

## AARP Premier Rate and Plan Benefit Comparison

Age 60

Effective Date 8.1.09

Zip Code 33327

 24 Hour Approval

 24 Hour Approval

 24 Hour Approval



### Premier \$5000 Deductible Plan

### Premier \$2500 Deductible Plan

### Premier \$1500 Deductible Plan

[Remove from comparison](#)

[Remove from comparison](#)

[Remove from comparison](#)

#### Estimated Cost

#### Estimated Cost

#### Estimated Cost

\$426.00 monthly

\$591.00 monthly

\$698.00 monthly

#### Plan Type

#### Plan Type

#### Plan Type

PPO

PPO

PPO

#### Office Visit for Primary Doctor

#### Office Visit for Primary Doctor

#### Office Visit for Primary Doctor

\$40 Copay

\$30 Copay

\$25 Copay

#### Office Visit for Specialist

#### Office Visit for Specialist

#### Office Visit for Specialist

\$50 Copay

\$40 Copay

\$35 Copay

#### Coinsurance

#### Coinsurance

#### Coinsurance

20% after deductible

20% after deductible

20% after deductible

#### Annual Deductible

#### Annual Deductible

#### Annual Deductible

Individual:\$5,000

Individual:\$2,500

Individual:\$1,500

#### Annual Out-of-Pocket Limit

#### Annual Out-of-Pocket Limit

#### Annual Out-of-Pocket Limit

Individual:\$7,500

Individual:\$5,000

Individual:\$3,000

Includes deductible

Includes deductible

Includes deductible

#### Lifetime Maximum

#### Lifetime Maximum

#### Lifetime Maximum

\$5 Million per person

\$5 Million per person

\$5 Million per person

#### Health Savings Account (HSA) Eligible

#### Health Savings Account (HSA) Eligible

#### Health Savings Account (HSA) Eligible

No

No

No

#### Out-of-Network Coverage

#### Out-of-Network Coverage

#### Out-of-Network Coverage

Yes

Yes

Yes

Out of Country Coverage

Out of Country Coverage

Out of Country Coverage

Yes. Paid at Out-of-Network benefit level

Yes. Paid at Out-of-Network benefit level

Yes. Paid at Out-of-Network benefit level

Optional Benefits

Optional Benefits

Optional Benefits

No

No

No

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Physicians

[Primary Care Physician \(PCP\) Required](#)

[Primary Care Physician \(PCP\) Required](#)

[Primary Care Physician \(PCP\) Required](#)

No

No

No

[Specialist Referrals Required](#)

[Specialist Referrals Required](#)

[Specialist Referrals Required](#)

No

No

No

Preventive Care Coverage

Periodic Health Exam

Periodic Health Exam

Periodic Health Exam

\$40 Copay

\$30 Copay

\$25 Copay

Periodic OB-GYN Exam

Periodic OB-GYN Exam

Periodic OB-GYN Exam

\$0 Copay

\$0 Copay

\$0 Copay

Well Baby Care

Well Baby Care

Well Baby Care

\$40 Copay

\$30 Copay

\$25 Copay

Prescription Drug Coverage

[Generic Prescription Drugs](#)

[Generic Prescription Drugs](#)

[Generic Prescription Drugs](#)

\$15 Copay

\$15 Copay

\$15 Copay

[Brand Prescription Drugs](#)

[Brand Prescription Drugs](#)

[Brand Prescription Drugs](#)

\$25 Copay after deductible

\$25 Copay after deductible

\$25 Copay after deductible

[Non-formulary Prescription Drugs Coverage](#)

[Non-formulary Prescription Drugs Coverage](#)

[Non-formulary Prescription Drugs Coverage](#)

\$40 Copay after deductible

\$40 Copay after deductible

\$40 Copay after deductible

[Mail Order for Prescription Drugs](#)

[Mail Order for Prescription Drugs](#)

[Mail Order for Prescription Drugs](#)

Generic: \$30 Copay

Generic: \$30 Copay

Generic: \$30 Copay

Brand: \$50 Copay after deductible

Brand: \$50 Copay after deductible

Brand: \$50 Copay after deductible

Non-Formulary: \$80 Copay after deductible

Non-Formulary: \$80 Copay after deductible

Non-Formulary: \$80 Copay after deductible

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Days Supply: 60

Days Supply: 60

Days Supply: 60

[Separate Prescription Drugs Deductible](#)

[Separate Prescription Drugs Deductible](#)

[Separate Prescription Drugs Deductible](#)

\$500 Individual

\$500 Individual

\$250 Individual

\$1,000 Family

\$1,000 Family

\$500 Family

applies to

applies to

applies to

Brand, Non-Formulary

Brand, Non-Formulary

Brand, Non-Formulary

Hospital Services Coverage

[Emergency Room](#)

[Emergency Room](#)

[Emergency Room](#)

\$150 Copay (waived if admitted) after deductible

\$150 Copay (waived if admitted) after deductible

\$150 Copay (waived if admitted) after deductible

[Outpatient Lab/X-Ray](#)

[Outpatient Lab/X-Ray](#)

[Outpatient Lab/X-Ray](#)

20% after deductible

20% after deductible

20% after deductible

[Outpatient Surgery](#)

[Outpatient Surgery](#)

[Outpatient Surgery](#)

20% after deductible

20% after deductible

20% after deductible

[Hospitalization](#)

[Hospitalization](#)

[Hospitalization](#)

20% after deductible

20% after deductible

20% after deductible

Maternity Coverage

[Pre & Postnatal Office Visit](#)

[Pre & Postnatal Office Visit](#)

[Pre & Postnatal Office Visit](#)

Not covered (except for pregnancy complications)

Not covered (except for pregnancy complications)

Not covered (except for pregnancy complications)

[Labor & Delivery Hospital Stay](#)

[Labor & Delivery Hospital Stay](#)

[Labor & Delivery Hospital Stay](#)

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 Essential Premier  
by Aetna

 Essential Premier  
by Aetna

 Essential Pren  
by Aetna

### Premier \$5000 Deductible Plan

### Premier \$2500 Deductible Plan

### Premier \$1500 Deductible Plan

Not covered (except for pregnancy complications)

Not covered (except for pregnancy complications)

Not covered (except for pregnancy complications)

Additional Coverage

Chiropractic Coverage

Chiropractic Coverage

Chiropractic Coverage

20% Coinsurance after deductible.  
24 Visits Per Year./\$25 Max. Per Visit

20% Coinsurance after deductible.  
24 Visits Per Year./\$25 Max. Per Visit

20% Coinsurance after deductible.  
24 Visits Per Year./\$25 Max. Per Visit

**Mental Health Coverage**



**Mental Health Coverage**

**Mental Health Coverage**

**20% Coinsurance after deductible.**

**Unlimited Days and Visits**

**20% Coinsurance after deductible.**

**Unlimited Days and Visits**

**20% Coinsurance after deductible.**

**Unlimited Days and Visits**

Additional Information

[A.M. Best Rating](#)

A as of 06/16/2008

[A.M. Best Rating](#)

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