	Aetna								Nationwide Insurance Company	
Plan Name	**POS Medical Core Plan**		**POS Medical Buy Up Plan**		**POS Medical High Deductible Health Plan (EE Only)**		**POS Medical High Deductible Health Plan (EE+Family)**		**Minimum Coverage Plan**	**Enhanced Minimum Coverage Plan**
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**In-Network**
Deductible: Individual/Family	$1,000/$2,000	$2,000/$4,000	$750/$1,500	$1,500/$3,000	$1,500	$2,000	$3,000	$4,000	N/A	N/A
Coinsurance	70%	50%	80%	60%	75%	60%	75%	60%	N/A	N/A
Out-of-Pocket Maximum: Individual/Family	$5,250/$10,500	$10,500/$21,000	$3,250/$6,500	$8,125/$16,250	$6,350	$12,700	$6,350/$12,700	$12,700/$25,400	N/A	N/A
Lifetime Maximum	Unlimited		Unlimited		Unlimited		Unlimited		N/A	N/A
PCP Selection	Not Required		Not Required		Not Required		Not Required		N/A	N/A
Referral Requirements	None		None		None		None		N/A	N/A
Preventative Care: Routine Adult Physical Exams, Well Child Exams, Pediatric Immunizations, Routine GYN care exams, Routine Mammograms and Routine Laboratory/Radiology	100% covered; no deductible	50% after deductible	100% covered; no deductible	60% after deductible	100%, no deductible	60% after deductible	100%, no deductible	60% after deductible	100%, no deductible	100%, no deductible
Primary Care Physician Office Visits	$30 copay; no deductible	50% after deductible	$20 copay; no deductible	60% after deductible	75% after deductible	60% after deductible	75% after deductible	60% after deductible	N/A	Plan Pays $75 per Day 6 Days per Person per Year
Specialist Office Visits	$50 copay; no deductible	50% after deductible	$40 copay; no deductible	60% after deductible	75% after deductible	60% after deductible	75% after deductible	60% after deductible	N/A	Plan Pays $75 per Day 6 Days per Person per Year
Maternity/OB Office Visits (Prenatal/Maternity)	100% no deductible/no co-pay	50% after deductible	100% no deductible/no co-pay	60% after deductible	75% after deductible	60% after deductible	75% after deductible	60% after deductible	N/A	N/A
Infertility Medical Maximum (lifetime)	$15,000	$15,000	$15,000	$15,000	$15,000	$15,000	$15,000	$15,000	N/A	N/A
Diagnostic Laboratory/Radiology	70% after deductible	50% after deductible	80% after deductible	60% after deductible	75% after deductible	60% after deductible	75% after deductible	60% after deductible	Discount Program	Plan Pays $75 per Testing Day 3 Days per Person per Year + Discount Program
Emergency Room	70% after $150 ER copay/deductible waived	70% after $150 ER copay /deductible waived	80% after $150 ER copay/deductible waived	80% after $150 ER copay/deductible waived	75% after deductible	75% after deductible	75% after deductible	75% after deductible	N/A	Plan Pays $75 per Day 4 Days per Person per Year
Urgent Care Facility	70% after deductible	50% after deductible	80% after deductible	60% after deductible	75% after deductible	60% after deductible	75% after deductible	60% after deductible	N/A	N/A
Hospice and Home Healthcare	70% after deductible	50% after deductible	80% after deductible	60% after deductible	75% after deductible	60% after deductible	75% after deductible	60% after deductible	N/A	N/A
Skilled Nursing Facility	100% no copay, no deductible	50% after deductible	100% no copay, no deductible	60% after deductible	75% after deductible	60% after deductible	75% after deductible	60% after deductible	N/A	Plan Pays $50 per Day 60 Days per Person per Stay
Telemedicine Medical	$5 copay*	Not Applicable	$5 copay*	Not Applicable	Deductible/Coinsurance based on type of service*	Not Applicable	Deductible/Coinsurance based on type of service*	Not Applicable	100%, no charge	100%, no charge
Eye Exams	Once per plan year	Once per plan year	Once per plan year	Once per plan year	Once per plan year	Once per plan year	Once per plan year	Once per plan year	N/A	80% up to $300 per year, 1 exam every 12 months and 1 pair of glasses or contacts every 24 months
Hearing Exam (Once every 24 months)	100% after $50 copay/no deductible	50% after deductible	100% after $40 copay/no deductible	60% after deductible	75% after deductible	60% after deductible	75% after deductible	60% after deductible	N/A	N/A
Hearing Aids	$3,000 per ear every 24 months	$3,000 per ear every 24 months	$3,000 per ear every 24 months	$3,000 per ear every 24 months	$3,000 per ear every 24 months	$3,000 per ear every 24 months	$3,000 per ear every 24 months	$3,000 per ear every 24 months	N/A	N/A
Outpatient Private Duty Nursing	70% after deductible	50% after deductible	80% after deductible	60% after deductible	75% after deductible	60% after deductible	75% after deductible	60% after deductible	N/A	N/A
Outpatient Rehab Therapy (Speech, Physical, Occupational)	100% after $50 copay/no deductible	50% after deductible	100% after $40 copay/no deductible	60% after deductible	75% after deductible	60% after deductible	75% after deductible	60% after deductible	N/A	N/A
Durable Medical Equipment	70% after deductible	50% after deductible	80% after deductible	60% after deductible	75% after deductible	60% after deductible	75% after deductible	60% after deductible	Discount Program	Discount Program
Bariatric Surgery (outpatient & office)	70% after deductible	50% after deductible	80% after deductible	60% after deductible	75% after deductible	60% after deductible	75% after deductible	60% after deductible	N/A	N/A
Inpatient Hospital (includes Bariatric, Transplant, maternity)	100% after $250 copay/deductible waived	50% after $500 copay/deductible waived	100% after $200 copay/deductible waived	60% after $400 copay/deductible waived	75% after deductible	60% after deductible	75% after deductible	60% after deductible	N/A	Plan Pays $100 per Day 500 Day Lifetime Maximum
Prescription Drug - Retail (30 day supply)	$10 Generic / $35 Brand Formulary / $55 Brand Non-Formulary / 70% coinsurance for specialty drugs	Not Applicable	$10 Generic / $35 Brand Formulary / $55 Brand Non-Formulary / 70% coinsurance for specialty drugs	Not Applicable	75% after deductible	Not Applicable	75% after deductible	Not Applicable	Select Generic & Brand name drugs for $10 copay, $20 copay or $50 copay	Select Generic & Brand name drugs for $10 copay, $20 copay or $50 copay
Prescription Drug - Mail Order or CVS - Maintenance Drugs (90 day supply) *can opt out	$25 Generic / $88 Brand Formulary / $138 Brand Non-Formulary / 70% coinsurance for specialty drugs		$25 Generic / $88 Brand Formulary / $138 Brand Non-Formulary /70% coinsurance for specialty drugs		75% after deductible		75% after deductible		N/A	N/A

*General visit only