

Employees who reside in New York - Medical Plan Comparison 2026

| | Aetna PPO ¹ | | Aetna HDHP with HSA ¹ | | Aetna EPO NY | Emblem Health |
|---|---|---|--|---|--|---|
| | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | In-Network |
| Plan Features | | | | | | |
| Employer HSA Contribution | N/A | N/A | Employee: \$750; Employee Plus One/Family \$1,500 | | N/A | N/A |
| Member Coinsurance | 20% | 40% | 10% | 40% | 0% | 0% |
| Deductibles (per calendar year) | \$1,000 per person \$2,000 per employee plus one/family | \$3,000 per person \$6,000 per employee plus one/family | \$1,850 per person \$3,700 per employee plus one/family | \$4,750 per person \$9,500 per employee plus one/family | \$100 per person \$200 per employee plus one/family | See plan provisions below |
| Out-of-Pocket Maximum – Medical and Prescription combined | \$8,700 per person \$17,400 per employee plus one/family | \$9,500 per person \$19,000 per employee plus one/family | \$4,750 per person \$9,500 per employee plus one/family | \$8,750 per person \$17,500 per employee plus one/family | \$2,000 Individual \$4,000 per employee plus one/family | \$6,600 Individual \$13,200 per employee plus one/family |
| Physician Services Office Visit | 20% after deductible | 40% after deductible | 10% after deductible | 40% after deductible | \$25 copay | \$25 copay |
| Specialist Office Visit | 20% after deductible | 40% after deductible | 10% after deductible | 40% after deductible | \$40 copay | \$40 copay |
| Emergency Room | 20% after deductible (no coverage for non- emergency use of the emergency room) | Same as in-network | 10% after deductible | Same as preferred care | \$100 copay (waived if admitted within 24 hours) | \$100 copay (waived if admitted within 24 hours) |
| Dependent Age Limit | To age 26 (end of month) | To age 26 (end of month) | To age 26 (end of month) | To age 26 (end of month) | To age 26 (end of month) | To age 26 (end of month) |

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|--|--|--|--|--|-------------------------------|--|
| | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | In-Network |
| Physician Office Visits | | | | | | |
| Preventive Care | Covered at 100% (no deductible) | 40% after deductible | Covered 100% (no deductible) | 40% after deductible | No copay | No copay |
| Diagnostic Lab & X-Ray at Physician Office | 20% after deductible | 40% after deductible | 10% after deductible | 40% after deductible | \$50 copay/visit | Included in office visit copay |
| Well Child Care/ Immunizations— Age 19 and under | Covered at 100% (no deductible) (exam limits) | 40% after deductible (exam limits) | Covered 100% (no deductible) (exam limits) | 40% after deductible (exam limits) | No copay | No copay |
| Well Woman Care (includes routine mammograms) | Covered at 100% (no deductible) | 40% after deductible | Covered 100% (no deductible) | 40% after deductible | No copay | No copay |
| Routine Physical Examinations (1 in 12 months) | Covered at 100% (no deductible) | 40% after deductible | Covered 100% (no deductible) | 40% after deductible | No copay | No copay |
| Outpatient Services | | | | | | |
| Outpatient Hospital Expenses (including surgery) | 20% after deductible | 40% after deductible | 10% after deductible | 40% after deductible | Covered 100% after deductible | \$100 copay— Ambulatory Surgery |
| Outpatient Rehabilitation (In-office) | | | | | | |
| Physical/Speech/ Occupational Therapy ² | 20% after deductible (60 visits calendar year limit) | 40% after deductible | 10% after deductible (60 visits calendar year limit) | 40% after deductible (60 visits calendar year limit) | \$40 copay | \$40 copay; limited to 60 visits per plan year |
| Hospital Care | | | | | | |
| Hospital Per- Admission | \$250 copay/day for the first 5 days, thereafter covered at 100%; after deductible | \$500 copay/day for the 1 st 5 days, 40% thereafter; after deductible | 10% after deductible | 40% after deductible | \$500 copay after deductible | \$500 copay |
| Maternity Care | | | | | | |
| Prenatal Maternity | Covered 100% (no deductible) | 40% after deductible | Covered 100% (no deductible) | 40% after deductible | No charge | No charge |

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|---|--|----------------------|--|----------------------|---|---|
| | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | In-Network |
| Durable Medical Equipment | | | | | | |
| Durable Medical Equipment | 20% after deductible | 40% after deductible | 10% after deductible | 40% after deductible | Covered 100% after deductible | \$100 deductible, Covered in Full |
| Prescription Drug Services³ – Administered by OptumRx⁴ | | | | | | |
| Retail – Up to 30 Days | | | | | | |
| Generic | 10% (\$7.50 minimum/\$30.00 maximum copay) | Not covered | 10% (\$7.50 minimum/\$30.00 maximum copay) | Not covered | \$15 copay | \$15 copay; annual \$50 Rx deductible applies |
| Brand (preferred) | 20% (\$20 minimum/\$100 maximum copay) | | 20% (\$20 minimum/\$100 maximum copay) | | \$30 copay | \$30 copay; annual \$50 Rx deductible applies |
| Brand (non-preferred) | 30% (\$40 minimum/\$200 maximum copay) | | 30% (\$40 minimum/\$200 maximum copay) | | \$50 copay | \$50 copay; annual \$50 Rx deductible applies |
| Specialty (non-preferred) ⁵ | 30% (\$80 minimum/\$400 maximum copay) | | 30% (\$80 minimum/\$400 maximum copay) | | Applicable cost as noted above for generic or brand drugs | Applicable cost as noted above for generic or brand drugs |
| Mail Order and Retail⁶ – Up to 90 Days | | | | | | |
| Generic | 10% (\$15 minimum/\$60 maximum copay) | Not covered | 10% (\$15 minimum/\$60 maximum copay) | Not covered | \$30 copay | \$22.50 copay; annual \$50 Rx deductible applies |
| Brand (preferred) | 20% (\$40 minimum/\$200 maximum copay) | | 20% (\$40 minimum/\$200 maximum copay) | | \$60 copay | \$45 copay; annual \$50 Rx deductible applies |
| Brand (non-preferred) | 30% (\$80 minimum/\$400 maximum copay) | | 30% (\$80 minimum/\$400 maximum copay) | | \$100 copay | \$75 copay; annual \$50 Rx deductible applies |

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|--------------------|--|---|--|---|--|---------------------------------------|
| | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | In-Network |
| Vision Care | | | | | | |
| Examinations | Covered at 100% (no deductible); one visit every 24 months | 40% after deductible; one visit every 24 months | 100%, no deductible; one visit every 24 months | 40% after deductible; one visit every 24 months | 1 routine exam covered at 100% every 24 months | No charge per covered period |
| Frames/Lenses | Not covered | Not covered | Not covered | Not covered | Not covered | \$35 copay eyeglasses every 24 months |

This comparison contains highlights of your health care plan option(s). If there is a discrepancy between the wording in this comparison and your insurance certificate or plan description, the insurance certificate or plan description will govern.

¹ For non-preventive drugs, you pay the full price of the drug until you meet the deductible, at which point you pay the applicable copay or coinsurance.

² If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.

³ If a brand drug is purchased when a generic is available, you pay the copayment plus the difference in cost between the brand and generic medication. For the HDHP plan, the Deductible applies before the above copay schedule (except for preventive medication).

⁴ Administered by OptumRx for the Aetna PPO and Aetna HDHP plans.

⁵ Specialty prescriptions are available through Optum Specialty only (not at retail).

⁶ 90-day prescriptions available from Walgreens-owned retail pharmacies (including Duane Reade).