



AETNA MEDICAL PLANS COMPARISON CHART

Please note: The dollar amounts are copays, deductibles, and maximums, which you pay; the percentages are coinsurance amounts, which you pay after you meet applicable deductibles.

Understanding How Much You Have to Pay

Health Reimbursement Account (HRA) (CDHP only). Use your HRA to pay your deductible, coinsurance, and Rx copays, reducing your out-of-pocket costs. The amount deposited in your HRA is prorated based on your benefits effective date.

See [page 35](#) in the 2027 Employee BeneFlex Guide. Note the IRS requires that 100% of disbursements made from your HRA be substantiated or verified. See [page 35](#) in the 2027 BeneFlex for the HRA rollover maximum, effective January 1, 2027.

- **Medical Plan Deductible:** (Basic Essential, CDHP + HRA, Select Choice). The amount you pay for medical expenses before the plan begins paying benefits.
- **Coinsurance:** (Basic Essential, CDHP + HRA, Select Choice). The percentage of eligible medical expenses you pay after paying the deductible for most services.
- **Copays:** The fixed amount you pay for medical care and prescriptions.
- **Aetna Prescription Drug Program:** (all plans). You pay copays for generic and preferred brand drugs. For non-preferred brand and specialty drugs, you pay the Rx deductible before you pay copays. In the Basic Essential plan, the deductible does not apply to the non-preferred brand drugs.

This chart provides a brief outline of the medical coverage options available to you through Aetna. Complete details are in the official plan documents. In any conflict between the plan documents and this basic comparison chart, the plan documents will supersede.

*Plan changes and health plan rates are subject to board approval. *Waived if transferred from hospital

Aetna Concierge Group #109718 866-253-0599 Benefit	Basic Essential In-Network Only	CDHP + HRA In-Network Only	Select Choice In-Network Only
Service Areas/Networks	Any provider in the Aetna Select Open Access national network	Any provider in the Aetna Select Open Access national network	Any provider in the Aetna Select Open Access national network
Health Reimbursement Account (HRA)—Individual/Family HRA funds can only be used for medical plan and prescription drug expenses.	N/A	\$500 Individual; \$750 Employee + Child(ren) or Employee + Spouse; \$1,000 Family. HRA contributions are prorated based on your effective date.	N/A
Deductibles—Individual/Family	\$2,500 Individual \$7,000 Family	\$1,750 Individual \$3,500 Family	\$1,000 Individual \$2,500 Family
Medical Out-of-Pocket Maximum—Includes medical deductible, coinsurance, and/or copays	\$9,000 Individual \$17,500 Family	\$5,500 Individual \$11,000 Family	\$5,000 Individual \$10,000 Family
Rx Out-of-Pocket Maximum—Includes Rx copays and deductible	Combined with Medical	\$2,500 Individual \$5,000 Family	\$2,000 Individual \$4,000 Family
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Physician Office Visits	You Pay:	You Pay:	You Pay:
Primary Care Physician (PCP)	\$60 copay	25% coinsurance after deductible	\$30 copay
Specialist (SPC)	30% coinsurance after deductible	25% coinsurance after deductible	\$60 copay
CVS 24/7 Virtual Care	\$40 copay	\$25 copay	\$25 copay
CVS Virtual Mental Health Care	0% no deductible	25% coinsurance after deductible	\$30 copay
Preventive Adult Physical Exams	0% no deductible	0% no deductible	No copay
Preventive GYN Care (including Pap test) (direct access to participating providers)	0% no deductible	0% no deductible	No copay
Mammography Preventive Screening	0% no deductible	0% no deductible	No copay
Preventative Immunizations	0% no deductible	0% no deductible	No copay
Allergy Injections	30% coinsurance after deductible	25% coinsurance after deductible	25% coinsurance after deductible
Lab X-Ray Outpatient Advanced Outpatient Radiology Services (MRI, CAT scan, PET scan, etc.)	30% coinsurance after deductible 30% coinsurance after deductible 30% coinsurance after deductible	25% coinsurance after deductible 25% coinsurance after deductible 25% coinsurance after deductible	25% coinsurance after deductible 25% coinsurance after deductible 25% coinsurance after deductible
Colonoscopy Screenings—Preventive and Diagnostic	0% no deductible	0% no deductible	No copay
Chiropractic Services (limits apply) (direct access to participating)	30% coinsurance after deductible 20 visits per calendar year	25% coinsurance after deductible 20 visits per calendar year	25% coinsurance after deductible 20 visits per calendar year
Hearing Exam	30% coinsurance after deductible	25% coinsurance after deductible	25% coinsurance after deductible



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Important Rx Information

Maintenance Choice Program

Pay 2 copays for a 90-day supply only when you fill your maintenance prescriptions through CVS Caremark mail order delivery or at a CVS and Costco Pharmacy retail location.

Rx Deductible May Apply

For non-preferred brand you must pay the \$250 per person or \$500 per family Rx deductible before you begin paying copays.

Diabetes Care

See [page 55](#) the 2027 Employee BeneFlex Guide for details about the Diabetes CARE Program and free diabetic testing supplies.

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* Some drugs may be subject to step-therapy or precertification. ** Not all specialty prescriptions offer assistance. Eligibility for third-party copay assistance program is dependent on the applicable terms and conditions required by that particular program and are subject to change.

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Hospital Inpatient (includes maternity and newborn services)	30% coinsurance after deductible	25% coinsurance after deductible	\$600 copay per day; up to 6-day maximum
Outpatient Surgery (including facility charges) Hospital Non-Hospital Provider Office	30% coinsurance after deductible 30% coinsurance after deductible 30% coinsurance after deductible	25% coinsurance after deductible 25% coinsurance after deductible 25% coinsurance after deductible	25% coinsurance after deductible 25% coinsurance after deductible \$60 copay
Emergency Room Services	30% coinsurance after deductible	25% coinsurance after deductible	30% coinsurance after deductible
Ambulance	30% coinsurance after deductible	25% coinsurance after deductible	25% coinsurance after deductible
CVS MinuteClinic/Walk-in Clinics	30% coinsurance after deductible	25% coinsurance after deductible	\$30 copay
Urgent Care Facility	30% coinsurance after deductible	25% coinsurance after deductible	\$100
Mental Health Services Outpatient Mental Health Office Visits Partial Hospitalization Mental Health Services	0% no deductible 30% coinsurance after deductible	25% coinsurance after deductible 25% coinsurance after deductible	\$25 / \$50 (specialists) copay 25% coinsurance after deductible
Inpatient Mental Health Services	30% coinsurance after deductible	25% coinsurance after deductible	\$600 copay per day; up to 6-day maximum
Miscellaneous Home Health Care (limits apply)	30% coinsurance after deductible; 90-visit limit per calendar year	25% coinsurance after deductible; 90-visit limit per calendar year	25% coinsurance after deductible; 90-visit limit per calendar year
Hospice—Inpatient (limits apply)	30% coinsurance after deductible	25% coinsurance after deductible	\$600 copay per day; up to 6-day maximum ¹
Skilled Nursing Facility (limits apply)	30% coinsurance after deductible up to 120-visit limit per calendar year	25% coinsurance after deductible up to 120-visit limit per calendar year	\$600 copay per day; up to 6-day maximum ¹ up to 120-visit limit per calendar year
Short-Term Rehabilitation/Outpatient Therapy (speech, physical, occupational)	30% coinsurance after deductible 60-visit limit per calendar year for all therapies combined	25% coinsurance after deductible 60-visit limit per calendar year for all therapies combined	25% coinsurance after deductible 60-visit limit per calendar year for all therapies combined
Diabetic Supplies (syringes, test strips)	N/A	See prescription drugs below	See prescription drugs below
Durable Medical Equipment (DME)	30% coinsurance after deductible	25% coinsurance after deductible	25% coinsurance after deductible
Aetna Prescription Drug Program*	<i>Mandatory Generics Unless Dispense As Written</i>	<i>Mandatory Generics Unless Dispense As Written</i>	<i>Mandatory Generics Unless Dispensed As Written</i>
Up to 30-day supply: Generic Preferred Brand Non-Preferred Brand Weight Loss Drugs Specialty—PrudentRx**	\$25 copay, no Rx deductible \$60 copay, no Rx deductible \$120 copay, no Rx deductible Not covered 30% coinsurance, \$0 if enrolled	\$15 copay, no Rx deductible \$60 copay, no Rx deductible \$120 after Rx deductible Not covered 30% coinsurance, \$0 if enrolled	\$15 copay, no Rx deductible \$60 copay, no Rx deductible \$120 after Rx deductible Not covered 30% coinsurance, \$0 if enrolled
90-day Supply (maintenance medications) at CVS and Costco or mail order (mail order must be through CVS Caremark mail order delivery.)	<i>Mandatory Generics Unless Dispense As Written</i>	<i>Mandatory Generics Unless Dispense As Written</i>	<i>Mandatory Generics Unless Dispensed As Written</i>
Generic Brand Preferred Brand Non-Preferred Brand Specialty—PrudentRx*	\$50 copay, no Rx deductible \$120 copay, no Rx deductible \$240 copay, no Rx deductible N/A	\$30 copay, no Rx deductible \$120 copay, no Rx deductible \$240 copay, after Rx deductible N/A	\$30 copay, no Rx deductible \$120 copay, no Rx deductible \$240 copay, after Rx deductible N/A