



	Children's Health Plan (Through OneNet PPO)		Kaiser Permanente	Aetna	M.D. Individual Practice Association
SERVICES	In-Network - You Pay	Out-Of-Network - You Pay	Select HMO - You Pay	Standard HMO - You Pay	HMO – You Pay
<b>ANNUAL DEDUCTIBLE (CALENDAR YEAR)</b>					
Individual	50% of first \$400 (\$200)	50% of first \$600 (\$300)	None	None	None
Individual Plus One Dependent	50% of first \$800 (\$400)	50% of first \$1,000 (\$500)	None	None	None
Family	50% of first \$800 (\$400)	50% of first \$1,000 (\$500)	None	None	None
<b>ANNUAL OUT-OF-POCKET LIMIT (CALENDAR YEAR)</b>			Maximum Annual Co-payment	Including Co-payments	Including Co-Payments
Individual	\$1,200	\$2,000	\$3,500	\$1,500	\$1,100
Individual Plus One Dependent	\$2,500	\$3,000	\$9,400	\$4,500	\$3,200
Family	\$2,500	\$3,000	\$9,400	\$4,500	\$3,200
	Co-payments do not apply				
<b>LIFETIME MAXIMUM</b>	\$2,000,000		None	None	None
<b>PREVENTIVE SERVICES</b>					
Well-Child Care					
0 – 36 months	\$20 co-pay per visit	30% after deductible up to UCR	No charge	\$10 co-pay per visit	\$10 co-pay per visit
3 – 19 years	\$20 co-pay per visit	30% after deductible up to UCR	\$5 co-pay per visit	\$10 co-pay per visit	\$10 co-pay per visit
Adult Physical Examination	\$20 co-pay per visit		\$5 co-pay per visit	\$10 co-pay per visit	\$10 co-pay per visit
Routine GYN Visits	\$20 co-pay per visit		\$5 co-pay per visit	\$10 co-pay per visit	\$10 co-pay per visit
Mammograms	20% after deductible	30% after deductible up to UCR	No Charge	No Charge	No Charge, in accordance with intervals
Cancer Screening (Pap Test, Prostate, and Colorectal)	20% after deductible	30% after deductible up to UCR	No Charge	\$10 co-pay per visit	No Charge after co-pay
<b>OFFICE VISITS, LABS &amp; TESTING</b>					
Office Visits for Illness	\$20 co-pay per visit	30% after deductible up to UCR	\$5 co-pay per visit	\$10 co-pay per visit	\$10 co-pay per visit
Diagnostic Services	20% after deductible	30% after deductible up to UCR	No Charge	\$10 co-pay per visit	No Charge after co-pay
X-ray and Lab Tests	20% after deductible	30% after deductible up to UCR	No Charge	\$10 co-pay per visit	No Charge after co-pay
Allergy Testing			\$5 co-pay per visit	\$10 co-pay per visit	\$10 co-pay per visit
Allergy Shots	20% after deductible	30% after deductible up to UCR	\$5 co-pay per visit	\$10 co-pay per visit	
	\$750 limit per Calendar Year, In-network and Out-of-network				
Outpatient Physical, Speech, and Occupational Therapy	20% after deductible	30% after deductible up to UCR	\$5 co-pay per visit, max per acute episode; short term rehab up to 60 days.	\$10 co-pay per visit, up to 60 consecutive days from initial treatment May differ in VA and MD	\$10 co-pay per visit, limit 60 combined days or 60 visits per condition
Outpatient Chiropractic	20% after deductible	30% after deductible up to UCR			50% co-pay of charges up to \$500 per member per year
	50 visit limit per Calendar Year, In-network and Out-of-network				
<b>EMERGENCY CARE AND URGENT CARE</b>					
Physician's Office	\$20 co-pay per visit	30% after deductible up to UCR	\$5 co-pay per visit	\$10 co-pay per visit	\$10 co-pay per visit

	Children's Health Plan (Through OneNet PPO)		Kaiser Permanente	Aetna	M.D. Individual Practice Association
SERVICES	In-Network - You Pay	Out-Of-Network - You Pay	Select HMO - You Pay	Standard HMO - You Pay	HMO – You Pay
Urgent Care Center	\$20 co-pay per visit	30% after deductible up to UCR	\$5 co-pay	\$50 co-pay	\$15 co-pay per visit
Hospital Emergency Room	20% after deductible	30% after deductible up to UCR	\$50 co-pay, waived if admitted immediately	\$50 co-pay, waived if admitted immediately	\$25 co-pay, waived if admitted
Ambulance	N/A	30% after deductible up to UCR	No Charge	No Charge	No Charge, if medically necessary
<b>HOSPITALIZATION</b>					
Inpatient Facility Services	20% after deductible	30% after deductible up to UCR	No Charge	No Charge	No Charge
Outpatient Facility Services	20% after deductible	30% after deductible up to UCR	No Charge		\$25 co-pay
Inpatient Physician Services	20% after deductible	30% after deductible up to UCR	No Charge	No Charge	No Charge
Outpatient Physician Services	No Charge	No Charge	No Charge		\$25 co-pay
<b>HOSPITAL ALTERNATIVES</b>					
Home Health Care	20% after deductible	30% after deductible up to UCR \$80 maximum benefit amount; 100 visits maximum per individual per Calendar Year, In-network and Out-of-network	No Charge when authorized by Kaiser Physician and skilled care is needed.	No Charge when authorized by Aetna Physician \$10 co-pay per Physician visit	No Charge when authorized by MD I.P.A PCP and approved by Plan.
Hospice	20% after deductible	30% after deductible up to UCR \$150 maximum benefit amount per day; \$15,000 maximum benefit per individual per Calendar Year, In-network and Out-of-network	No Charge	No Charge	No Charge
Skilled Nursing Facility	20% after deductible	30% after deductible up to UCR	No Charge	No Charge	No Charge, up to 60 days
Private Duty Nursing	20% after deductible	30% after deductible up to UCR \$10,000 maximum benefit per individual per Calendar Year, In-network and Out-of-network		Not Covered unless pre-authorized	
<b>MATERNITY</b>					
Prenatal and Postnatal Office Visits	\$20 co-pay	30% after deductible up to UCR	No Charge	\$10 co-pay	\$10 co-pay
Delivery and Facility Services	20% after deductible	30% after deductible up to UCR	No Charge	No Charge, after initial co-pay	No Charge, after initial co-pay
Nursery Care of Newborn	20% after deductible	30% after deductible up to UCR	No Charge	No Charge, after initial co-pay	No Charge, after initial co-pay
Infertility Testing	20% after deductible	30% after deductible up to UCR \$1,000 lifetime maximum benefit per individual; \$1,500 lifetime maximum benefit per family, In-network and Out-of-network			50% co-pay of Charges
In Vitro Fertilization Procedures	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
<b>MENTAL HEALTH (MH) &amp; SUBSTANCE ABUSE (SA)</b>					
Inpatient Facility Services (MH)	20% after deductible 30 day maximum benefit per Calendar Year with MAPSI Providers	30% after deductible up to UCR 30 day maximum benefit per Calendar Year	No Charge, Unlimited days	Covered in full up to 45 days per year for short-term therapy	Covered in full up to 45 days per contract year
Inpatient Physician Services (MH)	20% after deductible with MAPSI Providers	30% after deductible up to UCR 30 day maximum benefit per Calendar Year	No Charge	Covered in full up to 45 days per year for short-term therapy	Covered in full up to 45 days per contract year
Outpatient Services (MH)	35% after deductible with MAPSI Providers	50% after deductible up to UCR 30 visits maximum per Calendar Year	Determined by Affiliated MH provider. \$20 co-pay per visit, Individual	\$25 co-pay per visit for first 40 visits; \$40 co-pay per visit for remainder of year	25% co-pay for first 40 visits, 40% co-pay per visit for remainder of year

	Children's Health Plan (Through OneNet PPO)		Kaiser Permanente	Aetna	M.D. Individual Practice Association
SERVICES	In-Network - You Pay	Out-Of-Network - You Pay	Select HMO - You Pay	Standard HMO - You Pay	HMO – You Pay
			therapy \$10 co-pay per visit, Group therapy		
Inpatient Facility Services (SA)	20% after deductible 30 day maximum benefit per Calendar Year with MAPSI Providers	No Coverage	No Charge	No Charge, up to 30 days per calendar year.	No Charge, up to 60 days per calendar year
Inpatient Physician Services (SA)	20% after deductible with MAPSI Providers	No Coverage	No Charge	No Charge, up to 30 days per calendar year.	No Charge, up to 60 days per calendar year
Outpatient Services (SA)	35% after deductible 50 visits maximum per Calendar Year with MAPSI Providers	No Coverage	Unlimited days, determined by Affiliated MH provider.	\$10 co-pay per visit, up to 30 visits per calendar year.	\$10 co-pay per visit, up to 30 visits per calendar year.
Detoxification	20% after deductible 5 day maximum benefit per Calendar Year with MAPSI Providers	No Coverage		No Day Limit \$10 co-pay per visit	No Charge, up to 12 days per contract year
Rehabilitation Inpatient	20% after deductible for first 14 days; 50% 15+ days per Calendar Year with MAPSI Providers Lifetime maximum of one treatment plan	No Coverage	No Charge, determined by Affiliated MH provider.	No Charge, up to 30 days	
Rehabilitation Outpatient	50% after deductible 50 visits maximum per Calendar Year with MAPSI Providers Lifetime maximum of one treatment plan	No Coverage	Determined by Affiliated MH provider. \$20 co-pay per visit, Individual therapy \$10 co-pay per visit, Group therapy	\$10 co-pay per visit, up to 30 visits	\$10 co-pay per visit
<b>PRESCRIPTION DRUGS (RX)</b> 30-day Supply (from Retail Pharmacy) Generic Preferred ("Formulary") Brand Non-preferred ("Non-Formulary") Brand	\$15.00 \$25.00 \$40.00  \$5,000 maximum benefit amount per individual per Calendar Year		From Kaiser Pharmacy / From Community Pharmacy \$5.00 / \$15.00 \$5.00 / \$15.00 Not Covered	\$10.00 \$15.00 \$30.00  No benefit maximum	\$10.00 \$20.00 \$35.00  Member must pay difference between Generic and Brand when Generic is available.
90-day supply (from Mail Order Pharmacy) Generic Preferred ("Formulary") Brand Non-preferred ("Non-Formulary") Brand	\$25.00 \$50.00 \$80.00  \$5,000 maximum benefit amount for Specialty injectables per individual		\$3.00 \$3.00 Not Covered	\$20.00 \$30.00 \$60.00  No benefit maximum	\$20.00 \$40.00 \$70.00  20% co-pay, up to \$50, for

	Children's Health Plan (Through OneNet PPO)		Kaiser Permanente	Aetna	M.D. Individual Practice Association
SERVICES	In-Network - You Pay	Out-Of-Network - You Pay	Select HMO - You Pay	Standard HMO - You Pay	HMO – You Pay
	per Calendar Year				Injectables (Not including insulin)
<b>MISCELLANEOUS</b>					
Durable Medical Equipment	20% after deductible	30% after deductible up to UCR	No Charge	No Charge	50% co-pay of charges
Acupuncture	20% after deductible	30% after deductible up to UCR			
Hearing Exams	20% after deductible	30% after deductible up to UCR	\$5 co-pay	\$10 co-pay per visit, up to age 17 for routine hearing screenings	\$10 co-pay per visit
Out-of Area Care	20% after deductible with PHCS Providers	30% after deductible up to UCR	\$35 co-pay for emergency services in Hospital ER, waived if admitted immediately. \$5 co-pay per visit to Physician / Urgent Care, with Plan approval.	\$50 co-pay, waived if admitted.	\$25 co-pay, waived if admitted.

**THIS INFORMATION IS PROVIDED AS A SUMMARY ONLY. PLEASE CONSULT THE APPROPRIATE PLAN BOOKLET OR EVIDENCE OF COVERAGE FOR MORE COMPLETE INFORMATION.**

The information outlined in this Summary is intended as a brief and general understanding of your benefits at CNMC. Every effort has been made to ensure the accuracy of the information provided to you in this Summary. If there are any discrepancies between this Summary and the formal plan documents or Human Resources policies governing such plans and programs, the formal plan documents and/or Human Resources policies will govern. Employees covered by a specific collective bargaining agreement should also consult their agreement for benefits specific information. CNMC reserves the right to amend, in whole or in part, any of its benefits plans or programs at any time.

Dental Plans



	Children's Dental Plan	DentaQuest Dental	Kaiser Permanente	Aetna	M.D. Individual Practice Association
SERVICES	"Open" Network - You Pay	DHMO Classic (CL5) - You Pay	Select HMO - You Pay	Standard HMO - You Pay	HMO - You Pay
<b>ANNUAL DEDUCTIBLE (CALENDAR YEAR)</b> Per Individual	\$25	None	None	None	None
<b>ANNUAL OUT-OF-POCKET LIMIT (CALENDAR YEAR)</b> Per Individual	\$1,500	None	None	None	None
<b>PREVENTATIVE SERVICES</b> Office Visits	No Charge, Deductible waived.	No Charge Please see Fee Schedule	\$30 co-pay per visit, preventative care	\$2 co-pay per visit, basic dental	\$25 co-pay per exam
<b>BASIC DENTAL SERVICES</b>	20% after deductible	10% to 40% Please see Fee Schedule	Discount Dental Program	Discount Dental Program	25% Discount Dental Program from participating Providers
<b>MAJOR DENTAL SERVICES</b>	40% after deductible	40% to 60% Please see Fee Schedule			
<b>ORTHODONTICS</b>	Not Covered	\$2,050 Comprehensive Orthodontic Treatment for standard 2-year case for children under 18. Please see Fee Schedule			

**THIS INFORMATION IS PROVIDED AS A SUMMARY ONLY. PLEASE CONSULT THE APPROPRIATE PLAN BOOKLET OR EVIDENCE OF COVERAGE FOR MORE COMPLETE INFORMATION.**

The information outlined in this Summary is intended as a brief and general understanding of your benefits at CNMC. Every effort has been made to ensure the accuracy of the information provided to you in this Summary. If there are any discrepancies between this Summary and the formal plan documents or Human Resources policies governing such plans and programs, the formal plan documents and/or Human Resources policies will govern. Employees covered by a specific collective bargaining agreement should also consult their agreement for benefits specific information. CNMC reserves the right to amend, in whole or in part, any of its benefits plans or programs at any time.

Vision Plans



	Vision Service Plan	Kaiser Permanente	Aetna	M.D. Individual Practice Association
SERVICES	You Pay	Select HMO – You Pay	Standard HMO – You Pay	HMO – You Pay
<b>ANNUAL DEDUCTIBLE (CALENDAR YEAR)</b> Per Individual	None	None	None	None
<b>ANNUAL OUT-OF-POCKET LIMIT (CALENDAR YEAR)</b> Per Individual	None	None	None	None
<b>PREVENTATIVE SERVICES</b> Office visits and Examinations	In-Network / Out-of-Network \$10 co-pay / 100% of Charges over \$52 allowance	\$5 co-pay per examination	\$10 co-pay per examination	\$25 co-pay per exam
<b>PRESCRIPTION GLASSES</b> Lenses  Frames	No Charge, Single vision, Lined bi-focal, and Lined tri-focal / 100% of Charges over allowances (Single \$55; Lined bi-focal \$75; Lined tri-focal \$95) 20% discount on Charges over \$130 / 100% of Charges over \$45 allowance	25% discount for lenses and frames	Discounted eyewear services at participating Optometrists, fixed co-pay schedule	10% to 20% discount on eyewear at participating Optical Centers
<b>CONTACT LENSES</b>	When chosen instead of Lenses and Frames, 100% of Charges over \$130 allowance for cost of contacts and contact lens exam (evaluation and fitting) / 100% of Charges over \$105 allowance	15% discount for initial fitting and purchase of contact lenses at Kaiser optical centers only		
<b>MISCELLANEOUS SAVINGS AND DISCOUNTS</b> Laser Vision Prescription Glasses  Contacts	Discount program available Up to 20% savings on lens extras such as scratch resistant 20% off additional prescription glasses and sunglasses 15% off cost of contact lens exam (evaluation and fitting)			

**THIS INFORMATION IS PROVIDED AS A SUMMARY ONLY. PLEASE CONSULT THE APPROPRIATE PLAN BOOKLET OR EVIDENCE OF COVERAGE FOR MORE COMPLETE INFORMATION.**

The information outlined in this Summary is intended as a brief and general understanding of your benefits at CNMC. Every effort has been made to ensure the accuracy of the information provided to you in this Summary. If there are any discrepancies between this Summary and the formal plan documents or Human Resources policies governing such plans and programs, the formal plan documents and/or Human Resources policies will govern. Employees covered by a specific collective bargaining agreement should also consult their agreement for benefits specific information. CNMC reserves the right to amend, in whole or in part, any of its benefits plans or programs at any time.