Gold
Plan Locations	CT, NJ, NY	CT, NJ, NY	CT, NJ, NY	AL, AR, AZ, CO, DC, FL, GA, IA, IL, IN, KY, LA, MD, MI, MO, MS, NC, NJ, NY, OH, OK, OR, PA, RI, SC, TN, TX, UT, VA, WA, WI
Carrier Network	Aetna Managed Choice POS Open Access	Aetna Managed Choice POS Open Access	Aetna Managed Choice POS Open Access	Navigate Plus
Plan Features				
Calendar-Year Deductible (Deductible applies where specifically stated) * (does not apply if the employee and any family members are enrolled in the plan)	**In-Network:** None **Out-of-Network:** $2,500/person; $6,250/family	**In-Network:** None **Out-of-Network:** $2,500/person; $6,250/family	**In-Network:** None **Out-of-Network:** $3,000/person; $7,500/family	**In-Network:** $500/person; $1,000/family **Out-of-Network:** $1,000/person; $2,000/family
Deductible Carryover (Any covered expenses incurred in the last 3 months of a Calendar Year that apply toward that year's network/out-of-network Calendar Year deductible will also count toward the following year's network/out-of-network Calendar Year deductible.)	Yes	Yes	Yes	Yes
Calendar-Year Out-of-Pocket Expense Maximum (Includes deductible, coinsurance and medical/Rx copays unless otherwise stated)	**In-Network:** $2,500/person; $6,250/family **Out-of-Network:** $5,000/person; $12,500/family	**In-Network:** $3,000/person; $7,500/family **Out-of-Network:** $5,000/person; $12,500/family	**In-Network:** $4,000/person; $10,000/family **Out-of-Network:** $5,000/person; $12,500/family	**In-Network:** $2,000/person; $4,000/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:** Not covered
Vision Testing	Not Covered	Not Covered	Not Covered	Not covered; except for preventive screening to age 5

	Aetna POS 15 NY Tri-State	Aetna POS 20 NY Tri-State	Aetna POS 30 NY Tri-State	UHC POS 500
Routine Health Maintenance				
Hearing Testing	**In-Network:** 100% covered for routine screenings **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:** 70% covered after deductible (1 exam per 24 months)	Preventive screening to age 21
Physician & Hospital Services				
Physician Office Visit	**In-Network:** $15/visit Specialist: $20/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** $20/visit Specialist: $30/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** $30/visit Specialist: $50/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** $25/visit Specialist: $50/visit Non-Referral: 80% covered after deductible **Out-of-Network:** 50% covered after deductible
Surgery Outpatient	**In-Network:** $75/visit (facility only) **Out-of-Network:** 70% covered after deductible	**In-Network:** $75/visit (facility only) **Out-of-Network:** 70% covered after deductible	**In-Network:** $75/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible Non-Referral: 80% covered after deductible Outpatient Hospital: 90% covered after deductible after $250 Non-Referral: 80% covered after deductible after $250 **Out-of-Network:** 50% covered after deductible Outpatient Hospital: 50% covered after deductible after $250
Hospital Inpatient Room and Board Surgery Anesthesia Drugs/Supplies	**In-Network:** $250/day for the first 3 days **Out-of-Network:** 70% covered after deductible	**In-Network:** $350/day for the first 3 days **Out-of-Network:** 70% covered after deductible	**In-Network:** $500/day for the first 3 days **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible after $250/occurrence Non-Referral: 80% covered after deductible after $250/occurrence **Out-of-Network:** 50% covered after deductible after $250/occurrence
Emergency Room (Copay waived if admitted)	**In-Network:** $150/visit **Out-of-Network:** $150/visit	**In-Network:** $150/visit **Out-of-Network:** $150/visit	**In-Network:** $150/visit **Out-of-Network:** $150/visit	**In-Network:** $350/visit **Out-of-Network:** $350/visit

	Aetna POS 15 NY Tri-State	Aetna POS 20 NY Tri-State	Aetna POS 30 NY Tri-State	UHC POS 500
Physician & Hospital Services				
Urgent Care	**In-Network:** $75/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** $75/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** $75/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** $75/visit **Out-of-Network:** 50% covered after deductible
Pregnancy & Maternity Care				
Prenatal Care and Inpatient	**In-Network:** Office visits: 100% covered Inpatient: $250/day for the first 3 days **Out-of-Network:** 70% covered after deductible	**In-Network:** 100% covered Inpatient: $350/day for the first 3 days **Out-of-Network:** 70% covered after deductible	**In-Network:** Visits: 100% covered Inpatient: $500/day for the first 3 days **Out-of-Network:** 70% covered after deductible	**In-Network:** Initial Visit: $50 Inpatient: 90% covered after deductible after $250/occurrence Non-Referral: 80% covered after deductible after $250/occurrence **Out-of-Network:** 50% covered after deductible Inpatient: 50% covered after deductible after $250/occurrence
Other Medical Services (Including Alternative Care)				
X-Ray and Lab - Outpatient (Applicable deductibles and copays apply)	**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:** 50% covered after deductible
MRIs (Complex Imaging) 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:** 100% covered **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 50% covered after deductible
Chiropractic	**In-Network:** $20/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** $30/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** $50/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** $25/visit **Out-of-Network:** 50% covered after deductible (Up to 20 visits)
Physical, Occupational, and Speech Therapy (Subject to visit limits)	**In-Network:** $20/visit **Out-of-Network:** 70% covered after deductible (Up to 60 visits/year combined)	**In-Network:** 100% covered **Out-of-Network:** 70% covered after deductible (Up to 60 visits/year combined)	**In-Network:** 100% covered **Out-of-Network:** 70% covered after deductible (Up to 60 visits/year combined)	**In-Network:** $25/visit **Out-of-Network:** 50% covered after deductible (up to 20 visits each physical, occupational, and speech therapies)
Mental Health				

	Aetna POS 15 NY Tri-State	Aetna POS 20 NY Tri-State	Aetna POS 30 NY Tri-State	UHC POS 500
Mental Health				
Mental Health - Inpatient	**In-Network:** $250/day for the first 3 days **Out-of-Network:** 70% covered after deductible	**In-Network:** $350/day for the first 3 days **Out-of-Network:** 70% covered after deductible	**In-Network:** $500/day for the first 3 days **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 50% covered after deductible
Mental Health - Outpatient	**In-Network:** $20/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** $30/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** $50/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** $25/visit **Out-of-Network:** 50% covered after deductible
Substance Abuse				
Substance Abuse - Inpatient	**In-Network:** $250/day for the first 3 days **Out-of-Network:** 70% covered after deductible	**In-Network:** $350/day for the first 3 days **Out-of-Network:** 70% covered after deductible	**In-Network:** $500/day for the first 3 days **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 50% covered after deductible
Substance Abuse - Outpatient	**In-Network:** $20/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** $30/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** $50/visit copay **Out-of-Network:** 70% covered after deductible	**In-Network:** $25/visit **Out-of-Network:** 50% covered after deductible
Prescription Drugs				
Retail Pharmacy - In-Network (30-day supply if not specified) Member cost share amounts listed are generally generic/formulary brand/ non-formulary brand. Contact carrier for additional information	$10/$30/$50	$10/$30/$50	$10/$30/$50	$15/$45/$65
Mail-Order Program - In-Network (90-day supply if not specified; out-of-network not covered) Member cost share amounts listed are generally generic/formulary brand/ non-formulary brand. Contact the carrier for additional information	$20/$60/$100	$20/$60/$100	$20/$60/$100	$37.50/$112.50/$162.50
Specialty Pharmacy (Includes many specialty drugs. Call your carrier for more information.)	Refer to your COC or contact Aetna for further details	Refer to COC or contact Aetna for further details	Refer to COC or contact Aetna for further details	$15/$125/$250 (30-day supply)

	UHC POS 1500	UHC POS 2500	UHC POS 4000	Aetna PPO 750 NY Tri-State
Plan Basics				
Regional Plan Names	UHC POS 1500 - Silver	UHC POS 2500 - Silver	UHC POS 4000 - Silver	Aetna PPO 750 NY Tri-State - Gold
Plan Locations	AL, AR, AZ, CO, DC, FL, GA, IA, IL, IN, KY, LA, MD, MI, MO, MS, NC, NJ, NY, OH, OK, OR, PA, RI, SC, TN, TX, UT, VA, WA, WI	AL, AR, AZ, CO, DC, FL, GA, IA, IL, IN, KY, LA, MD, MI, MO, MS, NC, NJ, NY, OH, OK, OR, PA, RI, SC, TN, TX, UT, VA, WA, WI	AL, AR, AZ, CO, DC, FL, GA, IA, IL, IN, KY, LA, MD, MI, MO, MS, NC, NJ, NY, OH, OK, OR, PA, RI, SC, TN, TX, UT, VA, WA, WI	CT, NJ, NY
Carrier Network	Navigate Plus	Navigate Plus	Navigate Plus	Aetna Managed Choice POS Open Access
Plan Features				
Calendar-Year Deductible (Deductible applies where specifically stated) * (does not apply if the employee and any family members are enrolled in the plan)	**In-Network:** $1,500/person; $3,000/family **Out-of-Network:** $3,000/person; $6,000/family	**In-Network:** $2,500/person; $5,000/family **Out-of-Network:** $5,000/person; $10,000/family	**In-Network:** $4,000/person; $8,000/family **Out-of-Network:** $8,000/person; $16,000/family	**In-Network:** $750/person; $1,875/family **Out-of-Network:** $2,500/person; $6,250/family
Deductible Carryover (Any covered expenses incurred in the last 3 months of a Calendar Year that apply toward that year's network/out-of-network Calendar Year deductible will also count toward the following year's network/out-of-network Calendar Year deductible.)	Yes	Yes	Yes	Yes
Calendar-Year Out-of-Pocket Expense Maximum (Includes deductible, coinsurance and medical/Rx copays unless otherwise stated)	**In-Network:** $4,000/person; $8,000/family **Out-of-Network:** $8,000/person; $16,000/family	**In-Network:** $4,000/person; $8,000/family **Out-of-Network:** $10,000/person; $20,000/family	**In-Network:** $6,600/person; $13,200/family **Out-of-Network:** $15,000/person; $32,000/family	**In-Network:** $5,000/person; $12,500/family **Out-of-Network:** $8,000/person; $20,000/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:** Not covered	**In-Network:** 100% covered **Out-of-Network:** Not covered	**In-Network:** 100% covered **Out-of-Network:** Not covered	**In-Network:** 100% covered **Out-of-Network:** 70% covered after deductible
Vision Testing	Not covered; except for preventive screening to age 5	Not covered; except for preventive screening to age 5	Not covered; except for preventive screening to age 5	Not Covered

	UHC POS 1500	UHC POS 2500	UHC POS 4000	Aetna PPO 750 NY Tri-State
Routine Health Maintenance				
Hearing Testing	Preventive screening to age 21	Preventive screening to age 21	Preventive screening to age 21	**In-Network:** 100% covered **Out-of-Network:** 70% covered after deductible (1 exam per 24 months)
Physician & Hospital Services				
Physician Office Visit	**In-Network:** $25/visit Specialist: $50/visit Non-Referral: 80% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** $30/visit Specialist: $60/visit Non-Referral: 90% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** $40/visit Specialist: $80/visit Non-Referral: 80% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** $20/visit Specialist: $30/visit **Out-of-Network:** 70% covered after deductible
Surgery Outpatient	**In-Network:** 90% covered after deductible Non-Referral: 80% covered after deductible Outpatient Hospital: 90% covered after deductible after $500 Non-Referral: 80% covered after deductible after $500 **Out-of-Network:** 50% covered after deductible Outpatient Hospital: 50% covered after deductible after $500	**In-Network:** 100% covered after deductible Non-Referral: 90% covered after deductible Outpatient Hospital: 100% covered after deductible after $500 Non-Referral: 90% covered after deductible after $500 **Out-of-Network:** 50% covered after deductible Outpatient Hospital: 50% covered after deductible after $500	**In-Network:** 90% covered after deductible Non-Referral: 80% covered after deductible Outpatient Hospital: 90% covered after deductible after $500 Non-Referral: 80% covered after deductible after $500 **Out-of-Network:** 50% covered after deductible Outpatient Hospital: 50% covered after deductible after $500	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible
Hospital Inpatient Room and Board Surgery Anesthesia Drugs/Supplies	**In-Network:** 90% covered after deductible after $500/occurrence Non-Referral: 80% covered after deductible after $500/occurrence **Out-of-Network:** 50% covered after deductible after $500/occurrence	**In-Network:** 100% covered after deductible after $500/occurrence Non-Referral: 90% covered after deductible after $500/occurrence **Out-of-Network:** 50% covered after deductible after $500/occurrence	**In-Network:** 90% covered after deductible after $500/occurrence Non-Referral: 80% covered after deductible after $500/occurrence **Out-of-Network:** 50% covered after deductible after $500/occurrence	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible
Emergency Room (Copay waived if admitted)	**In-Network:** $350/visit **Out-of-Network:** $350/visit	**In-Network:** $350/visit **Out-of-Network:** $350/visit	**In-Network:** $500/visit **Out-of-Network:** $500/visit	**In-Network:** $150/visit **Out-of-Network:** $150/visit

	UHC POS 1500	UHC POS 2500	UHC POS 4000	Aetna PPO 750 NY Tri-State
Physician & Hospital Services				
Urgent Care	**In-Network:** $75/visit **Out-of-Network:** 50% covered after deductible	**In-Network:** $100/visit **Out-of-Network:** 50% covered after deductible	**In-Network:** $100/visit **Out-of-Network:** 50% covered after deductible	**In-Network:** $75/visit **Out-of-Network:** 70% covered after deductible
Pregnancy & Maternity Care				
Prenatal Care and Inpatient	**In-Network:** Initial Visit: $50 Inpatient: 90% covered after deductible after $500/occurrence **Out-of-Network:** 50% covered after deductible Inpatient: 50% covered after deductible after $500/occurrence	**In-Network:** Initial Visit: $60 Inpatient: 100% covered after deductible after $500/occurrence **Out-of-Network:** 50% covered after deductible after $500/occurrence	**In-Network:** Initial Visit: $80 Inpatient: 90% covered after deductible after $500/occurrence **Out-of-Network:** 50% covered after deductible Inpatient: 50% covered after deductible after $500/occurrence	**In-Network:** 100% covered Inpatient: 90% covered after deductible **Out-of-Network:** 70% covered after deductible
Other Medical Services (Including Alternative Care)				
X-Ray and Lab - Outpatient (Applicable deductibles and copays apply)	**In-Network:** 100% covered **Out-of-Network:** 50% 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	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible
MRIs (Complex Imaging) Outpatient	**In-Network:** 90% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 100% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible
Chiropractic	**In-Network:** $25/visit **Out-of-Network:** 50% covered after deductible (Up to 20 visits)	**In-Network:** $30/visit **Out-of-Network:** 50% covered after deductible (Up to 20 visits)	**In-Network:** $40/visit **Out-of-Network:** 50% covered after deductible (Up to 20 visits)	**In-Network:** $30/visit **Out-of-Network:** 70% covered after deductible
Physical, Occupational, and Speech Therapy (Subject to visit limits)	**In-Network:** $25/visit **Out-of-Network:** 50% covered after deductible (up to 20 visits each physical, occupational, and speech therapies)	**In-Network:** $30/visit **Out-of-Network:** 50% covered after deductible (up to 20 visits each physical, occupational, and speech therapies)	**In-Network:** $40/visit **Out-of-Network:** 50% covered after deductible (up to 20 visits each physical, occupational, and speech therapies)	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible (Up to 60 visits/year combined)
Mental Health				

	UHC POS 1500	UHC POS 2500	UHC POS 4000	Aetna PPO 750 NY Tri-State
Mental Health				
Mental Health - Inpatient	**In-Network:** 90% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 100% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible
Mental Health - Outpatient	**In-Network:** $25/visit **Out-of-Network:** 50% covered after deductible	**In-Network:** $30/visit **Out-of-Network:** 50% covered after deductible	**In-Network:** $40/visit **Out-of-Network:** 50% covered after deductible	**In-Network:** $30/visit **Out-of-Network:** 70% covered after deductible
Substance Abuse				
Substance Abuse - Inpatient	**In-Network:** 90% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 100% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 70% covered after deductible
Substance Abuse - Outpatient	**In-Network:** $25/visit **Out-of-Network:** 50% covered after deductible	**In-Network:** $30/visit **Out-of-Network:** 50% covered after deductible	**In-Network:** $40/visit **Out-of-Network:** 50% covered after deductible	**In-Network:** $30/visit **Out-of-Network:** 70% covered after deductible
Prescription Drugs				
Retail Pharmacy - In-Network (30-day supply if not specified) Member cost share amounts listed are generally generic/formulary brand/ non-formulary brand. Contact carrier for additional information	$15/$45/$65	$15/$45/$65	$15/$45/$65	$10/$30/$50
Mail-Order Program - In-Network (90-day supply if not specified; out-of-network not covered) Member cost share amounts listed are generally generic/formulary brand/ non-formulary brand. Contact the carrier for additional information	$37.50/$112.50/$162.50	$37.50/$112.50/$162.50	$37.50/$112.50/$162.50	$20/$60/$100
Specialty Pharmacy (Includes many specialty drugs. Call your carrier for more information.)	$15/$125/$250 (30-day supply)	$15/$125/$250 (30-day supply)	$15/$125/$250 (30-day supply)	Refer to your COC or contact Aetna for further details

	Aetna PPO 1000 NY Tri-State	Aetna PPO 2000 NY Tri-State	UHC PPO 0	UHC PPO 500
Plan Basics				
Regional Plan Names	Aetna PPO 1000 NY Tri-State - Gold	Aetna PPO 2000 NY Tri-State - Silver	UHC PPO 0 - Platinum	UHC PPO 500 - Gold
Plan Locations	CT, NJ, NY	CT, NJ, NY	Nationwide, except for employees residing in HI & NV	Nationwide, except for employees residing in HI & NV
Carrier Network	Aetna Managed Choice POS Open Access	Aetna Managed Choice POS Open Access	Choice Plus	Choice Plus
Plan Features				
Calendar-Year Deductible (Deductible applies where specifically stated) * (does not apply if the employee and any family members are enrolled in the plan)	**In-Network:** $1,000/person; $2,500/family **Out-of-Network:** $1,500/person; $3,750/family	**In-Network:** $2,000/person; $5,000/family **Out-of-Network:** $5,000/person; $12,500/family	**In-Network:** None **Out-of-Network:** $500/person; $1,000/family	**In-Network:** $500/person; $1,000/family **Out-of-Network:** $2,000/person; $4,000/family
Deductible Carryover (Any covered expenses incurred in the last 3 months of a Calendar Year that apply toward that year's network/out-of-network Calendar Year deductible will also count toward the following year's network/out-of-network Calendar Year deductible.)	Yes	Yes	Yes	Yes
Calendar-Year Out-of-Pocket Expense Maximum (Includes deductible, coinsurance and medical/Rx copays unless otherwise stated)	**In-Network:** $6,000/person; $12,000/family **Out-of-Network:** $8,000/person; $20,000/family	**In-Network:** $6,000/person; $12,000/family **Out-of-Network:** $15,000/person; $37,500/family	**In-Network:** $1,500/person; $3,000/family **Out-of-Network:** $3,500/person; $7,000/family	**In-Network:** $2,000/person; $4,000/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:** Not covered	**In-Network:** 100% covered **Out-of-Network:** Not covered
Vision Testing	Not Covered	Not Covered	Not covered; except for preventive screening to age 5	Not covered; except for preventive screening to age 5

	Aetna PPO 1000 NY Tri-State	Aetna PPO 2000 NY Tri-State	UHC PPO 0	UHC PPO 500
Routine Health Maintenance				
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:** 70% covered after deductible (1 exam per 24 months)	Preventive screening to age 21	Preventive screening to age 21
Physician & Hospital Services				
Physician Office Visit	**In-Network:** $25/visit Specialist: $40/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** $30/visit Specialist: $60/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** $10/visit Specialist: $10/visit **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:** 80% 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:** 100% covered **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:** 80% 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:** $250/admission **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:** $150/visit **Out-of-Network:** $150/visit	**In-Network:** $150/visit **Out-of-Network:** $150/visit	**In-Network:** $75/visit **Out-of-Network:** $75/visit	**In-Network:** $350/visit **Out-of-Network:** $350/visit
Urgent Care	**In-Network:** $75/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** $75/visit **Out-of-Network:** 60% covered after deductible	**In-Network:** $35/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** $75/visit **Out-of-Network:** 60% covered after deductible
Pregnancy & Maternity Care				
Prenatal Care and Inpatient	**In-Network:** 100% covered Inpatient: 80% covered after deductible **Out-of-Network:** 70% covered after deductible	**In-Network:** 100% covered Inpatient: 80% covered after deductible **Out-of-Network:** 70% covered after deductible Inpatient: 60% covered after deductible	**In-Network:** Initial Visit: $10 Inpatient: $250/admission **Out-of-Network:** 70% covered after deductible	**In-Network:** Initial Visit: $50 Inpatient: 90% covered after deductible **Out-of-Network:** 60% covered after deductible
Other Medical Services (Including Alternative Care)				
X-Ray and Lab - Outpatient (Applicable deductibles and copays apply)	**In-Network:** 80% 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:** 100% covered **Out-of-Network:** 70% covered after deductible	**In-Network:** 100% covered **Out-of-Network:** 60% covered after deductible

	Aetna PPO 1000 NY Tri-State	Aetna PPO 2000 NY Tri-State	UHC PPO 0	UHC PPO 500
Other Medical Services (Including Alternative Care)				
MRIs (Complex Imaging) Outpatient	**In-Network:** 80% 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:** 100% covered **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 60% covered after deductible
Chiropractic	**In-Network:** $40/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** $60/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** $10/visit **Out-of-Network:** 70% covered after deductible (Up to 20 visits)	**In-Network:** $25/visit **Out-of-Network:** 60% covered after deductible (Up to 20 visits)
Physical, Occupational, and Speech Therapy (Subject to visit limits)	**In-Network:** 80% 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:** 70% covered after deductible (Up to 60 visits/year combined)	**In-Network:** $10/visit **Out-of-Network:** 70% covered after deductible (up to 20 visits each physical, occupational, and speech therapies)	**In-Network:** $25/visit **Out-of-Network:** 60% covered after deductible (up to 20 visits each physical, occupational, and speech therapies)
Mental Health				
Mental Health - Inpatient	**In-Network:** 80% 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:** $250/admission **Out-of-Network:** 70% covered after deductible	**In-Network:** 90% covered after deductible **Out-of-Network:** 60% covered after deductible
Mental Health - Outpatient	**In-Network:** $40/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** $60/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** $10/visit **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:** 80% 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:** $250/admission **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:** $40/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** $60/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** $10/visit **Out-of-Network:** 70% covered after deductible	**In-Network:** $50/visit **Out-of-Network:** 60% covered after deductible
Prescription Drugs				

	Aetna PPO 1000 NY Tri-State	Aetna PPO 2000 NY Tri-State	UHC PPO 0	UHC PPO 500
Prescription Drugs				
Retail Pharmacy - In-Network (30-day supply if not specified) Member cost share amounts listed are generally generic/formulary brand/ non-formulary brand. Contact carrier for additional information	\$10/\$30/\$50	\$10/\$30/\$50	\$15/\$45/\$65	\$15/\$45/\$65
Mail-Order Program - In-Network (90-day supply if not specified; out-of-network not covered) Member cost share amounts listed are generally generic/formulary brand/ non-formulary brand. Contact the carrier for additional information	\$20/\$60/\$100	\$20/\$60/\$100	\$37.50/\$112.50/\$162.50	\$37.50/\$112.50/\$162.50
Specialty Pharmacy (Includes many specialty drugs. Call your carrier for more information.)	Refer to your COC or contact Aetna for further details	Refer to your COC or contact Aetna for further details	\$15/\$125/\$250 (30-day supply)	\$15/\$125/\$250 (30-day supply)

	UHC PPO 1000	UHC PPO 1500	UHC PPO 2500
Plan Basics			
Regional Plan Names	UHC PPO 1000 - Gold	UHC PPO 1500 - Silver	UHC PPO 2500 - Silver
Plan Locations	Nationwide, except for employees residing in HI & NV	Nationwide, except for employees residing in HI & NV	Nationwide, except for employees residing in HI & NV
Carrier Network	Choice Plus	Choice Plus	Choice Plus
Plan Features			
Calendar-Year Deductible (Deductible applies where specifically stated) * (does not apply if the employee and any family members are enrolled in the plan)	**In-Network:** $1,000/person; $2,000/family **Out-of-Network:** $2,000/person; $4,000/family	**In-Network:** $1,500/person; $3,000/family **Out-of-Network:** $6,000/person; $12,000/family	**In-Network:** $2,500/person; $5,000/family **Out-of-Network:** $5,000/person; $10,000/family
Deductible Carryover (Any covered expenses incurred in the last 3 months of a Calendar Year that apply toward that year's network/out-of-network Calendar Year deductible will also count toward the following year's network/out-of-network Calendar Year deductible.)	Yes	Yes	Yes
Calendar-Year Out-of-Pocket Expense Maximum (Includes deductible, coinsurance and medical/Rx copays unless otherwise stated)	**In-Network:** $4,000/person; $8,000/family **Out-of-Network:** $6,000/person; $12,000/family	**In-Network:** $5,000/person; $10,000/family **Out-of-Network:** $12,000/person; $24,000/family	**In-Network:** $6,000/person; $12,000/family **Out-of-Network:** $10,000/person; $20,000/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)	**In-Network:** 100% covered **Out-of-Network:** Not covered	**In-Network:** 100% covered **Out-of-Network:** Not covered	**In-Network:** 100% covered **Out-of-Network:** Not covered
Vision Testing	Not covered; except for preventive screening to age 5	Not covered; except for preventive screening to age 5	Not covered; except for preventive screening to age 5
Hearing Testing	Preventive screening to age 21	Preventive screening to age 21	Preventive screening to age 21
Physician & Hospital Services			
Physician Office Visit	**In-Network:** $30/visit Specialist: $60/visit **Out-of-Network:** 60% covered after deductible	**In-Network:** $40/visit Specialist: $80/visit **Out-of-Network:** 50% covered after deductible	**In-Network:** $30/visit Specialist: $60/visit Premium Tier 1: $30/visit **Out-of-Network:** 50% covered after deductible

	UHC PPO 1000	UHC PPO 1500	UHC PPO 2500
Physician & Hospital Services			
Surgery Outpatient	**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:** 80% covered after deductible after $250/occurrence **Out-of-Network:** 50% covered after deductible after $250/occurrence
Hospital Inpatient Room and Board Surgery Anesthesia Drugs/Supplies	**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:** 80% covered after deductible after $500/occurrence **Out-of-Network:** 50% covered after deductible after $500/occurrence
Emergency Room (Copay waived if admitted)	**In-Network:** $350/visit **Out-of-Network:** $350/visit	**In-Network:** $500/visit **Out-of-Network:** $500/visit	**In-Network:** $200/visit **Out-of-Network:** $200/visit
Urgent Care	**In-Network:** $75/visit **Out-of-Network:** 60% covered after deductible	**In-Network:** $100/visit **Out-of-Network:** 50% covered after deductible	**In-Network:** $75/visit **Out-of-Network:** 50% covered after deductible
Pregnancy & Maternity Care			
Prenatal Care and Inpatient	**In-Network:** Initial Visit: $60 Inpatient: 80% covered after deductible **Out-of-Network:** 60% covered after deductible	**In-Network:** Initial Visit: $80 Inpatient: 70% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** Initial Visit: $60 Initial Visit/Premium Tier 1: $30 Inpatient: 80% covered after deductible after $500/occurrence **Out-of-Network:** 50% covered after deductible after $500/occurrence
Other Medical Services (Including Alternative Care)			
X-Ray and Lab - Outpatient (Applicable deductibles and copays apply)	**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
MRIs (Complex Imaging) Outpatient	**In-Network:** $200/service **Out-of-Network:** 60% covered after deductible	**In-Network:** $200/service **Out-of-Network:** 50% covered after deductible	**In-Network:** 80% covered after deductible **Out-of-Network:** 50% covered after deductible
Chiropractic	**In-Network:** $30/visit **Out-of-Network:** 60% covered after deductible (Up to 20 visits)	**In-Network:** $40/visit **Out-of-Network:** 50% covered after deductible (Up to 20 visits)	**In-Network:** $30/visit **Out-of-Network:** 50% covered after deductible (Up to 20 visits)

	UHC PPO 1000	UHC PPO 1500	UHC PPO 2500
Other Medical Services (Including Alternative Care)			
Physical, Occupational, and Speech Therapy (Subject to visit limits)	**In-Network:** $30/visit **Out-of-Network:** 60% covered after deductible (up to 20 visits each physical, occupational, and speech therapies)	**In-Network:** $40/visit **Out-of-Network:** 50% covered after deductible (up to 20 visits each physical, occupational, and speech therapies)	**In-Network:** $30/visit **Out-of-Network:** 50% covered after deductible (up to 20 visits each physical, occupational, and speech therapies)
Mental Health			
Mental Health - Inpatient	**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:** 80% covered after deductible **Out-of-Network:** 50% covered after deductible
Mental Health - Outpatient	**In-Network:** $60/visit **Out-of-Network:** 60% covered after deductible	**In-Network:** $80/visit **Out-of-Network:** 50% covered after deductible	**In-Network:** $30/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:** 70% covered after deductible **Out-of-Network:** 50% covered after deductible	**In-Network:** 80% covered after deductible **Out-of-Network:** 50% covered after deductible
Substance Abuse - Outpatient	**In-Network:** $60/visit **Out-of-Network:** 60% covered after deductible	**In-Network:** $80/visit **Out-of-Network:** 50% covered after deductible	**In-Network:** $30/visit **Out-of-Network:** 50% covered after deductible
Prescription Drugs			
Retail Pharmacy - In-Network (30-day supply if not specified) Member cost share amounts listed are generally generic/formulary brand/ non-formulary brand. Contact carrier for additional information	$15/$45/$65	$15/$45/$65	$15/$45/$65
Mail-Order Program - In-Network (90-day supply if not specified; out-of-network not covered) Member cost share amounts listed are generally generic/formulary brand/ non-formulary brand. Contact the carrier for additional information	$37.50/$112.50/$162.50	$37.50/$112.50/$162.50	$37.50/$112.50/$162.50
Specialty Pharmacy (Includes many specialty drugs. Call your carrier for more information.)	$15/$125/$250 (30-day supply)	$15/$125/$250 (30-day supply)	$15/$125/$250 (30-day supply)