2025 Medical Plan Comparison

Plan Facts

Carrier	Anthem
Website	anthem.com
Phone Number	800.514.4538

Cost per Weekly Paycheck, *before* the Discount for LiveWell Participation is Applied**

Medical*****	Premium PPO	Basic PPO	Core Choice	Core Value	Essential
Partner Only	$51.75	$39.30	$31.35	$22.20	$15.00
Partner + Spouse	$122.25	$95.95	$79.70	$54.40	$41.25
Partner + Child(ren)	$92.15	$67.60	$53.30	$30.00	$21.75
Partner + Family	$162.60	$124.30	$101.75	$62.20	$48.00

*The Premium PPO Plan is only available to partners who were benefits-eligible before 1/1/12.

**Tobacco-user surcharge applies to partners and their spouse who are tobacco users. Spousal surcharge applies to partners whose spouse has medical coverage available through his or her employer.

LiveWell Participation Criteria ***

LiveWell Activity	Weekly Discount if Completed by:	Partner Only	Spouse Only	Partner + Spouse
Complete Biometric Screening Only		$10	$10	$20
Complete Biometric Screening with Health Assessment		$15	$15	$30

***Partners who began working at Cintas on or after 7/13/24, will receive the discount outlined above in 2025.
Spouses who were not enrolled in a Cintas medical plan before 7/13/24 will automatically receive the discount if enrolled in a Cintas medical plan in 2025.
Partners on Military leave at any point between 7/13/24 and 8/30/24 will automatically receive the discount if enrolled in a Cintas medical plan in 2025.

General Medical Expenses

	Premium PPO	Basic PPO	Core Choice	Core Value	Essential
Annual Deductible	**In Network*** $350 Individual; $700 Family** **Out of Network** $700 Individual; $1,400 Family	**In Network** $700 Individual; $1,400 Family** **Out of Network** $1,400 Individual; $2,800 Family	**In Network:** $1,650 Individual applies to Single coverage only; $3,300 Family, for coverage of any combination of a spouse and/or child*** **Out of Network:** $3,300/$6,600	**In Network:** $3,250 Individual applies to Single coverage only; $6,500 Family, for coverage of any combination of a spouse and/or child*** **Out of Network:** $6,500/$13,000	**In Network:** $5,850 Individual applies to Single coverage only; $11,700 Family, for coverage of any combination of a spouse and/or child**** **Out of Network:** $11,700/$23,400
Primary doctor office visit	**In Network** $15 copay **Out of Network** 60% covered after deductible met	**In Network** $30 copay **Out of Network** 60% covered after deductible met	**In Network** 80% covered after deductible met **Out of Network** 60% covered after deductible met	**In Network** 100% covered after deductible met **Out of Network** 60% covered after deductible met	**In Network** 100% covered after deductible met **Out of Network** 60% covered after deductible met
Specialist office visit	**In Network** $15 copay **Out of Network** 60% covered after deductible met	**In Network** $30 copay **Out of Network** 60% covered after deductible met	**In Network** 80% covered after deductible met **Out of Network** 60% covered after deductible met	**In Network** 100% covered after deductible met **Out of Network** 60% covered after deductible met	**In Network** 100% covered after deductible met **Out of Network** 60% covered after deductible met
Out-of-pocket maximum	**In Network** $2,300 Individual; $4,600 Family; includes deductible and copays **Out of Network** $4,600 Individual; $9,200 Family; includes deductible and copays	**In Network** $3,400 Individual; $6,800 Family; includes deductible and copays **Out of Network** $6,800 Individual; $13,600 Family; includes deductible and copays	**In Network:** $2,400 Individual applies to Single coverage only; $4,800 Family, for coverage of any combination of a spouse and/or child; includes dedictible*** **Out of Network:** $4,800 Individual; $9,600 Family; as above and includes deductible	**In Network:** $3,250 Individual applies to Single coverage only; $6,500 Family, for coverage of any combination of a spouse and/or child; includes dedictible*** **Out of Network:** $8,500 Individual; $17,000 Family; as above and includes deductible	**In Network:** $5,850 Individual applies to Single coverage only; $11,700 Family, for coverage of any combination of a spouse and/or child; includes dedictible**** **Out of Network:** $13,700 Individual; $27,400 Family; as above and includes deductible
Lifetime Limit	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited

* The Premium PPO Plan is only available to partners who were benefits eligible before Jan 1, 2012 or are grandfathered into the Plan.
** Copays do not count toward your deductible.
*** If you have coverage other than Partner Only, you must satisfy the family amount.
**** The Essential Plan for family applies to those partners covering any combination of a spouse and/or child, and the individual limit of $9,100 applies for family coverage.

2025 Medical Plan Comparison

	Premium PPO	Basic PPO	Core Choice	Core Value	Essential
Inpatient Hospital Care					
Hospital copay	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Hospital semi-private room	**In Network** 80% covered after deductible **Out of Network** 60% covered after deductible	**In Network** 80% covered after deductible **Out of Network** 60% covered after deductible	**In Network** 80% covered after deductible **Out of Network** 60% covered after deductible	**In Network** 100% covered after deductible **Out of Network** 60% covered after deductible	**In Network** 100% covered after deductible **Out of Network** 60% covered after deductible
Inpatient lab and X-ray	**In Network** 80% covered after deductible **Out of Network** 60% covered after deductible	**In Network** 80% covered after deductible **Out of Network** 60% covered after deductible	**In Network** 80% covered after deductible **Out of Network** 60% covered after deductible	**In Network** 100% covered after deductible **Out of Network** 60% covered after deductible	**In Network** 100% covered after deductible **Out of Network** 60% covered after deductible
Inpatient physician and surgeon services	**In Network** 80% covered after deductible **Out of Network** 60% covered after deductible	**In Network** 80% covered after deductible **Out of Network** 60% covered after deductible	**In Network** 80% covered after deductible **Out of Network** 60% covered after deductible	**In Network** 100% covered after deductible **Out of Network** 60% covered after deductible	**In Network** 100% covered after deductible **Out of Network** 60% covered after deductible
Outpatient Care					
Outpatient surgery	**In Network** 80% covered after deductible surgeries performed in an office setting are 100% covered after $15 copay **Out of Network** 60% covered after deductible	**In Network** 80% covered after deductible surgeries performed in an office setting are 100% covered after $30 copay **Out of Network** 60% covered after deductible	**In Network** 80% covered after deductible **Out of Network** 60% covered after deductible	**In Network** 100% covered after deductible **Out of Network** 60% covered after deductible	**In Network** 100% covered after deductible **Out of Network** 60% covered after deductible
Outpatient laboratory services	**In Network** 100% covered check with Plan for details **Out of Network** 60% covered after deductible	**In Network** 100% covered check with Plan for details **Out of Network** 60% covered after deductible	**In Network** 80% covered after deductible check with Plan for details **Out of Network** 60% covered after deductible	**In Network** 100% covered after deductible check with Plan for details **Out of Network** 60% covered after deductible	**In Network** 100% covered after deductible check with Plan for details **Out of Network** 60% covered after deductible
Outpatient X-ray	**In Network** 80% covered after deductible x-rays performed in an office setting or in conjunction with preventive care 100% covered **Out of Network** 60% covered after deductible	**In Network** 80% covered after deductible x-rays performed in an office setting or in conjunction with preventive care 100% covered **Out of Network** 60% covered after deductible	**In Network** 80% covered after deductible **Out of Network** 60% covered after deductible	**In Network** 100% covered after deductible **Out of Network** 60% covered after deductible	**In Network** 100% covered after deductible **Out of Network** 60% covered after deductible
Emergency room (not followed by admission)	**In Network** $175 copay **Out of Network** $175 copay	**In Network** $250 copay **Out of Network** $250 copay	**In Network** 80% covered after deductible **Out of Network** 80% covered after deductible (in-network deductible applies)	**In Network** 100% covered after deductible **Out of Network** 100% covered after deductible (in-network deductible applies)	**In Network** 100% covered after deductible **Out of Network** 100% covered after deductible (in-network deductible applies)
Urgent care clinic visit	**In Network** $35 copay **Out of Network** 60% covered after deductible	**In Network** $50 copay **Out of Network** 60% covered after deductible	**In Network** 80% covered after deductible **Out of Network** 60% covered after deductible	**In Network** 100% covered after deductible **Out of Network** 60% covered after deductible	**In Network** 100% covered after deductible **Out of Network** 60% covered after deductible

Prescription Drug Expenses

Vendor	CarelonRx
Website	www.anthem.com
Phone Number	844-721-1899

	Premium PPO	Basic PPO	Core Choice	Core Value	Essential
Retail generic	**In Network** $10 copay **Out of Network** Not covered	**In Network** $10 copay **Out of Network** Not covered	**In Network** 80% covered after deductible 30 day supply **Out of Network** Not covered	**In Network** 100% covered after deductible 30 day supply **Out of Network** Not covered	**In Network** 100% covered after deductible 30 day supply **Out of Network** Not covered
Retail formulary brand	**In Network** 80% covered $30 minimum/$75 maximum **Out of Network** Not covered	**In Network** 80% covered $30 minimum/$75 maximum **Out of Network** Not covered	**In Network** 80% covered after deductible 30 day supply **Out of Network** Not covered	**In Network** 100% covered after deductible 30 day supply **Out of Network** Not covered	**In Network** 100% covered after deductible 30 day supply **Out of Network** Not covered
Retail nonformulary brand	**In Network** 60% covered $60 minimum/$150 maximum **Out of Network** Not covered	**In Network** 60% covered $60 minimum/$150 maximum **Out of Network** Not covered	**In Network** 80% covered after deductible 30 day supply **Out of Network** Not covered	**In Network** 100% covered after deductible 30 day supply **Out of Network** Not covered	**In Network** 100% covered after deductible 30 day supply **Out of Network** Not covered
Retail Specialty Rx	70% covered for Preferred Formulary Drugs; 55% for Non-Preferred Formulary Drugs CarelonRx's Cost Relief Program for $0 copay	70% covered for Preferred Formulary Drugs; 55% for Non-Preferred Formulary Drugs CarelonRx's Cost Relief Program for $0 copay	80% covered after deductible is met	100% covered after deductible is met	100% covered after deductible is met
Mail order generic	$20 copay 90 day supply	$20 copay 90 day supply	80% covered after deductible 90 day supply	100% covered after deductible 90 day supply	100% covered after deductible 90 day supply
Mail order formulary brand	80% covered; $60 min/$150 max; 90 day supply	80% covered; $60 min/$150 max; 90 day supply	80% covered after deductible 90 day supply	100% covered after deductible 90 day supply	100% covered after deductible 90 day supply
Mail order nonformulary brand	60% covered; $120 min/$300 max; 90 day supply	60% covered; $120 min/$300 max; 90 day supply	80% covered after deductible 90 day supply	100% covered after deductible 90 day supply	100% covered after deductible 90 day supply
Mail order Specialty Rx	70% covered for Preferred Formulary Drugs; 55% for Non-Preferred Formulary Drugs CarelonRx's Cost Relief Program for $0 copay	70% covered for Preferred Formulary Drugs; 55% for Non-Preferred Formulary Drugs CarelonRx's Cost Relief Program for $0 copay	80% covered after deductible is met	100% covered after deductible is met	100% covered after deductible is met
Oral contraceptives	**In Network** Retail and mail order available **Out of Network** Not covered	**In Network** Retail and mail order available **Out of Network** Not covered	**In Network** Retail and mail order available **Out of Network** Not covered	**In Network** Retail and mail order available **Out of Network** Not covered	**In Network** Retail and mail order available **Out of Network** Not covered
Rx subject to overall medical deductible & OOP	No	No	Yes	Yes	Yes
Annual prescription out-of-pocket maximum	$3,250 Individual; $6,500 Family	$3,250 Individual; $6,500 Family	Not applicable	Not applicable	Not applicable

Basic PPO and Premium PPO Medical Plan options only — partners and eligible dependents will be automatically enrolled in CarelonRx's Cost Relief program and will have a $0 co-pay for specialty (only) drugs. Partners and dependents who opt out of CarelonRx's Cost Relief program will pay a 30% co-pay for specialty drugs.

Note: For coverage of weight loss medications, contact Anthem Health Guide at 800.514.4538.

Coverage

	Premium PPO	Basic PPO	Core Choice	Core Value	Essential
Adult Preventive Care					
Annual Physical Exam	**In Network:** 100% covered **Out of Network:** 60% covered after deductible	**In Network:** 100% covered **Out of Network:** 60% covered after deductible	**In Network:** 100% covered **Out of Network:** 60% covered after deductible	**In Network:** 100% covered **Out of Network:** 60% covered after deductible	**In Network:** 100% covered **Out of Network:** 60% covered after deductible

	Premium PPO	Basic PPO	Core Choice	Core Value	Essential
Well-woman exam (includes pap)	**In Network:** 100% covered **Out of Network:** 60% covered after deductible	**In Network:** 100% covered **Out of Network:** 60% covered after deductible	**In Network:** 100% covered **Out of Network:** 60% covered after deductible	**In Network:** 100% covered **Out of Network:** 60% covered after deductible	**In Network:** 100% covered **Out of Network:** 60% covered after deductible
Mammogram	**In Network:** 100% covered **Out of Network:** 60% covered after deductible	**In Network:** 100% covered **Out of Network:** 60% covered after deductible	**In Network:** 100% covered **Out of Network:** 60% covered after deductible	**In Network:** 100% covered **Out of Network:** 60% covered after deductible	**In Network:** 100% covered **Out of Network:** 60% covered after deductible
Cancer screenings	**In Network:** 100% covered **Out of Network:** 60% covered after deductible	**In Network:** 100% covered **Out of Network:** 60% covered after deductible	**In Network:** If routine, 100% covered; if diagnosis, 80% covered after deductible **Out of Network:** 60% covered after deductible	**In Network:** If routine, 100% covered; if diagnosis, 100% covered after deductible **Out of Network:** 60% covered after deductible	**In Network:** If routine, 100% covered; if diagnosis, 100% covered after deductible **Out of Network:** 60% covered after deductible
Cardiovascular screenings	**In Network:** 100% covered **Out of Network:** 60% covered after deductible	**In Network:** 100% covered **Out of Network:** 60% covered after deductible	**In Network:** 100% covered; 100% covered lab work **Out of Network:** 60% covered after deductible	**In Network:** 100% covered; 100% covered lab work **Out of Network:** 60% covered after deductible	**In Network:** 100% covered; 100% covered lab work **Out of Network:** 60% covered after deductible
Family Planning					
Fertility drugs	Covered under Prescription Drug Coverage; excluded under Medical	Covered under Prescription Drug Coverage; excluded under Medical	Covered under Prescription Drug Coverage; excluded under Medical	Covered under Prescription Drug Coverage; excluded under Medical	Covered under Prescription Drug Coverage; excluded under Medical
Fertility Services	**In Network:** 80% covered after deductible; limited to diagnosis and treatment of underlying cause of infertility **Out of Network:** 60% covered; limited to diagnosis and treatment of underlying cause of infertility	**In Network:** 80% covered after deductible; limited to diagnosis and treatment of underlying cause of infertility **Out of Network:** 60% covered; limited to diagnosis and treatment of underlying cause of infertility	**In Network:** 80% covered after deductible; limited to diagnosis and treatment of underlying cause of infertility **Out of Network:** 60% covered; limited to diagnosis and treatment of underlying cause of infertility	**In Network:** 100% covered after deductible; limited to diagnosis and treatment of underlying cause of infertility **Out of Network:** 60% covered; limited to diagnosis and treatment of underlying cause of infertility	**In Network:** 100% covered after deductible; limited to diagnosis and treatment of underlying cause of infertility **Out of Network:** 60% covered; limited to diagnosis and treatment of underlying cause of infertility
Artificial insemination	Not covered	Not covered	Not covered	Not covered	Not covered
In vitro fertilization	Not covered	Not covered	Not covered	Not covered	Not covered

	Premium PPO	Basic PPO	Core Choice	Core Value	Essential
Female tubal ligation	**In Network:** 80% covered after deductible reversals not covered **Out of Network:** 60% covered after deductible, reversals not covered	**In Network:** 80% covered after deductible reversals not covered **Out of Network:** 60% covered after deductible, reversals not covered	**In Network:** 80% covered after deductible reversals not covered **Out of Network:** 60% covered after deductible, reversals not covered	**In Network:** 100% covered after deductible; reversals not covered **Out of Network:** 60% covered after deductible, reversals not covered	**In Network:** 100% covered after deductible; reversals not covered **Out of Network:** 60% covered after deductible, reversals not covered
Male vasectomy	**In Network:** 80% covered after deductible reversals not covered **Out of Network:** 60% covered after deductible, reversals not covered	**In Network:** 80% covered after deductible reversals not covered **Out of Network:** 60% covered after deductible, reversals not covered	**In Network:** 80% covered after deductible reversals not covered **Out of Network:** 60% covered after deductible, reversals not covered	**In Network:** 100% covered after deductible; reversals not covered **Out of Network:** 60% covered after deductible, reversals not covered	**In Network:** 100% covered after deductible; reversals not covered **Out of Network:** 60% covered after deductible, reversals not covered
Maternity Care					
Office visit: Pre/postnatal	**In Network** $15 copay initial visit only **Out of Network** 60% covered after deductible	**In Network** $30 copay initial visit only **Out of Network** 60% covered after deductible	**In Network** 80% covered after deductible **Out of Network** 60% covered after deductible	**In Network** 100% covered after deductible **Out of Network** 60% covered after deductible	**In Network** 100% covered after deductible **Out of Network** 60% covered after deductible
In-hospital delivery services	**In Network** $15 copay; for first prenatal office visit; 80% covered after deductible **Out of Network** 60% covered after deductible	**In Network** $30 copay; for first prenatal office visit; 80% covered after deductible **Out of Network** 60% covered after deductible	**In Network** 80% covered after deductible **Out of Network** 60% covered after deductible	**In Network** 100% covered after deductible **Out of Network** 60% covered after deductible	**In Network** 100% covered after deductible **Out of Network** 60% covered after deductible
Newborn nursery services	**In Network** 100% covered if baby not admitted; if admitted then 80% covered after deductible **Out of Network** 100% covered if baby not admitted; if admitted then 60% covered after deductible	**In Network** 100% covered if baby not admitted; if admitted then 80% covered after deductible **Out of Network** 100% covered if baby not admitted; if admitted then 60% covered after deductible	**In Network** 100% covered if baby not admitted; if admitted then 80% covered after deductible **Out of Network** 100% covered if baby not admitted; if admitted then 60% covered after deductible	**In Network** 100% covered if baby not admitted; if admitted then 100% covered after deductible **Out of Network** 100% covered if baby not admitted; if admitted then 60% covered after deductible	**In Network** 100% covered if baby not admitted; if admitted then 100% covered after deductible **Out of Network** 100% covered if baby not admitted; if admitted then 60% covered after deductible
Prenatal care management			Yes, Future Moms Program webmdhealth.com/cintas		
Well-Baby/Well-Child Preventive Care					
Pediatric exams	**In Network:** 100% covered **Out of Network:** 60% covered after deductible	**In Network:** 100% covered **Out of Network:** 60% covered after deductible	**In Network:** 100% covered **Out of Network:** 60% covered after deductible	**In Network:** 100% covered **Out of Network:** 60% covered after deductible	**In Network:** 100% covered **Out of Network:** 60% covered after deductible
Immunizations (child)	**In Network:** 100% covered **Out of Network:** 60% covered after deductible	**In Network:** 100% covered **Out of Network:** 60% covered after deductible	**In Network:** 100% covered **Out of Network:** 60% covered after deductible	**In Network:** 100% covered **Out of Network:** 60% covered after deductible	**In Network:** 100% covered **Out of Network:** 60% covered after deductible

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	Premium PPO	Basic PPO	Core Choice	Core Value	Essential
Mental Health Care					
Mental Health: Outpatient coverage	**In Network:** $15 copay **Out of Network:** 60% covered after deductible	**In Network:** $30 copay **Out of Network:** 60% covered after deductible	**In Network:** 80% covered after deductible **Out of Network:** 60% covered after deductible	**In Network:** 100% covered after deductible **Out of Network:** 60% covered after deductible	**In Network:** 100% covered after deductible **Out of Network:** 60% covered after deductible
Mental Health: Inpatient coverage	**In Network:** 80% covered after deductible **Out of Network:** 60% covered after deductible	**In Network:** 80% covered after deductible **Out of Network:** 60% covered after deductible	**In Network:** 80% covered after deductible **Out of Network:** 60% covered after deductible	**In Network:** 100% covered after deductible **Out of Network:** 60% covered after deductible	**In Network:** 100% covered after deductible **Out of Network:** 60% covered after deductible
Substance Abuse Care					
Detox: Outpatient coverage	**In Network** $15 copay **Out of Network** 60% covered after deductible	**In Network** $30 copay **Out of Network** 60% covered after deductible	**In Network** 80% covered after deductible **Out of Network** 60% covered after deductible	**In Network** 100% covered after deductible **Out of Network** 60% covered after deductible	**In Network** 100% covered after deductible **Out of Network** 60% covered after deductible
Detox: Inpatient coverage	**In Network** 80% covered after deductible **Out of Network** 60% covered after deductible	**In Network** 80% covered after deductible **Out of Network** 60% covered after deductible	**In Network** 80% covered after deductible **Out of Network** 60% covered after deductible	**In Network** 100% covered after deductible **Out of Network** 60% covered after deductible	**In Network** 100% covered after deductible **Out of Network** 60% covered after deductible
Rehab: Outpatient coverage	**In Network** $15 copay **Out of Network** 60% covered after deductible	**In Network** $30 copay **Out of Network** 60% covered after deductible	**In Network** 80% covered after deductible **Out of Network** 60% covered after deductible	**In Network** 100% covered after deductible **Out of Network** 60% covered after deductible	**In Network** 100% covered after deductible **Out of Network** 60% covered after deductible
Rehab: Inpatient coverage	**In Network** 80% covered after deductible **Out of Network** 60% covered after deductible	**In Network** 80% covered after deductible **Out of Network** 60% covered after deductible	**In Network** 80% covered after deductible **Out of Network** 60% covered after deductible	**In Network** 100% covered after deductible **Out of Network** 60% covered after deductible	**In Network** 100% covered after deductible **Out of Network** 60% covered after deductible
Dental Care					
Implants	Not covered	Not covered	Not covered	Not covered	Not covered
Accidental injury to teeth	**In Network** 80% covered after deductible; limited to emergency care **Out of Network** 60% covered after deductible; limited to emergency care	**In Network** 80% covered after deductible; limited to emergency care **Out of Network** 60% covered after deductible; limited to emergency care	**In Network** 80% covered after deductible; limited to emergency care **Out of Network** 60% covered after deductible; limited to emergency care	**In Network** 100% covered after deductible; limited to emergency care **Out of Network** 60% covered after deductible; limited to emergency care	**In Network** 100% covered after deductible; limited to emergency care **Out of Network** 60% covered after deductible; limited to emergency care
Surgical removal: tumors, cysts, and impacted teeth	**In Network** 80% covered after deductible limited to bony and tissue impactions **Out of Network** 60% covered after deductible; limited to bony and tissue impactions	**In Network** 80% covered after deductible limited to bony and tissue impactions **Out of Network** 60% covered after deductible; limited to bony and tissue impactions	**In Network** 80% covered after deductible includes to bony and tissue impactions **Out of Network** 60% covered after deductible; includes to bony and tissue impactions	**In Network** 100% covered after deductible; includes to bony and tissue impactions **Out of Network** 60% covered after deductible; includes to bony and tissue impactions	**In Network** 100% covered after deductible; includes to bony and tissue impactions **Out of Network** 60% covered after deductible; includes to bony and tissue impactions

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	Premium PPO	Basic PPO	Core Choice	Core Value	Essential
Vision Care					
Routine vision exams	**In Network** 100% covered **Out of Network** 60% covered under Wellness, out-of-network coinsurance applies, no deductible	**In Network** 100% covered **Out of Network** 60% covered under Wellness, out-of-network coinsurance applies, no deductible	**In Network** 100% covered **Out of Network** 60% covered under Wellness, out-of-network coinsurance applies, no deductible	**In Network** 100% covered **Out of Network** 60% covered under Wellness, out-of-network coinsurance applies, no deductible	**In Network** 100% covered **Out of Network** 60% covered under Wellness, out-of-network coinsurance applies, no deductible
Regular lenses and frames	**In Network** 80% covered after deductible limited to services following cataract surgery **Out of Network** 60% covered; limited to services following cataract surgery	**In Network** 80% covered after deductible limited to services following cataract surgery **Out of Network** 60% covered; limited to services following cataract surgery	**In Network** 80% covered after deductible limited to services following cataract surgery **Out of Network** 60% covered; limited to services following cataract surgery	**In Network** 100% covered after deductible; limited to services following cataract surgery **Out of Network** 60% covered; limited to services following cataract surgery	**In Network** 100% covered after deductible; limited to services following cataract surgery **Out of Network** 60% covered; limited to services following cataract surgery
Contact lenses	**In Network** 80% covered after deductible; limited to services following cataract surgery **Out of Network** 60% covered; limited to services following cataract surgery	**In Network** 80% covered after deductible; limited to services following cataract surgery **Out of Network** 60% covered; limited to services following cataract surgery	**In Network** 80% covered after deductible; limited to services following cataract surgery **Out of Network** 60% covered; limited to services following cataract surgery	**In Network** 100% covered after deductible; limited to services following cataract surgery **Out of Network** 60% covered; limited to services following cataract surgery	**In Network** 100% covered after deductible; limited to services following cataract surgery **Out of Network** 60% covered; limited to services following cataract surgery
Other Services					
Ambulance Services (Ground and Air)	80% covered after deductible	80% covered after deductible	80% covered after deductible	100% covered after deductible	100% covered after deductible
Allergy tests and treatments	**In Network** 100% covered; **Out of Network** 60% covered after deductible	**In Network** 100% covered; OV copay applies if OV billed **Out of Network** 60% covered after deductible	**In Network** 80% covered after deductible **Out of Network** 60% covered after deductible	**In Network** 100% covered after deductible **Out of Network** 60% covered after deductible	**In Network** 100% covered after deductible **Out of Network** 60% covered after deductible
Durable medical equipment	**In Network** 80% covered after deductible **Out of Network** 80% covered after deductible	**In Network** 80% covered after deductible **Out of Network** 80% covered after deductible	**In Network** 80% covered after deductible **Out of Network** 60% covered after deductible	**In Network** 100% covered after deductible **Out of Network** 60% covered after deductible	**In Network** 100% covered after deductible **Out of Network** 60% covered after deductible
Smoking cessation program	Available through Quit for Life at 866.784.8454 or quitnow.net/Cintas				
Weight control program	Not covered; discounts are available through WW at: ww.com/cintas				

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	Premium PPO	Basic PPO	Core Choice	Core Value	Essential
Hearing Care					
Hearing evaluations	**In Network** 100% covered **Out of Network** 60% covered; deductible does not apply	**In Network** 100% covered **Out of Network** 60% covered; deductible does not apply	**In Network** 100% covered **Out of Network** 60% covered; deductible does not apply	**In Network** 100% covered **Out of Network** 60% covered; deductible does not apply	**In Network** 100% covered **Out of Network** 60% covered; deductible does not apply
Hearing aids	Not covered; discounts are available through Special Offers at www.anthem.com				
Medical Therapy					
Acupuncture	**In Network** $15 copay in doctor/specialist office; deductible and coinsurance in hospital or outpatient facility; coverage based on Anthem medical policy guidelines **Out of Network** $15 copay in doctor/specialist office; deductible and coinsurance in hospital or outpatient facility; coverage based on Anthem medical policy guidelines	**In Network** $30 copay in doctor/specialist office; deductible and coinsurance in hospital or outpatient facility; coverage based on Anthem medical policy guidelines **Out of Network** $30 copay in doctor/specialist office; deductible and coinsurance in hospital or outpatient facility; coverage based on Anthem medical policy guidelines	**In Network** 80% covered after deductible coverage based on Anthem medical policy guidelines **Out of Network** 60% covered after deductible; coverage based on Anthem medical policy guidelines	**In Network** 100% covered after deductible; coverage based on Anthem medical policy guidelines **Out of Network** 60% covered after deductible; coverage based on Anthem medical policy guidelines	**In Network** 100% covered after deductible; coverage based on Anthem medical policy guidelines **Out of Network** 60% covered after deductible; coverage based on Anthem medical policy guidelines
Chiropractic	**In Network** $15 copay limited to 30 visits per year for spinal manipulation **Out of Network** 60% covered after deductible; limited to 30 visits per year for spinal manipulation	**In Network** $30 copay limited to 30 visits per year for spinal manipulation **Out of Network** 60% covered after deductible; limited to 30 visits per year for spinal manipulation	**In Network** 80% covered after deductible; limited to 30 visits per year for spinal manipulation **Out of Network** 60% covered after deductible; limited to 30 visits per year for spinal manipulation	**In Network** 100% covered after deductible; limited to 30 visits per year for spinal manipulation **Out of Network** 60% covered after deductible; limited to 30 visits per year for spinal manipulation	**In Network** 100% covered after deductible; limited to 30 visits per year for spinal manipulation **Out of Network** 60% covered after deductible; limited to 30 visits per year for spinal manipulation
Outpatient physical therapy	**In Network** $15 copay in doctor/specialist office; deductible and coinsurance in hospital or outpatient facility; limited to 30 visits per year; in and out-of-network combined **Out of Network** 60% covered after deductible; limited to 30 visits per year; in and out-of-network combined	**In Network** $30 copay in doctor/specialist office; deductible and coinsurance in hospital or outpatient facility; limited to 30 visits per year; in and out-of-network combined **Out of Network** 60% covered after deductible; limited to 30 visits per year; in and out-of-network combined	**In Network** 80% covered after deductible; limited to 30 visits per year; in and out-of-network combined **Out of Network** 60% covered after deductible; limited to 30 visits per year; in and out-of-network combined	**In Network** 100% covered after deductible; limited to 30 visits per year; in and out-of-network combined **Out of Network** 60% covered after deductible; limited to 30 visits per year; in and out-of-network combined	**In Network** 100% covered after deductible; limited to 30 visits per year; in and out-of-network combined **Out of Network** 60% covered after deductible; limited to 30 visits per year; in and out-of-network combined

2025 Medical Plan Comparison

	Premium PPO	Basic PPO	Core Choice	Core Value	Essential
Outpatient speech therapy	**In Network** $15 copay in doctor/specialist office; deductible and coinsurance in hospital or outpatient facility; limited to 30 visits per year; **Out of Network** 60% covered after deductible; limited to 30 visits per year; in and out-of-network combined	**In Network** $30 copay in doctor/specialist office; deductible and coinsurance in hospital or outpatient facility; limited to 30 visits per year; **Out of Network** 60% covered after deductible; limited to 30 visits per year; in and out-of-network combined	**In Network** 80% covered after deductible; limited to 30 visits per year; in and out-of-network combined **Out of Network** 60% covered after deductible; limited to 30 visits per year; in and out-of-network combined	**In Network** 100% covered after deductible; limited to 30 visits per year; in and out-of-network combined **Out of Network** 60% covered after deductible; limited to 30 visits per year; in and out-of-network combined	**In Network** 100% covered after deductible; limited to 30 visits per year; in and out-of-network combined **Out of Network** 60% covered after deductible; limited to 30 visits per year; in and out-of-network combined
Outpatient occupational therapy	**In Network** $15 copay in doctor/specialist office; deductible and coinsurance in hospital or outpatient facility; limited to 30 visits per year; **Out of Network** 60% covered after deductible; limited to 30 visits per year; in and out-of-network combined	**In Network** $30 copay in doctor/specialist office; deductible and coinsurance in hospital or outpatient facility; limited to 30 visits per year; **Out of Network** 60% covered after deductible; limited to 30 visits per year; in and out-of-network combined	**In Network** 80% covered after deductible; limited to 30 visits per year; in and out-of-network combined **Out of Network** 60% covered after deductible; limited to 30 visits per year; in and out-of-network combined	**In Network** 100% covered after deductible; limited to 30 visits per year; in and out-of-network combined **Out of Network** 60% covered after deductible; limited to 30 visits per year; in and out-of-network combined	**In Network** 100% covered after deductible; limited to 30 visits per year; in and out-of-network combined **Out of Network** 60% covered after deductible; limited to 30 visits per year; in and out-of-network combined
Care at Alternate Sites					
Noncustodial home health care	**In Network** 80% covered after deductible; limit to 120 visits per calendar year; in and out-of-network combined **Out of Network** 60% covered after deductible; limit to 120 visits per calendar year; in and out-of-network combined	**In Network** 80% covered after deductible; limit to 120 visits per calendar year; in and out-of-network combined **Out of Network** 60% covered after deductible; limit to 120 visits per calendar year; in and out-of-network combined	**In Network** 80% covered after deductible; limit to 120 visits per calendar year; in and out-of-network combined **Out of Network** 60% covered after deductible; limit to 120 visits per calendar year; in and out-of-network combined	**In Network** 100% covered after deductible; limit to 120 visits per calendar year; in and out-of-network combined **Out of Network** 60% covered after deductible; limit to 120 visits per calendar year; in and out-of-network combined	**In Network** 100% covered after deductible; limit to 120 visits per calendar year; in and out-of-network combined **Out of Network** 60% covered after deductible; limit to 120 visits per calendar year; in and out-of-network combined
Prescribed care in noncustodial skilled nursing facility	**In Network** 80% covered after deductible **Out of Network** 60% covered after deductible	**In Network** 80% covered after deductible **Out of Network** 60% covered after deductible	**In Network** 80% covered after deductible **Out of Network** 60% covered after deductible	**In Network** 100% covered after deductible **Out of Network** 60% covered after deductible	**In Network** 100% covered after deductible **Out of Network** 60% covered after deductible
Hospice care	**In Network** 100% covered **Out of Network** 100% covered	**In Network** 100% covered **Out of Network** 100% covered	**In Network** 80% covered after deductible **Out of Network** 80% covered after deductible	**In Network** 100% covered after deductible **Out of Network** 100% covered after deductible	**In Network** 100% covered after deductible **Out of Network** 100% covered after deductible
LiveHealth Online visit	$10 copay	$20 copay	Subject to deductible and out-of-pocket maximum	Subject to deductible and out-of-pocket maximum	Subject to deductible and out-of-pocket maximum

The comparison charts are compiled using information that applies to a large number of health plan users and is commonly reported by the health plans. Depending on the chart type, such as charts for dental and vision plans, certain information and/or sections won't appear because the necessary data isn't available. If you have questions about a topic that isn't covered in the charts, contact the plan's member services department for additional information. Cintas Corporation is not responsible for the accuracy of this information. If there is a discrepancy between the information displayed on these charts and the official plan documents, the official plan documents will control. Cintas Corporation reserves the right to amend, suspend, or terminate the plan(s) or program(s) at any time.