

## Health Insurance Comparison Chart: Staff, Supervisors and Auxiliary

Plan Features	Aetna Meritain PPO for Staff	Aetna Meritain EPO	MVP Health Plan
	Network plus freedom of choice	Network only	Network only
<i>Primary Care Provider Required</i>	NO	NO	YES
<i>Medical services Deductible (Individual/Family)</i>	In Network: \$0 Out of Network: \$200/\$500	Not Applicable	Not Applicable
<i>Coinsurance: the % you pay after deductible</i>	In Network: None Out of Network: 20%	Not Applicable	Not Applicable
<i>Maximum Out of Pocket (Individual/Family)</i>	In Network: \$5,080 / \$12,700 (All In – Network copays) Out of Network: \$1,000/\$2,000	\$5,080 / \$12,700 (All In –Network copays)	\$5,080 / \$12,700 (All In –Network copays)
<i>Emergency Room</i>	\$35-waived if admitted in 24 hrs	\$75-waived if admitted inpatient within 24 hrs	\$50 waived if hospitalized
<b><i>Office Visit</i></b>	<b>In Network: \$12 copay Out of Network: Deductible &amp; Coinsurance</b>	<b>\$25 copay</b>	<b>\$15 copay</b>
<i>Lab &amp; Testing</i>	In Network: \$0 if in a freestanding lab; \$12 copay for office visit if in a medical center such as CareMount Out of Network: Deductible & Coinsurance	\$0 if in a freestanding lab; \$25 copay for office visit if in a medical center such as CareMount	\$15 copay
<i>Annual Physical / Well-Woman care</i>	\$0 copay	\$0 copay	\$15 copay
<b><i>Inpatient Surgery</i></b>	<b>\$0</b>	<b>\$250 copay</b>	<b>\$0</b>
<i>Vision: Exam every 2 yrs</i>	\$10 copay	\$10 copay	\$15 copay
<i>Vision: Eyewear</i>	\$130 allowance plus 15% of additional cost: Vision Service Plan providers only		Not covered
<b><i>Prescriptions</i></b>	<b>Optum RX: \$5 copay for Generic \$15 / \$25 for Brand</b>	<b>Optum RX: \$10 copay for Generic \$35 / \$70 for Brand after \$200 deductible</b>	<b>\$5 copay for Generic \$20 / \$40 Brand</b>
<i>Children's Preventive Dental Care</i>	Not covered	Not covered	2 visits/yr for children under 19
<i>Mental Health</i>	In-network inpatient hospital: \$0 Out-of-network: Deductible & Coinsurance In-network outpatient visit: \$12 copay/visit Out of network: Deductible & Coinsurance	Covers network providers only: \$250 copay inpatient hospital; \$0 inpatient psychiatrist; \$25 per visit outpatient visits.	\$0 inpatient hospital ; 50% or \$45 copay inpatient psychiatrist; \$15 copay outpatient visits.
<i>Alcohol/Substance Abuse Inpatient</i>	\$0 up to 30 days/year	\$20 copay for 3- month supply of generic RX \$70 / \$140 for 3-month supply of brand-name RX; no deductible	\$0 Detoxification
<i>Outpatient</i>	\$12 copay		\$15 copay
<i>Physical Therapy</i>	\$20 per visit up to 90 visits per year (Covered In-network only)	\$25 per visit up to 60 visits per year	\$15 per visit to 60 days

*Staff employees hired before January 1, 2004 may also enroll in MVP Choices point-of-service plan. Summary information on MVP Choices is available from Benefits.*