City of Anaheim Employee Benefits Summary Comparison Chart 2018

The following chart shows amounts the **member pays** for many covered services.

	Kaiser HMO	Aetna HMO	Aetna OAMC[1]		New Aetna HSA OAMC[1]	
			In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar Year Deductible						
▪ Individual	None	None	$500 (combined in-network and out-of-network)		$2,600 (combined in-network and out-of-network)	
▪ Family	None	None	$1,000 (combined in-network and out-of-network)		$5,200 (combined in-network and out-of-network) Individual limit: $2,600	
Calendar Year Out-of-Pocket Maximum						
▪ Individual	$1,500	$2,000	$2,000	No maximum	$6,550	
▪ Family	$3,000	$4,000	$4,000	No maximum	$13,100 Individual limit: $6,550	
▪ Lifetime maximum	None	None	None		None	
Professional Services (FOR AETNA HSA PLAN ONLY: You must pay all expenses in full until you meet the calendar year deductible. After you meet the deductible, you pay coinsurance.)						
▪ Office visits / consultations	$15 copay	$20 copay	$20 copay	40% (no deductible)	20%	30%
▪ Specialist visits / OB/GYN services	$15 copay	$40 copay	$40 copay	40% (no deductible)	20%	30%
▪ Allergy testing or treatment	Testing: $15 copay; Injections: No charge	PCP: $20 copay Specialist: $40 copay	PCP: $20 copay Specialist: $40 copay	40% (no deductible)	20%	30%
▪ Injectable medications (serum)	No charge	PCP: $20 copay Specialist: $40 copay	10%	40% (no deductible)	20%	30%
▪ Laboratory, X-ray, and diagnostic tests	No charge	Lab/X-ray: No charge; Diagnostic tests: No charge	$20 copay	40% (no deductible)	20%	30%
▪ Preventive care: well-baby, child, and adult physical exams	Well-Baby (up to 24 months): $5 copay; Adult: $15 copay	No charge	No charge	40% (no deductible)	Covered at 100%	30%
▪ Annual well-woman exams	$15 copay	No charge	No charge	40% (no deductible)	Covered at 100%	30% (no deductible)
▪ Immunizations	No charge	No charge	No charge	No charge	Covered at 100%	30%
▪ Mammograms	No charge	No charge	No charge	40% (no deductible)	Covered at 100%	30% (no deductible)
Outpatient Services						
▪ Non-emergency outpatient surgery /treatment	$15 copay	$50 copay/visit or surgery	10%	40%	20%	30%
Hospitalization Services						
▪ Inpatient visits and consultations	No charge	No charge	10%	40%	20%	30%
▪ Surgeons and assistants, anesthesiologists, pathologists, and radiologists	No charge	No charge	10%	40%	20%	30%
▪ Transplants	No charge	No charge	10%	40%	20%	30%
Emergency Care						
▪ Urgent care	$15 copay	Physician: $20 copay[2]; Facility: $50 copay	10%	40%	20%	30%
▪ Emergency room	$50 copay (waived if admitted)	$100 copay (waived if admitted)	10% after a $75 copay (waived if admitted)	10% after a $75 copay (waived if admitted)	20%	30%
▪ Ambulance service	No charge	No charge	10%	10%	20%	30%
▪ Durable medical equipment (DME)	20%	20%	10% (deductible waived)	40%	20%	30%
Home Health Services						
▪ Home health services	No charge (up to 100 visits per calendar year)	Agency: No charge/visit; Physician: $40 copay/visit	Agency: $40 copay/visit; Physician: $40 copay/visit	40%	20%	20%
Family Planning/Maternity						
▪ Pregnancy and maternity care	Prenatal: $5 copay/visit	$20 copay to determine pregnancy, then covered 100%	No charge	40% (no deductible)	No charge	30%
▪ All necessary inpatient hospital services	No charge	No charge	10%	40%	20%	30%
▪ Family planning and infertility services	In office: $15 copay; Hospital: No charge (testing only; infertility treatment not covered)	$40 copay (testing only; infertility treatment not covered)	In office: $40 copay; Hospital: 10%	40%	Your cost sharing is based on the type of service performed and the place of service where it is rendered	
▪ Vasectomy	$15 copay	In office: $40 copay; Hospital: No charge	10%	40%	Your cost sharing is based on the type of service performed and the place of service where it is rendered	
▪ Tubal ligation	No charge	In office: $40 copay; Hospital: No charge	No charge	40%	Covered at 100%	Your cost sharing is based on the type of service performed and the place of service where it is rendered
Other Services						
▪ Chiropractic coverage	$15 copay (up to 30 visits/year)	$20 copay (up to 30 visits/year)	$20 copay (up to 20 visits/year)	Not covered	20%	Not covered
▪ Rehabilitative therapy services	$15 copay	$20 copay	No charge after $40 copay (deductible waived)	40%	20%	30%
▪ Skilled nursing facility (SNF) services	No charge (up to 100 days/year)	No charge	10%	40% (20% if free-standing facility)	20%	20%
Hearing Aid Services						
▪ Initial hearing evaluation	$15 copay	$40 copay	$40 copay	40%	Not covered	
▪ Hearing aid (molds, initial battery, cords, and other ancillary equipment)	$2,500 hearing aid device (every 36 months)	No charge (up to $1,000/36 months)	10% in-network; 40% out-of-network (up to $1,000/36 months)		20% in-network; 30% out-of-network (up to $1,000/36 months)	
Mental Health/Substance Abuse						
▪ Inpatient mental health	No charge	No charge	10%	40%	20%	30%
▪ Outpatient mental health	Individual: $15 copay; Group: $7 copay	No charge (individual or group)	No charge	40% (no deductible)	20%	30%
▪ Inpatient substance abuse	Non-residential: No charge; Residential: $100 copay/ admittance; Transitional recovery services: No charge	No charge	10%	40%	20%	30%
▪ Outpatient substance abuse	Individual: $15 copay; Group: $5 copay	No charge	No charge	40% (no deductible)	20%	30%

1. If you live outside the participating provider network area, you are responsible for 10% of the OAMC eligible expenses and 20% of the HSA OAMC eligible expenses. The OAMC plan pays 90% of your eligible expenses, and the HSA OAMC plan pays 80% of your eligible expenses.
2. A physician may charge up to $25 for urgent care provided after hours.
3. Includes dental prescriptions.
4. Prescription drugs are covered only when the prescription is filled at a network pharmacy.

(continued on back)

Note: These comparison charts are offered for the convenience of the City of Anaheim employees. It serves only as a summary of each plan's benefits as displayed in their brochures. This chart contains the major features of the plans and is not intended to replace the legal documents containing the complete provisions of each plan.

The following chart shows amounts the **member pays** for many covered services. (continued)

	Kaiser HMO	Aetna HMO	Aetna OAMC[1]		New Aetna HSA OAMC[1]	
			In-Network	Out-of-Network	In-Network	Out-of-Network
Prescription Drugs (FOR AETNA HSA PLAN ONLY: You must pay the full cost of prescription drugs until you meet the calendar year deductible. After you meet the deductible, you pay copays.)						
▪ Generic	$10 copay[3] (up to 100-day supply)	$10 copay[4] (up to 30-day supply)	$10 copay[4] (up to 30-day supply)		$10 (up to 30-day supply)	Not covered
▪ Brand name	$10 copay[3] (up to 100-day supply)	$30 copay[4] (up to 30-day supply)	$30 copay[4] (up to 30-day supply)		$30 (up to 30-day supply)	Not covered
▪ Non-formulary	Subject to a copay if medically necessary	$50 copay[4] (up to 30-day supply)	$50 copay[4] (up to 30-day supply)		$50 (up to 30-day supply)	Not covered
▪ Mail order	$10 copay[3] (up to 100-day supply)	Double the applicable copay[4] (up to 90-day supply)	Double the applicable copay[4] (up to 90-day supply)		Double the applicable copay (up to 90-day supply)	Not covered

1. If you live outside the participating provider network area, you are responsible for 10% of the OAMC eligible expenses and 20% of the HSA OAMC eligible expenses. The OAMC plan pays 90% of your eligible expenses, and theHSA OAMC plan pays 80% of your eligible expenses.
2. A physician may charge up to $50 for urgent care provided after hours.
3. Includes dental prescriptions.
4. Prescription drugs are covered only when the prescription is filled at a network pharmacy.

Vision Coverage

The vision coverage shown in the chart below is included with the medical plan you elect. The following chart shows amounts the **member pays** for covered services.

	Kaiser HMO	Aetna HMO	Aetna OAMC[1]		New Aetna HSA OAMC[1]	
			In-Network	Out-of-Network	In-Network	Out-of-Network
▪ Initial eye exam	$15 copay (annual)	No charge (annual; must use a network provider)	No charge (annual)	40% (no deductible) (annual)	No charge (annual)	30% (annual)
▪ Frames, lenses, and contacts[2]	No charge up to $150 retail allowance (every 24 months)	No charge up to $200 materials allowance every 12 months, plus discounted fees through EyeMed	No charge up to $200 materials allowance every 12 months Discounted fees through EyeMed		No charge up to $200 materials allowance every 12 months Discounted fees through EyeMed	

1. If you live outside the participating provider network area, you're responsible for 10% of the OAMC eligible expenses and 20% of the HSA OAMC eligible expenses. The OAMC plan pays 90% of your eligible expenses, and the HSA OAMC plan pays 80% of your eligible expenses.
2. Frames, lenses, and contacts share same allowance.

Dental Summary Comparison Chart

The following chart shows amounts the **member pays** for many covered services.

	Delta Dental PPO Plan		DeltaCare USA DHMO
	In-Network	Out-of-Network	
▪ Calendar year deductible	$25[1]	$50	No deductible
▪ Maximum annual benefit	$1,500	$1,500	No maximum
▪ Choice of dentist	Delta Dental PPO dentist	Any dentist	Choice of DeltaCare USA provider network
Diagnostic and Preventive			
▪ Periodic oral exam (2 per calendar year)	No charge[2]	20%[2]	No charge
▪ Teeth cleaning (2 per calendar year)	No charge[2]	20%[2]	No charge (1 every 6 months)
▪ Routine X-rays	No charge	20%	No charge
Restorative Services			
▪ Amalgam filling	No charge[3]	20%[3]	No charge
Oral Surgery			
▪ Biopsy of oral tissue	20%	20%	No charge[4]
▪ Extractions	20%	20%	$0-$25
▪ Removal of impacted teeth	20%	20%	Soft tissue $50 Partially bony $70 Completely bony $90[5]
Periodontics (treatment of the gums)			
▪ Periodontal scaling and root planing (per quadrant)	20%[2]	20%[2]	1–3 teeth $20[6] 4+ teeth $25[6]
▪ Gingivectomy per quadrant	20%	20%	1–3 teeth $80 4+ teeth $130
Endodontics			
▪ Root canal – anterior	20%	20%	$55
▪ Root canal – bicuspid	20%	20%	$120
▪ Root canal – molar	20%	20%	$250
Prosthetics			
▪ Complete maxillary or mandibular denture	40%	50%	$145
▪ Denture adjustment	40%	50%	$10
Orthodontics			
▪ Adult (full banded)	50% (subject to a $1,500 lifetime maximum benefit per person)	50% (subject to a $1,500 lifetime maximum benefit per person)	100% (after $1,900 copay) up to 24 months, plus start up fees[7]
▪ Child (full banded)	50% (subject to a $1,500 lifetime maximum benefit per person)	50% (subject to a $1,500 lifetime maximum benefit per person)	100% (after $1,700 copay) up to 24 months, plus start up fees[8]

1. In-network deductible waived for diagnostic and preventive services.
2. One additional oral exam and either one additional routine cleaning or periodontal scaling and root planing per quadrant per year is covered for pregnant women.
3. In-network and out-of-network deductibles waived for amalgam fillings.
4. Doesn't include pathology laboratory procedures.
5. $110 if there are unusual surgical complications.
6. Limited to four quadrants during any 12 consecutive months.
7. Includes covered dependent adult children age 19 to 26.
8. Children to age 19.

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