Aetna Open Choice PPO is most similar to CareFirst Triple Option

CareFirst BlueChoice Triple Option Plan Open *Actives/Retirees Under 65—January 2021*				Aetna Open Choice PPO *Effective 1/1/22*	
BlueChoice Triple Option Plan Open Access				**Aetna PPO**	
	Level 1 No Referrals Required	Level 2 No Referrals Required	Level 3 No Referrals Required	In Network - No Referrals Required	Out of Network - No Referrals Required
NETWORK	BlueChoice HMO (MD, DC, No. VA)	Preferred Provider (PPO Blue Card)	Participating/Non-Participating	Open Access Aetna Open Choice PPO national network	Non-Participating
COPAYS	$15 PCP/$35 Specialist	$25 PCP/$50 Specialist	N/A	$15 PCP/$35 Specialist	N/A
ANNUAL DEDUCTIBLE					
Individual	$125	$250	$500	$125	$500
Individual & Child	$250	$500	$1,000	$250	$1,000
Individual & Adult	$250	$500	$1,000	$250	$1,000
Family	$250	$500	$1,000	$250	$1,000
ANNUAL OUT-OF-POCKET MAXIMUM					
Medical	$500 Ind. / $1,000 Family	$1,000 Ind. / $2,000 Family	$1,500 Ind. / $3,000 Family	$500 Ind. / $1,000 Family	$1,500 Ind. / $3,000 Family
LIFETIME MAXIMUM BENEFIT	Unlimited except on fertility services			Unlimited except on fertility services	Unlimited except on fertility services
PREVENTIVE SERVICES					
Well-Child Care					
0-24 months	No charge	No charge	Deductible, then 70% AB	No charge	Deductible, then 70% AB
24 months-13 years (immunization visit)	No charge	No charge	Deductible, then 70% AB	No charge	Deductible, then 70% AB
24 months-13 years (non-immunization visit)	No charge	No charge	Deductible, then 70% AB	No charge	Deductible, then 70% AB
14-17 years	No charge	No charge	Deductible, then 70% AB	No charge	Deductible, then 70% AB
Adult Physical Examination	No charge	No charge	Deductible, then 70% AB	No charge	Deductible, then 70% AB
Routine GYN Visits	No charge ($35 copay non- routine)	No charge ($50 copay non- routine)	Deductible, then 70% AB	No charge ($35 copay non-routine)	Deductible, then 70% AB
Mammograms	No charge	No charge	70% AB, No deductible	No charge	70% AB, No deductible
Cancer Screening (Pap Test, Prostate and Colorectal)	No charge	No charge	Deductible, then 70% AB	No charge	Deductible, then 70% AB
OFFICE VISITS, LABS AND TESTING					
Office Visits for Illness	$15 PCP/$35 Specialist copay	$25 PCP/$50 Specialist copay	Deductible, then 70% AB	$15 PCP/$35 Specialist copay	Deductible, then 70% AB
Diagnostic Services	Deductible, then 95% AB	Deductible, then 95% AB	Deductible, then 95% AB	Deductible, then 95% AB	Deductible, then 95% AB
Lab Tests	No copay (LabCorp)	100% AB	100% AB	No copay (LabCorp & Quest)	100% AB
Allergy Testing	Deductible, then 95% AB	Deductible, then 85% AB	Deductible, then 70% AB	Deductible, then 95% AB	Deductible, then 70% AB
Allergy Shots	$15 PCP/$35 Specialist copay	$25 PCP/$50 Specialist copay	Deductible, then 70% AB	$15 PCP/$35 Specialist copay	Deductible, then 70% AB
Outpatient Physical, Speech and Occupational Therapy (Office Setting)	$35 copay (limited to 100 days combined/condition/benefit period)	$50 copay (limited to 100 days combined in-network and out-of- network/benefit period)	Deductible, then 70% AB (limited to 100 days combined in-network and out-of-network/benefit period)	$35 copay (limited to 300 visits combined in-network and out-of-network per benefit period)	Deductible, then 70% AB (limited to 300 visits combined in-network and out-of-network per benefit period)
Outpatient Chiropractic	$35 copay (unlimited visits)	$50 copay (unlimited visits)	Deductible, then 70% AB (unlimited visits)	$35 copay (unlimited visits)	Deductible, then 70% AB (unlimited visits)
EMERGENCY CARE AND URGENT CARE					
Physician's Office	$15 PCP/$35 Specialist copay	$15 PCP/$35 Specialist copay	$15 PCP/$35 Specialist copay	$15 PCP/$35 Specialist copay	$15 PCP/$35 Specialist copay
Urgent Care Center	$35 copay	$35 copay	$35 copay	$35 copay	$35 copay
Hospital Emergency Room	$75 copay (waived if admitted)	Considered under Level 1. If benefits are not available under Level 1, benefits may be payable under the appropriate level	Considered under Level 1. If benefits are not available under Level 1, benefits may be payable under the appropriate level .	$75 copay (waived if admitted)	$75 copay (waived if admitted)
Ambulance (if medically necessary)	No charge	Considered under Level 1. If benefits are not available under Level 1, benefits may be payable under the appropriate level	Considered under Level 1. If benefits are not available under Level 1, benefits may be payable under the appropriate level .	No charge	No charge

Aetna Open Choice PPO is most similar to CareFirst Triple Option

CareFirst BlueChoice Triple Option Plan Open *Actives/Retirees Under 65—January 2021*				Aetna Open Choice PPO *Effective 1/1/22*	
BlueChoice Triple Option Plan Open Access				**Aetna PPO**	
	Level 1 No Referrals Required	Level 2 No Referrals Required	Level 3 No Referrals Required	In Network - No Referrals Required	Out of Network - No Referrals Required
HOSPITALIZATION					
Inpatient Facility Services	Deductible, then 95% AB	Deductible, then 85% AB	Deductible, then 70% AB	Deductible, then 95% AB	Deductible, then 70% AB
Outpatient Facility Services (includes diagnostic xray)	Deductible, then 95% AB	Deductible, then 85% AB	Deductible, then 70% AB	Deductible, then 95% AB	Deductible, then 70% AB
Inpatient Physician Services	Deductible, then 95% AB	Deductible, then 85% AB	Deductible, then 70% AB	Deductible, then 95% AB	Deductible, then 70% AB
Outpatient Physician Services	$15 PCP/$35 Specialist copay	$25 PCP/$50 Specialist copay	Deductible, then 70% AB	$15 PCP/$35 Specialist copay	Deductible, then 70% AB
HOSPITAL ALTERNATIVES					
Home Health Care	Deductible, then 95% AB	Deductible, then 95% AB	Deductible, then 95% AB	No charge	No charge
Hospice	Deductible, then 95% AB	Deductible, then 95% AB	Deductible, then 95% AB	No charge	No charge
Skilled Nursing Facility	Deductible, then 95% AB (no limit)	Deductible, then 85% AB (limited to 120 days/benefit period)	Deductible, then 70% AB (limited to 120 days/benefit period)	Deductible, then 95% AB (no limit)	Deductible, then 70% AB (limited to 120 days/benefit period)
MATERNITY					
Preventative Prenatal Office Visits	No charge	No charge	Deductible, then 70% AB	No charge	Deductible, then 70% AB
Delivery and Facility Services	Deductible, then 95% AB	Deductible, then 85% AB	Deductible, then 70% AB	Deductible, then 95% AB	Deductible, then 70% AB
Nursery Care of Newborn	Deductible, then 95% AB	Deductible, then 85% AB	Deductible, then 70% AB	Deductible, then 95% AB	Deductible, then 70% AB
Artificial Insemination— limited to 6 attempts per live birth	Deductible, then 95% AB	Deductible, then 95% AB	Deductible, then 70% AB	Deductible, then 95% AB	Deductible, then 70% AB
InVitro Fertilization Procedures—limited to 3 attempts per live birth & $100,000 lifetime max	Deductible, then 95% AB	Deductible, then 95% AB	Deductible, then 70% AB	Deductible, then 95% AB	Deductible, then 70% AB
MENTAL HEALTH AND SUBSTANCE USE DISORDER—Subject to Federal Mandate	MAGELLAN'S NETWORK	PREFERRED PROVIDER NETWORK	PARTICIPATING/NON- PARTICIPATING	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Facility Services (requires Pre-authorization)	Deductible, then 95% AB	Deductible, then 85% AB	Deductible, then 70% AB	Deductible, then 95% AB	Deductible, then 70% AB
Inpatient Physician Services	Deductible, then 95% AB	Deductible, then 85% AB	Deductible, then 70% AB	Deductible, then 95% AB	Deductible, then 70% AB
Outpatient Services (office)	$15 copay	$15 copay	Deductible, then 70% AB	$15 copay	Deductible, then 70% AB
Partial Hospitalization	Deductible, then 95% AB	Deductible, then 95% AB	Deductible, then 70% AB	Deductible, then 95% AB	Deductible, then 70% AB
Medication Management Visit	$15 copay	$15 copay	Deductible, then 70% AB	$15 copay	Deductible, then 70% AB
MISCELLANEOUS					
Durable Medical Equipment	Deductible, then 95% AB	Deductible, then 95% AB	Deductible, then 95% AB	Deductible, then 95% AB	Deductible, then 95% AB
Acupuncture	$35 copay	$50 copay	Deductible, then 70% AB	$35 copay	Deductible, then 70% AB
Hearing Aids (limited to once/36 months)	100% AB per aid/per ear (children and adults), maximum $1,400 per hearing aid	100% AB per aid/per ear (children and adults)	100% AB per aid/per ear (children and adults), maximum $1,400 per hearing aid	100% AB per aid/per ear (children and adults), maximum $1,400 per hearing aid	100% AB per aid/per ear (children and adults), maximum $1,400 per hearing aid
Outpatient Surgery (office)	$35 copay	$50 copay	Deductible, then 70% AB	$35 copay	Deductible, then 70% AB
Chemotherapy/Radiation Therapy (office)	Deductible, then 95% AB	Deductible, then 95% AB	Deductible, then 70% AB	Deductible, then 95% AB	Deductible, then 70% AB
Renal Dialysis	Deductible, then 95% AB	Deductible, then 95% AB	Deductible, then 70% AB	Deductible, then 95% AB	Deductible, then 70% AB
Cardiac Rehab (subject to Medical Policy review)	Deductible, then 95% AB	Deductible, then 95% AB	Deductible, then 70% AB	Deductible, then 95% AB	Deductible, then 70% AB
DEPENDENT AGE LIMIT	To age 26, end of month	To age 26, end of month	To age 26, end of month	To age 26, end of month	To age 26, end of month

AB = Allowed Benefit

This material is believed to be accurate as of the production date, it is subject to change.

Aetna HMO/EPO is most similar to CareFirst EPO

CareFirst EPO *Actives/Retirees Under 65—January 2021*		Aetna HMO/EPO *Effective 1/1/22*
CareFirst EPO - No Referrals Required		**Aetna - HMO/EPO**
SERVICES (For treatment at an outpatient hospital facility an additional professional charge/copay may apply)		No Referrals Required
NETWORK	In-network using the PPO national network	In-network using Open Access Aetna Select national network
COPAYS	$15 PCP/$15 Specialist copay	$15 PCP/$15 Specialist copay
ANNUAL DEDUCTIBLE		
Individual	$100	$100
Individual & Child	$200	$200
Individual & Adult	$200	$200
Family	$200	$200
ANNUAL OUT-OF-POCKET MAXIMUM		
Medical	$1,100 Ind. / $3,600 Family	$1,100 Ind. / $3,600 Family
LIFETIME MAXIMUM BENEFIT	Unlimited except on fertility services	Unlimited except on fertility services
PREVENTIVE SERVICES		
Well-Child Care		
▪ 0-24 months	No charge	No charge
▪ 24 months-13 years (immunization visit)	No charge	No charge
▪ 24 months-13 years (non-immunization visit)	No charge	No charge
▪ 14-17 years	No charge	No charge
Adult Physical Examination	No charge	No charge
Routine GYN Visits	No charge	No charge
Mammograms	No charge	No charge
Cancer Screening (Pap Test, Prostate and Colorectal)	No charge	No charge
OFFICE VISITS, LABS AND TESTING		
Office Visits for Illness	$15 PCP/$15 Specialist copay	$15 PCP/$15 Specialist copay
Diagnostic Services	Deductible, then no charge	Deductible, then no charge
X-ray and Lab Tests	Deductible, then no charge	Deductible, then no charge
Allergy Testing	$15 PCP/$15 Specialist copay	$15 PCP/$15 Specialist copay
Allergy Shots	$15 PCP/$15 Specialist copay	$15 PCP/$15 Specialist copay
Outpatient Physical, Speech and Occupational Therapy	$15 copay (limited to 50 visits each/benefit period)	$15 copay (limited to 150 visits combined per benefit period)
Outpatient Chiropractic	$15 copay (unlimited visits/condition/benefit period)	$15 copay (unlimited visits)
EMERGENCY CARE AND URGENT CARE		
Physician's Office	$15 copay	$15 copay
Urgent Care Center	$35 copay	$35 copay
Hospital Emergency Room	$75 copay (waived if admitted)	$75 copay (waived if admitted)
Ambulance (if medically necessary)	No charge	No charge
HOSPITALIZATION (365 days per year)		
Inpatient Facility Services	Deductible, then no charge	Deductible, then no charge
Outpatient Facility Services	$25 copay	$25 copay
Inpatient Physician Services	Deductible, then no charge	Deductible, then no charge
Outpatient Physician Services	$15 copay	$15 copay

Aetna HMO/EPO is most similar to CareFirst EPO

CareFirst EPO *Actives/Retirees Under 65—January 2021*		Aetna HMO/EPO *Effective 1/1/22*
CareFirst EPO - No Referrals Required		**Aetna - HMO/EPO**
SERVICES (For treatment at an outpatient hospital facility an additional professional charge/copay may apply)		No Referrals Required
HOSPITAL ALTERNATIVES		
Home Health Care	Deductible, then no charge	Deductible, then no charge
Hospice—Inpatient Facility or At-Home Care	Deductible, then no charge	No charge
Skilled Nursing Facility — Room, Board and Physician and Medical Services (limited to 120 days/benefit period)	Deductible, then no charge	Deductible, then no charge
MATERNITY		
Preventive Prenatal Office Visits	No charge	No charge
Delivery & Hospitalization	Deductible, then no charge	Deductible, then no charge
Nursery Care of Newborn	Deductible, then no charge	Deductible, then no charge
Artificial Insemination— limited to 6 attempts per live birth	Paid same as other outpatient hospital/facility/practitioner covered services	Paid same as other outpatient hospital/facility/practitioner covered services
InVitro Fertilization Procedures— limited to 3 attempts per live birth &	Paid same as other outpatient hospital/facility/practitioner covered services	Paid same as other outpatient hospital/facility/practitioner covered services
MENTAL HEALTH AND SUBSTANCE USE DISORDER — Inpatient Requires Preauthorization		
Inpatient Facility Services (requires Pre-authorization)	Deductible, then no charge	Deductible, then no charge
Inpatient Physician Services	Deductible, then no charge	Deductible, then no charge
Outpatient Services (office)	$15 copay	$15 copay
Partial Hospitalization	$15 copay (practitioner)/No charge after deductible (facility)	$15 copay (practitioner)/No charge after deductible (facility)
Medication Management Visit	$15 copay	$15 copay
MISCELLANEOUS		
Durable Medical Equipment	Deductible, then no charge	Deductible, then no charge
Acupuncture	$15 copay per visit (limited to 50 days/benefit period)	$15 copay per visit (limited to 50 days/benefit period)
Hearing Aids (limited to once/36 months)	No copay per aid/per ear (children and adults), maximum $1,400 per hearing aid	No copay per aid/per ear (children and adults), maximum $1,400 per hearing aid
Outpatient Surgery (office)	$15 PCP/$15 Specialist (Facility $25)	$15 PCP/$15 Specialist (Facility $25)
Chemotherapy/Radiation Therapy (office)	$15 copay (per visit office)/$25 copay (facility)	$15 copay (per visit office)/$25 copay (facility)
Renal Dialysis	$15 copay (per visit office)/$25 copay (facility)	$15 copay (per visit office)/$25 copay (facility)
Cardiac Rehab (subject to Medical Policy review)	$25 copay (outpatient facility)/$15 copay (outpatient facility practitioner)	$25 copay (outpatient facility)/$15 copay (outpatient facility
DEPENDENT AGE LIMIT	To age 26, end of month	To age 26, end of month

AB= Allowed Benefit

This material is believed to be accurate as of the production date, it is subject to change.

Aetna HMO/EPO is most similar to CareFirst HMO

CareFirst BlueChoice HMO *Actives/Retirees Under 65—January 2021*		Aetna HMO/EPO *Effective 1/1/22*
BlueChoice HMO Open Access		**Aetna - HMO/EPO**
SERVICES (For treatment at an outpatient hospital facility an additional professional charge/copay may apply)		No Referrals Required
NETWORK	BlueChoice (Maryland, District of Columbia, Northern Virginia)*	In-network using Open Access Aetna Select national network
COPAYS	$15 PCP/$15 Specialist copay	$15 PCP/$15 Specialist copay
ANNUAL DEDUCTIBLE		
Individual	$100	$100
Individual & Child	$200	$200
Individual & Adult	$200	$200
Family	$200	$200
ANNUAL OUT-OF-POCKET MAXIMUM		
Medical	$800 Ind. / $1,600 Family	$1,100 Ind. / $3,600 Family
LIFETIME MAXIMUM BENEFIT	Unlimited except on fertility services	Unlimited except on fertility services
PREVENTIVE SERVICES		
Well-Child Care		
▪ 0-24 months	No charge	No charge
▪ 24 months-13 years (immunization visit)	No charge	No charge
▪ 24 months-13 years (non-immunization	No charge	No charge
▪ 14-17 years	No charge	No charge
Adult Physical Examination	No charge	No charge
Routine GYN Visits	No charge	No charge
Mammograms	No charge	No charge
Cancer Screening (Pap Test, Prostate and	No charge	No charge
OFFICE VISITS, LABS AND TESTING		
Office Visits for Illness	$15 PCP/$15 Specialist copay	$15 PCP/$15 Specialist copay
Diagnostic Services	No charge	Deductible, then no charge
Xray and Lab Tests	No charge (LabCorp only)	Deductible, then no charge
Allergy Testing	$15 PCP/$15 Specialist copay	$15 PCP/$15 Specialist copay
Allergy Shots	$15 PCP/$15 Specialist copay	$15 PCP/$15 Specialist copay
Outpatient Physical, Speech and	$15 copay (limited to 50 visits each/condition/benefit period)	$15 copay (limited to 150 visits combined per benefit period)
Outpatient Chiropractic	$15 copay (unlimited visits/condition/benefit period)	$15 copay (unlimited visits)
EMERGENCY CARE AND URGENT CARE		
Physician's Office	$15 PCP/$15 Specialist copay	$15 PCP/$15 Specialist copay
Urgent Care Center	$35 copay	$35 copay
Hospital Emergency Room	$75 copay (waived if admitted)	$75 copay (waived if admitted)
Ambulance (if medically necessary)	No charge	No charge

Aetna HMO/EPO is most similar to CareFirst HMO

CareFirst BlueChoice HMO *Actives/Retirees Under 65—January 2021*		Aetna HMO/EPO *Effective 1/1/22*
BlueChoice HMO Open Access		**Aetna - HMO/EPO**
SERVICES (For treatment at an outpatient hospital facility an additional professional charge/copay may apply)		No Referrals Required
HOSPITALIZATION		
Inpatient Facility Services	Deductible, then no charge	Deductible, then no charge
Outpatient Facility Services	$25 copay	$25 copay
Inpatient Physician Services	Deductible, then no charge	Deductible, then no charge
Outpatient Physician Services	$15 copay	$15 copay
HOSPITAL ALTERNATIVES		
Home Health Care	No charge after deductible	Deductible, then no charge
Hospice	No charge after deductible	No charge
Skilled Nursing Facility (limited to 365 days/	No charge after deductible	Deductible, then no charge
MATERNITY		
Preventative Prenatal Office Visits	No charge	No charge
Delivery and Facility Services	No charge after deductible	Deductible, then no charge
Nursery Care of Newborn	No charge after deductible	Deductible, then no charge
Artificial Insemination— limited to 6 attempts per live birth	$15 copay per visit (office)/No charge after deductible (facility)	Paid same as other outpatient hospital/facility/practitioner covered services
InVitro Fertilization Procedures—Subject to State Mandate (limited to 3 attempts per	$15 copay per visit (office)/No charge after deductible (facility)	Paid same as other outpatient hospital/facility/practitioner covered services
MENTAL HEALTH AND SUBSTANCE USE DISORDER—Subject to Federal Mandate		
Inpatient Facility Services (requires Pre-	No charge after deductible	Deductible, then no charge
Inpatient Physician Services	No charge after deductible	Deductible, then no charge
Outpatient Services (MH & SA) (office)	$15 copay	$15 copay
Partial Hospitalization	$15 copay (practitioner)/No charge after deductible (facility)	$15 copay (practitioner)/No charge after deductible (facility)
Medication Management Visit	$15 copay	$15 copay
MISCELLANEOUS		
Durable Medical Equipment	No charge after deductible	Deductible, then no charge
Acupuncture	$15 copay per visit (limited to 50 days/benefit period)	$15 copay per visit (limited to 50 days/benefit period)
Hearing Aids (limited to once/36 months)	No copay per aid/per ear (children and adults)	No copay per aid/per ear (children and adults), maximum $1,400 per hearing aid
Outpatient Surgery (office)	$15 PCP/$15 Specialist (Facility $25)	$15 PCP/$15 Specialist (Facility $25)
Chemotherapy/Radiation Therapy (office)	$15 copay (per visit office)/$25 copay (facility)	$15 copay (per visit office)/$25 copay (facility)
Renal Dialysis	$15 copay (per visit office)/$25 copay (facility)	$15 copay (per visit office)/$25 copay (facility)
Cardiac Rehab (subject to Medical Policy review)	$25 copay (outpatient facility)/$15 copay (outpatient facility practitioner)	$25 copay (outpatient facility)/$15 copay (outpatient facility practitioner)
DEPENDENT AGE LIMIT	To age 26, end of month	To age 26, end of month