# Health Plan Comparison Chart: Security Officers

<table>
<thead>
<tr>
<th>Name of Plan</th>
<th>Aetna Meritain PPO</th>
<th>MVP Health Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of Plan</strong></td>
<td>Preferred Provider Organization (PPO)</td>
<td>Health Maintenance Organization (HMO)</td>
</tr>
<tr>
<td><strong>Features</strong></td>
<td>Network plus freedom of choice</td>
<td>Network only</td>
</tr>
<tr>
<td><strong>Primary Care Provider Required</strong></td>
<td>NO</td>
<td>YES</td>
</tr>
</tbody>
</table>
| **Deductible (Individual/Family)** | In Network: $0 for medical services; $200 for brand name RX  
Out of Network: $500/$1,250 for medical services | Not Applicable                                                                   |
| **Coinsurance: the % you pay after deductible** | In Network: None  
Out of Network: 20%                                                        | Not Applicable                                                                   |
| **Maximum Out of Pocket (Individual/Family)** | In Network: $5,080 / $12,700 (All In–Network copays)  
Out of Network: $1,000/$2,000                                               | $5,800 / $12,700 (25%) / $12,700 (All In–Network copays)                        |
| **Emergency Room**    | $75-waived if admitted in 24 hrs                                                  | $50 waived if hospitalized                                                       |
| **Home/Office Visit** | In Network: $20 copay  
Out of Network: Deductible & Coinsurance                                           | $15 copay                                                                       |
| **Lab & Testing**     | In Network: $0  
Out of Network: Deductible & Coinsurance                                        | $15 copay                                                                       |
| **Annual Physical**   | In Network: $0 copay  
Out of Network: Not Covered                                                             | $15 copay                                                                       |
| **Preventative GYN screen** | In Network: $0 copay  
Out of Network: Deductible & Coinsurance                                           | $15 copay                                                                       |
| **Inpatient Hospitalization** | In Network: $250 copay  
Out of Network: Deductible & Coinsurance                                               | No charge                                                                       |
| **Vision Care:**      | Vision Service Plan:  
- Eye Exams: $10 copay; one visit every 2 years  
- Glasses / Contact Lenses: In Network: $135 allowance per year, plus 15% of additional costs.  
Out of Network: $25-$55 allowance | $15 copay; one visit every 2 years  
Not covered  
Not covered |
| **Prescriptions**     | Provided by Optum RX  
- $10 copay for Generic  
- $25 or $50 for Brand after a $200 deductible | $5 copay for Generic  
$20 copay for Formulary Brand  
$40 for Non-formulary Brand |
| **Children’s Preventive Dental Care** | Not covered                                                                      | 2 visits/year for children under 19                                             |
| **Mental Health Care:** | **Inpatient Hospital**  
- In-network: $250 copay  
Out-of-network: Deductible & Coinsurance                                          | $0 inpatient                                                                    |
| **Inpatient Physician** | In-network: $0  
Out-of-network: Deductible & Coinsurance                                         | $15 copay                                                                       |
| **Outpatient Physician** | In-network: $20 copay/visit  
Out of network: Deductible & Coinsurance                                            | Outpatient: $15 copay                                                          |
| **Alcohol/Substance Abuse Inpatient** | $0: inpatient drug/alcohol rehab limited to 30 days/year | $0 Detoxification                                                               |
| **Outpatient**        | $20 copay                                                                        | $15 copay                                                                        |
| **Physical Therapy**  | $20 per visit up to 90 visits per year (Covered In-network only)                  | $15 per visit; maximum 60 day period per injury                                 |