



# Employee Benefits Summary Comparison Chart 2012

City of Anaheim

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

	Kaiser HMO	Aetna Value HMO	Aetna OAMC <sup>1</sup>		Aetna High Option OAMC <sup>1</sup>	
			In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Calendar Year Deductible</b>						
▪ Individual	None	None	\$500 (combined in-network and out-of-network)		\$1,000 (combined in-network and out-of-network)	
▪ Family	None	None	\$1,000 (combined in-network and out-of-network)		\$3,000 (combined in-network and out-of-network)	
<b>Calendar Year Out-of-Pocket Maximum</b>						
▪ Individual	\$1,500	\$2,000	\$2,000 <sup>2</sup>	No maximum	\$6,000 <sup>2</sup>	\$9,000 <sup>2</sup>
▪ Family	\$3,000	\$4,000	\$4,000 <sup>2</sup>	No maximum	\$18,000 <sup>2</sup>	\$27,000 <sup>2</sup>
▪ Lifetime maximum	None	None	None		None	
<b>Professional Services</b>						
▪ Office visits/consultations	\$15 copay	\$20 copay	\$20 copay	40% (no deductible)	20% (no deductible)	30% (no deductible)
▪ Specialist visits / OB/GYN services	\$15 copay	\$40 copay	\$40 copay	40% (no deductible)	20% (no deductible)	30% (no deductible)
▪ Allergy testing or treatment	\$15 copay	\$40 copay	\$40 copay	40%	20%	30%
▪ Injectable medications (serum)	No charge	\$40 copay	\$40 copay	40%	20%	30%
▪ Laboratory, X-ray, and diagnostic tests	No charge	Lab/X-ray: No charge; Diagnostic tests: \$40 copay	\$20 copay	40%	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)	No charge	30% (no deductible)
▪ Annual well-woman exams	\$15 copay	No charge	No charge	40% (no deductible)	No charge	30% (no deductible)
▪ Immunizations	No charge	No charge	No charge	No charge	No charge	30% (no deductible)
▪ Mammograms	No charge	No charge	No charge	40% (no deductible)	No charge	30% (no deductible)
<b>Outpatient Services</b>						
▪ Non-emergency outpatient surgery/treatment	\$15 copay	\$50 copay/visit or surgery	10%	40%	20%	30%
<b>Hospitalization Services</b>						
▪ Inpatient visits and consultations	No charge	No charge	10%	40%	20%	30%
▪ Surgeons and assistants, anesthesiologists, pathologists, radiologists	No charge	No charge	10%	40%	20%	30%
▪ Transplants	No charge	No charge	10%	40%	20%	30%
<b>Emergency Care</b>						
▪ Urgent care	\$15 copay	Physician: \$20 copay <sup>3</sup> 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% (no deductible)	20% (no deductible)
▪ Ambulance service	No charge	No charge	10%	10%	20%	20%
▪ Durable medical equipment (DME)	20%	50%	10%	40%	20%	30%
<b>Home Health Services</b>						
▪ 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%
<b>Family Planning/Maternity</b>						
▪ Pregnancy and maternity care	Prenatal: \$5 copay/visit	\$20 copay to determine pregnancy, then covered 100%	\$40 copay (no deductible)	40% (no deductible)	20% (no deductible)	30% (no deductible)
▪ 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	\$40 copay (testing only; infertility treatment not covered)	In office: \$40 copay; Hospital: 10% (testing only; infertility treatment not covered)	40%	20% (testing only; infertility treatment not covered)	30% (testing only; infertility treatment not covered)
▪ Tubal ligation and vasectomy	Tubal ligation: No charge; Vasectomy: \$15 copay	In office: \$40 copay; Hospital: No charge	10%	40%	20%	30%
<b>Other Services</b>						
▪ 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% (up to 20 visits/year)	Not covered
▪ Rehabilitative therapy services	\$15 copay	\$40 copay	\$40 copay	40%	20%	30%
▪ Skilled nursing facility (SNF) services	No charge (up to 100 days/year)	No charge	10% (preauthorization required; up to 100 days/year combined)	40% (20% if free-standing facility)	20% (preauthorization required; up to 100 days/year combined)	
<b>Hearing Aid Services</b>						
▪ Initial hearing evaluation	\$15 copay	\$40 copay	\$40 copay	40%	20%	
▪ Hearing aid (molds, initial battery, cords and other ancillary equipment)	\$2,500 hearing aid device (every 36 months)	No charge (up to \$1,000 maximum/36 months)	No charge (up to \$1,000 maximum/36 months)		No charge (up to \$1,000 maximum/36 months)	
<b>Mental Health/Substance Abuse</b>						
▪ Inpatient mental health	No charge	No charge	10%	40%	20%	30%
▪ Outpatient mental health	Individual: \$15 copay Group: \$7 copay	\$40 copay (individual or group)	\$40 copay	40%	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	\$40 copay	\$40 copay	40%	20%	30%
<b>Prescription Drugs</b>						
▪ Generic	\$10 copay <sup>4</sup> (up to 100-day supply)	\$10 copay <sup>5</sup> (up to 30-day supply)	\$10 copay <sup>5</sup> (up to 30-day supply)		\$10 copay <sup>5</sup> (up to 30-day supply)	
▪ Brand name	\$10 copay <sup>4</sup> (up to 100-day supply)	\$30 copay <sup>5</sup> (up to 30-day supply)	\$30 copay <sup>5</sup> (up to 30-day supply)		\$30 copay <sup>5</sup> (up to 30-day supply)	
▪ Non-formulary	Not covered	\$50 copay <sup>5</sup> (up to 30-day supply)	\$50 copay <sup>5</sup> (up to 30-day supply)		\$50 copay <sup>5</sup> (up to 30-day supply)	
▪ Mail order	\$10 copay <sup>4</sup> (up to 100-day supply)	Double the applicable copay <sup>5</sup> (up to 90-day supply)	Double the applicable copay <sup>5</sup> (up to 90-day supply)		Double the applicable copay <sup>5</sup> (up to 90-day supply)	

1. If you live outside California or live in California but outside the participating provider network area, you are responsible for 10% of the OAMC eligible expenses and 20% of the High Option OAMC eligible expenses. The OAMC plan pays 90% of your eligible expenses, and the High Option OAMC plan pays 80% of your eligible expenses.  
 2. Excluding copays and deductibles.  
 3. A physician may charge up to \$50 for urgent care provided after hours.

4. Includes dental prescriptions.  
 5. Prescription drugs are covered only when the prescription is filled at a network pharmacy.  
 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.

## 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 Value HMO	Aetna OAMC <sup>1</sup>		Aetna High Option OAMC <sup>1</sup>	
			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% (annual)	No charge (annual)	30% (annual)
▪ Frames, lenses, contacts <sup>2</sup>	No charge up to \$150 retail allowance (every 24 months)	No charge up to \$200 materials allowance every 12 months, plus discounted fees through Vision One network	No charge up to \$200 materials allowance every 12 months Discounted fees through Vision One network		No charge up to \$200 materials allowance every 12 months Discounted fees through Vision One network	

1. If you live outside California or live in California but outside the participating provider network area, you're responsible for 10% of the OAMC eligible expenses and 20% of the High Option OAMC eligible expenses. The OAMC plan pays 90% of your eligible expenses, and the High Option 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 <sup>1</sup>		DeltaCare USA DHMO
	In-Network	Out-of-Network	
▪ Calendar year deductible	\$25	\$50	No charge
▪ Maximum annual benefit	\$1,500	\$1,500	No maximum
▪ Choice of dentist	Delta Dental PPO dentist	Any dentist	Choice of DeltaCare USA provider network
<b>Diagnostic and Preventive</b>			
▪ Periodic oral exam (2 per calendar year)	No charge <sup>2</sup>	20% <sup>2</sup>	No charge
▪ Teeth cleaning (2 per calendar year)	No charge <sup>2</sup>	20% <sup>2</sup>	No charge (1 every 6 months)
▪ Routine X-rays	No charge	20%	No charge
<b>Restorative Services</b>			
▪ Amalgam filling	No charge <sup>3</sup>	20% <sup>3</sup>	No charge
<b>Oral Surgery</b>			
▪ Biopsy of oral tissue	20%	20%	No charge <sup>4</sup>
▪ Extractions	20%	20%	\$5
▪ Removal of impacted teeth	20%	20%	Soft tissue \$50 Partially bony \$70 Completely bony \$90 <sup>5</sup>
<b>Periodontics (treatment of the gums)</b>			
▪ Periodontal scaling and root planing (per quadrant)	20%	20%	1 – 3 teeth \$20 <sup>6</sup> 4+ teeth \$25 <sup>6</sup>
▪ Gingivectomy per quadrant	20%	20%	1 – 3 teeth \$80 <sup>6</sup> 4+ teeth \$130 <sup>6</sup>
<b>Endodontics</b>			
▪ Root canal — anterior	20%	20%	\$55
▪ Root canal — bicuspid	20%	20%	\$120
▪ Root canal — molar	20%	20%	\$250
<b>Prosthetics</b>			
▪ Complete maxillary or mandibular denture	40%	50%	\$145
▪ Denture adjustment	40%	50%	\$10
<b>Orthodontics</b>			
▪ 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 <sup>7</sup>
▪ 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 <sup>8</sup>

1. In-network deductible waived for diagnostic and preventive services.
2. One additional oral exam and cleaning 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.
8. Children to age 19.