DISTRICT OF COLUMBIA PUBLIC SCHOOLS

# DCEHB Health Provider Comparison Chart

Healthcare Providers for employees hired on or after 10/1/1987

| | Aetna Healthcare CDHP Preferred | Aetna Healthcare CDHP Non-Preferred | Aetna HMO | Aetna PPO Preferred | Aetna PPO Non-Preferred | Kaiser Permanente HMO | United Healthcare Choice Nationwide |
|---|---|---|---|---|---|---|---|
| **Deductible (ded) Per Calendar Year** | $1,250 self<br>$2,500 family | $2,500 self<br>$5,000 family | None | $750 self<br>$1,500 family | $1,500 self<br>$3,000 family | None | None |
| **Health Savings Account (HSA)** | **HSA applies only to Aetna Healthcare CDHP:** Employee Maximum Contribution to Health Savings Account $3,100 Self/ $6,250 Self +1/ $6,250 Family<br>Unused funds roll over into the following year and are portable. Employees cannot participate in both CDHP and a Healthcare Flexible Spending Account. | | | | | | |
| **Out of Pocket Maximum Annual Copay** | $6,050 self<br>$12,100 family | $6,050 self<br>$12,100 family | None | $1,500 self<br>$3,000 family | $3,000 self<br>$6,000 family | $3,500 self<br>$9,400 family | $3,500 self<br>$9,400 family |
| **Primary Care Physician (PCP) Selection** | Not Required | | Not Required | Not Required | | Required | Not Required |
| **Referral Required for Specialist** | Not Required | | None | Not Required | | Required | Not Required |
| **Preventive Care Office Visit** | No Charge | 40% after ded | No Charge | No Charge | Ded waived $150 max | No Charge | No Charge |
| **Primary Care Office Visits** | 15% after ded | 40% after ded | $10 copay | $15 copay | 25% after ded | $10 per visit (Waived for kids under 5) | $10 copay |
| **Specialist Office Visit** | 15% after ded | 40% after ded | $20 copay | $30 copay | 25% after ded | $20 per visit | $20 copay |
| **Routine Pediatric Care** | Covered 100% | 40% after ded | Covered 100% | Covered 100% | 25% after ded | $10 per visit | $10 copay |
| **Emergency Service:** | | | | | | | |
| **Urgent Care Office Visit** | 15% after ded | 40% after ded | $20 copay | $25 copay | 25% after ded | $10 per visit (PCP) /$20 per visit (Specialty) | $20 copay |
| **Emergency Room Visit** | 15% After Deductible | | $50 copay | $100 copay Waived if admitted | $100 copay after deductible | $50 per visit (waived if admitted) | $50 copay (waived if admitted) |
| **Ambulance Service** | 15% After Deductible | | No Charge | Covered 100% | 25% after ded | No Charge | No Charge |
| **Mental Health: In-Patient** | 15% after ded | 40% after ded | $100 per admission | Covered 100% after ded | 25% after ded | $100 per admission | $100 per admission |
| **Mental Health: Out-Patient** | 15% after ded | 40% after ded | $10 copay visits 1-40<br>$10 copay visits 41+ | $15 copay after ded | 25% after ded | $10 per visit for individual therapy<br>$5 per visit for group therapy | $10 copay |
| **Pharmacy (Retail) G: Generic P:Preferred N:Non Preferred** | G:$10/ P:$30/ N:$60 \| 20% after copay | | G:$20/ P:$40/ N:$55 | G:$10/P:$20/N:$40 | Not Covered | G:$10/P:$20 /N:$35 | Tier1:$20 / Tier2:$40 / Tier3:$55 |
| **Hospitalization** | 15% after ded | 40% after ded | $100 per admission | Covered 100% after ded | 25% after ded | $100 per admission | $100 per admission |
| **Infertility Treatment** | Cost sharing based on service type | | 50% of charges | Cost sharing based on service type | | 50% of allowable charge | 50% of allowable charge |
| **Pregnancy Office Visits** | 15% after ded | 40% after ded | $20 initial visit, 100% covered thereafter | $30 copay Initial visit only | 25% after ded | No charge--Routine pre-natal visit (after confirmation of pregnancy) and first post-natal visit | $10 copay applies to first visit only |
| **Diagnostic Lab Work & X-Ray** | 15% after ded | 40% after ded | Covered 100% | Covered 100% if part of office visit | 25% after ded | No charge | No charge |
| **Dental Care Discount** | Dental Discount Provided | | Discount Program | Dental Discount Provided | | $30 for preventive dental care services | N/A |
| **Vision Care** | $100 per 24 months<br>Covered 100% for 1 exam per 12months | | $100 per 24 months<br>$20 copay | $30 copay/ 1 visit per 24m | Not Covered | $10 per visit (PCP) /$20 per visit (Specialty) | N/A |