WORLD

AASP NATIONAL ALLIANCE OF AUTOMOTIVE SERVICE PROVIDERS

PHCS/ RBP

IN-NETWORK BENEFITS	1000 CLASSIC	1500 CLASSIC	2500 CLASSIC	3500 CLASSIC	5000 CLASSIC	5000 HSA	7350
Plan Design	RBP	RBP	RBP	RBP	RBP	RBP	RBP
Deductible Individual / Family	$1,000/$2,000	$1,500/$3,000	$2,500/$5,000	$3,500/$7,000	$5,000/$10,000	$5,000 / $10,000	$7,350/$14,700
Coinsurance Plan Pays /Member Pays	80%/20%	80%/20%	80%/20%	80%/20%	80%/20%	80%/20%	100%
Out-of-Pocket Maximum Individual / Family	$5,000/$10,000	$7,350 / $14,700	$7,350 / $14,700	$7,350 / $14,700	$7,350 / $14,700	$6,550/$13,100	$7,350/$14,700
Routine Preventive Services (Non Diagnostic)	No Member Cost Sharing Deductible Waived	No Member Cost Sharing Deductible Waived	No Member Cost Sharing Deductible Waived	No Member Cost Sharing Deductible Waived	No Member Cost Sharing Deductible Waived	No Member Cost Sharing Deductible Waived	No Member Cost Sharing Deductible Waived
Inpatient Hospital (patient responsibility)	Facility: 20% no ded. Professional: 20% after ded.	Facility: 20% no ded. Professional: 20% after ded.	Facility: 20% no ded. Professional: 20% after ded.	Facility: 20% no ded. Professional: 20% after ded.	Facility: 20% no ded. Professional: 20% after ded.	Facility: 20% no ded. Professional: 20% after ded.	Facility: 0%; dedutible waived Professional: 0% after ded.
Out Patient Services **Surgical Services** (Procedure & Anesthesia)	Facility: 20% no ded. Professional: 20% after ded.	Facility: 20% no ded. Professional: 20% after ded.	Facility: 20% no ded. Professional: 20% after ded.	Facility: 20% no ded. Professional: 20% after ded.	Facility: 20% no ded. Professional: 20% after ded.	Facility: 20% no ded. Professional: 20% after ded.	Facility: 0%; dedutible waived Professional: 0% after ded.
Free Standing Lab & Diagnostic Services (Lab & x-ray)	0% when perfomed and billed in an outpatient facility	0% when perfomed and billed in an outpatient facility	0% when perfomed and billed in an outpatient facility	0% when perfomed and billed in an outpatient facility	0% when perfomed and billed in an outpatient facility	Facility: 20% no ded. Professional: 20% after ded.	0% when perfomed and billed in an outpatient facility
Complex Diagnositc Services (CT Scan, MRI, Ultra Sound, PET, Nuclear Medicine)	Facility: 20% no ded. Professional: 20% after ded.	Facility: 20% no ded. Professional: 20% after ded.	Facility: 20% no ded. Professional: 20% after ded.	Facility: 20% no ded. Professional: 20% after ded.	Facility: 20% no ded. Professional: 20% after ded.	Facility: 20% no ded. Professional: 20% after ded.	Facility: 0%; dedutible waived Professional: 0% after ded.
Emergency Room	Facility: 20% no ded. Professional: 20% after ded.	Facility: 20% no ded. Professional: 20% after ded.	Facility: 20% no ded. Professional: 20% after ded.	Facility: 20% no ded. Professional: 20% after ded.	Facility: 20% no ded. Professional: 20% after ded.	Facility: 20% no ded. Professional: 20% after ded.	Facility: 0%; dedutible waived Professional: 0% after ded.
Urgent Care	$40 Copay	$80 Copay	$80	$90 Copay	$90 Copay	20% after deductible	$100 Copay
Primary Care / Specialist	$20/$40 Copay	$40/$80 Copay	$40/$80 Copay	$45/$90 Copay	$45/$90 Copay	20% after deductible	$50/$100 Copay
Telemedicine	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Prescription Drug	In-Network	In-Network	In-Network	In-Network	In-Network	In-Network	In-Network
Deductible	None	None	None	None	None	None	None
Retail (31 Days)	$15/$45/$85	$15/$45/$85	$15/$45/$85	$15/$65/$100	$15/$65/$100	Drug Discount Card	Drug Discount Card
Mail Order (90 Days)	$45/$90/$150	$45/$90/$150	$45/$90/$150	$45/$90/$150	$45/$90/$150	Drug Discount Card	Drug Discount Card

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PHCS/ RBP

NON-NETWORK SERVICES	1000 CLASSIC	1500 CLASSIC	2500 CLASSIC	3500 CLASSIC	5000 CLASSIC	5000 HSA	7350
Coinsurance Plan Pays/Member Pays	60%/40%	60%/40%	60%/40%	60%/40%	60%/40%	50%/50%	60%/40%
Deductible Individual/Family	$2,000/$4,000	$3,000/$6,000	$5,000/$10,000	$7,000/$14,000	$10,000/$20,000	$10,000/$20,000	$14,700/$29,400

AETNA FIRST HEALTH NETWORK

IN-NETWORK BENEFITS	1000 CLASSIC	1500 CLASSIC	2500 CLASSIC	3500 CLASSIC	5000 CLASSIC	5000 HSA	7350
Plan Design	PPO First Health	PPO First Health	PPO First Health	PPO First Health	PPO First Health	PPO First Health	PPO First Health
Deductible Individual / Family	$1,000/$3000	$1,500/$3,000	$2,500/$5,000	$3,500/$7,000	$5,000/$10,000	$5,000 / $10,000	$7,350/$14,700
Coinsurance Plan Pays /Member Pays	80%/20%	80%/20%	80%/20%	80%/20%	80%/20%	80%/20%	100%
Out-of-Pocket Maximum Individual / Family	$7,350/$14,700	$7,350 / $14,700	$7,350 / $14,700	$7,350 / $14,700	$7,350 / $14,700	$6,550/$13,100	$7,350/$14,700
Routine Preventive Services (Non Diagnostic)	No Member Cost Sharing Deductible Waived	No Member Cost Sharing Deductible Waived	No Member Cost Sharing Deductible Waived	No Member Cost Sharing Deductible Waived	No Member Cost Sharing Deductible Waived	No Member Cost Sharing Deductible Waived	No Member Cost Sharing Deductible Waived
Inpatient Hospital (patient responsibility)	Facility: 20% no ded. Professional: 20% after ded.	Facility: 20% no ded. Professional: 20% after ded.	Facility: 20% no ded. Professional: 20% after ded.	Facility: 20% no ded. Professional: 20% after ded.	Facility: 20% no ded. Professional: 20% after ded.	Facility: 20% no ded. Professional: 20% after ded.	Facility: 0%; dedutible waived Professional: 0% after ded.
Out Patient Services Surgical Services (Procedure & Anesthesia)	Facility: 20% no ded. Professional: 20% after ded.	Facility: 20% no ded. Professional: 20% after ded.	Facility: 20% no ded. Professional: 20% after ded.	Facility: 20% no ded. Professional: 20% after ded.	Facility: 20% no ded. Professional: 20% after ded.	Facility: 20% no ded. Professional: 20% after ded.	Facility: 0%; dedutible waived Professional: 0% after ded.
Free Standing Lab & Diagnostic Services (Lab & x-ray)	Facility: 0%; dedutible waived Professional: 0% after ded.	Facility: 0%; dedutible waived Professional: 0% after ded.	Facility: 0%; dedutible waived Professional: 0% after ded.	Facility: 0%; dedutible waived Professional: 0% after ded.	Facility: 0%; dedutible waived Professional: 0% after ded.	Facility: 0%; dedutible waived Professional: 0% after ded.	Facility: 0%; dedutible waived Professional: 0% after ded.

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AETNA FIRST HEALTH NETWORK							
Complex Diagnositc Services (CT Scan, MRI, Ultra Sound, PET, Nuclear Medicine)	Facility: 20% no ded. Professional: 20% after ded.	Facility: 20% no ded. Professional: 20% after ded.	Facility: 20% no ded. Professional: 20% after ded.	Facility: 20% no ded. Professional: 20% after ded.	Facility: 20% no ded. Professional: 20% after ded.	Facility: 20% no ded. Professional: 20% after ded.	Facility: 0%; dedutible waived Professional: 0% after ded.
Emergency Room	Facility: 20% no ded. Professional: 20% after ded.	Facility: 20% no ded. Professional: 20% after ded.	Facility: 20% no ded. Professional: 20% after ded.	Facility: 20% no ded. Professional: 20% after ded.	Facility: 20% no ded. Professional: 20% after ded.	Facility: 20% no ded. Professional: 20% after ded.	Facility: 0%; dedutible waived Professional: 0% after ded.
Urgent Care	$80 Copay	$80 Copay	$80	$80 Copay	$90 Copay	20% after deductible	$100 Copay
Primary Care / Specialist	$40/$80 Copay	$40/$80 Copay	$40/$80 Copay	$40/$80 Copay	$45/$90 Copay	20% after deductible	$50/$100 Copay
Telemedicine	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Prescription Drug	In-Network	In-Network	In-Network	In-Network	In-Network	In-Network	In-Network
Deductible	None	None	None	None	None	None	None
Retail (31 Days)	$15/$45/$85	$15/$45/$85	$15/$45/$85	$15/$45/$85	$15/$65/$100	Drug Discount Card	Drug Discount Card
Mail Order (90 Days)	$45/$90/$150	$45/$90/$150	$45/$90/$150	$45/$90/$150	$45/$90/$150	Drug Discount Card	Drug Discount Card
NON-NETWORK SERVICES	**1000 CLASSIC**	**1500 CLASSIC**	**2500 CLASSIC**	**3500 CLASSIC**	**5000 CLASSIC**	**5000 HSA**	**7350**
Coinsurance Plan Pays/Member Pays	60%/40%	60%/40%	60%/40%	60%/40%	60%/40%	60%/40%	50%/50%
Deductible Individual/Family	$3,000/$6,000	$3,000/$6000	$5,000/$10,000	$7,000/$14,000	$10,000/$20,000	$10,000/$20,000	$14,700/$29,400
Out of Pocket Maximum Individual/Family	$14,700/$29,400	$14,700/$29,400	$14,700/$29,400	$14,700/$29,400	$14,700/$29,400	$20,000/$40,000	$14,700/$29,400

NOTE: Precerticiation is required for all in-hospital admissions, chemotherapy, diagnostic testing and outpatient surgery. Penalty may apply for not obtaining precetification.

This comparison describes the plan in an easy understood manner and presented as a matter of general information.
The contents are not to be accepted as a substitute for the provision of the plan.