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
Calendar Year deductible.) 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	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
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	\$30/visit	\$45/visit	In-Network:
	Specialist:	Specialist:	Specialist:	90% covered after deductible
	\$40/visit	\$50/visit	\$65/visit	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	80% after deductible	100% covered after \$750/admission	\$500/day for the first 5 days	In-Network: 90% covered after deductible
Surgery Anesthesia Drugs/Supplies				Out-of-Network: 70% covered after deductible
Emergency Room	\$200/visit	\$200/visit	\$200/visit	In-Network:
(Copay waived if admitted)				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:	Visits:	Visits:	In-Network:
	100% covered	100% covered	100% covered	Visits: 100% covered
	Inpatient:	Inpatient:	Inpatient:	Inpatient: 90% covered after deductible
	80% covered after deductible	100% covered after	\$500/day for the first 5 days	GOUGHING
		\$750/admission		Out-of-Network: 70% covered after deductible
Other Medical Services (Includ	ding Alternative Care)			
X-Ray and Lab - Outpatient	80% after deductible	100% covered	100% covered	In-Network:
(Applicable deductibles and copays apply)				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 (Includin				
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
\$20/\$60/\$100	\$20/\$60/\$100	\$20/\$60/\$100	\$20/\$60/\$100 after deductible
Prescription drug plan year deductible:	Prescription drug plan year deductible:	Prescription drug plan year deductible:	
\$100 individual/\$300 family	\$100 individual/\$300 family	\$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.	Must be met before any drug benefits are paid. Mandatory mail order for all maintenance drugs. Refer to COC for further details.	Must be met before any drug benefits are paid. Mandatory mail order for all maintenance drugs. Refer to COC for further details.	
Refer to your COC or contact Aetna for further details Must use Aetna's specialty pharmacy after 1st purchase	Refer to your COC or contact Aetna for further details Must use Aetna's specialty pharmacy after 1st purchase	Refer to your COC or contact Aetna for further details Must use Aetna's specialty pharmacy after 1st purchase	Refer to your COC or contact Aetna 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. Refer to your COC or contact Aetna for further details Must use Aetna's specialty	\$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. Refer to your COC or contact Aetna 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. Refer to your COC or contact Aetna for further details Must use Aetna's specialty Must use Aetna's specialty	\$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. Refer to your COC or contact Aetna for further details \$20/\$60/\$100 \$20/\$60/\$100 Prescription drug plan year deductible: \$100 individual/\$300 family \$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. Refer to your COC or contact Aetna for further details Must use Aetna's specialty Must use Aetna's specialty Must use Aetna's specialty Must use Aetna's specialty Must use Aetna's specialty

	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)	In-Network: \$6,350/person; \$12,700/family	In-Network: \$2,600/person; \$5,200/family	In-Network: \$5,500/person; \$11,000/family	\$500/person; \$1,000/family
t (does not apply if the employee and any family members are enrolled in the plan)	Out-of-Network: \$10,000/person; \$20,000/family	Out-of-Network: \$5,000/person; \$10,000/family	Out-of-Network: \$15,000/person; \$30,000/family	
Peductible 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, roinsurance and medical/Rx ropays 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, outine 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
Hearing Testing	In-Network: 100% covered	Preventive screening to age 21	Preventive screening to age 21	Preventive screening to age 2
	Out-of-Network: 70% covered after deductible			
	(1 exam per 24 months)			
Physician & Hospital Services	3			
Physician Office Visit	In-Network: 100% covered after deductible	In-Network: 90% covered after deductible	In-Network: 100% covered after deductible	80% covered after deductible
	Out-of-Network: 70% covered after deductible	Out-of-Network: 50% covered after deductible	Out-of-Network: 70% covered after deductible	
Surgery Outpatient	In-Network: 100% covered after deductible	In-Network: 90% covered after deductible	In-Network: 100% covered after deductible	80% covered after deductible
	Out-of-Network: 70% covered after deductible	Out-of-Network: 50% covered after deductible	Out-of-Network: 70% covered after deductible	
Rospital Inpatient Room and Board Burgery unesthesia 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
imergency 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
Irgent 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				
renatal 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

	Aetna HDHP 6350 Tri-State	UHC HDHP 2600	UHC HDHP 5500	UHC Indemnity 500
Other Medical Services (Including				
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 - 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	In-Network:	In-Network:	In-Network:	In-Network:
(Deductible applies where specifically stated)	None Out-of-Network:	None Out-of-Network:	None Out-of-Network:	\$500/person; \$1,000/family
* (does not apply if the employee and any family members are enrolled in the plan)	\$2,500/person; \$6,250/family	\$2,500/person; \$6,250/family	\$3,000/person; \$7,500/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	In-Network: \$2,500/person; \$6,250/family	In-Network: \$3,000/person; \$7,500/family	In-Network: \$4,000/person; \$10,000/family	In-Network: \$2,000/person; \$4,000/family
(Includes deductible,	Out-of-Network:	Out-of-Network:	Out-of-Network:	Out-of-Network:
coinsurance and medical/Rx copays unless otherwise stated)	\$5,000/person;	\$5,000/person;	\$5,000/person;	\$6,000/person;
copays unless otherwise stated)	\$12,500/family	\$12,500/family	\$12,500/family	\$12,000/family
Lifetime Benefits Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Routine Health Maintenance				
Preventive Care	In-Network:	In-Network:	In-Network:	In-Network:
Well-woman	100% covered	100% covered	100% covered	100% covered
Well-baby				
Well-man	Out-of-Network:	Out-of-Network:	Out-of-Network:	Out-of-Network:
(Includes annual Pap smear, routine mammogram, and annual prostate exam)	70% covered after deductible	70% covered after deductible	70% covered after deductible	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
Hearing Testing	In-Network:	In-Network:	In-Network:	Preventive screening to age 2
	100% covered for routine	100% covered	100% covered	
	screenings			
		Out-of-Network:	Out-of-Network:	
	Out-of-Network:	70% covered after deductible	70% covered after deductible	
	70% covered after deductible			
	(1 exam per 24 months)	(1 exam per 24 months)	(1 exam per 24 months)	
Physician & Hospital Service				
Physician Office Visit	In-Network:	In-Network:	In-Network:	In-Network:
	\$15/visit	\$20/visit	\$30/visit	\$25/visit
	Specialist:	Specialist:	Specialist:	Specialist:
	\$20/visit	\$30/visit	\$50/visit	\$50/visit
				Non-Referral:
	Out-of-Network:	Out-of-Network:	Out-of-Network:	80% covered after deductible
	70% covered after deductible	70% covered after deductible	70% covered after deductible	
				Out-of-Network:
				50% covered after deductible
Surgery Outpatient	In-Network:	In-Network:	In-Network:	In-Network:
	\$75/visit (facility only)	\$75/visit (facility only)	\$75/visit	90% covered after deductible
	, , ,	, , , , , , , , , , , , , , , , , , , ,		Non-Referral:
	Out-of-Network:	Out-of-Network:	Out-of-Network:	80% covered after deductible
	70% covered after deductible	70% covered after deductible	70% covered after deductible	
				Outpatient Hospital:
				90% covered after deductible
				after \$250
				Non-Referral:
				80% covered after deductible
				after \$250
				Out of Notworks
				Out-of-Network:
				50% covered after deductible
				Outpatient Hospital:
				50% covered after deductible
				after \$250
				αποι φ250
Hospital Inpatient	In-Network:	In-Network:	In-Network:	In-Network:
Room and Board	\$250/day for the first 3 days	\$350/day for the first 3 days	\$500/day for the first 3 days	90% covered after deductible
Surgery				after \$250/occurrence
Anesthesia	Out-of-Network:	Out-of-Network:	Out-of-Network:	Non-Referral:
Orugs/Supplies	70% covered after deductible	70% covered after deductible	70% covered after deductible	80% covered after deductible
				after \$250/occurrence
				Out-of-Network:
				50% covered after deductible
				after \$250/occurrence
Emergency Room	In-Network:	In-Network:	In-Network:	In-Network:
(Copay waived if admitted)	\$150/visit	\$150/visit	\$150/visit	\$350/visit
	Out-of-Network:	Out-of-Network:	Out-of-Network:	Out-of-Network:
	\$150/visit	\$150/visit	\$150/visit	\$350/visit

	Aetna POS 15 NY Tri-State	Aetna POS 20 NY Tri-State	Aetna POS 30 NY Tri-State	UHC POS 500
rgent Care	In-Network: \$75/visit	In-Network: \$75/visit	In-Network: \$75/visit	In-Network: \$75/visit
	Out-of-Network: 70% covered after deductible	Out-of-Network: 70% covered after deductible	Out-of-Network: 70% covered after deductible	Out-of-Network: 50% covered after deductible
regnancy & Maternity Care				
renatal 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
-Ray and Lab - Outpatient	In-Network:	In-Network:	In-Network:	In-Network:
-Ray and Lab - 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: 50% covered after deductible
-Ray and Lab - Outpatient Applicable deductibles and copays apply)	In-Network: 100% covered Out-of-Network:	100% covered Out-of-Network:	100% covered Out-of-Network:	Out-of-Network: 50% covered after deductible In-Network: 90% covered after deductible Out-of-Network:
-Ray and Lab - Outpatient Applicable deductibles and copays apply) IRIs (Complex Imaging) Autpatient	In-Network: 100% covered Out-of-Network: 70% covered after deductible In-Network: 100% covered Out-of-Network:	100% covered Out-of-Network: 70% covered after deductible In-Network: 100% covered Out-of-Network:	100% covered Out-of-Network: 70% covered after deductible In-Network: 100% covered Out-of-Network:	Out-of-Network: 50% covered after deductible In-Network: 90% covered after deductible Out-of-Network:
Partner Medical Services (Incluing Partner Medical	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 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 In-Network: 90% covered after deductible Out-of-Network: 50% covered after deductible In-Network:
-Ray and Lab - Outpatient pplicable deductibles and copays apply) RIs (Complex Imaging) utpatient	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:	100% covered Out-of-Network: 70% covered after deductible In-Network: 100% covered Out-of-Network: 70% covered after deductible In-Network: \$30/visit Out-of-Network:	100% covered Out-of-Network: 70% covered after deductible In-Network: 100% covered Out-of-Network: 70% covered after deductible In-Network: \$50/visit Out-of-Network:	Out-of-Network: 50% covered after deductible In-Network: 90% covered after deductible Out-of-Network: 50% covered after deductible In-Network: \$25/visit Out-of-Network: 50% covered after deductible

	Aetna POS 15 NY Tri-State	Aetna POS 20 NY Tri-State	Aetna POS 30 NY Tri-State	UHC POS 500
Mental Health - Inpatient	In-Network: \$250/day for the first 3 days	In-Network: \$350/day for the first 3 days	In-Network: \$500/day for the first 3 days	In-Network: 90% covered after deductible
	Out-of-Network: 70% covered after deductible	Out-of-Network: 70% covered after deductible	Out-of-Network: 70% covered after deductible	Out-of-Network: 50% covered after deductible
Mental Health - Outpatient	In-Network: \$20/visit	In-Network: \$30/visit	In-Network: \$50/visit	In-Network: \$25/visit
	Out-of-Network: 70% covered after deductible	Out-of-Network: 70% covered after deductible	Out-of-Network: 70% covered after deductible	Out-of-Network: 50% covered after deductible
Substance Abuse				
Substance Abuse - Inpatient	In-Network: \$250/day for the first 3 days	In-Network: \$350/day for the first 3 days	In-Network: \$500/day for the first 3 days	In-Network: 90% covered after deductible
	Out-of-Network: 70% covered after deductible	Out-of-Network: 70% covered after deductible	Out-of-Network: 70% covered after deductible	Out-of-Network: 50% covered after deductible
Substance Abuse - Outpatient	In-Network: \$20/visit	In-Network: \$30/visit	In-Network: \$50/visit copay	In-Network: \$25/visit
	Out-of-Network: 70% covered after deductible	Out-of-Network: 70% covered after deductible	Out-of-Network: 70% covered after deductible	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-Sta
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	In-Network:	In-Network:	In-Network:	In-Network:
(Deductible applies where specifically stated)	\$1,500/person; \$3,000/family	\$2,500/person; \$5,000/family	\$4,000/person; \$8,000/family	\$750/person; \$1,875/family
* (does not apply if the employee and any family members are enrolled in the plan)	Out-of-Network: \$3,000/person; \$6,000/family	Out-of-Network: \$5,000/person; \$10,000/family	Out-of-Network: \$8,000/person; \$16,000/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	In-Network:	In-Network:	In-Network:	In-Network:
Out-of-Pocket Expense Maximum	\$4,000/person; \$8,000/family	\$4,000/person; \$8,000/family	\$6,600/person; \$13,200/family	\$5,000/person; \$12,500/family
(Includes deductible,	φο,σοσ/iairilly	ψο,ουο/ιαιτιιιγ	ψ13,200/1allilly	ψ12,000/Tarrilly
coinsurance and medical/Rx copays unless otherwise stated)	Out-of-Network: \$8,000/person; \$16,000/family	Out-of-Network: \$10,000/person; \$20,000/family	Out-of-Network: \$15,000/person; \$32,000/family	Out-of-Network: \$8,000/person; \$20,000/family
Lifetime Benefits Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Routine Health Maintenance				
Preventive Care	In-Network:	In-Network:	In-Network:	In-Network:
Well-woman	100% covered	100% covered	100% covered	100% covered
Well-baby				
Well-man (Includes annual Pap smear, routine mammogram, and annual prostate exam)	Out-of-Network: Not covered	Out-of-Network: Not covered	Out-of-Network: Not 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
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 Service				
Physician Office Visit	In-Network:	In-Network:	In-Network:	In-Network:
	\$25/visit	\$30/visit	\$40/visit	\$20/visit
	Specialist:	Specialist:	Specialist:	Specialist:
	\$50/visit	\$60/visit	\$80/visit	\$30/visit
	Non-Referral:	Non-Referral:	Non-Referral:	
	80% covered after deductible	90% covered after deductible	80% covered after deductible	Out-of-Network: 70% covered after deductible
	Out-of-Network:	Out-of-Network:	Out-of-Network:	
	50% covered after deductible	50% covered after deductible	50% covered after deductible	
Surgery Outpatient	In-Network:	In-Network:	In-Network:	In-Network:
	90% covered after deductible	100% covered after deductible	90% covered after deductible	90% covered after deductible
	Non-Referral: 80% covered after deductible	Non-Referral: 90% covered after deductible	Non-Referral: 80% covered after deductible	Out-of-Network: 70% covered after deductible
	Outpatient Hospital:	Outpatient Hospital:	Outpatient Hospital:	70% covered after deductible
	90% covered after deductible	100% covered after deductible	90% covered after deductible	
	after \$500	after \$500	after \$500	
	Non-Referral:	Non-Referral:	Non-Referral:	
	80% covered after deductible after \$500	90% covered after deductible after \$500	80% covered after deductible after \$500	
	Out-of-Network: 50% covered after deductible	Out-of-Network: 50% covered after deductible	Out-of-Network: 50% covered after deductible	
	Outpatient Hospital:	Outpatient Hospital:	Outpatient Hospital:	
	50% covered after deductible	50% covered after deductible	50% covered after deductible	
	after \$500	after \$500	after \$500	
Hospital Innations	In-Network:	In-Network:	In-Network:	In-Network:
Hospital Inpatient Room and Board Surgery	90% covered after deductible after \$500/occurrence	100% covered after deductible after \$500/occurrence	90% covered after deductible after \$500/occurrence	90% covered after deductible
Anesthesia	Non-Referral:	Non-Referral:	Non-Referral:	Out-of-Network:
Anestnesia Drugs/Supplies	80% covered after deductible	90% covered after deductible	80% covered after deductible	70% covered after deductible
лидь/ эиррнеѕ	after \$500/occurrence	after \$500/occurrence	after \$500/occurrence	70% covered after deductible
	Out-of-Network:	Out-of-Network:	Out-of-Network:	
	50% covered after deductible after \$500/occurrence	50% covered after deductible after \$500/occurrence	50% covered after deductible after \$500/occurrence	
Emergency Room	In-Network:	In-Network:	In-Network:	In-Network:
(Copay waived if admitted)	\$350/visit	\$350/visit	\$500/visit	\$150/visit
	Out-of-Network:	Out-of-Network:	Out-of-Network:	Out-of-Network:

Pregnancy & Maternity Care Prenatal Care and Inpatient In-Netwo Initial Visit Inpatient: 90% cover after \$500 Out-of-Ni- 50% cover Inpatient: deductible \$500/occu Other Medical Services (Including Altern: X-Ray and Lab - Outpatient (Applicable deductibles and copays apply) Out-of-Ni- 50% cover Outpatient Out-of-Ni- 50% cover Out-of-Ni- 50% cover Out-of-Ni- 50% cover Out-of-Ni-	letwork: ered after deductible brk: t: \$50 ered after deductible b/occurrence letwork: ered after deductible 50% covered after e after urrence lative Care) brk: ered	In-Network: \$100/visit Out-of-Network: 50% covered after deductible 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: \$100/visit Out-of-Network: 50% covered after deductible 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: \$75/visit Out-of-Network: 70% covered after deductible In-Network: 100% covered Inpatient: 90% covered after deductible Out-of-Network: 70% covered after deductible
\$75/visit Out-of-Ni 50% cover Pregnancy & Maternity Care Prenatal Care and Inpatient In-Netwo Initial Visit Inpatient: 90% cover after \$500 Out-of-Ni 50% cover Inpatient: deductible \$500/occu Other Medical Services (Including Alterni Applicable deductibles In-Netwo 100% cover Out-of-Ni 50% cover MRIs (Complex Imaging) Outpatient In-Netwo 90% cover Out-of-Ni 50% cover	letwork: ered after deductible brk: t: \$50 ered after deductible b/occurrence letwork: ered after deductible 50% covered after e after urrence lative Care) brk: ered	In-Network: 100% covered after deductible In-Network: Initial Visit: \$60 Inpatient: 100% covered after deductible after \$500/occurrence Out-of-Network: 50% covered after deductible after \$500/occurrence	\$100/visit Out-of-Network: 50% covered after deductible 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	\$75/visit Out-of-Network: 70% covered after deductible In-Network: 100% covered Inpatient: 90% covered after deductible Out-of-Network: 70% covered after deductible
Out-of-Ni 50% cover Pregnancy & Maternity Care Prenatal Care and Inpatient In-Netwo Initial Visit Inpatient: 90% cover after \$500 Out-of-Ni 50% cover Inpatient: deductible \$500/occu Other Medical Services (Including Alterni Applicable deductibles and copays apply) Out-of-Ni 50% cover MRIs (Complex Imaging) Outpatient Outpatient In-Netwo 100% cover Out-of-Ni 50% cover Chiropractic In-Netwo \$25/visit Out-of-Ni 50% cover	ork: t: \$50 ered after deductible o/occurrence eletwork: ered after deductible 50% covered after e after urrence eletic deductible for covered after e after ered after deductible	Out-of-Network: 50% covered after deductible In-Network: Initial Visit: \$60 Inpatient: 100% covered after deductible after \$500/occurrence Out-of-Network: 50% covered after deductible after \$500/occurrence	Out-of-Network: 50% covered after deductible 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	Out-of-Network: 70% covered after deductible In-Network: 100% covered Inpatient: 90% covered after deductible Out-of-Network: 70% covered after deductible
Pregnancy & Maternity Care Prenatal Care and Inpatient In-Netwo Initial Visit Inpatient: 90% cover after \$500 Out-of-Ni 50% cover Inpatient: deductible \$500/occu Other Medical Services (Including Alternit deductible \$500/occu In-Netwo 100% cover Inpatient In-Netwo	ork: t: \$50 ered after deductible o/occurrence eletwork: ered after deductible 50% covered after e after urrence eletic deductible for covered after e after ered after deductible	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 after deductible Inpatient: 90% covered after deductible Out-of-Network: 70% covered after deductible
Pregnancy & Maternity Care Prenatal Care and Inpatient In-Netwo Initial Visit Inpatient: 90% cove after \$500 Out-of-Ni 50% cove Inpatient: deductible \$500/occu Other Medical Services (Including Altern: 4-Ray and Lab - Outpatient Applicable deductibles and copays apply) Out-of-Ni 50% cove Out-of-Ni 50% cove Chiropractic In-Netwo 90% cove Out-of-Ni 50% cove Chiropractic In-Netwo \$25/visit Out-of-Ni 50% cove	ered after deductible D/occurrence letwork: ered after deductible 50% covered after e after urrence lative Care) ork: vered	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
Prenatal Care and Inpatient In-Netwo Initial Visit Inpatient: 90% cove after \$500 Out-of-Ni 50% cove Inpatient: deductible \$500/occu Other Medical Services (Including Altern: Applicable deductibles and copays apply) Out-of-Ni 50% cove Out-of-Ni 50% cove Chiropractic In-Netwo 90% cove Out-of-Ni 50% cove Chiropractic In-Netwo 90% cove Out-of-Ni 50% cove	t: \$50 ered after deductible D/occurrence letwork: ered after deductible 50% covered after e after urrence lattive Care) ork: ered	Initial Visit: \$60 Inpatient: 100% covered after deductible after \$500/occurrence Out-of-Network: 50% covered after deductible after \$500/occurrence	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	100% covered Inpatient: 90% covered after deductible Out-of-Network: 70% covered after deductible
Initial Visit Inpatient: 90% cover after \$500 Out-of-Ni 50% cover Inpatient: deductible \$500/occu Other Medical Services (Including Alterni G-Ray and Lab - Outpatient Applicable deductibles and copays apply) Out-of-Ni 50% cover Outpatient MRIs (Complex Imaging) Outpatient In-Netwo 90% cover Out-of-Ni 50% cover Out-of-Ni	t: \$50 ered after deductible D/occurrence letwork: ered after deductible 50% covered after e after urrence lattive Care) ork: ered	Initial Visit: \$60 Inpatient: 100% covered after deductible after \$500/occurrence Out-of-Network: 50% covered after deductible after \$500/occurrence	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	100% covered Inpatient: 90% covered after deductible Out-of-Network: 70% covered after deductible
Inpatient: 90% cover after \$500 Out-of-Ni 50% cover Inpatient: deductible \$500/occu Other Medical Services (Including Alterni Applicable deductibles and copays apply) In-Netwo 90% cover Inpatient Applicable Medical Services (Including Alterni In-Netwo 100% cover Inpatient In-Netwo 100% cover Inpatient In-Netwo 90% cover Inpatient In-Netwo 90% cover Inpatient In-Netwo 90% cover Inpatient In-Netwo 90% cover Inpatient In-Netwo \$25/visit In-Netwo	ered after deductible D/occurrence letwork: ered after deductible 50% covered after e after urrence lative Care) ork: ered	Inpatient: 100% covered after deductible after \$500/occurrence Out-of-Network: 50% covered after deductible after \$500/occurrence In-Network: 100% covered	Inpatient: 90% covered after deductible after \$500/occurrence Out-of-Network: 50% covered after deductible Inpatient: 50% covered after deductible after \$500/occurrence	Inpatient: 90% covered after deductible Out-of-Network: 70% covered after deductible In-Network:
90% cover after \$500 Out-of-Ni 50% cover Inpatient: deductible \$500/occu Other Medical Services (Including Alterni deductible \$500/occu Other Medical Services (Including Alterni deductible \$500/occu In-Netwo 100% cover 100% cov	O/occurrence letwork: ered after deductible 50% covered after e after urrence mative Care) ork: ered	100% covered after deductible after \$500/occurrence Out-of-Network: 50% covered after deductible after \$500/occurrence In-Network: 100% covered	90% covered after deductible after \$500/occurrence Out-of-Network: 50% covered after deductible Inpatient: 50% covered after deductible after \$500/occurrence	deductible Out-of-Network: 70% covered after deductible In-Network:
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Dther Medical Services (Including Alternative deductible \$500/occus) C-Ray and Lab - Outpatient Applicable deductibles and copays apply) Out-of-Ni 50% cover Out-of-Ni 50% cover Chiropractic In-Netwo 90% cover Out-of-Ni 50% cover Service In-Netwo \$25/visit Out-of-Ni 50% cover Service In-Netwo \$25/visit Out-of-Ni 50% cover Service In-Netwo \$25/visit Out-of-Ni 50% cover In-Netwo \$25/visit Out-of-Ni 50% Co	sered after deductible 50% covered after e after urrence mative Care) ork: ered	50% covered after deductible after \$500/occurrence In-Network: 100% covered	50% covered after deductible Inpatient: 50% covered after deductible after \$500/occurrence In-Network: 100% covered	In-Network:
Inpatient: deductible \$500/occu C-Ray and Lab - Outpatient Applicable deductibles and copays apply) MRIs (Complex Imaging) Outpatient In-Netwo 0ut-of-Ne 50% cover Out-of-Ne 50% cover Chiropractic In-Netwo \$25/visit Out-of-Ne 50% cover	50% covered after e after urrence native Care) ork: eered	In-Network: 100% covered	Inpatient: 50% covered after deductible after \$500/occurrence In-Network: 100% covered	
deductible \$500/occu Chiropractic In-Netwo 90% cove In-Netwo 100% cove	e after urrence native Care) ork: ered	In-Network: 100% covered	deductible after \$500/occurrence	
deductible \$500/occu Chiropractic In-Netwo 90% cove In-Netwo 100% cove	e after urrence native Care) ork: ered	100% covered	deductible after \$500/occurrence	
\$500/occu Other Medical Services (Including Alternative Management of Services) Applicable deductibles and copays apply) Out-of-No. 50% cover. WRIs (Complex Imaging) Outpatient In-Netwo 90% cover. Out-of-No. 50% cover. Chiropractic In-Netwo \$25/visit Out-of-No. 50% cover.	urrence native Care) ork: ered	100% covered	\$500/occurrence In-Network: 100% covered	
Applicable deductibles and copays apply) Out-of-Ni 50% cover in the first part of t	ork: vered	100% covered	100% covered	
Applicable deductibles and copays apply) Out-of-Ni 50% cover in the first part of t	ork: vered	100% covered	100% covered	
Applicable deductibles and copays apply) Out-of-Ni 50% cover in the first of the f	vered	100% covered	100% covered	
Out-of-Ni 50% cove MRIs (Complex Imaging) Dutpatient In-Netwo 90% cove Out-of-Ni 50% cove Chiropractic In-Netwo \$25/visit Out-of-Ni 50% cove				90% covered after deductible
Out-of-Ni 50% cove In-Netwo 90% cove Out-of-Ni 50% cove Chiropractic In-Netwo \$25/visit Out-of-Ni 50% cove	etwork:	Out-of-Network:	Out-of-Network:	
MRIs (Complex Imaging) Dutpatient 90% cover Out-of-No 50% cover Chiropractic In-Netwo \$25/visit Out-of-No 50% cover	GLWOIR.		JUL-UI-INGLWUIK.	Out-of-Network:
Outpatient 90% cover Out-of-Ni 50% cover String Out-of-Ni 50% cover Out-of-Ni 50% cove	ered after deductible	50% covered after deductible	50% covered after deductible	70% covered after deductible
Out-of-Ni 50% cove Chiropractic In-Netwo \$25/visit Out-of-Ni 50% cove		In-Network:	In-Network:	In-Network:
Chiropractic In-Netwo \$25/visit Out-of-Note to \$25	ered after deductible	100% covered after deductible	90% covered after deductible	90% covered after deductible
Chiropractic In-Netwo \$25/visit Out-of-N: 50% cover	etwork:	Out-of-Network:	Out-of-Network:	Out-of-Network:
Substitution Subst	ered after deductible	50% covered after deductible	50% covered after deductible	70% covered after deductible
Substitution Subst	ork:	In-Network:	In-Network:	In-Network:
50% cover		\$30/visit	\$40/visit	\$30/visit
	etwork:	Out-of-Network:	Out-of-Network:	Out-of-Network:
(Up to 20	ered after deductible	50% covered after deductible	50% covered after deductible	70% covered after deductible
	visits)	(Up to 20 visits)	(Up to 20 visits)	
Physical, Occupational, and In-Netwo	ork:	In-Network:	In-Network:	In-Network:
Speech Therapy \$25/visit		\$30/visit	\$40/visit	90% covered after deductible
Subject to visit limits) Out-of-No	etwork:	Out-of-Network:	Out-of-Network:	Out-of-Network:
		50% covered after deductible	50% covered after deductible	70% covered after deductible
(up to 20 v	ered after deductible			
		(up to 20 visits each physical.	(up to 20 visits each physical.	(Up to 60 visits/vear combined
therapies)	visits each physical, nal, and speech	(up to 20 visits each physical, occupational, and speech	(up to 20 visits each physical, occupational, and speech	(Up to 60 visits/year combined

	UHC POS 1500	UHC POS 2500	UHC POS 4000	Aetna PPO 750 NY Tri-State
Mental Health - Inpatient	In-Network: 90% covered after deductible	In-Network: 100% covered after deductible	In-Network: 90% covered after deductible	In-Network: 90% covered after deductible
	Out-of-Network: 50% covered after deductible	Out-of-Network: 50% covered after deductible	Out-of-Network: 50% covered after deductible	Out-of-Network: 70% covered after deductible
Mental Health - Outpatient	In-Network: \$25/visit	In-Network: \$30/visit	In-Network: \$40/visit	In-Network: \$30/visit
	Out-of-Network: 50% covered after deductible	Out-of-Network: 50% covered after deductible	Out-of-Network: 50% covered after deductible	Out-of-Network: 70% covered after deductible
Substance Abuse				
Substance Abuse -	In-Network:	In-Network:	In-Network:	In-Network:
Inpatient	90% covered after deductible	100% covered after deductible	90% covered after deductible	90% covered after deductible
	Out-of-Network: 50% covered after deductible	Out-of-Network: 50% covered after deductible	Out-of-Network: 50% covered after deductible	Out-of-Network: 70% covered after deductible
Substance Abuse - Outpatient	In-Network: \$25/visit	In-Network: \$30/visit	In-Network: \$40/visit	In-Network: \$30/visit
	Out-of-Network: 50% covered after deductible	Out-of-Network: 50% covered after deductible	Out-of-Network: 50% covered after deductible	Out-of-Network: 70% covered after deductible
Prescription Drugs				
Retail Pharmacy - In-Network	\$15/\$45/\$65	\$15/\$45/\$65	\$15/\$45/\$65	\$10/\$30/\$50
(30-day supply if not specified) Member cost share amounts listed are generally				
generic/formulary brand/				
non-formulary brand. Contact carrier for additional information				
Mail-Order Program - In-Network	\$37.50/\$112.50/\$162.50	\$37.50/\$112.50/\$162.50	\$37.50/\$112.50/\$162.50	\$20/\$60/\$100
(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				
Specialty Pharmacy	\$15/\$125/\$250 (30-day supply)	\$15/\$125/\$250 (30-day supply)	\$15/\$125/\$250 (30-day supply)	Refer to your COC or contact
(Includes many specialty drugs. Call your carrier for more information.)				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	In-Network: \$1,000/person; \$2,500/family Out-of-Network: \$1,500/person;	In-Network: \$2,000/person; \$5,000/family Out-of-Network: \$5,000/person;	In-Network: None Out-of-Network: \$500/person; \$1,000/family	In-Network: \$500/person; \$1,000/family Out-of-Network: \$2,000/person;
members are enrolled in the plan)	\$3,750/family	\$12,500/family		\$4,000/family
Calendar Year deductible.) 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	In-Network: \$6,000/person; \$12,000/family	In-Network: \$6,000/person; \$12,000/family	In-Network: \$1,500/person; \$3,000/family	In-Network: \$2,000/person; \$4,000/family
(Includes deductible, coinsurance and medical/Rx	Out-of-Network:	Out-of-Network:	Out-of-Network:	Out-of-Network:
copays unless otherwise stated)	\$8,000/person; \$20,000/family	\$15,000/person; \$37,500/family	\$3,500/person; \$7,000/family	\$6,000/person; \$12,000/family
Lifetime Benefits Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Routine Health Maintenance				
Preventive Care Well-woman	In-Network: 100% covered	In-Network: 100% covered	In-Network: 100% covered	In-Network: 100% covered
Well-baby Well-man (Includes annual Pap smear, routine mammogram, and annual prostate exam)	Out-of-Network: 70% covered after deductible	Out-of-Network: 70% covered after deductible	Out-of-Network: Not 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	Aetna PPO 2000 NY	UHC PPO 0	UHC PPO 500
	Tri-State	Tri-State		
Hearing Testing	In-Network: 100% covered	In-Network: 100% covered	Preventive screening to age 21	Preventive screening to age 21
	Out-of-Network: 70% covered after deductible	Out-of-Network: 70% covered after deductible		
	(1 exam per 24 months)	(1 exam per 24 months)		
Physician & Hospital Services				
Physician Office Visit	In-Network:	In-Network:	In-Network:	In-Network:
	\$25/visit Specialist:	\$30/visit Specialist:	\$10/visit Specialist:	\$25/visit Specialist:
	\$40/visit	\$60/visit	\$10/visit	\$50/visit
	Out-of-Network:	Out-of-Network:	Out-of-Network:	Out-of-Network:
	70% covered after deductible	70% covered after deductible	70% covered after deductible	60% covered after deductible
Surgery Outpatient	In-Network:	In-Network:	In-Network:	In-Network:
	80% covered after deductible Out-of-Network:	80% covered after deductible Out-of-Network:	100% covered Out-of-Network:	90% covered after deductible Out-of-Network:
	70% covered after deductible	60% covered after deductible	70% covered after deductible	60% covered after deductible
Hospital Inpatient Room and Board	In-Network: 80% covered after deductible	In-Network: 80% covered after deductible	In-Network: \$250/admission	In-Network: 90% covered after deductible
Surgery Anesthesia	Out-of-Network:	Out-of-Network:	Out-of-Network:	Out-of-Network:
Drugs/Supplies	70% covered after deductible	60% covered after deductible	70% covered after deductible	60% covered after deductible
Emergency Room (Copay waived if admitted)	In-Network: \$150/visit	In-Network: \$150/visit	In-Network: \$75/visit	In-Network: \$350/visit
	Out-of-Network: \$150/visit	Out-of-Network: \$150/visit	Out-of-Network: \$75/visit	Out-of-Network: \$350/visit
Urgent Care	In-Network: \$75/visit	In-Network: \$75/visit	In-Network: \$35/visit	In-Network: \$75/visit
	Out-of-Network:	Out-of-Network:	Out-of-Network:	Out-of-Network:
	70% covered after deductible	60% covered after deductible	70% covered after deductible	60% covered after deductible
Pregnancy & Maternity Care				
Prenatal Care and Inpatient	In-Network:	In-Network:	In-Network:	In-Network:
	100% covered Inpatient: 80% covered after	100% covered Inpatient: 80% covered after	Initial Visit: \$10 Inpatient:	Initial Visit: \$50 Inpatient:
	deductible	deductible	\$250/admission	90% covered after deductible
	Out-of-Network:	Out-of-Network:	Out-of-Network:	Out-of-Network:
	70% covered after deductible	70% covered after deductible Inpatient: 60% covered after deductible	70% covered after deductible	60% covered after deductible
Other Medical Services (Includ	ling Alternative Care)			
X-Ray and Lab - Outpatient (Applicable deductibles	In-Network: 80% covered after deductible	In-Network: 80% covered after deductible	In-Network: 100% covered	In-Network: 100% covered
and copays apply)	00/0 covered and deductible	5070 COVERED AILER DEGUCTIONE	100 /0 GOVEREU	10070 COVEIED
	Out-of-Network:	Out-of-Network:	Out-of-Network:	Out-of-Network:

	Aetna PPO 1000 NY Tri-State	Aetna PPO 2000 NY Tri-State	UHC PPO 0	UHC PPO 500
MRIs (Complex Imaging)	In-Network:	In-Network:	In-Network:	In-Network:
Outpatient	80% covered after deductible	80% covered after deductible	100% covered	90% covered after deductible
	Out-of-Network:	Out-of-Network:	Out-of-Network:	Out-of-Network:
	70% covered after deductible	60% covered after deductible	70% covered after deductible	60% covered after deductible
Chiropractic	In-Network:	In-Network:	In-Network:	In-Network:
	\$40/visit	\$60/visit	\$10/visit	\$25/visit
	Out-of-Network:	Out-of-Network:	Out-of-Network:	Out-of-Network:
	70% covered after deductible	70% covered after deductible	70% covered after deductible	60% covered after deductible
			(Up to 20 visits)	(Up to 20 visits)
			(= ,	
Physical, Occupational, and	In-Network:	In-Network:	In-Network:	In-Network:
Speech Therapy	80% covered after deductible	80% covered after deductible	\$10/visit	\$25/visit
(Subject to visit limits)	Out-of-Network:	Out-of-Network:	Out-of-Network:	Out-of-Network:
	70% covered after deductible	70% covered after deductible	70% covered after deductible	60% covered after deductible
	(Lin to 60 visite/veer combined)	(Up to 60 visits/year combined)	(up to 20 visits each physical,	(up to 20 visits each physical
	(Up to 60 visits/year combined)	(op to 60 visits/year combined)	occupational, and speech	occupational, and speech
			therapies)	therapies)
Mental Health				
Mental Health - Inpatient	In-Network:	In-Network:	In-Network:	In-Network:
	80% covered after deductible	80% covered after deductible	\$250/admission	90% covered after deductible
	Out-of-Network:	Out-of-Network:	Out-of-Network:	Out-of-Network:
	70% covered after deductible	60% covered after deductible	70% covered after deductible	60% covered after deductible
Manufal Haalth Cotoatiant	In Materials	In Naturally	In National	In Naturally
Mental Health - Outpatient	In-Network: \$40/visit	In-Network: \$60/visit	In-Network: \$10/visit	In-Network: \$50/visit
	Out-of-Network:	Out-of-Network:	Out-of-Network:	Out-of-Network:
	70% covered after deductible	70% covered after deductible	70% covered after deductible	60% covered after deductible
Substance Abuse				
Substance Abuse -	In-Network:	In-Network:	In-Network:	In-Network:
Inpatient	80% covered after deductible	80% covered after deductible	\$250/admission	90% covered after deductible
	Out-of-Network:	Out-of-Network:	Out-of-Network:	Out-of-Network:
	70% covered after deductible	60% covered after deductible	70% covered after deductible	60% covered after deductible
Substance Abuse - Outpatient	In-Network: \$40/visit	In-Network: \$60/visit	In-Network: \$10/visit	In-Network: \$50/visit
outpatient	ψτο/ Violi	ψου/ visit	ψ10/VISIL	ψου/ visit
	Out-of-Network:	Out-of-Network:	Out-of-Network:	Out-of-Network:
		7000	70% covered after deductible	60% covered after deductible
	70% covered after deductible	70% covered after deductible	70% covered after deductible	00% covered after deductible

	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	In-Network:	In-Network:	In-Network:
(Deductible applies where specifically	\$1,000/person;	\$1,500/person;	\$2,500/person;
stated)	\$2,000/family	\$3,000/family	\$5,000/family
		, , , , , , , , , , , , , , , , , , ,	4 -,,
* (does not apply if the employee and any	Out-of-Network:	Out-of-Network:	Out-of-Network:
family members are enrolled in the plan)	\$2,000/person;	\$6,000/person;	\$5,000/person;
, and an and planty	\$4,000/family	\$12,000/family	\$10,000/family
	4.,000/idiliny	\$12,000/10/11iiy	\$10,000/lanny
Doductible Carryover	Voc	Vos	Vos
Deductible Carryover (Any covered expenses incurred in the	Yes	Yes	Yes
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.)			
Calendar-Year Out-of-Pocket	In-Network:	In-Network:	In-Network:
Expense Maximum	\$4,000/person;	\$5,000/person;	\$6,000/person;
(Includes deductible, coinsurance and	\$8,000/family	\$10,000/family	\$12,000/family
medical/Rx copays unless otherwise	ф0,000/таптту	\$10,000/fairing	\$12,000/Tallilly
stated)	Out-of-Network:	Out-of-Network:	Out-of-Network:
sialeu)			
	\$6,000/person;	\$12,000/person;	\$10,000/person;
	\$12,000/family	\$24,000/family	\$20,000/family
Lifetime Benefits Maximum	Unlimited	Unlimited	Unlimited
Politing Hoolth Maintenance			
Routine Health Maintenance			
	In-Network:	In-Network:	In-Network:
Well-woman	100% covered	100% covered	100% covered
Preventive Care Well-woman Well-baby	100% covered		100% covered
Well-woman Well-baby Well-man	100% covered Out-of-Network:	Out-of-Network:	100% covered Out-of-Network:
Well-woman Well-baby Well-man (Includes annual Pap smear, routine	100% covered		100% covered
Well-woman Well-baby Well-man (Includes annual Pap smear, routine	100% covered Out-of-Network:	Out-of-Network:	100% covered Out-of-Network:
Well-woman Well-baby Well-man (Includes annual Pap smear, routine	100% covered Out-of-Network:	Out-of-Network:	100% covered Out-of-Network:
Well-woman Well-baby Well-man (Includes annual Pap smear, routine mammogram, and annual prostate exam)	100% covered Out-of-Network: Not covered	Out-of-Network: Not covered	100% covered Out-of-Network: Not covered
Well-woman Well-baby Well-man (Includes annual Pap smear, routine mammogram, and annual prostate exam)	100% covered Out-of-Network: Not covered Not covered; except for preventive	Out-of-Network: Not covered Not covered; except for preventive	100% covered Out-of-Network: Not covered Not covered; except for preventive
Well-woman Well-baby Well-man (Includes annual Pap smear, routine mammogram, and annual prostate exam) Vision Testing	Out-of-Network: Not covered Not covered; except for preventive screening to age 5	Out-of-Network: Not covered Not covered; except for preventive screening to age 5	Out-of-Network: Not covered Not covered; except for preventive screening to age 5
Well-woman Well-baby Well-man (Includes annual Pap smear, routine mammogram, and annual prostate exam) Vision Testing	100% covered Out-of-Network: Not covered Not covered; except for preventive	Out-of-Network: Not covered Not covered; except for preventive	100% covered Out-of-Network: Not covered Not covered; except for preventive
Well-woman Well-baby Well-man (Includes annual Pap smear, routine mammogram, and annual prostate exam) Vision Testing Hearing Testing	Out-of-Network: Not covered Not covered; except for preventive screening to age 5	Out-of-Network: Not covered Not covered; except for preventive screening to age 5	Out-of-Network: Not covered Not covered; except for preventive screening to age 5
Well-woman Well-baby Well-man (Includes annual Pap smear, routine mammogram, and annual prostate exam) Vision Testing Hearing Testing Physician & Hospital Services	Out-of-Network: Not covered Not covered; except for preventive screening to age 5 Preventive screening to age 21	Out-of-Network: Not covered Not covered; except for preventive screening to age 5 Preventive screening to age 21	Out-of-Network: Not covered Not covered; except for preventive screening to age 5 Preventive screening to age 21
Well-woman Well-baby Well-man (Includes annual Pap smear, routine mammogram, and annual prostate exam) Vision Testing Hearing Testing Physician & Hospital Services	Out-of-Network: Not covered Not covered; except for preventive screening to age 5 Preventive screening to age 21	Out-of-Network: Not covered Not covered; except for preventive screening to age 5 Preventive screening to age 21 In-Network:	Out-of-Network: Not covered Not covered; except for preventive screening to age 5 Preventive screening to age 21
Well-woman Well-baby Well-man (Includes annual Pap smear, routine mammogram, and annual prostate exam) Vision Testing Hearing Testing Physician & Hospital Services	100% covered Out-of-Network: Not covered Not covered; except for preventive screening to age 5 Preventive screening to age 21 In-Network: \$30/visit	Out-of-Network: Not covered Not covered; except for preventive screening to age 5 Preventive screening to age 21 In-Network: \$40/visit	100% covered Out-of-Network: Not covered Not covered; except for preventive screening to age 5 Preventive screening to age 21 In-Network: \$30/visit
Well-woman Well-baby Well-man (Includes annual Pap smear, routine mammogram, and annual prostate exam) Vision Testing Hearing Testing Physician & Hospital Services	100% covered Out-of-Network: Not covered Not covered; except for preventive screening to age 5 Preventive screening to age 21 In-Network: \$30/visit Specialist:	Out-of-Network: Not covered Not covered; except for preventive screening to age 5 Preventive screening to age 21 In-Network: \$40/visit Specialist:	Out-of-Network: Not covered Not covered; except for preventive screening to age 5 Preventive screening to age 21 In-Network: \$30/visit Specialist:
Well-woman Well-baby Well-man (Includes annual Pap smear, routine mammogram, and annual prostate exam) Vision Testing Hearing Testing Physician & Hospital Services	100% covered Out-of-Network: Not covered Not covered; except for preventive screening to age 5 Preventive screening to age 21 In-Network: \$30/visit	Out-of-Network: Not covered Not covered; except for preventive screening to age 5 Preventive screening to age 21 In-Network: \$40/visit	100% covered Out-of-Network: Not covered Not covered; except for preventive screening to age 5 Preventive screening to age 21 In-Network: \$30/visit Specialist: \$60/visit
Well-woman Well-baby Well-man (Includes annual Pap smear, routine mammogram, and annual prostate exam) Vision Testing Hearing Testing Physician & Hospital Services	Out-of-Network: Not covered Not covered; except for preventive screening to age 5 Preventive screening to age 21 In-Network: \$30/visit Specialist: \$60/visit	Out-of-Network: Not covered Not covered; except for preventive screening to age 5 Preventive screening to age 21 In-Network: \$40/visit Specialist: \$80/visit	Out-of-Network: Not covered Not covered; except for preventive screening to age 5 Preventive screening to age 21 In-Network: \$30/visit Specialist: \$60/visit Premium Tier 1:
Well-woman Well-baby Well-man (Includes annual Pap smear, routine mammogram, and annual prostate exam) Vision Testing Hearing Testing Physician & Hospital Services	Out-of-Network: Not covered Not covered; except for preventive screening to age 5 Preventive screening to age 21 In-Network: \$30/visit Specialist: \$60/visit Out-of-Network:	Out-of-Network: Not covered Not covered; except for preventive screening to age 5 Preventive screening to age 21 In-Network: \$40/visit Specialist: \$80/visit Out-of-Network:	100% covered Out-of-Network: Not covered Not covered; except for preventive screening to age 5 Preventive screening to age 21 In-Network: \$30/visit Specialist: \$60/visit
Well-woman Well-baby Well-man (Includes annual Pap smear, routine mammogram, and annual prostate exam) Vision Testing Hearing Testing Physician & Hospital Services	Out-of-Network: Not covered Not covered; except for preventive screening to age 5 Preventive screening to age 21 In-Network: \$30/visit Specialist: \$60/visit	Out-of-Network: Not covered Not covered; except for preventive screening to age 5 Preventive screening to age 21 In-Network: \$40/visit Specialist: \$80/visit	Out-of-Network: Not covered Not covered; except for preventive screening to age 5 Preventive screening to age 21 In-Network: \$30/visit Specialist: \$60/visit Premium Tier 1: \$30/visit
Well-woman Well-baby Well-man (Includes annual Pap smear, routine mammogram, and annual prostate exam) Vision Testing Hearing Testing	Out-of-Network: Not covered Not covered; except for preventive screening to age 5 Preventive screening to age 21 In-Network: \$30/visit Specialist: \$60/visit Out-of-Network:	Out-of-Network: Not covered Not covered; except for preventive screening to age 5 Preventive screening to age 21 In-Network: \$40/visit Specialist: \$80/visit Out-of-Network:	Out-of-Network: Not covered Not covered; except for preventive screening to age 5 Preventive screening to age 21 In-Network: \$30/visit Specialist: \$60/visit Premium Tier 1:

	UHC PPO 1000	UHC PPO 1500	UHC PPO 2500
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: \$60 Inpatient: 80% covered after deductible after \$500/occurrence Out-of-Network: 50% covered after deductible after \$500/occurrence
Other Medical Services (Including Alte	ernative 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	In-Network: \$40/visit Out-of-Network: 50% covered after deductible	In-Network: \$30/visit Out-of-Network: 50% covered after deductible
	(Up to 20 visits)	(Up to 20 visits)	(Up to 20 visits)

	UHC PPO 1000	UHC PPO 1500	UHC PPO 2500			
Other Medical Services (Including Alternation						
Physical, Occupational, and Speech Therapy (Subject to visit limits)	In-Network: \$30/visit Out-of-Network:	In-Network: \$40/visit Out-of-Network:	In-Network: \$30/visit Out-of-Network:			
	60% covered after deductible (up to 20 visits each physical, occupational, and speech therapies)	50% covered after deductible (up to 20 visits each physical, occupational, and speech therapies)	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	In-Network: 70% covered after deductible	In-Network: 80% covered after deductible			
	Out-of-Network: 60% covered after deductible	Out-of-Network: 50% covered after deductible	Out-of-Network: 50% covered after deductible			
Mental Health - Outpatient	In-Network: \$60/visit	In-Network: \$80/visit	In-Network: \$30/visit			
	Out-of-Network: 60% covered after deductible	Out-of-Network: 50% covered after deductible	Out-of-Network: 50% covered after deductible			
Substance Abuse						
Substance Abuse - Inpatient	In-Network: 80% covered after deductible	In-Network: 70% covered after deductible	In-Network: 80% covered after deductible			
	Out-of-Network: 60% covered after deductible	Out-of-Network: 50% covered after deductible	Out-of-Network: 50% covered after deductible			
Substance Abuse - Outpatient	In-Network: \$60/visit	In-Network: \$80/visit	In-Network: \$30/visit			
	Out-of-Network: 60% covered after deductible	Out-of-Network: 50% covered after deductible	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)			