2020 BSO medical plan options at a glance

Plan	HNOnly 1	HNOnly 2	HNOption	
Network name Provider search tool > "Select a Plan"	Aetna Health Network Only℠ (Open Access)		Aetna Health Network Option℠ (Open Access)	
	In network	**In network**	**In network**	**Out of network**
Deductible				
Individual	$300	$200	$250	$300
Family	$600	$400	$500	$600
Out-of-pocket maximum				
Individual	$2,000	$2,000	$2,500	$30,000
Family	$4,000	$4,000	$5,000	$90,000
Preventive care	100%	100%	100%	30%; deductible waived
Office visit	$15	$15	$20	30% per visit, after deductible
Specialist visit	$30	$25	$40	30% per visit, after deductible
Teladoc®	$15	$15	$20	Not covered
Emergency medical care				
Urgent care	$30	$25	$40	30%, after deductible
Emergency room visit*	$200; deductible waived	$200; deductible waived	$200; deductible waived	$200; deductible waived
Ambulance	100%; deductible waived	100%, after deductible	100%, after deductible	100%, after deductible
Hospital				
Inpatient	$100 copay per day for first 5 days; thereafter 100%, after deductible	$300 copay, after deductible	$300 copay, after deductible	30% after $500 per admission copay, after deductible
Inpatient maternity	$100 copay per day for first 5 days; thereafter 100%, after deductible	$300 copay, after deductible	100% for physician maternity services; deductible waived; $300 copay for facility services, after deductible	30% for physician maternity services; 30% after $500 per admission copay for facility services, after deductible
Outpatient medical care				
Diagnostic lab Quest Diagnostics® and LabCorp®**	100%; deductible waived	100%; deductible waived	100%; deductible waived	30%, after deductible
Diagnostic x-ray	100%; deductible waived	100%; deductible waived	100%; deductible waived	30%, after deductible
Diagnostics complex imaging	$80 copay at hospital after deductible; $30 copay at freestanding	$75 copay at hospital after deductible; $25 copay at freestanding	$50 copay, after deductible	30%, after deductible
Outpatient surgery – hospital	$150 per visit, after deductible	$150 per visit, after deductible	$150 per visit, after deductible	30% per visit, after deductible
Outpatient surgery – freestanding facility	$100 per visit; deductible waived	$100 per visit; deductible waived	$50 per visit; deductible waived	30% per visit, after deductible
Outpatient short-term rehabilitation therapy	$30 copay; deductible waived	$25 copay; deductible waived	100%, after deductible	30% per visit, after deductible
(Limited to 60 visits per therapy per calendar year; includes speech, physical and occupational)				

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	In network	**In network**	**In network**	**Out of network**
Other services				
Skilled nursing facility	$50 per day for first 2 days; thereafter 100%, deductible waived	100%, after deductible	100%, after deductible	30% per admission, after deductible
Home health care	100%, after deductible	100%, after deductible	100%, after deductible	30%, after deductible
Hospice – inpatient	100%; deductible waived	100%, after deductible	100%, after deductible	30%, after deductible
Hospice – outpatient	100%; deductible waived	100%, after deductible	100%, after deductible	30%, after deductible
Spinal manipulation therapy	$30 copay; deductible waived	$25 copay; deductible waived	$40 copay; deductible waived	30%, after deductible
Durable medical equipment	100%; deductible waived	100%, after deductible	100%, after deductible	30%, after deductible (must precertify if over $1,500)
Diabetic supplies	Pharmacy cost sharing applies; otherwise PCP office visit cost sharing applies	Pharmacy cost sharing applies; otherwise PCP office visit cost sharing applies	Pharmacy cost sharing applies; otherwise PCP office visit cost sharing applies	30%, after deductible
Bariatric surgery	Not covered	Not covered	Not covered	Not covered
Infertility (comprehensive infertility & ART)	Covered 100%; deductible waived. Limited to $15,000 per calendar year.	Covered 100%; deductible waived. Limited to $15,000 per calendar year.	Not covered	Not covered
Mental health (MA)/substance abuse (SA)				
Inpatient	$100 copay for the first 5 days MA/2 days SA; thereafter covered 100% after deductible	$300 copay; deductible waived	$300 copay, after deductible	30% after $500 admission copay, after deductible
Mental health office visits	$30 copay; deductible waived	$15 copay; deductible waived	100%; deductible waived	30% per visit, after deductible
Pharmacy plan type (Aetna Value Open Formulary Plus)				
Retail (up to a 30-day supply at participating pharmacies)	$10 Tier 1 (generic) $25 Tier 2 (preferred brand-name) $50 Tier 3 (non preferred brand-name drugs)	$10 Tier 1 (generic) $25 Tier 2 (preferred brand-name) $50 Tier 3 (non preferred brand-name drugs)	$10 Tier 1 (generic) $25 Tier 2 (preferred brand-name) $50 Tier 3 (non preferred brand-name drugs)	Not covered
Mail order (up to a 90-day supply from CVS Caremark Mail Service Pharmacy™)	$20 Tier 1 (generic) $50 Tier 2 (preferred brand-name) $100 Tier 3 (non preferred brand-name drugs)	$20 Tier 1 (generic) $50 Tier 2 (preferred brand-name) $100 Tier 3 (non preferred brand-name drugs)	$20 Tier 1 (generic) $50 Tier 2 (preferred brand-name) $100 Tier 3 (non preferred brand-name drugs)	Not covered
Specialty drugs (maximum $150)	20% (preferred and non preferred)	20% (preferred and non preferred)	20% (preferred and non preferred)	Not covered

*For true emergencies, copay waived if admitted.

**Quest Diagnostics and LabCorp are the preferred participating laboratories.

Note: These are benefits at a glance and provided for information only; it does not contain complete details of the plan, which are available only in the Summary Plan Description, and it does not constitute an Agreement.