EVERETT PUBLIC SCHOOL 2016 COMPARISON OF PLANS
January 2017 - December 2017

Summary of Covered Medical Benefits *Benefits subject to calendar year deductible, unless noted otherwise.*						
Benefit	**Group Health Cooperative (HMO)**	**Aetna CORE (Previously Option 4)**	**Aetna STANDARD (Previously Option 3)**	**Aetna TRADITIONAL (Previously Option 2)**	**Aetna CLASSIC (Previously Option 1)**	**Aetna SAVER + HSA (Previously Option 7)**
		*** The amount the plan pays for covered services is based on the usual, customary, and reasonable (UCR) amount. If a non-network provider charges more than the UCR amount, you may have to pay the difference. For example, if a non-network hospital charges $1,500 for an overnight stay, and the UCR amount is $1,000, you may have to pay the $500 difference (this is balance billing).**				
Choice of Providers	Choose a GH family practice provider at GH Medical Centers or at a contracted GH medical center. You may self-refer to most GH specialists at Group Health owned or operated medical centers. Referrals to non-GH contracted specialists must be obtained through your regular physician. Contact Group Health for details.	Open Choice PPO	Open Choice PPO	Open Choice PPO	Open Choice PPO	Open Choice PPO
Out-of-Area Benefits	Emergency care at non-GH-designated facilities subject to $100 copay per emergency. If admitted directly from the emergency room, the $100 copay is waived, and requires notification to GH within 24 hours of admission.	For Domestic services, see Out-of-Network benefits. International services will be handled as foreign claims.	For Domestic services, see Out-of-Network benefits. International services will be handled as foreign claims.	For Domestic services, see Out-of-Network benefits. International services will be handled as foreign claims.	For Domestic services, see Out-of-Network benefits. International services will be handled as foreign claims.	For Domestic services, see Out-of-Network benefits. International services will be handled as foreign claims.
Calendar Year Deductible	None	**In-Network**: $1,000 per person or $3,000 per family ***Out-of-Network**: $2,000 per person or $6,000 per family (waived for office visits and in-network preventive care) There is a separate deductible for prescription drugs	**Combined in-network and *out-of-network:** $300 per person or $900 per family (waived for office visits, in-network preventive care and prescription drugs)	**Combined in-network and *out-of-network:** $200 per person or $600 per family (waived for office visits, in-network preventive care and prescription drugs)	**In-Network:** $200 per person or $600 per family ***Out-of-Network:** $350 per person (waived for office visits, in-network preventive care and prescription drugs)	**In-Network:** $1,500 individual or $3,000 family ***Out-of-Network:** $3,000 individual or $6,000 family (waived for in-network preventive care)
Coinsurance	No plan coinsurance	**In-Network:** 80% ***Out-of-Network:** 50%	**In-Network:** 80% ***Out-of-Network:** 60%	**In-Network:** 80% ***Out-of-Network:** 60%	**In-Network:** 90% ***Out-of-Network:** 70%	**In-Network:** 80% ***Out-of-Network:** 50%
Annual Out-of-Pocket Maximum	$2,000/person; $4,000/family.	**In-Network**: $4,000 per person or $12,000 per family (includes deductible, coinsurance and copays) ***Out-of-Network:** Unlimited	**Combined in-network and *out-of-network:** $2,750 per person or $8,250 per family (includes deductible, coinsurance and copays)	**Combined in-network and *out-of-network:** $1,500 per person or $4,500 per family (includes deductible, coinsurance and copays)	**In-Network**: $500 per person/$1,500 family (includes deductible, coinsurance and copays) ***Out-of-Network:** Unlimited	**In-Network**: $4,000 individual or $8,000 family (includes deductible, coinsurance and copays) ***Out-of-Network:** Unlimited
Lifetime Maximum	None	None	None	None	None	None
Office Visit Copays / Coinsurance	Your copay for most office visits is $15/visit.	**In-Network:** $15 ***Out-of-Network:** 50%	**In-Network:** $30 ***Out-of-Network:** $40	**In-Network:** $25 ***Out-of-Network:** $30	**In-Network:** $15 ***Out-of-Network**: 70%	**In-Network:** 80% ***Out-of-Network**: 50%
Preexisting Conditions	None	None	None	None	None	None
Questions about covered expenses? Limitations? List of providers? Call the plan or check their website.						
Group Health Cooperative HMO (Group # 00261000): Customer Service: 1-888-901-4636, 8am-5pm (PST) Mon-Fri, www.ghc.org						
Aetna Customer Service: All other plans: 1-855-687-3078, 8am-6pm (PST) www.aetna.com						

This is a brief summary of the plans offered by Everett School District and does not constitute a contract. Please refer to the specific plan booklets for complete information regarding benefits, exclusions and eligibility requirements.

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		*** The amount the plan pays for covered services is based on the usual, customary, and reasonable (UCR) amount. If a non-network provider charges more than the UCR amount, you may have to pay the difference. For example, if a non-network hospital charges $1,500 for an overnight stay, and the UCR amount is $1,000, you may have to pay the $500 difference (this is balance billing).**				
Alternative Care	Acupuncture: Self-referral up to 8 visits per condition/calendar year subject to a $15 copay per visit. GHC contracted providers only	Acupuncture: Limited to 12 visits per calendar year **In-Network:** $15, not subject to deductible ***Out-of-Network**: 50%	Acupuncture: Limited to 12 visits per calendar year, not subject to deductible **In-Network:** $30 ***Out-of-Network:** $40	Acupuncture: Limited to 12 visits per calendar year, not subject to deductible **In-Network:** $25 ***Out-of-Network:** $30	Acupuncture: Unlimited; **In-Network:** $15, not subject to deductible ***Out-of-Network:** 70%	Acupuncture: Limited to 12 visits per calendar year **In-Network:** 80% ***Out-of-Network:** 50%
	Naturopathy: Self-referral up to 3 visits per condition/calendar year subject to a $15 copay per visit. GHC contracted providers only	Naturopathy: Unlimited **In-Network:** $15, not subject to deductible ***Out-of-Network:** 50%	Naturopathy: Unlimited, not subject to deductible **In-Network:** $30 ***Out-of-Network:** $40	Naturopathy: Unlimited, not subject to deductible **In-Network:** $25 ***Out-of-Network:** $30	Naturopathy: Unlimited **In-Network:** $15, not subject to deductible ***Out-of-Network:** 70%	Naturopathy: Unlimited **In-Network:** 80% ***Out-of-Network:** 50%
Ambulance	80% for emergency ground/air transport and for nonemergency ground/air interfacility transfers; 100% for hospital to hospital ground transfers.	80%	80%	80%	$50 copay after deductible	80%
Convalescent (Skilled Nursing) Facility	100% up to 60 days/calendar year. Services must be medically necessary and authorized in advance by a GH provider.	Up to 30 days per calendar year **In-Network:** 80% ***Out-of-Network:** 50% (custodial care/ private duty nursing not covered)	Up to 130 days per calendar year **In-Network:** 80% ***Out-of-Network**: not covered (custodial care/ private duty nursing not covered)	Unlimited **In-Network:** 100% ***Out-of-Network:** not covered (custodial care/ private duty nursing not covered)	Up to 60 days per calendar year **In-Network: 9**0% ***Out-of-Network:** 70% (custodial care/ private duty nursing not covered)	Up to 60 days per calendar year **In-Network: 8**0% ***Out-of-Network: 5**0% (custodial care/ private duty nursing not covered)
Diagnostic X-ray & Lab	100%.	**In-Network:** Not subject to deductible. Minor diagnostic: 100% Major diagnostic: 80% ***Out-of-Network**: 50%	**In-Network:** 80% ***Out-of-Network:** 60%	**In-Network:** 80% ***Out-of-Network:** 60%	**In-Network:** 90% ***Out-of-Network:** 70%	**In-Network:** 80% ***Out-of-Network**: 50%
Durable Medical Equipment	80%.	**In-Network:** 80% ***Out-of-Network:** 50%	**In-Network:** 80% ***Out-of-Network:** 60%	**In-Network:** 80% ***Out-of-Network:** 60%	**In-Network:** 90% ***Out-of-Network:** 70%	**In-Network:** 80% ***Out-of-Network**: 50%
Emergency Room	Emergency room care at GH-designated facilities subject to a $100 copay/visit. Copay is	$100 copay; waived if admitted	$100 copay; waived if admitted	$75 copay; waived if admitted **In-Network:** 80%	$50 copay; waived if admitted **In-Network**: 90%	**In-Network**: 80% ***Out-of-Network:** 80%

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		*** The amount the plan pays for covered services is based on the usual, customary, and reasonable (UCR) amount. If a non-network provider charges more than the UCR amount, you may have to pay the difference. For example, if a non-network hospital charges $1,500 for an overnight stay, and the UCR amount is $1,000, you may have to pay the $500 difference (this is balance billing).**				
	a $100 copay/visit. Copay is waived if admitted directly to the hospital from the emergency department. Emergency care at non-GH-designated facilities subject to a $100 copay (waived if admitted); if admitted, requires notification to GH within 24 hours of admission.	**In-Network:** 80% ***Out-of-Network:** 80% (medical emergencies are always paid at the in-network benefit levels)	**In-Network**: 80% ***Out-of-Network:**80% (medical emergencies are always paid at the in-network benefit levels)	**In-Network:** 80% ***Out-of-Network:** 80% (medical emergencies are always paid at the in-network benefit levels)	**In-Network**: 90% ***Out-of-Network:** 90% (medical emergencies are always paid at the in-network benefit levels)	(medical emergencies are always paid at the in-network benefit levels)
Hearing Care — Exam & Hardware	Hearing exam: 100% after $15 copay/visit. Hearing aids not covered.	One hearing exam per calendar year. Up to $5,000 for hearing aids each 3 consecutive years. **In-Network:** 80% ***Out-of-Network:** 50%	One hearing exam per calendar year. Up to $5,000 for hearing aids each 3 consecutive years. **In-Network:** 80% ***Out-of-Network:** 60%	One hearing exam per calendar year. Up to $5,000 for hearing aids each 3 consecutive years. **In-Network:** 80% ***Out-of-Network:** 60%	One hearing exam per calendar year. Up to $5,000 for hearing aids each 3 consecutive years. **In-Network:** 90% ***Out-of-Network:** 70%	One hearing exam per calendar year. Up to $5,000 for hearing aids each 3 consecutive years. **In-Network:** 80% ***Out-of-Network:** 50%
Home Health Care	100% when authorized.	Limited to 130 visits per calendar year **In-Network:** 80% ***Out-of-Network:** 50% (custodial care not covered)	Unlimited; subject to deductible **In-Network:** 80% ***Out-of-Network:** 60% (custodial care not covered)	Unlimited; subject to deductible (custodial care not covered)	Limited to 130 visits per calendar year **In-Network:** 90% ***Out-of-Network**: 70% (custodial care not covered)	Limited to 130 visits per calendar year **In-Network:** 80% ***Out-of-Network**: 50% (custodial care not covered)
Hospice Care	100% when authorized and provided/coordinated through GH hospice program or GH-approved hospice program.	**In-Network:** 80% ***Out-of-Network:** 50%	Subject to deductible	Subject to deductible	**In-Network:** 90% ***Out-of-Network:** 70%	**In-Network:** 80% ***Out-of-Network:** 50%
Hospital						
Inpatient Room & Board	100% after $100 copay/day to a maximum of $300 per admission.	**In-Network:** 80% ***Out-of-Network: 50%**	**In-Network:** 80% $300 copay per admission ***Out-of-Network:** 60%	**In-Network:** 80% $150 copay per admission ***Out-of-Network:** 60%	**In-Network:** 90% $200 copay per admission ***Out-of-Network:** 70%	**In-Network:** 80% ***Out-of-Network: 5**0%
Outpatient Surgery	100% after $15 copay/visit.	**In-Network:** 80% ***Out-of-Network:** 50%	**In-Network:** 80% $150 outpatient surgery copay ***Out-of-Network**: 60%	**In-Network:** 80% $100 outpatient surgery copay ***Out-of-Network:** 60%	**In-Network:** 90% ***Out-of-Network:** 70%	**In-Network:** 80% ***Out-of-Network:** 50%

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		*** The amount the plan pays for covered services is based on the usual, customary, and reasonable (UCR) amount. If a non-network provider charges more than the UCR amount, you may have to pay the difference. For example, if a non-network hospital charges $1,500 for an overnight stay, and the UCR amount is $1,000, you may have to pay the $500 difference (this is balance billing).**				
Hospital Inpatient Stay (Any applicable cost share for newborn services is separate from that of the mother)	$100 copay, per day for up to 3 days per admit for inpatient stay.	**In-Network:** 80% ***Out-of-Network:** 50%	**In-Network:** 80% $300 copay per admission ***Out-of-Network:** 60%	**In-Network:** 80% $150 copay per admission ***Out-of-Network:** 60%	**In-Network:** 90% $200 copay per admission ***Out-of-Network:** 70%	**In-Network:** 80% ***Out-of-Network:** 50%
Physicians Fees for Surgical and Medical Services	Subject to hospital copay	**In-Network:** 80% ***Out-of-Network:** 50%	**In-Network:** 80% ***Out-of-Network**: 60%	**In-Network:** 80% ***Out-of-Network:** 60%	**In-Network:** 90% ***Out-of-Network:** 70%	**In-Network:** 80% ***Out-of-Network:** 50%
Maternity **Physician Office Services**	Prenatal/postpartum outpatient visits, covered at 100% after $15 copay for first visit only.	**In-Network:** $15, not subject to deductible ***Out-of-Network:** 50% For covered health services provided in the Physician's office, a copayment will only apply to the initial office visit.	**In-Network:** $30, not subject to deductible ***Out-of-Network:** $40 For covered health services provided in the Physician's office, a copayment will only apply to the initial office visit.	**In-Network:** $25, not subject to deductible ***Out-of-Network**: $30 For covered health services provided in the Physician's office, a copayment will only apply to the initial office visit.	**In-Network:** $15, not subject to deductible ***Out-of-Network**: 70% For covered health services provided in the Physician's office, a copayment will only apply to the initial office visit.	**In-Network:** 80% ***Out-of-Network:** 50%
Mental Health Care **Inpatient**	Inpatient: subject to inpatient cost share when authorized in advance by GH for treatment in a GH-approved facility.	Inpatient: **In-Network:** 80% ***Out-of-Network:** 50%	Inpatient: **In-Network:** 80% subject to inpatient hospital copay ***Out-of-Network:** 60%	Inpatient: **In-Network:** 80% subject to inpatient hospital copay ***Out-of-Network:** 60%	Inpatient: **In-Network:** 90% subject to inpatient hospital copay ***Out-of-Network:** 70%	Inpatient: **In-Network:** 80% ***Out-of-Network:** 50%
Outpatient	Outpatient: 100% after $15 copay/visit.	Outpatient: **In-Network:** $15, not subject to deductible ***Out-of-Network:** 50%	Outpatient: not subject to deductible **In-Network:** $30 ***Out-of-Network:** $40	Outpatient: not subject to deductible **In-Network:** $25 ***Out-of-Network:** $30	Outpatient: **In-Network:** $15, not subject to deductible ***Out-of-Network:** 70%	Outpatient: **In-Network:** 80% ***Out-of-Network:** 50%
Orthotics	Not covered.	**In-Network:** 80% ***Out-of-Network:** 50%	**In-Network:** 80% ***Out-of-Network:** 60%	**In-Network:** 80% ***Out-of-Network:** 60%	**In-Network:** 90% ***Out-of-Network:** 70%	**In-Network:** 80% ***Out-of-Network:** 50%

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Physician Visits						
Office, Clinic or Home	100% after $15 copay/visit. Home calls covered within GH service area when prescribed as medically necessary by a GH provider.	Office, clinic or home visit: **In-Network:** $15, not subject to deductible ***Out-of-Network**: 50%	Office, clinic or home visit: not subject to deductible **In-Network:** $30 ***Out-of-Network:** $40	Office, clinic or home visit: not subject to deductible **In-Network:** $25 ***Out-of-Network:** $30	Office, clinic or home visit: **In-Network:** $15, not subject to deductible ***Out-of-Network:** 70%	Office, clinic or home visit: **In-Network:** 80% ***Out-of-Network:** 50%
Hospital Outpatient Physician Visit		Hospital outpatient physician visit: **In-Network**: 80% ***Out-of-Network:** 50%	Hospital outpatient physician visit: **In-Network:** 80% ***Out-of-Network:** 60%	Hospital outpatient physician visit: **In-Network:** 80% ***Out-of-Network:** 60%	Hospital outpatient physician visit: **In-Network:** 90% ***Out-of-Network:** 70%	Hospital outpatient physician visit: **In-Network:** 80% ***Out-of-Network:** 50%
Hospital Inpatient	Subject to inpatient hospital cost share.	**In-Network:** 80% ***Out-of-Network:** 50%	**In-Network:** 80% ***Out-of-Network:** 60%	**In-Network:** 80% ***Out-of-Network:** 60%	**In-Network:** 90% ***Out-of-Network:** 70%	**In-Network: 8**0% ***Out-of-Network:** 50%
Prescription Drugs - Premier Open Formulary	100% after $10 (generic) and $20 (brand) copay for each 30-day supply or less. Non-formulary drugs are not covered.	*Retail: Up to a 31 day supply; Generic - $0 Formulary Brand - 30% Non-Formulary Brand - 30%	*Retail: Up to a 31 day supply; Generic - $15 Formulary Brand - $25 Non-Formulary Brand - $40	*Retail: Up to a 31 day supply; Generic - $10 Formulary Brand - $20 Non-Formulary Brand - $35	*Retail: Up to a 31 day supply; Generic - $10 Formulary Brand - $15 Non-Formulary Brand - $30	*Retail: Up to a 31 day supply; 80% coinsurance
	Mail order: 100% after $20 (generic) and $40 (brand) copay for each 90-day supply.	Mail order: Up to a 90 day supply; Generic - $0 Formulary Brand - 25% Non-Formulary Brand - 25%	Mail order: Up to a 90 day supply; Generic - $15 Formulary Brand - $25 Non-Formulary Brand - $40	Mail order: Up to a 90 day supply; Generic - $10 Formulary Brand - $20 Non-Formulary Brand - $35	Mail order: Up to a 90 day supply; Generic - $10 Formulary Brand - $30 Non-Formulary Brand - $60	Mail order: Up to a 90 day supply; 80% coinsurance
		Drug deductible: $500 per person, $1000 per family per calendar year; waived for Generics. Subject to medical out-of-pocket maximum.	No deductible. Subject to the medical out-of-pocket maximum.	No deductible. Subject to the medical out-of-pocket maximum.	No deductible. Subject to the medical out-of-pocket maximum.	Combined with medical deductible. Subject to the medical out-of-pocket maximum.
		Specialty drugs: up to 31 day supply subject to Retail cost.	Specialty drugs: up to 31 day supply subject to Retail cost.	Specialty drugs: up to 31 day supply subject to Retail cost.	Specialty drugs: up to 31 day supply subject to Retail cost.	Specialty drugs: up to 31 day supply. **In-Network:** 80% ***Out-of-Network:** 80%

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Short-Term Rehabilitation	**Inpatient:** Inpatient physical, occupational and restorative speech therapy combined, including services for neurodevelopmentally disabled children age 6 and under, covered to 60 days each calendar year, at 100% after $100 copay/day to a maximum of $300 per admission. **Outpatient:** Covered up to 60 visits (combined with speech and occupational therapy) per calendar year, at 100% after $15 copay/visit.	Occupational, speech, massage and physical therapy. Combined 30 visit limit per calendar year. **Inpatient:** **In-Network:** 80% ***Out-of-Network:** 50% **Outpatient:** **In-Network:** $15, not subject to deductible ***Out-of-Network**: 50%	Occupational, speech, massage, and physical therapy. No visit limits per calendar year. **Inpatient:** **In-Network:** 80% ***Out-of-Network:** 60% **Outpatient:** **In-Network:** $30, not subject to deductible ***Out-of-Network:** $40, not subject to deductible	Occupational, speech, massage, and physical therapy. No visit limits per calendar year. **Inpatient**: **In-Network:** 80% ***Out-of-Network:** 60% **Outpatient:** **In-Network:** $25, not subject to deductible ***Out-of-Network:** $30, not subject to deductible	Occupational, speech, massage and physical therapy. Combined 45 visit limit per calendar year. **Inpatient:** **In-Network:** 90% ***Out-of-Network:** 70% **Outpatient:** **In-Network:** $15, not subject to deductible ***Out-of-Network**: 70%	Occupational, speech, massage and physical therapy. Combined 20 visit limit per calendar year. **Inpatient:** **In-Network:** 80% ***Out-of-Network:** 50% **Outpatient:** **In-Network:** 80% ***Out-of-Network**: 50%
Preventive Care - Exam and Immunizations	Well-care physicals, immunizations are covered at 100%	**In-Network:** Paid in full, not subject to deductible ***Out-of-Network:** Not covered	**In-Network:** Paid in full, not subject to deductible ***Out-of-Network:** Not covered	**In-Network**: Paid in full, not subject to deductible ***Out-of-Network:** Not covered	**In-Network:** Paid in full, not subject to deductible ***Out-of-Network**: Not covered	**In-Network:** Paid in full, not subject to deductible ***Out-of-Network**: Not covered
Preventive Care - Screenings	Covered at 100%	**In-Network:** Paid in full, not subject to deductible ***Out-of-Network:** Not covered	**In-Network:** Paid in full, not subject to deductible ***Out-of-Network:** Not covered	**In-Network:** Paid in full, not subject to deductible ***Out-of-Network:** Not covered	**In-Network:** Paid in full, not subject to deductible ***Out-of-Network:** Not covered	**In-Network:** Paid in full, not subject to deductible ***Out-of-Network:** Not covered

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Smoking/Tobacco Cessation	Approved pharmacy products covered 100% when prescribed and dispensed as part of GHC-designated program. Quit for Life products dispensed through mail order only.	Tobacco cessation programs **In-Network:** Paid in full, not subject to deductible ***Out-of-Network:** Not covered Office visits for Tobacco cessation covered as Preventive Care. Prescription drugs for Tobacco cessation are covered in full under Preventive Care Benefit; over-the-counter medications are not included.	Tobacco cessation programs **In-Network:** Paid in full, not subject to deductible ***Out-of-Network:** Not covered Office visits for Tobacco cessation covered as Preventive Care. Prescription drugs for Tobacco cessation are covered in full under Preventive Care Benefit; over-the-counter medications are not included.	Tobacco cessation programs **In-Network:** Paid in full, not subject to deductible ***Out-of-Network:** Not covered Office visits for Tobacco cessation covered as Preventive Care. Prescription drugs for Tobacco cessation are covered in full under Preventive Care Benefit; over-the-counter medications are not included.	Tobacco cessation programs **In-Network:** Paid in full, not subject to deductible ***Out-of-Network:** Not covered Office visits for Tobacco cessation covered as Preventive Care. Prescription drugs for Tobacco cessation are covered in full under Preventive Care Benefit; over-the-counter medications are not included.	Tobacco cessation programs **In-Network:** Paid in full, not subject to deductible ***Out-of-Network:** Not covered Office visits for Tobacco cessation covered as Preventive Care. Prescription drugs for Tobacco cessation are covered in full under Preventive Care Benefit; over-the-counter medications are not included.
Spinal Manipulation Therapy (Chiropractic Care)	Self-referrals for manipulative therapy of spine by GH contracted providers covered up to 10 visits per calendar year, at 100% after $15 copay.	Limited to 12 visits per calendar year **In-Network:** $15, not subject to deductible ***Out-of-Network:** 50%	Unlimited, not subject to deductible **In-Network:** $30 ***Out-of-Network:** $40	Unlimited, not subject to deductible **In-Network:** $25 ***Out-of-Network:** $30	Unlimited **In-Network:** $15, not subject to deductible ***Out-of-Network:** 70%	Limited to 12 visits per calendar year **In-Network:** 80% ***Out-of-Network:** 50%
Substance Abuse Disorder	Inpatient: 100% after $100 copay/day to a maximum of $300 per admission.	Inpatient: **In-Network**: 80% ***Out-of-Network:** 50%	Inpatient: **In-Network:** 80% (subject to inpatient hospital copay) ***Out-of-Network:** 60%	Inpatient: **In-Network:** 80% (subject to inpatient hospital copay) ***Out-of-Network:** 60%	Inpatient: **In-Network:** 90% (subject to inpatient hospital copay) ***Out-of-Network:** 70%	Inpatient: **In-Network:** 80% ***Out-of-Network:** 50%
	Outpatient: 100% after $15 copay/visit.	Outpatient: **In-Network:** $15, not subject to deductible ***Out-of-Network**: 50%	Outpatient: not subject to deductible **In-Network:** $30 ***Out-of-Network:** $40	Outpatient: not subject to deductible **In-Network:** $25 ***Out-of-Network:** $30	Outpatient: **In-Network**: $15, not subject to deductible ***Out-of-Network:** 70%	Outpatient: **In-Network:** 80% ***Out-of-Network:** 50%
Surgeon Fees	100% if provided by a GH provider at a GH facility.	**In-Network:** 80% ***Out-of-Network:** 50%	**In-Network:** 80% ***Out-of-Network:** 60%	**In-Network:** 80% ***Out-of-Network:** 60%	**In-Network:** 90% ***Out-of-Network:** 70%	**In-Network:** 80% ***Out-of-Network:** 50%
Temporomandibular Joint Disorder/Maxillofacial Surgery	100%** TMJ appliances: 80%. **Inpatient: after $100 copay per day (3 days max) Outpatient: $15 copay	**In-Network:** 80% ***Out-of-Network:** 50% Includes coverage for TMJ surgery. Non-surgical treatment limited to $1,000 calendar year maximum and $5,000 lifetime maximum, in-network or out-of-network combined.	**In-Network:** 50% ***Out-of-Network:** 50% Includes coverage for TMJ surgery. Non-surgical treatment limited to $1,000 calendar year maximum and $5,000 lifetime maximum, in-network or out-of-network combined.	**In-Network:** 50% ***Out-of-Network:** 50% Includes coverage for TMJ surgery. Non-surgical treatment limited to $1,000 calendar year maximum and $5,000 lifetime maximum, in-network or out-of-network combined.	**In-Network:** 50% ***Out-of-Network:** 50% Includes coverage for TMJ surgery. Non-surgical treatment limited to $1,000 calendar year maximum and $5,000 lifetime maximum, in-network or out-of-network combined.	**In-Network:** 80% ***Out-of-Network:** 50% Includes coverage for TMJ surgery. Non-surgical treatment limited to $1,000 calendar year maximum and $5,000 lifetime maximum, in-network or out-of-network combined.

EVERETT PUBLIC SCHOOL 2016 COMPARISON OF PLANS
January 2017 - December 2017

Summary of Covered Medical Benefits *Benefits subject to calendar year deductible, unless noted otherwise.*						
Benefit	**Group Health Cooperative (HMO)**	**Aetna CORE (Previously Option 4)**	**Aetna STANDARD (Previously Option 3)**	**Aetna TRADITIONAL (Previously Option 2)**	**Aetna CLASSIC (Previously Option 1)**	**Aetna SAVER + HSA (Previously Option 7)**
		*** The amount the plan pays for covered services is based on the usual, customary, and reasonable (UCR) amount. If a non-network provider charges more than the UCR amount, you may have to pay the difference. For example, if a non-network hospital charges $1,500 for an overnight stay, and the UCR amount is $1,000, you may have to pay the $500 difference (this is balance billing).**				
Therapeutic Treatments - Outpatient	Outpatient: subject to $15 copay. Therapeutic treatments performed at home, covered in full.	See Short-Term Rehabilitation	See Short-Term Rehabilitation	See Short-Term Rehabilitation	See Short-Term Rehabilitation	See Short-Term Rehabilitation

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		*** The amount the plan pays for covered services is based on the usual, customary, and reasonable (UCR) amount. If a non-network provider charges more than the UCR amount, you may have to pay the difference. For example, if a non-network hospital charges $1,500 for an overnight stay, and the UCR amount is $1,000, you may have to pay the $500 difference (this is balance billing).**				
Transplants	100% after $100 copay/day for up to 3 days per admission.	**In-Network:** 80% ***Out-of-Network:** 50% In-Network coverage is provided at an IOE contracted facility only.	**In-Network:** 80% ***Out-of-Network:** 60% In-Network coverage is provided at an IOE contracted facility only.	**In-Network:** 80% ***Out-of-Network:** 60% In-Network coverage is provided at an IOE contracted facility only.	**In-Network:** 90% ***Out-of-Network:** 70% In-Network coverage is provided at an IOE contracted facility only.	**In-Network:** 80% ***Out-of-Network:** 50% In-Network coverage is provided at an IOE contracted facility only.
Urgent Care		**In-Network:** $15, not subject to deductible ***Out-of-Network:** 50%	**In-Network:** $30, not subject to deductible ***Out-of-Network:** 60%	**In-Network:** $25, not subject to deductible ***Out-of-Network:** 60%	**In-Network:** $15, not subject to deductible ***Out-of-Network:** 70%	**In-Network:** 80% ***Out-of-Network:** 50%
Voluntary Second Surgical Opinion	100% after a $15 copay/visit when received from GH provider.	**In-Network:** $15, not subject to deductible ***Out-of-Network:** 50%	Not subject to deductible **In-Network:** $30 ***Out-of-Network:** $40	Not subject to deductible **In-Network:** $25 ***Out-of-Network:** $30	**In-Network:** $15, not subject to deductible ***Out-of-Network:** 70%	**In-Network:** 80% ***Out-of-Network:** 50%
Weight-Loss Surgery (Bariatric surgery/Lap Band surgery)	Not covered.	Not covered.	Not covered.	Not covered.	Not covered.	Not covered.
Well-Baby/Child Care	Well-care physicals, immunizations are covered at 100% according to Group Health's Well Child schedule.	See Preventive Care	See Preventive Care	See Preventive Care	See Preventive Care	See Preventive Care
Wellness program	Not offered.	Enhanced Wellness	Enhanced Wellness	Enhanced Wellness	Enhanced Wellness	Enhanced Wellness
Wigs (Prosthetic Devices)	Not covered.	**In-Network:** 80% ***Out-of-Network:** 50%	**In-Network:** 80% ***Out-of-Network:** 50%	**In-Network:** 80% ***Out-of-Network:** 50%	**In-Network:** 80% ***Out-of-Network:** 50%	**In-Network:** 80% ***Out-of-Network:** 50%