

Health Benefits

PLAN COMPARISONS AT A GLANCE

Benefit	Aetna CDHP	Aetna HMO	Aetna PPO	CareFirst CDHP	CareFirst HMO	CareFirst PPO	Kaiser Permanente	UHC HMO	UHC PPO
In-Network Calendar-Year Deductible									
Employee Only	\$1,650	None	\$750	\$1,650	None	\$750	None	None	\$750
Family	\$3,300	None	\$1,500	\$3,300	None	\$1,500	None	None	\$1,500
Out-of-Pocket Maximum (per calendar year) *Please Note: Some benefits do not apply toward the out-of-pocket maximum.									
Employee Only	\$3,425	\$3,500	\$1,500	\$3,425	\$3,500	\$1,500	\$3,500	\$3,500	\$1,500
Family	\$6,850	\$9,400	\$3,000	\$6,850	\$9,400	\$3,000	\$9,400	\$9,400	\$3,000
Inpatient Services									
Inpatient Hospital	85% after deductible	\$100 copay per admission	85% after deductible	\$300 copay per admission after deductible	\$100 copay per admission	85% after deductible	\$100 copay per admission	\$100 copay	85% after deductible
Hospice Care	85% after deductible	100% (no visit limit)	85% after deductible	\$300 copay per admission after deductible	100% (180 day limit per year)	85% after deductible (180 day limit per year)	100% (no visit limit)	100% (no visit limit)	85% after deductible
Skilled Nursing Facility	85% after deductible (60 day limit per year)	\$100 copay	85% after deductible (60 day limit per year)	\$300 copay per admission after deductible	\$100 copay per admission	85% after deductible (60 day limit per year)	\$100 copay per admission	\$100 copay (60 day limit per year)	85% after deductible (60 day limit per year)
Outpatient Services									
PCP Office Visits	85% after deductible	\$10 copay	\$15 copay	\$30 copay per admission after deductible	\$10 copay	\$15 copay	\$10 copay	\$10 copay Covered persons less than age 19 No copay	\$15 copay Covered persons less than age 19 No copay
Specialist Office Visits	85% after deductible	\$20 copay	\$15 copay	\$30 copay after deductible	\$20 copay	\$15 copay	\$20 copay	\$20 copay	\$15 copay
Virtual/Video Visits	85% after deductible	\$10 copay for PCP; \$20 copay for Specialist	\$15 copay	\$30 copay after deductible	\$10 copay for PCP; \$20 copay for Specialist	\$15 copay	No charge	No charge when using designated virtual visit network. \$10 PCP/\$20 specialist	No charge when using designated virtual visit network. \$15 PCP/\$15 specialist



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<i>Outpatient Services, cont.</i>									
X-rays, Lab Tests	85% after deductible	100%	Covered 100% if part of an office visit; 85% after deductible otherwise	85% after deductible	100%	85% after deductible	100%	100%	85% after deductible
Routine Exams	100%	100%	100%	100%	100%	100%	100%	100%	100%
Routine Immunization	100%	100%	100%	100%	100%	100%	100%	100%	100%
Preventive Care	100%	100%	100%	100%	100%	100%	100%	100%	100%
Outpatient Surgery (plan facility)	85% after deductible	\$50 copay	85% after deductible	\$30 copay after deductible	\$50 copay	85% after deductible	\$50 copay	\$50 copay	85% after deductible
Short-Term Rehab (physical, occupational or speech therapy)	85% after deductible (60 visit limit per year)	\$10 copay	85% after deductible	\$30 copay after deductible	\$10 copay	85% after deductible	\$20 copay	\$10 copay (60 visit limit per year)	85% after deductible
Chiropractic Care	85% after deductible (20 visit limit per year)	\$10 copay; (20 visit limit per year)	85% after deductible (no visit limit)	\$30 copay after deductible	\$10 copay	85% after deductible	\$20 copay (20 visit limit per year)	\$10 copay (60 visit limit per year)	85% after deductible
Acupuncture	85% after deductible (10 visit limit per year)	\$10 copay; (10 visit limit per year)	\$15 copay (10 visit limit per year)	\$30 copay after deductible	Not Covered (except when approved or authorized by Plan for Anesthesia)	85% after deductible (when approved or authorized by Plan for Anesthesia)	\$20 copay (20 visit limit per year)	\$20 copay (12 visit limit per year)	\$15 copay (10 visit limit per year)
Home Health Care	85% after deductible (60 visit limit per year)	100%	85% after deductible (90 visit limit per year)	\$30 copay after deductible	100%	85% after deductible	100%	100% (60 visit limit per year)	85% after deductible (90 visit limit per year)



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Emergency Services									
Emergency Room Services & Supplies	85% after deductible	\$100 copay, waived if admitted	\$100 copay, waived if admitted	\$300 copay per admission after deductible (copay waived if admitted)	100% (\$100 copay waived if admitted)	100% (\$100 copay waived if admitted)	\$50 copay	\$100 copay per admission (copay waived if admitted)	\$100 copay per admission (deductible does not apply)
Ambulance	85% after deductible	100%	100%; deductible waived	\$30 copay per admission after deductible	100%	100%	100%	100%	85% after deductible
Maternity Care									
Office Visits (mother)	100%	100%	100%	100%	100%	100%	No Charge	100% (after initial diagnosis of pregnancy)	100% (after initial diagnosis of pregnancy)
Hospital (mother)	85% after deductible	\$100 copay	85% after deductible	\$300 copay per admission after deductible (copay waived if admitted)	\$100 copay per admission	85% after deductible	\$100 copay	\$100 copay	85% after deductible
Office Visits (infant)	Routine 100% deductible waived	Routine covered at 100%	Routine 100% deductible waived	Routine 100%	100%	85% after deductible	\$10 Copay (waived for children under age 5); Specialist is \$20	100%	100%
Medical Equipment									
Durable Medical Equipment	85% after deductible	50%	85% after deductible	\$30 copay per admission after deductible	50% of allowed	85% after deductible	50%	50% (deductible does not apply)	85% after deductible



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<i>Mental Health</i>									
Inpatient Care	85% after deductible	\$100 copay	85% after deductible	\$300 copay per admission after deductible	\$100 copay per admission	85% after deductible	\$100 copay per admission	\$100 copay per admission (deductible does not apply)	85% after deductible
Outpatient Care	85% after deductible	\$5 copay	\$5 copay	\$30 copay per admission after deductible	\$10 copay	\$15 Copay	Individual: \$10 per visit; Group: \$5 per visit	\$10 copay per admission (deductible does not apply)	\$15 copay per admission (deductible does not apply)
<i>Substance Abuse</i>									
Inpatient Care	85% after deductible	\$100 copay	85% after deductible	\$300 copay per admission after deductible	\$100 copay per admission	85% after deductible	\$100 copay per admission	\$100 copay per admission (deductible does not apply)	85% after deductible
Outpatient Care	85% after deductible	\$5 copay	\$5 copay	\$30 copay per admission after deductible	No Charge	No Charge	Individual: \$10 per visit; Group: \$5 per visit	\$10 copay per admission (deductible does not apply)	\$15 copay per admission (deductible does not apply)
<i>Prescription Drugs</i>									
Generic	Retail: \$10 copay (after deductible); Mail Order: \$20 copay (after deductible)	\$20 copay (Retail & Mail Order)	\$20 copay (Retail & Mail Order)	\$20 copay after deductible	\$20 copay	\$20 copay	Kaiser \$10 copay; Participating Pharmacies \$20 copay	Retail: \$20 copay; Mail Order: \$16 copay	Retail: \$20 copay; Mail Order: \$20 copay
Preferred Brand	Retail: \$30 copay (after deductible); Mail Order: \$60 copay (after deductible)	\$40 copay (Retail & Mail Order)	\$40 copay (Retail & Mail Order)	\$40 copay after deductible	\$40 copay	\$40 copay	Kaiser \$20 copay; Participating Pharmacies \$40 copay	Retail: \$40 copay; Mail Order: \$36 copay	Retail: \$40 copay; Mail Order: \$40 copay
Non-Preferred Brand	Retail: \$60 copay (after deductible); Mail Order: \$120 copay (after deductible)	\$55 copay (Retail & Mail Order)	\$55 copay (Retail & Mail Order)	\$55 copay after deductible	\$55 copay	\$55 copay	Kaiser \$35 copay; Participating Pharmacies \$55 copay	Retail: \$55 copay; Mail Order: \$66 copay	Retail: \$55 copay; Mail Order: \$55 copay

Disclaimer: This Guide is not a contract. Its purpose is to provide summary information about employee benefits. Refer to Summary Plan Descriptions and provider materials for details of each benefit. Every effort has been made to ensure this Guide is accurate. Provisions of the actual contract will govern in the event of a discrepancy.



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Infertility Treatment	Diagnosis & treatment of underlying medical condition, including Artificial Insemination; In vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery and embryo transfers with three egg retrievals per lifetime; Ovulation induction (OI) limited to six cycles per lifetime; Cryopreservation for iatrogenic preservation; Oral and injectable fertility drugs. Cost sharing is based on the type and place of service	Diagnosis & treatment of underlying medical condition, including Artificial Insemination; In vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery and embryo transfers with three egg retrievals per lifetime; Ovulation induction (OI) limited to six cycles per lifetime; Cryopreservation for iatrogenic preservation; Oral and injectable fertility drugs. Cost sharing is based on the type and place of service.	Diagnosis & treatment of underlying medical condition, including Artificial Insemination; In vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery and embryo transfers with three egg retrievals per lifetime; Ovulation induction (OI) limited to six cycles per lifetime; Cryopreservation for iatrogenic preservation; Oral and injectable fertility drugs. Cost sharing is based on the type and place of service.	Diagnosis & treatment of underlying medical condition covered same as any other expense. Artificial insemination, ovulation induction and Advanced Reproductive Technology are excluded	50% for AI & infertility	50% for AI and Infertility	Infertility Diagnosis & Testing: 50% coins Infertility Assistive Reproductive Technology Infertility Diagnosis & Testing: 50% coins Infertility Assistive Reproductive Technology: 50% coins \$100,000 ben max/life, 3 procedures/life Applicable cost share based on place of service	Limited to \$30,000 per Covered Person per lifetime. 50% co-insurance Prior Authorization is required.	Limited to \$100,000 per Covered Person per lifetime This limit only applies to IVF Treatment and related services. IVF is further limited to 3 courses of treatment per live birth. Artificial insemination & ovulation induction are limited to 6 courses of treatment per live birth. 50% co-insurance
Applied Behavior Analysis (ABA Services)	Covered 85% after deductible	Covered 100%; no deductible or copay	Covered 100%; no deductible or copay	\$30 copay per admission after deductible	\$50 copay	85% after deductible	\$10 copay	\$10 copay for Outpatient visit	15% for Inpatient; \$15 Copay for Outpatient; 15% for partial Hospital