

	Aetna 2025 Plans			
Plan Name	Consumer Core HDHP	Network Core Plan	Choice PPO	
Network	Open Access Elect Choice	Open Access Elect Choice	Open Access Managed Choice	
	In Network	In Network	In Network	Out of Network
Deductible	\$1,650/\$3,300 (Cumulative)	\$250 / \$500	\$850/\$1,700	\$2,500/\$5,000
Coinsurance	90%	Covered 100%	85%	60%
Out of Pocket Maximum	\$2,500/\$5,000 (Cumulative)	\$2,000/\$4,000	\$2,000/\$4,000	\$6,000/\$12,000
Annual Maximum ,	Unlimited	Unlimited	Unlimited	Unlimited
Lifetime Maximum,	Unlimited	Unlimited	Unlimited	Unlimited
Prescription Drug Deductible	Combined with medical	\$125/\$375 waived for generic	\$125/\$375 waived for generic	\$125/\$375 waived for generic
Pharmacy Maximum Out of Pocket	Combined with medical	\$4,000/\$8,000	\$4,000/\$8,000	\$4,000/\$8,000
Prescription Drugs	Deductible and then 80%/70%/50% Coinsurance up to the Out of Pocket Maximum (Generic Preventive Medication - \$0 copay & not subject to deductible)	\$20/\$45/\$70 (Generic Preventive Medication - \$0 copay & not subject to deductible)	\$20/\$45/\$70 (Generic Preventive Medication - \$0 copay & not subject to deductible)	30% of submitted cost after applicable copay
Mail Order Prescription Drugs (Three (3) month Supply)	Deductible and then 80%/70%/50% Coinsurance (Generic Preventive Medication - \$0 copay & not subject to deductible)	\$20/\$45/\$70 (Generic Preventive Medication - \$0 copay & not subject to deductible)	\$20/\$45/\$70 (Generic Preventive Medication - \$0 copay & not subject to deductible)	In-Network Benefit Only
Oral Contraceptive	Included	Included	Included	Included
PCP Office Visits	Deductible and Coinsurance	\$30	\$30	Deductible & 70% Coinsurance
Specialist Visits	Deductible and Coinsurance	\$50	\$50	Deductible & 70% Coinsurance
Telehealth Connection	Deductible and Coinsurance	\$30	\$30	Not covered
OB/GYN Visits	Deductible and Coinsurance; Preventive care - Covered 100%	Office Visit - \$30/\$50 copay Preventive care - Covered 100%	Office Visit - \$30/\$50 copay Preventive care - Covered 100%	Deductible and 70% Coinsurance

Routine Preventive Care (adult)	100%	100%	100%	Deductible & 70% Coinsurance
Well Child Exams (through age 18)	100%	100%	100%	100%
Vision Coverage	1 routine exam covered every 24 months; Separate vision plan through Aetna Vision	1 routine exam covered every 24 months; Separate vision plan through Aetna Vision	1 routine exam covered every 24 months; Separate vision plan through Aetna Vision	Deductible & Coinsurance; 1 routine exam covered every 24 months; Separate vision plan through Aetna Vision
Gym Reimbursement	Reimbursement program up to \$200/ee and \$100/sp/dp every 6 months for 50 visits.	Reimbursement program up to \$200/ee and \$100/sp/dp every 6 months for 50 visits.	Reimbursement program up to \$200/ee and \$100/sp/dp every 6 months for 50 visits.	
Lab and X-ray	Deductible & Coinsurance	Participating lab - 100% Office Visit - \$30/\$50 copay (If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing) Outpatient - 100%	Participating lab - 100%, no deductible Office Visit - \$30/\$50 copay (If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing) Outpatient - 100%	Deductible & 70% Coinsurance
Advanced Radiology	Deductible & Coinsurance	Office Visit - \$30/\$50 copay (If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing) Outpatient - 100%	100% (If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing)	Deductible & 70% Coinsurance
Chiropractic	Deductible & Coinsurance Unlimited visits per calendar yr	\$50 Unlimited visits per calendar yr	\$50 Unlimited visits per calendar yr	Deductible & 70% Coinsurance Unlimited visits per calendar yr
Ambulance Service	Deductible & Coinsurance (Emergency Use only)	100% (Emergency Use only)	Deductible & Coinsurance (Emergency Use only)	Deductible & 85% Coinsurance (Emergency Use only)

Emergency Room	Deductible & Coinsurance	\$100 per visit; Waived if admitted	\$100 per visit; Waived if admitted	\$100 per visit; Waived if admitted
Urgent Care	Deductible & Coinsurance	\$30 per visit	\$30 per visit	\$30 per visit
Hospitalization	Deductible & Coinsurance	100% after deductible	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient Surgery	Deductible & Coinsurance	100% after deductible	Deductible & Coinsurance	Deductible & Coinsurance
Inpatient Mental Health	Deductible & Coinsurance	100% after deductible	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient Mental Health	Deductible & Coinsurance	Office Visit - \$30 copay Outpatient Facility - 100%	Office Visit - \$30 copay Outpatient Facility - 100%	Deductible & 70% Coinsurance
Substance Abuse	Deductible & Coinsurance	Inpatient - 100%; after deductible Office Visit - \$30 Copay Outpatient Services - 100%	Inpatient - Deductible & Coinsurance Office Visits - \$30 Copay Outpatient Services - 100%	Inpatient - Deductible & Coinsurance Office Visits - Deductible & 70% Coinsurance Outpatient Services - Deductible & 70% Coinsurance
Inpatient Physical Therapy	Deductible & Coinsurance 60 days maximum per calendar year includes Skilled Nursing Facility, Rehabilitation Hospital, Sub Acute Facilities	100%; after deductible 60 days maximum per calendar year includes Skilled Nursing, Rehabilitation Hospital and Sub Acute Facilities	Deductible & Coinsurance; 60 days maximum per calendar year includes Skilled Nursing, Rehabilitation Hospital and Sub Acute Facilities	Deductible & Coinsurance; 60 days maximum per calendar year includes Skilled Nursing, Rehabilitation Hospital and Sub Acute Facilities

Outpatient Physical Therapy	Deductible & Coinsurance Limited to 90 visits per year. Unlimited for early intervention services from birth to age 3. Includes: Cardiac Rehab, Physical Therapy, Speech Therapy, Occupational Therapy, Pulmonary Rehab, Cognitive Therapy	\$50 Copay Limited to 90 visits per year. Unlimited for early intervention services from birth to age 3. Includes: Cardiac Rehab, Physical Therapy, Speech Therapy, Occupational Therapy, Pulmonary Rehab, Cognitive Therapy	\$50 Copay Limited to 90 visits per year. Unlimited for Early Intervention Services from birth to age 3. Includes: Cardiac Rehab, Physical Therapy, Speech Therapy, Occupational Therapy, Pulmonary Rehab, Cognitive Therapy	Deductible & 70% Coinsurance Limited to 90 visits per year. Unlimited for Early Intervention Services from birth to age 3. Includes: Cardiac Rehab, Physical Therapy, Speech Therapy, Occupational Therapy, Pulmonary Rehab, Cognitive Therapy
Hospice Care	Deductible & Coinsurance	100% after deductible	Deductible & Coinsurance	Deductible & Coinsurance
Home Health Care (includes Outpatient Private Duty Nursing)	Deductible & Coinsurance Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less	100% Home health care services include private duty nursing Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less	Deductible & Coinsurance Home health care services include private duty nursing; Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less	Deductible & 25% Coinsurance Home health care services include private duty nursing; Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less
Skilled Nursing Facility	Deductible & Coinsurance Limited to 60 days per year Includes Rehabilitation Hospital and Sub-Acute Facilities	100% after deductible Limited to 60 days per year Includes Rehabilitation Hospital and Sub-Acute Facilities	Deductible & Coinsurance Limited to 60 days per year Includes Rehabilitation Hospital and Sub-Acute Facilities	Deductible & Coinsurance Limited to 60 days per year Includes Rehabilitation Hospital and Sub-Acute Facilities
TMJ- Surgical and Non Surgical - Always excludes appliances & orthodontic treatment. Subject to medical necessity.	Deductible & Coinsurance	Office Visit - \$30/\$50 copay Inpatient and Outpatient facility - 100% after deductible	Office Visit - \$30/\$50 copay Inpatient and Outpatient facility - Deductible & Coinsurance	Office Visit - Deductible & 70% Coinsurance Inpatient and Outpatient facility - Deductible & Coinsurance

Infertility	Deductible & Coinsurance; Comprehensive (includes artificial insemination) - Unlimited maximum Advanced Infertility (IV, ZIFT, GIFT) - Unlimited maximum	Office Visit - \$30/\$50 copay Inpatient & Outpatient Facility - 100% after deductible; Comprehensive (includes artificial insemination) - Unlimited maximum Advanced Infertility (IV, ZIFT, GIFT) - Unlimited maximum	Office Visit - \$30/\$50; Inpatient & Outpatient Facility - Deductible & Coinsurance Comprehensive (includes artificial insemination) - Unlimited maximum Advanced Infertility (IV, ZIFT, GIFT) - Unlimited maximum	Deductible & Coinsurance; Comprehensive (includes artificial insemination) - Unlimited maximum Advanced Infertility (IV, ZIFT, GIFT) - Unlimited maximum
Abortion	Deductible & Coinsurance	Office Visit - \$30/\$50 copay Inpatient & Outpatient Facility - 100% after deductible	Office Visit - \$30/\$50 copay Inpatient & Outpatient Facility - Deductible & Coinsurance	Office Visit - Deductible & 70% Coinsurance Inpatient & Outpatient Facility - Deductible & Coinsurance
Dependent Age	26, End of calendar yr	26, End of calendar yr	26, End of calendar yr	26, End of calendar yr
Durable Medical Equip.	Deductible & Coinsurance; Unlimited maximum	100%; Unlimited maximum	Deductible & Coinsurance; Unlimited maximum	Deductible & Coinsurance; Unlimited maximum
Out of Network Reasonable & Customary	N/A	N/A	N/A	300% of Medicare
Pre-certification required	Yes, coordinated by provider/PCP	Yes, coordinated by provider/ PCP	Yes, coordinated by provider/ PCP	Yes, EE responsible
Penalty for Failure to Pre-certify	N/A	N/A	N/A	Lesser of 50% or \$500

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