

BLUE SHIELD (2023) vs AETNA (2024) MEDICAL PLANS

Common services and plan features

MEDICAL PLANS	2023 Blue Shield Trio HMO In Network Only	2024 Aetna AWH Northern CA HMO In Network Only
Benefit Accumulation (Plan or Calendar Year)	Calendar Year	Calendar Year
Deductible - Individual / Family	\$0	\$0
Out of Pocket Maximum - Individual / Family	\$2,000 / \$4,000	\$2,000 / \$4,000
Medical Services		
Preventive Care	No Charge	No Charge
Primary Care Visit	\$20 Copay	\$20 Copay
Specialist Office Visit (Trio+)	\$20 Copay	\$20 Copay
Basic X-ray and Laboratory	No Charge	No Charge
Complex Imaging (MRI, CT Scan, etc.)	\$100 Copay	\$100 Copay
Inpatient Hospital	\$250 Copay	\$250 Copay
Outpatient Hospital Surgery	\$125 Copay	No Charge
Emergency Room	\$100 Copay	\$100 Copay
Urgent Care	\$20 Copay	\$20 Copay
Therapy (incl. Physical Occ & Speech)	\$20 Copay	\$20 Copay
Inpatient Mental Health / Substance Abuse	\$250 Copay	\$250 Copay
Outpatient Mental Health / Substance Abuse	\$20 Copay	\$20 Copay
Prescription Drugs		
Preventive Immunizations & Contraceptives	No Charge	No Charge
Generic / Tier 1	\$10 Copay	\$10 Copay
Formulary / Tier 2	\$25 Copay	\$25 Copay
Non-Formulary / Tier 3	\$50 Copay	\$50 Copay
Specialty / Tier 4	20% up to \$200	20% up to \$200
Mail Order Copay	2 x Retail	2 x Retail
Days Supply - Retail / Mail	30 / 90	30 / 90

BLUE SHIELD (2023) vs AETNA (2024) MEDICAL PLANS

Common services and plan features

MEDICAL PLANS	2023 Blue Shield Access + HMO In Network Only	2024 Aetna HMO In Network Only
Benefit Accumulation (Plan or Calendar Year)	Calendar Year	Calendar Year
Deductible - Individual / Family	\$0	\$0
Out of Pocket Maximum - Individual / Family	\$2,000 / \$4,000	\$2,000 / \$4,000
Medical Services		
Preventive Care	No Charge	No Charge
Primary Care Visit	\$20 Copay	\$20 Copay
Specialist Office Visit	\$40 Copay	\$20 Copay
Basic X-ray and Laboratory	No Charge	No Charge
Complex Imaging (MRI, CT Scan, etc.)	\$100 Copay	\$100 Copay
Inpatient Hospital	\$250 Copay	\$250 Copay
Outpatient Hospital Surgery	\$125 Copay	No Charge
Emergency Room	\$100 Copay	\$100 Copay
Urgent Care	\$20 Copay	\$20 Copay
Therapy (incl. Physical Occ & Speech)	\$20 Copay	\$20 Copay
Inpatient Mental Health / Substance Abuse	\$250 Copay	\$250 Copay
Outpatient Mental Health / Substance Abuse	\$20 Copay	\$20 Copay
Prescription Drugs		
Preventive Immunizations & Contraceptives	No Charge	No Charge
Generic / Tier 1	\$10 Copay	\$10 Copay
Formulary / Tier 2	\$25 Copay	\$25 Copay
Non-Formulary / Tier 3	\$50 Copay	\$50 Copay
Specialty / Tier 4	20% up to \$200	20% up to \$200
Mail Order Copay	2 x Retail	2 x Retail
Days Supply - Retail / Mail	30 / 90	30 / 90

BLUE SHIELD (2023) vs AETNA (2024) MEDICAL PLANS

Common services and plan features

MEDICAL PLANS	2023 Blue Shield HDHP HSA		2024 Aetna PPO (OAMC POS) HDHP	
	In	Out	In	Out
Benefit Accumulation (Plan or Calendar Year)	Calendar Year		Calendar Year	
Deductible - Individual / Family	\$2,000 / \$3,200 / \$4,000	\$4,000 / \$5,200 / \$8,000	\$2,000 / \$3,200 / \$4,000	\$4,000 / \$4,000 / \$8,000
Out of Pocket Maximum - Individual / Family	\$3,425 / \$6,850	\$12,000 / \$24,000	\$4,000 / \$8,000	\$8,000 / \$16,000
Coinsurance	10%	30%	10%	30%
Medical Services				
Preventive Care	No Charge	30% after Ded.	No Charge	30% after Ded.
Primary Care Visit	10% after Ded.	30% after Ded.	10% after Ded.	30% after Ded.
Specialist Office Visit	10% after Ded.	30% after Ded.	10% after Ded.	30% after Ded.
Basic X-ray and Laboratory	10% after Ded.	30% after Ded.	10% after Ded.	30% after Ded.
Complex Imaging (MRI, CT Scan, etc.)	10% after Ded.	30% after Ded.	10% after Ded.	30% after Ded.
Inpatient Hospital	10% after Ded.	30% after Ded., \$1,000/day benefit max	10% after Ded.	30% after Ded.
Outpatient Hospital Surgery	10% after Ded.	30% after Ded. of up to \$350/day + 100% of additional charges	10% after Ded.	30% after Ded.
Emergency Room	10% after Ded.	10% after Ded.	10% after Ded.	10% after Ded.
Urgent Care	10% after Ded.	30% after Ded.	10% after Ded.	30% after Ded.
Therapy (incl. Physical Occ & Speech)	10% after Ded.	30% after Ded.	10% after Ded.	30% after Ded.
Inpatient Mental Health / Substance Abuse	10% after Ded.	30% after Ded., \$1,000/day benefit max	10% after Ded.	30% after Ded.
Outpatient Mental Health / Substance Abuse	10% after Ded.	30% after Ded.	10% after Ded.	30% after Ded.
Prescription Drugs				
Deductible	Medical Deductible Applies		Advanced Control Formulary Medical Deductible Applies	
Preventive Immunizations & Contraceptives	No Charge	Applicable Tier 1, Tier 2, or Tier 3 Copayment	No Charge	
Generic / Tier 1	\$10 Copay after Ded.	25% + \$10 after Ded.	\$10 Copay after Ded.	
Formulary / Tier 2	\$40 Copay after Ded.	25% + \$40 after Ded.	\$30 Copay after Ded.	
Non-Formulary / Tier 3	\$60 Copay after Ded.	25% + \$60 after Ded.	\$50 Copay after Ded.	N/A
Specialty / Tier 4	30% after Ded. up to \$250/prescription	30% after Ded. up to \$250/prescription plus 25% of purchase price	30% after Ded. up to \$250/prescription	
Mail Order Copay	2 x Retail	N/A	2 x Retail	
Days Supply - Retail / Mail		30 / 90		30 / 90