2027 Medical Benefits Summary

Plan Facts

Carrier	
Website	
Phone Number	

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

Medical	Clear Choice	Basic PPO	Core Choice	Core Value	Essential
Partner Only	$43.20	$42.25	$33.35	$23.10	$15.00
Partner + Spouse	$108.45	$104.10	$85.85	$57.45	$42.65
Partner + Child(ren)	$76.15	$74.10	$58.05	$31.85	$22.55
Partner + Family	$140.20	$135.90	$110.55	$66.20	$50.20

****Tobacco-user surcharge applies to partners and their spouse who are tobacco users.**

Note: Effective October 19, 2026, spouses with access to employer medical coverage are ineligible for Cintas medical coverage for partners hired on or after that date. Grandfathered working spouses pay a $35 per-pay-period surcharge in 2027.

LiveWell Participation Criteria ***

LiveWell Activity	Partner Only	Spouse Only	Partner + Spouse
Complete Biometric Screening C	$10.00	$10.00	$20.00
Complete Biometric Screening v	$15.00	$15.00	$30.00

****Partners who began working at Cintas on or after 7/18/26, will receive the discount outlined above in 2027.**

Spouses who were not enrolled in a Cintas medical plan before 7/18/26 will automatically receive the discount if enrolled in a Cintas medical plan in 2027.
Partners on Military leave at any point between 7/18/26 and 8/28/26 will automatically receive the discount if enrolled in a Cintas medical plan in 2027.

General Medical Expenses

	Clear Choice	Basic PPO**	Core Choice	Core Value	Essential
Annual Deductible	**In Network:** $0 Individual; $0 Family	**In Network:** $1,100 Individual applies to Single coverage only; $2,200 Family, for coverage of any combination of a spouse and/or child***	**In Network:** $1,900 Individual applies to Single coverage only; $3,800 Family, for coverage of any combination of a spouse and/or child***	**In Network:** $3,700 Individual applies to Single coverage only; $7,400 Family, for coverage of any combination of a spouse and/or child***	**In Network:** $6,600 Individual applies to Single coverage only; $13,200 Family, for coverage of any combination of a spouse and/or child****
	Out of Network :$0 Individual; $0 Family	**Out of Network: $2,200/$4,400**	**Out of Network: $3,800/$7,600**	**Out of Network: $7,400/$14,800**	**Out of Network: $13,200/$26,400**

	Clear Choice	Basic PPO**	Core Choice	Core Value	Essential
Primary doctor office visit	**In Network** $30 Anthem Diamond Provider / $50 Other **Out of Network** $100 copay	**In Network** $40 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** $30 Anthem Diamond Provider / $50 Other **Out of Network** $100 copay	**In Network** $40 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** $4,500 Individual; $9,000 Family *** **Out of Network** $9,000 Individual; $18,000 Family	**In Network:** $4,400 Individual applies to Single coverage only; $8,800 Family, for coverage of any combination of a spouse and/or child; includes deductible and copays *** **Out of Network** $8,800 Individual; $17,600 Family; includes deductible and copays	**In Network:** $3,000 Individual applies to Single coverage only; $6,000 Family, for coverage of any combination of a spouse and/or child; includes deductible*** **Out of Network:** $6,000 Individual; $12,000 Family; as above and includes deductible	**In Network:** $3,700 Individual applies to Single coverage only; $7,400 Family, for coverage of any combination of a spouse and/or child; includes deductible*** **Out of Network:** $10,000 Individual; $20,000 Family; as above and includes deductible	**In Network:** $6,600 Individual applies to Single coverage only; $13,200 Family, for coverage of any combination of a spouse and/or child; includes deductible**** **Out of Network:** $14,600 Individual; $29,200 Family; as above and includes deductible
Lifetime Limit	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited

**** 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 $12,000 applies for family coverage.**

	Clear Choice	Basic PPO**	Core Choice	Core Value	Essential
Inpatient Hospital Care					
Hospital copay	**In Network:** $2,000 copay **Out of Network:** $4,000 copay	Not applicable	Not applicable	Not applicable	Not applicable
Hospital semi-private room	**In Network:** $2,000 copay **Out of Network** $4,000 copay	**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

	Clear Choice	Basic PPO**	Core Choice	Core Value	Essential
Inpatient lab and X-ray	**In Network** 100% covered **Out of Network** 100% covered	**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** 100% covered **Out of Network** 100% covered	**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:** $30 copay Anthem Diamond Provider; $50 copay Other; $1,000 copay (outpatient facility) **Out of Network:** $100 copay; $2,000 copay (outpatient facility)	**In Network** 80% covered after deductible surgeries performed in an office setting are 100% covered after $40 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:** $50 copay **Out of Network** $100 copay	**In Network** 80% covered after deductible 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:** $50 copay (office); $500 copay (outpatient facility) **Out of Network:** $100 copay (office); $2,000 copay (outpatient facility)	**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:** $500 copay **Out of Network:** $500 copay	**In Network** $500 copay **Out of Network** $500 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)

	Clear Choice	Basic PPO**	Core Choice	Core Value	Essential
Urgent care clinic visit	**In Network:** $50 copay **Out of Network:** $100 copay	**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	
Website	
Phone Number	

	Clear Choice	Basic PPO**	Core Choice	Core Value	Essential
Retail generic	**In Network** Level 1: $12 copay Level 2: $20 copay **Out of Network** Not covered	**In Network** Level 1: $10 copay Level 2: $15 copay **Out of Network** Not covered	**In Network** Level 1: 80% covered after deductible Level 2: 70% 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** Level 1: $50 copay Level 2: $60 copay **Out of Network** Not covered	**In Network** Level 1: 80% covered Level 2: 70% covered $30 minimum; $75 maximum **Out of Network** Not covered	**In Network** Level 1: 80% covered after deductible Level 2: 70% 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** Level 1: $130 copay Level 2: $145 copay **Out of Network** Not covered	**In Network** Level 1: 60% covered Level 2: 50% covered $60 minimum/$150 maximum **Out of Network** Not covered	**In Network** Level 1: 80% covered after deductible Level 2: 70% 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	Level 1: $30 copay Level 2: $50 copay 90 day supply	Level 1: $20 copay Level 2: $30 copay 90 day supply	Level 1: 80% covered after deductible Level 2: 70% covered after deductible 90 day supply	100% covered after deductible 90 day supply	100% covered after deductible 90 day supply

	Clear Choice	Basic PPO**	Core Choice	Core Value	Essential
Mail order formulary brand	Level 1: $125 copay Level 2: $150 copay 90 day supply	Level 1: 80% covered Level 2: 70% covered $60 minimum; $150 maximum 90 day supply	Level 1: 80% covered after deductible Level 2: 70% covered after deductible 90 day supply	100% covered after deductible 90 day supply	100% covered after deductible 90 day supply
Mail order nonformulary brand	Level 1: $325 copay Level 2: $350 copay 90 day supply	Level 1: 60% covered Level 2: 50% covered $120 minimum; $300 maximum 90 day supply	Level 1: 80% covered after deductible Level 2: 70% 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	$3,000 Individual; $6,500 Family	$3,000 Individual; $6,500 Family	Not applicable	Not applicable	Not applicable

Basic PPO Medical Plan 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.

Adult Preventive Care

Annual Physical Exam	**In Network:** 100% covered **Out of Network:** $100 copay	**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
Well-woman exam (includes pap)	**In Network:** 100% covered **Out of Network:** $100 copay	**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

	Clear Choice	Basic PPO**	Core Choice	Core Value	Essential
Mammogram	**In Network:** 100% covered **Out of Network:** $100 copay	**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 (routine) **Out of Network:** $100 copay	**In Network:** 100% covered (routine) **Out of Network:** 60% covered after deductible	**In Network:** 100% covered (routine) **Out of Network:** 60% covered after deductible	**In Network:** 100% covered (routine) **Out of Network:** 60% covered after deductible	**In Network:** 100% covered (routine) **Out of Network:** 60% covered after deductible
Cardiovascular screenings	**In Network:** 100% covered (routine) **Out of Network:** $100 copay	**In Network:** 100% covered (routine) **Out of Network:** 60% covered after deductible	**In Network:** 100% covered (routine) **Out of Network:** 60% covered after deductible	**In Network:** 100% covered (routine) **Out of Network:** 60% covered after deductible	**In Network:** 100% covered (routine) **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:** $30 copay Anthem Diamond Provider; $50 copay Other (office); $1,000 copay (outpatient facility); limited to diagnosis and treatment of underlying cause of infertility **Out of Network:** $100 copay Other (office); $2,000 copay (outpatient facility); 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 after deductible; 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 after deductible; 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 after deductible; 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 after deductible; 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

	Clear Choice	Basic PPO**	Core Choice	Core Value	Essential
Female tubal ligation	**In Network:** $1,000 copay; reversals not covered **Out of Network:** $2,000 copay; reversals not covered	**In Network:** 100% covered; reversals not covered **Out of Network:** 60% covered after deductible, reversals not covered	**In Network:** 100% covered; reversals not covered **Out of Network:** 60% covered after deductible, reversals not covered	**In Network:** 100% covered; reversals not covered **Out of Network:** 60% covered after deductible, reversals not covered	**In Network:** 100% covered; reversals not covered **Out of Network:** 60% covered after deductible, reversals not covered
Male vasectomy	**In Network:** $1,000 copay; reversals not covered **Out of Network:** $2,000 copay; 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** $30 Anthem Diamond Provider $50 Other copay; initial visit only **Out of Network** $100 copay	**In Network** $40 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** $2,000 copay **Out of Network** $4,000 copay	**In Network** $40 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 **Out of Network** 100% covered	**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	Future Moms - webmdhealth.com/cintas Building Healthy Familes Program - www.anthem.com				

	Clear Choice	Basic PPO**	Core Choice	Core Value	Essential
Well-Baby/Well-Child Preventive Care					
Pediatric exams	**In Network:** 100% covered **Out of Network:** $100 copay	**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:** $100 copay	**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
Mental Health Care					
Mental Health: Outpatient coverage	**In Network:** $30 copay Anthem Diamond Provider; $50 copay Other (office); $1,000 copay (outpatient facility) **Out of Network:** $100 copay (office); $2,000 copay (outpatient facility)	**In Network:** $40 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:** $2,000 copay **Out of Network:** $4,000 copay	**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:** $30 copay Anthem Diamond Provider; $50 copay Other (office); $1,000 copay (outpatient facility) **Out of Network:** $100 copay (office); $2,000 copay (outpatient facility)	**In Network** $40 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:** $2,000 copay **Out of Network:** $4,000 copay	**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

	Clear Choice	Basic PPO**	Core Choice	Core Value	Essential
Rehab: Outpatient coverage	**In Network:** $30 copay Anthem Diamond Provider; $50 copay Other (office); $1,000 copay (outpatient facility) **Out of Network:** $100 copay (office); $2,000 copay (outpatient facility)	**In Network** $40 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:** $2,000 copay **Out of Network:** $4,000 copay	**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:** $30 copay Anthem Diamond Provider; $50 copay Other (office); $1,000 copay (outpatient facility) **Out of Network:** $100 copay (office); $2,000 copay (outpatient facility)	**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:** $30 copay Anthem Diamond Provider; $50 copay Other (office); $1,000 copay (outpatient facility) **Out of Network:** $100 copay (office); $2,000 copay (outpatient facility)	**In Network** 80% covered after deductible limitations apply **Out of Network** 60% covered after deductible; limitations apply	**In Network** 80% covered after deductible limitations apply **Out of Network** 60% covered after deductible; limitations apply	**In Network** 100% covered after deductible; limitations apply **Out of Network** 60% covered after deductible; limitations apply	**In Network** 100% covered after deductible; limitations apply **Out of Network** 60% covered after deductible; limitations apply
Vision Care					
Routine vision exams	**In Network** 100% covered **Out of Network** $100 copay	**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

	Clear Choice	Basic PPO**	Core Choice	Core Value	Essential
Regular lenses and frames	**In Network** $50 copay; limited to services following cataract surgery **Out of Network** $100 copay; 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** $50 copay; limited to services following cataract surgery **Out of Network** $100 copay; 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)	$500 copay	80% covered after deductible	80% covered after deductible	100% covered after deductible	100% covered after deductible
Allergy tests and treatments	**In Network** $30 copay Anthem Diamond Provider; $50 copay Other (office testing); $30 copay (injections) **Out of Network:** $100 copay	**In Network** 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
Durable medical equipment	**In Network** $750 copay **Out of Network** $1,500 copay	**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** 100% covered after deductible **Out of Network** 100% covered after deductible	**In Network** 100% covered after deductible **Out of Network** 100% 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 WeightWatchers at ww.com/cintas				

	Clear Choice	Basic PPO**	Core Choice	Core Value	Essential
Hearing Care					
Hearing evaluations	**In Network** 100% covered **Out of Network** $100 copay	**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
Hearing aids	Not covered; discounts are available through Special Offers at www.anthem.com				
Medical Therapy					
Acupuncture	**In Network** $30 copay Anthem Diamond Provider; $50 copay Other coverage based on Anthem medical policy guidelines **Out of Network** $100 copay coverage based on Anthem medical policy guidelines	**In Network** $40 copay (office) 80% covered after deductible (hospital or outpatatient facility); coverage based on Anthem medical policy guidelines **Out of Network** $40 copay (office) 80% covered after deductible (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** 80% 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** 100% 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** 100% covered after deductible; coverage based on Anthem medical policy guidelines
Chiropractic	**In Network** $30 copay Anthem Diamond Provider $50 copay Other limited to 30 visits per year **Out of Network** $100 copay limited to 30 visits per year	**In Network** $40 copay limited to 30 visits per year **Out of Network** 60% covered after deductible; limited to 30 visits per year	**In Network** 80% covered after deductible; limited to 30 visits per year **Out of Network** 60% covered after deductible; limited to 30 visits per year	**In Network** 100% covered after deductible; limited to 30 visits per year **Out of Network** 60% covered after deductible; limited to 30 visits per year	**In Network** 100% covered after deductible; limited to 30 visits per year **Out of Network** 60% covered after deductible; limited to 30 visits per year

	Clear Choice	Basic PPO**	Core Choice	Core Value	Essential
Outpatient physical therapy	**In Network** $50 copay (office); $1,000 (outpatient facility); limited to 30 visits per year	**In Network** $40 copay (office) 80% covered after deductible (hospital or outpatient facility); limited to 30 visits per year	**In Network** 80% 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	**In Network** 100% covered after deductible; limited to 30 visits per year; in and out-of-network combined
	Out of Network $100 copay (office); $2,000 (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	**Out of Network** 60% 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	**Out of Network** 60% covered after deductible; limited to 30 visits per year; in and out-of-network combined
Outpatient speech therapy	**In Network** $50 copay (office); $1000 (outpatient facility); limited to 30 visits per year	**In Network** $40 copay (office) 80% covered after deductible (hospital or outpatient facility); limited to 30 visits per year	**In Network** 80% 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	**In Network** 100% covered after deductible; limited to 30 visits per year; in and out-of-network combined
	Out of Network $100 copay (office); $2,000 (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	**Out of Network** 60% 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	**Out of Network** 60% covered after deductible; limited to 30 visits per year; in and out-of-network combined
Outpatient occupational therapy	**In Network** $50 copay (office); $1,000 (outpatient facility); limited to 30 visits per year	**In Network** $40 copay (office) 80% covered after deductible (hospital or outpatient facility); limited to 30 visits per year	**In Network** 80% 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	**In Network** 100% covered after deductible; limited to 30 visits per year; in and out-of-network combined
	Out of Network $100 copay (office); $2,000 (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	**Out of Network** 60% 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	**Out of Network** 60% covered after deductible; limited to 30 visits per year; in and out-of-network combined

	Clear Choice	Basic PPO**	Core Choice	Core Value	Essential
Care at Alternate Sites					
Noncustodial home health care	**In Network** $50 copay; limit to 120 visits per calendar year; **Out of Network** $100 copay; 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; **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; **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; **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; **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** $2,000 copay **Out of Network** $4,000 copay	**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	$0 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.