



Medical Plan Options

The outline of benefits below is provided for comparative purposes only and is not intended as a contract of benefits. All final benefit determinations will be in accordance with the medical plan contract. Have a question about the medical plan? Contact the Benefits Office at 410-996-5415.

	Aetna HDHP		Aetna Select	CareFirst Core	
	In Network	Out-of-Network	In Network	In Network	Out-of-Network
Deductibles					
Individual	\$1,600	\$3,200	\$200	\$500	\$1,000
Family	\$3,200**	\$6,400**	\$400	\$1,500	\$3,000
Co-insurance	10%	30%	N/A	10%	30%
Out-of-Pocket Max					
Individual	\$3,200***	\$6,400	\$1,500	\$2,500	\$2,500
Family	\$6,400***	\$12,800	\$4,500	\$5,000	\$5,000
Preventative Care Visit (including pre-natal)	Covered in full	Deductible, then 30%*	Covered in full	Covered in full	Deductible, then 30%
Office Visit	Deductible, then 10%	Deductible, then 30%*	Deductible, then \$20	Deductible, then \$20	Deductible, then 30%*
Specialist Visit	Deductible, then 10%	Deductible, then 30%*	Deductible, then \$25	Deductible, then \$20	Deductible, then 30%*
Practitioner Hospital	Deductible, then 10%	Deductible, then 30%*	Deductible, then \$20	Deductible, then \$20	Deductible, then 30%*
Hospital Facility	Deductible, then 10%	Deductible, then 30%*	Deductible, then \$0	Deductible, then \$35	Deductible, then 30%*
Inpatient Hospital Stay	Deductible, then 10%	Deductible, then 30%*	Deductible, then \$0	Deductible, then 10%	Deductible, then 30%*
Inpatient Surgery	Deductible, then 10%	Deductible, then 30%*	Deductible, then \$0	Deductible, then 10%	Deductible, then 30%*
Outpatient Surgery	Deductible, then 10%	Deductible, then 30%*	Deductible, then \$75	Deductible, then \$35	Deductible, then 30%*
Telehealth Consultations	Deductible, then 10%	N/A	Deductible, then \$20	Deductible, then \$20	N/A
Urgent Care	Deductible, then 10%	Deductible, then 30%*	Deductible, then \$35	Deductible, then \$35	Deductible, then \$35
Emergency Room	Deductible, then 10%	Deductible, then 10%*	Deductible, then \$75	Deductible, then \$100	Deductible, then \$100
X-Ray & Lab	Deductible, then 10%	Deductible, then 30%*	Deductible, then \$15	Deductible, then \$15	Deductible, then 30%*
CT Scan & MRI	Deductible, then 10%	Deductible, then 30%*	Deductible, then \$50	Deductible, then \$75	Deductible, then 30%*

*You may be billed up to the total charges for visits with out of network providers.

**If you have Family coverage under the HDHP, the Family Deductible must be satisfied before the Plan will pay any benefits.

***Your maximum out-of-pocket limit for prescription is \$3,450 (individual) and \$6,900 (family)

	Aetna HDHP		Aetna Select	CareFirst Core	
	In Network	Out-of-Network	In Network	In Network	Out-of-Network
Physical, Occ, & Speech Therapy	Deductible, then 10%	Deductible, then 30%*	Deductible, then \$25	Up to \$35 after deductible	Deductible, then 30%*
Chiropractic Care	Deductible, then 10%	Deductible, then 30%*	Deductible, then \$25	Deductible, then \$20	Deductible, then 30%*
Chemotherapy & Radiation	Deductible, then 10%	Deductible, then 30%*	Deductible, then \$25	Deductible, then \$35	Deductible, then 30%*
Durable Medical Equipment	Deductible, then 10%	Deductible, then 30%*	Deductible, then \$0	Deductible, then 10%	Deductible, then 30%*
Home Health Care	Deductible, then 10%	Deductible, then 30%*	Deductible, then \$0	Deductible, then 10%	Deductible, then 30%*
Hospice Care	Deductible, then 10%	Deductible, then 30%*	Deductible, then \$0	Deductible, then 10%	Deductible, then 30%*
Organ Transplant	Deductible, then 10%	Deductible, then 30%*	Deductible, then 30%	Deductible, then 10%	Deductible, then 30%*
Skilled Nursing Facility	Deductible, then 10%	Deductible, then 30%*	Deductible, then \$0	Deductible, then 10%	Deductible, then 30%*
Delivery /Maternity Care	Deductible, then 10%	Deductible, then 30%*	Deductible, then \$0	Deductible, then 10%	Deductible, then 30%*
Infertility Services with Prior Auth.	Deductible, then 10% - 3 lifetime attempt max	Deductible, then 30%* - 3 lifetime attempt max	Deductible, then 50% - \$100,000 lifetime max	Deductible, then 10% - 2 lifetime attempt max	Deductible, then 30%* - 2 lifetime attempt max
Mental Health/ Substance Abuse Inpatient Therapy	Deductible, then 10% , with pre-certification	Deductible, then 30%* , with pre-certification	Deductible, then \$0, with pre-certification	Deductible, then 10% , with pre-certification	Deductible, then 30%* , with pre-certification
Mental Health/ Substance Abuse Outpatient Therapy	Deductible, then 10% ,	Deductible, then 30%*	Deductible, then \$25	Deductible, then \$35	Deductible, then 30%*

Glossary of Terms

Deductible: The amount you are required to pay before the plan begins to cover any of the costs. The deductible does not apply to in-network routine preventative wellness care.

Co-pay: The fixed dollar amount you pay towards the cost of covered medical services. This payment will vary by the type of service for each health plan option.

Co-insurance: The percentage you pay towards covered medical services. The remaining balance of the bill is paid by the health care plan. You are responsible for paying this percentage until you have reached the plan's out-of-pocket maximum.

Out-of-Pocket Maximum: The most you will have to pay towards covered expenses during the benefit plan year. Once you meet the out-of-pocket maximum, the plan will pay for any additional covered expenses at 100% for the remainder of the benefit plan year with in-network providers.