2019

Health Management Organization Comparison Chart

THE HEALTH INSURANCE PLANS ARE GROUPED BY PLAN TYPE. PLEASE NOTE THAT THE BENEFITS ARE BASED ON USING THE PREFERRED NETWORK. FOR BENEFITS UNDER THE NON-PREFERRED NETWORK, PLEASE REVIEW ACTUAL BROCHURES ON THE PLAN WEBSITE. SOME BENEFITS MAY INCLUDE A MAXIMUM ALLOWABLE AMOUNT.

Plan Name Enrollment Code Plan Type	Aetna Value (F54/F56/F55) HMO	Aetna Open Access High (JN1/JN3/JN2) HMO	Aetna Open Access Basic (JN4/JN6/JN5) HMO	CareFirst BlueChoice Standard (2G4/2G6/2G5) HMO/PPO
Deductible	$700/$1,400/$1,400	None	None	$500/$1,000/$1,000
Annual Out-of-Pocket Limit	$6,000/$7,900/$7,900	$5,000/$7,900/$7,900	$6,000/$7,900/$7,900	$2,500/$5,000/$5,000
Physician care				
PCP co-pay	$25	$15	$20	Nothing
Specialist co-pay	$40	$30	$45	$40
Virtual visits	$40	$30	$40	Nothing
Preventative care				
Child/Adult routine screenings	Nothing	Nothing	Nothing	Nothing
Annual vision eye exam	Not covered	$30	$45	$10
Routine dental care (2x/year)	Not covered	$5	$5	Not covered
Emergency Care				
Urgent care	Deductible, then 20%	$50	$50	$50
Emergency room	Deductible, then 20%	$125	$175	Deductible, then $200
Hospital/Facility care				
Inpatient Services and Supplies	Deductible, then 20%	$150/day ($450 max)	10% of plan allowance per admission	Deductible, then $50
Inpatient Surgery	Deductible, then 20%	Nothing	Nothing	Deductible, then $50
Outpatient Services and Supplies	Deductible, then 20%	Nothing	Nothing	Deductible, then $40
Outpatient Surgery	Deductible, then 20%	$150	$175	Deductible, then $40
Alternative Care				
Chiropractor co-pay	20% (20x/yr)	$15(PCP)/$30 (Specialist) (20x/yr)	$20 (PCP)/$45 (Specialist) (20x/yr)	$40 (20x/yr)
Acupuncture co-pay	20% (anesthesia for covered surgery)	Nothing (anesthesia for covered surgery)	Nothing (anesthesia for covered surgery)	$40
Maternity Services				
Prenatal routine care	Nothing	Nothing	Nothing	Nothing
Inpatient Hospital Care	Deductible, then 20%	Nothing	Nothing	Deductible, then nothing
Infertility Services				
Diagnosis and Treatment	$25 PCP/$40 Specialist	50%	50%	Deductible, then 50%
In Vitro Fertilization	Not covered	Not covered	Not covered	Not covered
Hearing devices				
Hearing aids (every 36 months)	Not covered	All charges over $1,400/ear/every 36 month period (member will be reimbursed)	All charges over $1,400/ear/every 36 month period (member will be reimbursed)	100% (up to the allowed benefit per ear) (deductible applies)
Cochlear implants	Deductible, then 20%	30%	30%	Deductible, then 25%
Gender Transition Surgery	Deductible, then 20% (subject to medical necessity)	$15 (PCP)/$30 (Specialist) Nothing for surgery, requires precertification	$20 (PCP)/$45 (Specialist) Nothing for surgery, requires precertification	$0 PCP/$40 specialist (prior authorization required)
Prescription				
* Retail (30-day)	$10/30%/50%	$35/50%	30%/50%	$0/$35/$65/$100
*Mail Order (90-day)	$20/30%/50%	$70/50%	30%/50%	$0/$70/$130/$200
Biweekly Premiums				
Self	$97.79	$286.34	$83.88	$137.98
Self Plus One	$241.77	$657.44	$167.73	$244.04
Family	$223.41	$635.90	$193.41	$349.41
Website	www.aetnafeds.com	www.aetnafeds.com	www.aetnafeds.com	www.carefirst.com/fedhmo/

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Plan Name Enrollment Code Plan Type	Kaiser High (E31/E33/E32) HMO	Kaiser Standard (E34/E36/E35) HMO	Kaiser Basic (T71/T73/T72) HMO	MD IPA High (JP1/JP3/JP2) HMO
Deductible	None	None	$100/$200/$200	None
Annual Out-of-Pocket Limit	$2,250/$4,500/$4,500	$3,500/$7,000/$7,000	$4,000/$8,000/$8,000	$5,000/$10,000/$10,000
Physician care				
PCP co-pay	$10 (Nothing from infancy through age 4)	$20 (Nothing from infancy through age 17)	$30 (Nothing from infancy through age 17)	$25 for 18+, $0 through age 17
Specialist co-pay	$20	$30	$40	$40
Virtual visits				$5
Preventative care				
Child/Adult routine screenings	Nothing	Nothing	Nothing	Nothing
Annual vision eye exam	$10	$20	$30	$40
Routine dental care (2x/year)	$30 (2x/yr)	$30 (2x/yr)	Not covered	Discount
Emergency Care				
Urgent care	$20	$30	$40	$75
Emergency room	$100	$150	Deductible, then $150	$125
Hospital Care				
Inpatient Services and Supplies	$100	$500	Deductible, then $750	$150/day ($450 max)
Inpatient Surgery	$100	$500	Deductible, then $750	Nothing
Outpatient Services and Supplies	$75	$150	$300	$200 (hospital)
Outpatient Surgery	$75	$150	$300	$100
Alternative Care				
Chiropractor co-pay	$20 (20x/yr)	$30 (20x/yr)	$40 (20x/yr)	50% (limited to $500/yr)
Acupuncture co-pay	$20 (20x/yr)	$30 (20x/yr)	$40 (20x/yr)	$40 (12x/yr)
Maternity Services				
Prenatal routine care	Nothing	Nothing	Nothing	Nothing
Inpatient Hospital Care	Nothing	Nothing	Deductible, then $750	Nothing
Infertility Services				
Diagnosis and Treatment	50%	50%	Deductible, then 50%	$25 PCP/$40 Specialist
In Vitro Fertilization	Not covered	Not covered	Not covered	Not covered
Hearing devices				
Hearing aids (every 36 months)	Nothing (limited to one hearing aid each every 36 months, up to age 19)	Nothing (limited to one hearing aid each every 36 months, up to age 19)	Nothing (limited to one hearing aid each every 36 months, up to age 19)	50% up to $1,400 (until age 18) & excess charges over $1,400
* Cochlear implants	Nothing	Nothing	Deductible, then nothing	50%
Gender Transition Surgery	Nothing (prior approval required)	Nothing (prior approval required)	Deductible, then nothing (prior approval required)	$40 Specialist (mastectomy, hysterectomy, oophorectomy & gonadectomy)
Prescriptions				
* Retail (30-day)	$7/$30/$45/$100 (specialist)	$10/$40/$60/$150 (specialist)	$10/$45/$65/$200 (specialist)	$7/$35/$65/$100
* Mail Order (90-day)	$5/$28/$43/$100 (specialist)	$8/$38/$56/$150 (specialist)	$8/$43/$63/$200 (specialist)	$21/$105/$195/$300
Biweekly Premiums				
Self	$89.52	$60.20	$48.47	$134.83
Self Plus One	$243.03	$138.46	$107.87	$220.59
Family	$209.98	$138.46	$118.40	$498.16
Website	www.kp.org/feds	www.kp.org/feds	www.kp.org/feds	www.uhcfeds.com

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Plan Name Enrollment Code Plan Type	United Healthcare Choice HMO High (LR1/LR2/LR3) HMO	United Healthcare Choice Plus Advanced Value (L91/L92/L93) HMO
Deductible	None	$500/$1,000/$1,000
Annual Out-of-Pocket Limit	$5,000/$10,000/$10,000	$3,000/$6,000/$6,000
Physician care		
PCP co-pay	$25	$25
Specialist co-pay	$35	$50
Virtual visits	$5	$5
Preventative care		
Child/Adult routine screenings	Nothing	Nothing
Annual vision eye exam	Not covered	Not covered
Routine dental care (2x/year)	Discount	Discount
Emergency Care		
Urgent care	$35	$100
Emergency room	$150	$250
Hospital Care		
Inpatient Services and Supplies	Nothing	Deductible, then $75/day ($750 max)
Inpatient Surgery	$150 (up to $750)	Deductible, then 20%
Outpatient Services and Supplies	$150	Deductible, then $250
Outpatient Surgery	150 (up to $300)	Deductible, then 20%
Alternative Care		
Chiropractor co-pay	50% (20x/yr)	$25 (20x/yr)
Acupuncture co-pay	$50 (12x/yr)	Deductible, then 20% (12x/yr)
Maternity Services		
Prenatal routine care	Nothing	Nothing
Inpatient Hospital Care	Nothing	Nothing
Infertility Services		
Diagnosis and Treatment	$25 PCP/$50 Specialist	Deductible, then 20%
In Vitro Fertilization	Not covered	Not covered
Hearing devices		
Hearing aids (every 36 months)	Not covered	Deductible, then 20% for up age 18 (every 3 years) $2,500 per ear/every 3 years for adults
* Cochlear implants	50%	Deductible, then 20%
Gender Transition Surgery	$25 PCP/$35 Specialist (mastectomy, hysterectomy, oophorectomy, orchiectomy & gonadectomy)	Deductible, then 20% (mastectomy, hysterectomy, oophorectomies, orchiectomy & gonadectomy)
Prescriptions		
* Retail (30-day)	$10/$40/$85/$175	$10/$35/$60/$100
* Mail Order (90-day)	$25/$100/$212.50/$437.50	$25/$87.50/$150/$250
Biweekly Premiums		
Self	$78.10	$50.43
Self Plus One	$170.52	$98.49
Family	$205.29	$141.40
Website	www.uhcfeds.com	www.uhcfeds.com

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