2014 Health Coverage Comparison Chart

Use this helpful comparison chart to determine which medical plan option best meets your health and financial needs.

For more information, visit **www.fmrbenefits.com**.

New for 2014:

- ☐ **New Health Savings Account Limits:** The new employee contribution limits for 2014 are $2,800 for individual coverage and $5,550 if you cover one or more family members. If you are contributing up to the 2013 annual maximum ($2,750 for individual coverage and $5,450 if you cover one or more family members), you will automatically have your contributions increased to reach the 2014 limits. You can change your contribution amount at any time.
- ☐ **Enhanced Health & Wellness Program:** Fidelity is committed to expanding our Health & Wellness Program offered to employees and families. Becoming a tobacco-free workplace is also part of that commitment. Refer to **www.fmrbenefits.com** for more information.
- ☐ **Premium Physician Program:** This program becomes available in the Westlake and Jacksonville regions beginning January 1, 2014. By using one of UnitedHealthcare's designated Premium Physicians, you receive the same services at a lower cost. Refer to **www.fmrbenefits.com** for more information.

Fidelity INVESTMENTS

2014 Medical Coverage Comparison Chart

KEY PROVISIONS	FIDELITY HEALTH PLAN (IN-NETWORK)[5]	HEALTHFLEX PPO (IN-NETWORK)[5]	HEALTH MAINTENANCE ORGANIZATIONS[1] (HMOs) Varies by State[2, 4]
ANNUAL DEDUCTIBLE	Individual: $1,500 Ind. +1/Family: $3,000	Individual: $300[7] Ind. +1/Family: $600[7]	None
ANNUAL OUT-OF-POCKET MAXIMUM (INCLUDES DEDUCTIBLE)	Individual: $2,000 Ind. +1/Family: $4,000	Individual: $1,000 Ind. +1/Family: $2,000	Varies by plan. Contact your HMO for details on out-of-pocket maximums.
REFERRALS	Not required.	Not required.	Varies by plan. Contact your HMO for details as to whether referrals[3] are required.
OFFICE VISITS • *Routine Well Office Visits and Screenings*	Covered at 100%, no copay.	Covered at 100%, no copay.	Covered at 100%, no copay.
• *Well Baby/Well Child Visits*	Covered at 100%, no copay.	Covered at 100%, no copay.	Covered at 100%, no copay.
• *Diagnostic Visits*	Covered at 90%, after deductible.	Covered at 100%, after $20 copay.	Covered at 100%, after $20 copay.
• *Specialty Visits*	Covered at 90%, after deductible.	Covered at 100%, after $40 copay.	Covered at 100%, after $40 copay.
MATERNITY CARE • *Prenatal Care*	Covered at 100%, no copay.	Covered at 100%, no copay.	Covered at 100%, no copay.
• *Hospital & Delivery Services*	Covered at 90%, after deductible.	Covered at 90%, after deductible.	Covered at 100%, no copay.
• *Postnatal Exams*	Covered at 90%, after deductible.	Covered at 100%, no copay.	Covered at 100%, no copay.
HOSPITAL CARE • *Inpatient Care*	Covered at 90%, after deductible.	Covered at 90%, after deductible.	Covered at 100%, no copay.
• *Emergency Room*	Covered at 90%, after deductible.	Covered at 100%, after $150 copay (waived if admitted).	Covered at 100%, after $150 copay (waived if admitted).
• *Outpatient Surgery*	Covered at 90%, after deductible.	In facility: Covered at 90%, after deductible. In physician's office: Covered at 100%, after $40 copay.	In facility: Covered at 100%, no copay. In physician's office: Covered at 100%, after $40 copay.
OUTPATIENT (PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY)	Covered at 90%, after deductible. Physical and occupational therapy limited to 60 visits per year combined. Speech therapy limited to 52 visits per year.	Covered at 100%, after $40 copay per visit. Physical and occupational therapy limited to 60 visits per year combined. Speech therapy limited to 52 visits per year.	Covered at 100%, after $40 copay per visit. Physical and occupational therapy limited to 60 visits per year combined. Speech therapy limited to 52 visits per year.
MENTAL HEALTH/ SUBSTANCE ABUSE • *Inpatient*	Covered at 90%, after deductible; unlimited days per calendar year. Prior authorization may be required.	Covered at 90%, after deductible; unlimited days per calendar year. Prior authorization may be required.	Covered at 100%, no copay; unlimited days per calendar year. Prior authorization may be required.
• *Outpatient*	Covered at 90%, after deductible; unlimited visits per calendar year. Prior authorization may be required.	Covered at 100%, after $20 copay per visit; unlimited visits per calendar year. Prior authorization may be required.	Covered at 100%, after $20 copay per visit; unlimited visits per calendar year. Prior authorization may be required.
CHIROPRACTIC AND ACUPUNCTURE SERVICES	Covered at 90%, after deductible; limited to 20 visits per year for chiropractic and acupuncture services (not combined).	Covered at 90%, after deductible; limited to 20 visits per year for chiropractic and acupuncture services (not combined).	Covered at 100%, after $40 copay per visit. Limited to 20 visits per year for chiropractic and acupuncture services (not combined).
VISION AND HEARING EXAMS	Covered at 100%, no copay (one exam per year).	Covered at 100%, no copay (one exam per year).	Covered at 100%, no copay (one exam per year).
PRESCRIPTION COVERAGE *Administered by Express Scripts (formerly Medco)* • *Retail (30-day supply) Generic/Formulary/Non-formulary*	Preventive: Covered at 100%, after applicable copay ($10/$20/$40).[6] Non-preventive: Covered at 90%, after deductible.	Covered at 100%, after applicable copay ($10/$20/$40).	Covered at 100%, after applicable copay ($10/$20/$40).
• *Mail Order (90-day supply) Generic/Formulary/Non-formulary*	Preventive: Covered at 100%, after applicable copay ($20/$40/$80).[6] Non-preventive: Covered at 90%, after deductible.	Covered at 100%, after applicable copay ($20/$40/$80).	Covered at 100%, after applicable copay ($20/$40/$80).

[1] For purposes of this chart, HMO means an HMO-like self-funded plan.
[2] In all cases, you must reside in the appropriate service area in the states offered to obtain the HMO coverage.
[3] Under the HMO, you may be required to obtain referrals from your Primary Care Physician to obtain care or no benefits will be paid.
[4] There may be slight variations by state. Please check your Summary Plan Description or contact the plan carrier for detailed coverage information.
[5] Note that the coverage information pertains only to in-network providers and that the coverage for out-of-network providers is reduced.
[6] Preventive prescription drug copays will not apply toward the deductible, but will apply toward the out-of-pocket maximum.
[7] Copay amounts do not apply to the annual deductible.

2014 Dental Coverage Information

KEY PROVISIONS	COVERAGE	SERVICES INCLUDED IN TREATMENT[3]
Annual Deductible[1]	**Individual/Individual + 1:** $50 per covered person **Family:** $150 per family	
Benefit Maximum	**Dental Services:** $2,000 per covered person per calendar year **Orthodontic Services:** $2,500 per covered person per lifetime	
Preventive Treatment	Covered at 100%.[2]	Oral exams, routine cleanings, X-rays, sealants, fluoride treatments, and space maintainers.
Basic Treatment	Covered at 80%[2] after deductible.	Fillings, oral surgery, periodontal treatment, endodontics, extractions, and diagnostic lab tests.
Major Restorative and Orthodontic Treatment	Covered at 60%[2] after deductible.	Crowns and bridgework, dentures, implants, inlays, and onlays. Orthodontic treatment subject to lifetime maximum.

[1] Deductible applies to basic and major treatment only (excludes orthodontic treatment).
[2] Coverage is either the cost provided by a Preferred Dental Provider or the Reasonable and Customary amount.
[3] This is a sample list of services covered under each treatment; see the Summary Plan Description for a list of all services covered.

2014 Health Care Biweekly Contributions*

EMPLOYEE COSTS

- **Medical:** Costs for each medical plan option are based on your salary and your work status—full-time (regular employees regularly scheduled to work 30 or more hours per week) or part-time (regular employees regularly scheduled to work at least 20 but less than 30 hours per week).
- **Dental:** Costs for the dental plan are based on your work status.

Remember: The following medical and dental contributions are deducted from each of your biweekly paychecks. To determine your full cost for the year, use the rates below and multiply by 26. Weekly contributions are calculated by dividing the rates below by 2.

	INDIVIDUAL		INDIVIDUAL + 1		FAMILY	
	FT	PT	FT	PT	FT	PT
EXEMPT EMPLOYEES WITH BASE SALARY OR BENEFITS BASE OF LESS THAN $75,000 AND ALL NON-EXEMPT EMPLOYEES AS OF 8/1/2013						
Fidelity Health Plan	$44.00	$118.00	$84.00	$232.00	$120.00	$342.00
HealthFlex PPO	$65.00	$138.00	$124.00	$272.00	$181.00	$403.00
Aetna Mid-Atlantic HMO (CT, NJ, NY, PA)	$107.00	$178.00	$207.00	$349.00	$305.00	$518.00
Aetna Texas HMO (TX)	$81.00	$156.00	$158.00	$308.00	$232.00	$457.00
CIGNA HMO (NC)	$78.00	$148.00	$148.00	$290.00	$217.00	$430.00
Harvard Pilgrim HMO (ME, MA, NH, RI)	$76.00	$151.00	$148.00	$298.00	$217.00	$442.00
Humana HMO (IN, KY, OH)	$72.00	$145.00	$136.00	$286.00	$199.00	$424.00
SelectHealth HMO (UT)	$72.00	$147.00	$140.00	$290.00	$205.00	$430.00
EXEMPT EMPLOYEES WITH BASE SALARY OR BENEFITS BASE BETWEEN $75,000 AND $149,999 AS OF 8/1/2013						
Fidelity Health Plan	$44.00	$118.00	$84.00	$232.00	$120.00	$342.00
HealthFlex PPO	$76.00	$138.00	$149.00	$272.00	$218.00	$403.00
Aetna Mid-Atlantic HMO (CT, NJ, NY, PA)	$121.00	$178.00	$235.00	$349.00	$348.00	$518.00
Aetna Texas HMO (TX)	$94.00	$156.00	$185.00	$308.00	$273.00	$457.00
CIGNA HMO (NC)	$91.00	$148.00	$174.00	$290.00	$255.00	$430.00
Harvard Pilgrim HMO (ME, MA, NH, RI)	$89.00	$151.00	$175.00	$298.00	$257.00	$442.00
Humana HMO (IN, KY, OH)	$83.00	$145.00	$162.00	$286.00	$238.00	$424.00
SelectHealth HMO (UT)	$85.00	$147.00	$166.00	$290.00	$244.00	$430.00
EXEMPT EMPLOYEES WITH BASE SALARY OR BENEFITS BASE OF $150,000 OR MORE AS OF 8/1/2013						
Fidelity Health Plan	$44.00	$118.00	$84.00	$232.00	$120.00	$342.00
HealthFlex PPO	$89.00	$138.00	$175.00	$272.00	$256.00	$403.00
Aetna Mid-Atlantic HMO (CT, NJ, NY, PA)	$135.00	$178.00	$264.00	$349.00	$390.00	$518.00
Aetna Texas HMO (TX)	$108.00	$156.00	$212.00	$308.00	$313.00	$457.00
CIGNA HMO (NC)	$103.00	$148.00	$200.00	$290.00	$294.00	$430.00
Harvard Pilgrim HMO (ME, MA, NH, RI)	$102.00	$151.00	$201.00	$298.00	$296.00	$442.00
Humana HMO (IN, KY, OH)	$96.00	$145.00	$188.00	$286.00	$276.00	$424.00
SelectHealth HMO (UT)	$98.00	$147.00	$192.00	$290.00	$283.00	$430.00

** These contribution amounts do not reflect any premium reduction associated with Fidelity's health improvement and incentive program.*

Dental	$8.00	$16.00	$17.00	$34.00	$26.00	$52.00

For more information about your medical plan options, visit **www.fmrbenefits.com**. For general questions, enrollment and eligibility information, call HR Solutions at 800-835-5099, prompt 1, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern time. For detailed coverage information, please contact the plan carrier directly.

Carrier contact information appears below and is also available on *NetBenefits® > Health & Insurance > Contact Directory* (under "Contact Us").

Aetna Mid-Atlantic HMO and Aetna Texas HMO	800-238-6291 www.aetna.com*
CIGNA HMO	800-CIGNA24 (800-244-6224) www.cigna.com
Express Scripts (formerly Medco) Prescription Drug	866-383-7314 www.express-scripts.com*
Fidelity Health Plan (UnitedHealthcare)	877-240-4016 www.myuhc.com* *Pre-enrollment: http://welcometouhc.com/fmr*
Harvard Pilgrim HMO	888-333-4742 www.harvardpilgrim.org
HealthFlex PPO (UnitedHealthcare)	800-331-0265 www.myuhc.com* *Pre-enrollment: http://welcometouhc.com/fmr*
Humana HMO	888-357-6767 www.humana.com
MetLife Dental	888-660-1046 mybenefits.metlife.com*
SelectHealth HMO	800-538-5038 www.selecthealth.org

**You can link directly to these sites through NetBenefits without entering a separate password. Simply access the Contact Directory on the Health & Insurance tab.*

Note: For some websites, login and/or registration may be required.

Unless otherwise noted, prospective members can use the phone numbers and websites above for information before enrolling.

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