

2012 Benefits- DC/MD/VA Under 65	UNITED HEALTHCARE PPO	BLUE CROSS/BLUE SHIELD PPO	AETNA HMO Open Access	KAISER MID-ATLANTIC
	Group # 195643	Group #13570-00	Group # 813972	Group # 10030-0
BENEFITS				
Retiree Monthly Rates - Harris	Single: \$484.97	Single: \$469.52	Single: \$478.28	Single: \$372.84
	Two-person: \$969.94	Two-person: \$939.06	Two-person: \$956.58	Two-person: \$745.72
	Family: \$1,454.90	Family: \$1,408.59	Family: \$1,434.86	Family: \$1,081.28
In-network annual deductible	None	None	None	None
Annual out-of-pocket limit	Single, \$1,500; family \$3,000; prescription copayments per person, \$2,500	Single, \$1,250; family \$2,500; prescription copayments per person, \$2,500	Single, \$1,500; family \$3,000; including copayments; prescription copayments per person, \$2,500	Single, \$3,500; family, \$9,400
Lifetime maximum	None	None	None	None
Out of network option	Annual deductible: single, \$500; family \$1,500; Then 70% to Out of pocket limit (\$3,000/\$6,000)	Annual deductible: single, \$500; family \$1,500; Then 70% to Out of Pocket limit (\$2,500/\$5,000)	None	None
Fitness Center	None	None	GlobalFit Discount Program	None
HOSPITAL / Inpatient Care				
Hospital care (semi-private room), surgery, x-rays and lab	\$250 copay per admission, then 85% coverage	\$250 copay, then 90% coverage	\$250 copay, then 100% coverage	\$250 copay, then 100% coverage
Skilled Nursing Facility	85% coverage, up to 120 days per confinement	90% coverage	\$250 copay, then 100% coverage	\$100 per admission, 100 days per year
URGENT CARE	\$25 copay, then 85%	\$20 copay, then 90%	\$25 copay, then 100%	\$20 copay, then 100%
EMERGENCY CARE				
Emergency Room	\$100 copay, then 85% coverage; copay waived if admitted	\$100 copay, then 90% coverage; copay waived if admitted	\$100 copay, then 100% coverage; copay waived if admitted	\$100 copay, then 100% coverage; copay waived if admitted
Emergency transportation	85% coverage	90% coverage	100% coverage	\$50 copay
OUTPATIENT CARE				
Office visit	\$25 copay, PCP; \$35 copay, specialist	\$20 copay, PCP; \$30 copay, specialist	\$25 copay, PCP; \$35 copay, specialist	\$20 copay, PCP \$30 copay, Specialist
Immunizations and injections	\$7 copay	90% coverage ; Adult and pediatric immunizations through Preventive Care 100% coverage	\$25 copay, PCP; \$35 copay, specialist. No serum copay	100% coverage
Preventive care (care covered under the Affordable Care Act is reimbursed at 100% with no copay)	\$25 copay, PCP; \$35 copay, specialist	Highmark Preventive Schedule; Routine Physical, \$20 copay, PCP; \$30 copay, specialist	\$25 copay, PCP; \$35 copay, specialist	100% coverage
Maternity care	\$25 copay for first visit, then 15% coinsurance of global obstetrician's fee	90% coverage	Inpatient maternity care 100% after \$250 copay	100% coverage
Pediatric care	\$25 copay, includes well baby and child care	\$20 copay, includes well baby and child care, 100% immunizations	\$25 copay	\$20 copay, PCP \$30 copay, Specialist 100% coverage for well child care through age 5.
Gynecological care	\$25 copay	\$20 copay	\$25 copay	\$30 copay
X-ray, lab and diagnostic testing	Included in copay if performed in a physician's office, otherwise 85% coverage	90% coverage for all diagnostic lab and x-ray	\$35 copay, for lab and x-rays performed in outpatient facility. Office copay applies to diagnostic testing performed in a physician's office.	100% coverage; specialty imaging \$50 (CT, MRI, PET Scan, nuclear medicine)

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OTHER BENEFITS				
Mental health				
Outpatient	\$35 copay, visit	\$30 copay per visit	\$35 copay per visit	\$20 copay, individual visit; \$10 copay, group therapy visit.
Inpatient	\$250 copay per admission, then 85% coverage	\$250 copay per admission, then 90% coverage	\$250 copay per admission, then 100% coverage	\$250 copay per admission, then 100% coverage
Substance abuse				
Outpatient	\$35 copay, visit	\$30 copay, visit	\$35 copay per visit	\$20 copay, individual visit; \$10 copay, group therapy visit.
Inpatient	\$250 copay per admission, then 85% coverage	\$250 copay per admission, then 90% coverage	\$250 copay per admission, then 100% coverage	\$250 copay per admission, then 100% coverage for detoxification
Cancer care (radiation therapy and chemotherapy)	\$35 copay, visit	90% coverage	\$35 copay per visit	100% coverage
Outpatient Short-term speech, physical, occupational and respiratory therapy	\$35 copay, visit; limited to 20 visits per calendar year	\$30 copay, visit; limited to 30 visits per calendar year	\$35 copay, 60 visits per calendar year	\$30 copay; 90 days per episode
Medical Supplies				
Prosthetics	85% coverage	90% coverage	100% coverage	100% coverage
Durable Medical	85% coverage	90% coverage	100% coverage	100% coverage for Basic DME
Prescriptions	30-day Supply: Generic - \$7 copay Formulary - 20% (Min-\$25; Max \$75) Non-Formulary - (50% Min - \$50; Max \$100) Mail Order 90-day Supply: \$17.50, 20% - \$62.50, \$187.50 and 50%, \$125, \$250 copays. Administered through ExpressScripts (https://expressscripts.com)	30-day Supply: Generic - \$7 copay Formulary - 20% (Min-\$25; Max \$75) Non-Formulary - (50% Min - \$50; Max \$100) Mail Order 90-day Supply: \$17.50, 20% - \$62.50, \$187.50 and 50%, \$125, \$250 copays. Administered through ExpressScripts (https://expressscripts.com)	30-day Supply: Generic - \$7 copay Formulary - 20% (Min-\$25; Max \$75) Non-Formulary - (50% Min - \$50; Max \$100) Mail Order 90-day Supply: \$17.50, 20% - \$62.50, \$187.50 and 50%, \$125, \$250 copays. Administered through ExpressScripts (https://expressscripts.com)	\$10/\$30/\$50 copay at Kaiser Pharmacy; \$30/\$50/\$75 copay at other pharmacies Mail Order: 90-day supply: \$16/\$56/\$96 copay
Vision				
Routine Exam	None	None	\$35 copay, one routine exam per 24 months; through Vision One Discount Program	\$15 copay with an Optometrist; \$25 copay with an Ophthalmologist (referral required)
Materials	None	None	Discounts available through Vision One Discount Program	25% discount on lenses, frames every 12 months; 15% discount on medically necessary contact lenses
Hearing				
Routine Exam	None	None	None	\$30 copayment
Materials	None	None	None	Not covered
Chiropractic	\$35 copay, visit; \$1,500 limit	\$30 copay, visit; limited to 20 visits per calendar year	\$35 copay, limited to 20 visits per year	Not covered
Website/Provider Directory	https://www.myuhc.com	www.mybenefitshome.com	http://www.aetna.com/docfind/	https://kp.org
Product Name	Choice Plus PPO		Aetna Select (SM) Open Access	Signature HMO
*The above contains a brief overview of the various benefit programs and does not describe any plan, its provisions or limitations in any detail. Please refer to the benefit plan booklet for more information.				