

# 2020 MEDICAL PLAN COMPARISON CHART



	Health Investment Plan with HSA		Blue Care Elect Preferred (PPO)		Advantage Blue (EPO)	Kaiser (California only)	Kaiser HSA (California only)
	In-Network	Out-of-Network*	In-Network	Out-of-Network*	In-Network Only		
<b>Calendar-year deductible</b>	\$1,400 per individual membership/\$2,800 per family membership for in-network and out-of-network services combined. The entire family deductible must be satisfied before benefits are provided for any one member enrolled under a family membership		\$350 per member/\$700 per family for in-network and out-of-network services combined		\$300 per member/\$600 per family	None	\$1,500 per individual membership/ Individual in a family \$2,800***/ \$3,000 per family
<b>Calendar-year out-of-pocket maximum (medical &amp; pharmacy combined)</b>	\$3,550 per member/\$7,100 per family for in-network and out-of-network services combined**		\$3,000 per member/\$6,000 per family for in-network and out-of-network services combined		\$2,000 per member/ \$4,000 per family	\$1,500 per member/ \$3,000 per family	\$3,000 per member/ \$6,000 per family
<b>Lifetime maximum</b>	None		None		None	None	None
<b>Preventative Health Services</b>							
<b>Well-child care visits, including related tests</b>	Ten visits first year; three visits up to age 2; Two visits up to age 3; One visit each calendar year for ages 3 through 18.	30% co-insurance after deductible	Ten visits first year; three visits up to age 2; Two visits up to age 3; One visit each calendar year for ages 3 through 18.	30% co-insurance after deductible	Ten visits first year; three visits up to age 2; Two visits up to age 3; One visit each calendar year for ages 3 through 18.	Well-child care exams covered 100% with no copay through age 23 months; 1 annual visit for ages 2 through age 18	No charge; deductible does not apply
<b>Routine adult physical exam, including related tests</b>	Covered 100% with no copay for one visit per calendar year	30% co-insurance after deductible	Covered 100% with no copay for one visit per calendar year	30% co-insurance after deductible	Covered 100% with no copay for one visit per calendar year	Covered 100% with no copay for one visit per calendar year	Covered 100% with no copay for one visit per calendar year
<b>Routine GYN exam, including related tests</b>	Covered 100% for one visit per calendar year. No cost for routine tests	30% co-insurance after deductible	Covered 100% for one visit per calendar year. No cost for routine tests	30% co-insurance after deductible	Covered 100% for one visit per calendar year. No cost for routine tests	Covered 100% for one visit per calendar year. No cost for routine tests	Covered 100% for one visit per calendar year. No cost for routine tests
<b>Routine hearing exam</b>	Covered 100% with no copay	30% co-insurance after deductible	Covered 100% with no copay	30% co-insurance after deductible	Covered 100% with no copay	Covered 100% with no copay	Covered 100% with no copay
<b>Routine vision exam</b>	Covered 100% with no copay (one every 24 months)	30% co-insurance after deductible	Covered 100% with no copay (one every 24 months)	30% co-insurance after deductible	Covered 100% with no copay (one every 24 months)	Covered 100% with no copay	No charge; deductible does not apply
<b>Other Outpatient Care</b>							
<b>Emergency Room Visit</b>	\$100 per visit after deductible (waived if admitted or for observation stay)	\$100 per visit after deductible (waived if admitted or for observation stay)	\$150 per visit (waived if admitted or for observation stay)	\$150 per visit (waived if admitted or for observation stay)	\$150 per visit (waived if admitted or for observation stay)	\$100 per visit (waived if admitted or for observation stay)	10% Co-insurance after deductible
<b>Telehealth Virtual Visits</b>	100% after deductible;	30% coinsurance after deductible	\$10 per visit, no deductible	30% co-insurance after deductible	\$10 per visit	Covered 100% with no copay	Covered 100% with no copay
<b>Office Visits</b>	10% co-insurance after deductible	30% co-insurance after deductible	Primary Care providers - \$20 per visit, No deductible Specialists - \$40 per visit, No deductible Hospital or health center - \$40 per visit, No deductible	30% co-insurance after deductible	Primary Care providers - \$20 per visit Specialists - \$40 per visit Hospital or health center - \$40 per visit	\$20 per visit	10% Co-insurance after deductible
<b>Mental Health and substance abuse treatment</b>	10% co-insurance after deductible	30% co-insurance after deductible	\$20 per visit, no deductible	30% co-insurance after deductible	\$20 per visit	\$20 per visit	10% Co-insurance after deductible
<b>Chiropractors' office visit</b>	10% co-insurance after deductible	30% co-insurance after deductible	\$40 per visit, no deductible	30% co-insurance after deductible	\$40 per visit	\$15 per visit up to 20 visits	10% coinsurance after deductible up to 20 visits
<b>Acupuncture office visits</b>	10% co-insurance after deductible	30% co-insurance after deductible	\$40 per visit, no deductible	30% co-insurance after deductible	\$40 per visit	\$15 per visit up to 20 visits	10% coinsurance after deductible up to 20 visits
<b>Allergy testing and treatment</b>	10% co-insurance after deductible	30% co-insurance after deductible	\$40 per visit; no deductible. No cost when visit is for allergy injections only	30% co-insurance after deductible	\$40 per visit. No cost when visit is for allergy injections only	\$3.00 per allergy injection visit; \$20 per allergy testing visits	10% Co-insurance after deductible
<b>Infertility services - office visits</b>	10% co-insurance after deductible. Lifetime infertility maximum of \$25,000	30% co-insurance after deductible. Lifetime infertility maximum of \$25,000	\$40 per visit, no deductible; and all charges beyond the lifetime maximum of \$25,000	30% co-insurance after deductible. Lifetime infertility maximum of \$25,000	\$40 per visit and all charges beyond the lifetime maximum of \$25,000	\$20 per visit; 50% co-insurance for covered services related to infertility	Not Covered

\* Out-Of-Network reimbursement to providers is capped at 150% of the Medicare reimbursement rate per claim. However, the allowed charge may sometimes be less than the health care provider's actual charge. If this is the case, you will be responsible for the amount of the covered provider's actual charge that is in excess of the allowed charge ("balance billing")

\*\* Once any one member enrolled in a family membership reaches the per member out-of-pocket maximum of \$3,550, all future eligible costs are covered 100% for that member. The family out-of-pocket maximum of \$7,100 applies as the maximum exposure for all members of the family combined

\*\*\* Each member's deductible in a family of two or more members cannot exceed \$2,800

(over)

The information provided in this comparison chart represents only highlights of the plan benefits. The actual terms and conditions of each plan are governed by the official plan documents. While this comparison is intended to be as accurate as possible, the explanations are subject, in all aspects, to the detailed provisions of the legal documents and contracts of the individual plans.

# 2020 MEDICAL PLAN COMPARISON CHART (CONTINUED)



	Health Investment Plan with HSA		Blue Care Elect Preferred (PPO)		Advantage Blue (EPO)	Kaiser (California only)	Kaiser HSA (California only)
	In-Network	Out-of-Network*	In-Network	Out-of-Network*	In-Network Only		
<b>Other Outpatient Care (continued)</b>							
<b>Speech, hearing and language disorder treatment - speech therapy</b>	10% co-insurance after deductible	30% co-insurance after deductible	\$20 per visit, no deductible	30% co-insurance after deductible	\$20 per visit	\$20 per visit	10% Co-insurance after deductible
<b>Diagnostic x-rays, lab tests and other tests, excluding CT scans, MRIs, PET Scans, and nuclear cardiac imaging tests</b>	10% co-insurance after deductible (excludes routine tests)	30% co-insurance after deductible. (excludes routine tests)	10% co-insurance after deductible	30% co-insurance after deductible	Deductible applies first; then covered at 100% no copays	Covered 100% no copays	10% Co-insurance after deductible
<b>CT scans, MRIs, PET Scans, and nuclear cardiac imaging tests</b>	10% co-insurance after deductible	30% co-insurance after deductible	\$50 per category per date of service (no cost for interpretation)	30% co-insurance after deductible	\$50 per category per date of service (no cost for interpretation)	Covered 100% no copays	10% Co-insurance after deductible
<b>Durable medical equipment</b>	10% co-insurance after deductible	30% co-insurance after deductible	10% co-insurance after deductible	30% co-insurance after deductible	Deductible applies first	20% co-insurance related to durable medical equipment for home use	10% Co-insurance after deductible
<b>Surgery and related anesthesia</b>							
• <i>Primary Care office setting</i>	10% co-insurance after deductible	30% co-insurance after deductible	\$20 per visit, no deductible	30% co-insurance after deductible	No charge	\$20 per procedure	10% Co-insurance after deductible
• <i>Specialist office setting</i>	10% co-insurance after deductible	30% co-insurance after deductible	\$40 per visit, no deductible	30% co-insurance after deductible	No charge	\$20 per procedure	10% Co-insurance after deductible
• <i>Ambulatory surgical facility, hospital, or surgical day care unit</i>	10% co-insurance after deductible	30% co-insurance after deductible	10% co-insurance after deductible	30% co-insurance after deductible	Deductible applies first; then \$150 per admission (no cost for medically necessary colonoscopies)	\$20 per procedure	10% Co-insurance after deductible
<b>Inpatient Covered Services</b>							
<b>Hospital care in general or chronic disease hospital</b>	10% co-insurance after deductible	30% co-insurance after deductible	\$300 per admission then 10% co-insurance after deductible (as many days as medically necessary)	\$300 per admission then 30% co-insurance after deductible (as many days as medically necessary)	Deductible applies first; then \$300 per admission (as many days as medically necessary)	\$250 per admission	10% Co-insurance after deductible
<b>Mental Hospital or substance abuse facility</b>	10% co-insurance after deductible	30% co-insurance after deductible	\$300 per admission then 10% co-insurance after deductible (as many days as medically necessary)	\$300 per admission then 30% co-insurance after deductible (as many days as medically necessary)	Deductible applies first; then \$300 per admission (as many days as medically necessary)	\$250 per admission	10% Co-insurance after deductible
<b>Skilled nursing facility care</b>	10% co-insurance after deductible; coverage for up to 100 days per year	30% co-insurance after deductible; coverage for up to 100 days per year	10% co-insurance after deductible; coverage for up to 100 days per year	30% co-insurance after deductible; coverage for up to 100 days per year	Deductible applies first; then fully covered up to 100 days per calendar year	Fully covered up to 100 days per year	Fully covered up to 100 days per year
<b>Rehabilitation hospital care</b>	10% co-insurance after deductible; coverage for up to 60 days per year	30% co-insurance after deductible; coverage for up to 60 days per year	10% co-insurance after deductible; coverage for up to 60 days per year	30% co-insurance after deductible; coverage for up to 60 days per year	Deductible applies first; then fully covered up to 60 days per calendar year	\$250 per admission	10% Co-insurance after deductible
<b>Prescription Drug</b>							
<b>Prescription Drug Benefit**</b>	Express Scripts	Express Scripts	Express Scripts	Express Scripts	Express Scripts	Kaiser (California only)	Kaiser (California only)
<b>Retail</b> At designated retail pharmacies (up to 30-day formulary supply for each covered prescription/refill or supply)	After deductible Copays are \$10 for Tier 1; \$30 for Tier 2; \$50 for Tier 3 Deductible waived for certain preventive care medications <sup>†</sup>	After deductible Copays are \$10 for Tier 1; \$30 for Tier 2; \$50 for Tier 3 Deductible waived for certain preventive care medications <sup>†</sup>	\$10 for Tier 1; \$30 for Tier 2; \$50 for Tier 3	\$10 for Tier 1; \$30 for Tier 2; \$50 for Tier 3	\$10 for Tier 1; \$30 for Tier 2; \$50 for Tier 3	\$10 copay for generic and \$25 copay for brand-name drugs	After deductible Copays are \$10 copay for generic and \$30 copay for brand-name drugs
<b>Mail-Service</b> Through mail-service drug program for 90-day supply	After Deductible Copays are \$20 for Tier 1; \$75 for Tier 2; \$125 for Tier 3 Deductible waived for certain preventive care medications <sup>†</sup>	Not Available	\$20 for Tier 1; \$75 for Tier 2; \$125 for Tier 3	Not Available	\$20 for Tier 1; \$75 for Tier 2; \$125 for Tier 3	\$20 copay for generic & \$50 copay for 100-day supply	After deductible Copays are \$20 copay for generic & \$60 copay for 100-day supply
Lifetime infertility maximum of \$15,000							

\* Out-Of-Network reimbursement to providers is capped at 150% of the Medicare reimbursement rate per claim. However, the allowed charge may sometimes be less than the health care provider's actual charge. If this is the case, you will be responsible for the amount of the covered provider's actual charge that is in excess of the allowed charge ("balance billing").

† Certain preventive care medications will not be subject to the Health Investment Plan deductible. See Preventive Care Drug list at [www.Teradyne.com/benefits](http://www.Teradyne.com/benefits) for full listing.

The information provided in this comparison chart represents only highlights of the plan benefits. The actual terms and conditions of each plan are governed by the official plan documents. While this comparison is intended to be as accurate as possible, the explanations are subject, in all aspects, to the detailed provisions of the legal documents and contracts of the individual plans.