

# Medical Plan Comparison Chart

	Aetna Choice POS II		Aetna HealthFund HSA		Kaiser HMO	SelectHealth HMO
	In-Network	Out-of-Network	In-Network	Out-of-Network	(Southern CA only)	(UT only)
<b>Annual Deductible</b>	\$325 individual / \$650 family (Rx not subject to the deductible)	\$975 individual / \$1,950 family (Rx not subject to the deductible)	Employee: \$1,500 Employee + Spouse/DP: \$2,800 Employee + Child(ren): \$2,800 Family: \$2,800		None	\$300 individual / \$600 family, per calendar year
<b>Health Savings Account</b>	Not Available		<b>Company Contribution</b> Employee: \$600 Employee+ Spouse/DP: \$925 Employee+ Child(ren): \$925 Family: \$1,300	<b>Employee Maximum Contribution</b> Employee: \$2,950 Employee+ Spouse/DP: \$6,175 Employee+ Child(ren): \$6,175 Family: \$5,800	Not Available	Not Available
<b>Out-of-Pocket Maximum (includes deductible)</b>	\$3,600 individual / \$7,100 family	\$8,800 individual / \$18,900 family	Employee: \$5,000 Employee+1 or more: \$8,000 Individual out-of-pocket max not to exceed \$6,850	Employee: \$9,000 Employee+1 or more: \$15,000	\$1,500 individual / \$3,000 family, per calendar year	\$2,000 individual / \$4,000 family, per calendar year
<b>Preventive Care (age/frequency limits apply)</b>	Covered at 100%	Mammogram covered at 60% after deductible. No Coverage otherwise.	Covered at 100%	Mammogram covered at 60% after deductible. No Coverage otherwise.	Covered at 100%	Covered at 100%
<b>Maternity Care <sup>(BR)</sup></b>	Initial office visit copay after deductible applies to confirm pregnancy; prenatal visits covered at 100%. Physician delivery and postpartum care covered at 90% after deductible. See "Hospital" section below for hospital charges. <sup>(AX)</sup>	Prenatal, delivery and postpartum care covered at 60% after deductible. See "Hospital" section below for hospital charges.	Initial office visit to confirm pregnancy, delivery and postpartum care covered at 90% after deductible. Prenatal care visits covered at 100%. <sup>(AX)</sup>	Prenatal, delivery and postpartum care covered at 60% after deductible	\$0-\$20 copay, depending on service	\$20 copay/first visit, delivery covered at 90% after deductible
<b>Chiropractic Care</b>	\$20 copay after deductible. Up to 12 visits per plan year.	60% after deductible. Up to 12 visits per plan year.	90% after deductible Up to 12 visits per plan year	60% after deductible Up to 12 visits per plan year	\$10 copay, 30 visits per calendar year (includes acupuncture)	Not covered
<b>Office Visits</b>	\$20 copay after deductible <sup>(AX)</sup>	60% after deductible	90% after deductible <sup>(AX)</sup>	60% after deductible	\$20 copay	\$20 PCP \$20 specialist
<b>Urgent Care</b>	\$50 copay after deductible	60% after deductible	90% after deductible	60% after deductible	\$20 copay	\$30 copay
<b>Emergency Room</b>	100% after deductible and \$150 copay (waived if admitted); no coverage if non-emergency	100% after deductible and \$150 copay (waived if admitted); no coverage if non-emergency	90% after deductible; no coverage if non-emergency	90% after deductible; no coverage if non-emergency	\$150 per visit; waived if admitted	\$150 copay after deductible; waived if admitted
<b>Hospital*</b>	90% after deductible and \$150 copay per day/\$750 annual copay maximum. Physician – 90% after deductible.	60% after deductible and \$150 copay per day/\$750 annual copay maximum. Physician – 60% after deductible.	90% after deductible	60% after deductible	Covered at 100% after \$100 copay per stay	\$150 per admission, then 90% after deductible
<b>Infertility Treatment/Testing (office visit including tests and counseling)</b>	100% after deductible <sup>(AX)</sup> and \$20 copay in accordance with the type of expense and place where service is provided	60% after deductible	90% after deductible <sup>(AX)</sup>	60% after deductible	\$20 per visit	50% cover after deductible, limit \$1,500 per calendar year, \$5,000 lifetime max. (select services)
<b>Artificial Insemination</b>	90% after deductible <sup>(AX)</sup> up to 3 cycles	60% after deductible up to 3 cycles	90% after deductible <sup>(AX)</sup> up to 3 cycles	60% after deductible up to 3 cycles	\$20 per visit, limits apply	Not covered
<b>In Vitro</b>	90% after deductible <sup>(AX)</sup> up to 3 cycles	60% after deductible up to 3 cycles	90% after deductible <sup>(AX)</sup> up to 3 cycles	60% after deductible up to 3 cycles	Not covered	Not covered
<b>Infertility Surgery (diagnostic purposes)</b>	90% after deductible <sup>(AX)</sup>	60% after deductible	90% after deductible <sup>(AX)</sup>	60% after deductible	Not covered	Not covered
<b>Inpatient Facility (diagnostic purposes)</b>	90% after \$150 copay per day, \$750 max copay per plan year	60% after \$150 copay per day, \$750 max copay per plan year	90% after deductible <sup>(AX)</sup>	60% after deductible	Not covered	Not covered
<b>Outpatient Facility (diagnostic purposes)</b>	90% after deductible <sup>(AX)</sup>	60% after deductible	90% after deductible <sup>(AX)</sup>	60% after deductible	Not covered	Not covered
<b>Prescription Drugs (Rx)**</b>	Generic substitution mandatory; generic and brand-name drugs: pharmacy max. \$1,500 per member/year, \$3,000 per family/year; specialty injectable drugs must be filled through Aetna Specialty Pharmacy		Plan pays after annual deductible is met; preventive drugs are not subject to the deductible; generic substitution mandatory; specialty injectable drugs must be filled through Aetna Specialty Pharmacy		Closed formulary	Generic substitution mandatory or pay copay plus the difference between brand and generic
<b>Generic (30-day supply)</b>	\$10 copay; generic contraceptives and injectables 100% covered		\$10 copay; generic contraceptives and injectables 100% covered		\$10 copay	\$10 copay
<b>Brand-Name &amp; Specialty Injectables (30-day supply)</b>	20% with \$25 minimum and \$75 maximum if generic not available for preferred; 40% with \$45 minimum and \$100 maximum for non-preferred		20% with \$25 minimum and \$75 maximum if generic not available for preferred; 40% with \$45 minimum and \$100 maximum for non-preferred		\$35 copay	\$25 preferred \$45 non-preferred \$100 specialty injectables
<b>Mail-Order (90-day supply)</b>	\$20 generic; 20% with \$50 minimum and \$150 maximum for brand preferred; 40% with \$100 minimum and \$200 maximum for brand non-preferred		\$20 generic; 20% with \$50 minimum and \$150 maximum for brand preferred; 40% with \$100 minimum and \$200 maximum for brand non-preferred		\$20 copay generic \$70 copay brand (up to 100-day supply)	\$10 generic \$50 preferred \$135 non-preferred

(AX) – In-network care received from non-Aexcel providers is paid at a lower amount for some specialists if you live in certain counties. Search *Summary Plan Description* on MyHR for more information.

(BR) – Aetna medical plans only. Newborn hospital copay may be waived for the Aetna POS II Plan if a Health Risk Assessment is done through the Beginning Right Maternity Management program in the first trimester. See page 10 of the Edwards Health, Welfare & Supplemental Benefits Guide and Aetna's website at [www.aetna.com](http://www.aetna.com) for more information.

\*Coverage may be higher for some services in Aetna plans when using an Institute of Quality. \*\*For Aetna plans, be sure to review your formulary for quantity limits and updates.

**Note:** If there is a conflict between this chart and the official Plan Documents that govern these plans, the official Plan Documents will prevail.