

Active

City of Baltimore 2012 Benefit Plan Comparison Chart

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Schedule & Life/AD&D Insurance**

Note: This Comparison Is To Be Used As A Guide Only. Actual Benefits Will Be Governed by The Terms And Conditions of the Master Contract.

Section 1

Important Notices

Important Information About Medicare

Important Medicare Information

The City requires all its members (including you and your dependents) to enroll in Medicare Part B at the time you become eligible for Medicare Part A. Once enrolled in Medicare part B, you must remain enrolled in order to continue receiving the maximum possible benefit from the City's supplemental medical plan.

Disability Retirees as Determined by Social Security

When you (or spouse/child) become disabled as determined by the SSA, you must apply for Medicare Part B through SSA at the time you become eligible for Medicare Part A and provide Employee Benefits with your Medicare information immediately. If you decline your Medicare Part B, you will be responsible for all Medicare Part B (Medical) claims that would ordinarily be covered by Medicare B. Your medical coverage with the City will be converted to the supplemental coverage and the City will only cover 20% of the claims up to the Medicare Allowed Amount.

Information About Your Benefits for 2012

Express Scripts Clinical Programs

The City of Baltimore will be implementing Rx Clinical Programs, which include Step Therapy, Prior Authorization and Quantity Limits effective January 1, 2012.

Step Therapy is a process that requires a person to try lower cost drugs before a higher cost drug in the same class is approved. Step Therapy will be waived if you are currently taking a higher cost prescribed drug prior to implementation of this program. However, new prescriptions will be subject to the Step Therapy process.

Prior Authorization from your physician will be required for certain drugs. A list of the drugs that will require prior authorization will be provided in your Express Scripts Prescription Drug booklet. Prior Authorization will be waived if you are currently taking a prescribed drug that is on the Prior Authorization drug list. However, new prescriptions will be subject to the Prior Authorization process.

Drug Quantity Management limits the amount of medication that can be dispensed during a given period in accordance with the Food and Drug Administration's (FDA) guidelines. If the quantity prescribed exceeds FDA limit, then the quantity will be dispensed at the FDA approved amount.

Flexible Spending Account

Effective January 1, 2012 WageWorks will be your flexible spending account administrator. WageWorks will offer the WageWorks Health Care Card for OTC/Rx. Use it instead of cash for your prescription and eligible Over-the-Counter (OTC) purchases at your local IAS certified pharmacy, or your Express Scripts mail order pharmacy.

Life/AD&D Insurance

Effective January 1, 2012 Minnesota Life will be the new Life/AD&D provider for the City of Baltimore.

Administrative Information

Duplicate Coverage Information	If you and your spouse/partner are both a City employee/retiree, you both cannot enroll each other or the same eligible dependents on your City medical, dental, vision and prescription plans during any coverage period. You will be notified to adjust duplicate coverage, if applicable.
Family Status Change	If you experience a family status change, you must update your health benefits enrollment status online by logging onto BOSS at www.baltimorecity.essbenefits.com and submitting the required documentation to Employee Benefits, within 60 days from the date of the change.
Medicare Secondary Payer (MSP) Mandatory Reporting	Under the Medicare Secondary Payer (MSP) Mandatory Reporting, the federal law requires the mandatory collection and reporting of social security numbers of all covered participants including employees, retirees and their dependents through employer group health benefits. Noncompliance may result in the loss of coverage for covered participants with invalid or missing social security numbers.
Address Change	You must update your change of address, in writing, through your agency.
Enrollment Website	<u>www.baltimorecity.essbenefits.com</u>

Section 1**Contact Phone Numbers & Websites**

Provider	Phone Number	Website
CareFirst PPN	1-800-535-2292	www.carefirst.com
ValueOptions Mental Health (CareFirst Members Only)	1-866-468-5633	www.achievesolutions.net/baltimore
UnitedHealthcare	1-877-462-5027	www.myuhc.com
Optimum Choice	1-800-815-8958	www.myuhc.com
Kaiser Permanente HMO	1-866-248-0715	www.kaiserpermanente.org
Aetna PPO	1-800-900-7562	www.aetna.com
Aetna HMO	1-877-440-4711	www.aetna.com
Express Scripts Prescription Plan	1-800-354-8123	www.express-scripts.com
CareFirst Dental PPO	1-866-891-2802	www.carefirst.com
The Dental Network (HMO)	1-888-833-8464	www.thedentalnet.org
CareFirst Select Vision	1-800-535-1181	www.carefirst.com
Minnesota Life (Life and AD&D) New for January 1,2012	1-888-658-0193 (Claims)	www.lifebenefits.com/plandesign/baltimorecity
WageWorks (Flexible Spending Account)	1-877-924-3967	www.wageworks.com
ADP COBRA	1-800-526-2750	www.benedirect.adp.com

2012 Active Benefit Plan Comparison Charts

Section 2: POS, PPN & PPO

*Allowed Benefit is 50% of R & C ** any out-of-network provider can balance bill the difference between allowed amount and billed amount

	UnitedHealthcare POS		CareFirst PPN		Aetna PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network**	In-Network	Out-of-Network
Are Referrals Required?	no	no	no	no	no	no
Dependent Eligibility	Dependent children, until the end of the calendar year they reach age 26, regardless of student or marital status.					
Plan Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Routine & Preventive Services						
Routine Office Visit (Maps & Unrepresented)	\$5 copay per visit	\$5 copay per visit, 100% allowed Benefit*	\$5 copay, then 100% Allowed Benefit (1 exam every 36 months)	80% allowed benefit (1 exam every 36 months)	\$5 copay per visit	\$5 copay per visit 100% allowed benefit*
Routine Office Visit (Represented)	\$5 copay per visit	\$5 copay per visit, 100% allowed Benefit*	\$10 copay, then 100% Allowed Benefit (1 exam every 36 months)	80% allowed benefit (1 exam every 36 months)	\$5 copay per visit	\$5 copay per visit 100% allowed benefit*
Physician's Office Visit (Maps & Unrepresented)	\$5 copay per visit	\$5 copay per visit, 100% allowed Benefit*	\$20 copay per visit 100% allowed benefit	80% allowed benefit	\$5 copay per visit	\$5 copay per visit 100% allowed benefit*
Physician's Office Visit (Represented)	\$5 copay per visit	\$5 copay per visit, 100% allowed Benefit*	\$10 copay per visit 100% allowed benefit	80% allowed benefit	\$5 copay per visit	\$5 copay per visit 100% allowed benefit*
Specialist Office Visit (Maps & Unrepresented)	\$5 copay per visit	\$5 copay per visit, 100% allowed Benefit*	\$25 copay per visit 100% allowed benefit	80% allowed benefit	\$5 copay per visit	\$5 copay per visit 100% allowed benefit*
Specialist Office Visit (Represented)	\$5 copay per visit	\$5 copay per visit, 100% allowed Benefit*	\$15 copay per visit 100% allowed benefit	80% allowed benefit	\$5 copay per visit	\$5 copay per visit 100% allowed benefit*
Routine GYN Examination (limit-one per year) (Maps & Unrepresented)	\$5 copay per visit;	\$5 copay per visit, 100% allowed Benefit*	\$5 copay then 100% allowed benefit	80% allowed benefit	\$5 copay per visit	\$5 copay per visit 100% allowed benefit*
Routine GYN Examination (limit- one per year) (Represented)	\$5 copay per visit;	\$5 copay per visit, 100% allowed Benefit*	\$10 copay, then 100% allowed amount	80% allowed benefit	\$5 copay per visit	\$5 copay per visit 100% allowed benefit*
Hearing Exams	\$5 copay per visit	\$5 copay per visit 100% allowed benefit*	100% allowed benefit with medical diagnosis; one exam every 36 months (routine exams excluded)	80% allowed benefit with medical diagnosis; one exam every 36 months (routine exams excluded)	\$5 copay per visit	\$5 copay per visit 100% allowed benefit*
Mammography, Colorectal Screening, Prostate Screening	covered in full call plan for frequency limits	covered in full 100% allowed benefit*	100% allowed benefit: ages 40 - 49= 1 every 24 months; ages 50 + 1 every 12 months	80% allowed benefit: ages 40 - 49= 1 every 24 months; ages 50+ 1 every 12 months	covered in full (call plan for frequency limits)	\$5 copay for colorectal & prostate screenings, no copay for mammography; covered in full after copay; call plan for frequency limits
Well Baby/Child Care	\$5 copay per visit	\$5 copay per visit; 100% allowed Benefit*	\$10 copay then 100% allowed benefit; 0-11 Months 4 Visits; 12-23 Months 3 Visits; 2-6 Years 1 per Year; 7-12 Years 100% allowed Benefit.	\$10 copay, then 80% of allowed benefit; 0-11 Months 4 Visits; 12-23 Months 3 Visits; 2-6 Years 1 per Year; 7-12 Years 100% allowed Benefit.	\$5 copay	\$5 copay; 100% allowed benefit*

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	UnitedHealthcare POS		CareFirst PPN		Aetna PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network**	In-Network	Out-of-Network
Emergency Room and Urgent Care Services						
Ambulance Service (based on medical necessity)	Covered in full for emergency only	100 % allowed benefit for emergency only	major medical subject to deductible and coinsurance if applicable (Ground Only)	major medical subject to deductible and coinsurance if applicable (Ground Only)	covered in full	100% allowed benefit*
Emergency Room (copay waived if admitted)	\$50 copay	\$50 copay	\$50 copay	\$50 copay	\$50 copay	\$50 copay
Urgent Care	\$5 copay per visit	\$5 copay per visit, 100% allowed Benefit*	\$10 copay per visit;	These services are for specific providers and none are out of network	\$5 copay per visit	\$5 copay per visit
Hospital Inpatient Services						
Anesthesia	covered in full	100% allowed benefit*	100% allowed benefit	80% allowed benefit	covered in full	100% allowed benefit*
Hospital Services, including Room, Board & General Nursing Services (Maps & Unrepresented)	covered in full	100% allowed benefit*	100% allowed benefit preauthorization required (Acute Inpatient Rehabilitation Not Covered)	\$100 deductible per admission, then plan pays 70% up to \$1,500 out of pocket maximum per admission, then 100% allowed benefit. preauthorization required (Acute Inpatient Rehabilitation Not Covered)	covered in full	100% allowed benefit*
Hospital Services, including Room, Board & General Nursing Services (Represented)	covered in full	100% allowed benefit*	100% allowed benefit preauthorization required (Acute Inpatient Rehabilitation Not Covered)	\$100 deductible per admission, then plan pays 80% up to \$1,500 out of pocket maximum per admission, then 100% allowed benefit. preauthorization required (Acute Inpatient Rehabilitation Not Covered)	covered in full	100% allowed benefit*
Diagnostic Lab Work & X-rays	covered in full	100% allowed benefit*	100% allowed benefit	80% allowed benefit	covered in full	100% allowed benefit*
Medical Surgical Physician Services	covered in full	100% allowed benefit*	100% allowed benefit	80% allowed benefit	covered in full	100% allowed benefit*
Physical, Speech & Occupational Therapy	covered in full	100% allowed benefit*	100% allowed benefit	80% allowed benefit	covered in full	100% allowed benefit*
Organ Transplant (Pre-Authorization Required)	covered in full for non-experimental transplants	100% allowed benefit*-limited to \$30,000 per transplant; for non-experimental transplants	100% allowed benefit - kidney, bone marrow, cornea, liver, heart, heart-lung or pancreas	100% allowed benefit - kidney, bone marrow, cornea, liver, heart, heart-lung or pancreas	Covered in full for non-experimental transplants, no maximum	no coverage
Outpatient Services						
Chemotherapy & Radiation	\$5 copay per visit	\$5 copay per visit, 100% allowed benefit*	100% allowed benefit	80% allowed benefit	\$5 copay per visit	\$5 copay per visit, 100% allowed benefit*
Renal Dialysis	covered in full	100% allowed benefit*	100% allowed benefit	80% allowed benefit	covered in full	100% allowed benefit *
Diagnostic Lab Work & X-rays	covered in full	100% allowed benefit*	100% allowed benefit	80% allowed benefit	covered in full	100% allowed benefit*

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	UnitedHealthcare POS		CareFirst PPN		Aetna PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network**	In-Network	Out-of-Network
Outpatient Services Continued						
Outpatient Surgery	covered in full	100% allowed benefit*	100% allowed benefit	80% allowed benefit	covered in full	100% allowed benefit*
Physical, Speech & Occupational Therapy (Maps & Unrepresented)	\$5 copay per visit; combined maximum 60 visits per year for short term care	\$5 copay per visit; 100% allowed benefit*, combined maximum 60 visits per year for short term care	office 100% allowed benefit - precertification required after 10th lifetime visit - limited to 100 combined visits per calendar year	80% allowed benefit for 100 visits per calendar year for physical, speech and occupational therapies combined. Pre-certification required after first 10 visits.	\$5 copay per visit Call Plan for Visit limits	\$5 copay per visit, 100% allowed benefit* Call Plan for Visit limits
Physical, Speech & Occupational Therapy (Represented)	\$5 copay per visit; combined maximum 60 visits per year for short term care	\$5 copay per visit; 100% allowed benefit*, combined maximum 60 visits per year for short term care	facility \$10 copay; office 100% allowed benefit - precertification required after 10th lifetime visit - limited to 100 combined visits per calendar year	80% allowed benefit for 100 visits per calendar year for physical, speech and occupational therapies combined. Pre-certification required after first 10 visits.	\$5 copay per visit Call Plan for Visit limits	\$5 copay per visit, 100% allowed benefit* Call Plan for Visit limits
Pre-Admission Testing	\$5 copay per visit, testing covered in full	\$5 copay per visit, 100% allowed benefit*	100% allowed benefit	80% allowed benefit	covered in full	100% allowed benefit*
Allergy Testing	\$5 copay per visit	\$5 copay per visit; 100% allowed benefit*	100% allowed benefit	80% allowed benefit	\$5 copay per visit	\$5 copay per visit, 100% allowed benefit *
Allergy Serum	Covered up to a \$200 maximum per year	Covered up to a \$200 maximum per year	Not covered - See pharmacy benefits	Not covered - See pharmacy benefits	\$5 copay per visit	\$5 copay per visit, 100% allowed benefit*
Maternity						
Pre and Post-Natal (Physician Services)	\$5 copay for initial visit to determine pregnancy, then covered in full	\$5 copay for initial visit to determine pregnancy, then 100% allowed benefit*	100% allowed benefit	80% allowed benefit	\$5 copay for the first visit only, then covered in full	\$5 copay for the first visit only, then covered in full; 100% allowed benefit*
Delivery (Inpatient) (Maps & Unrepresented)	covered in full	100% allowed benefit*	100% allowed benefit Pre-authorization required	\$100 deductible per admission, then plan pays 70% up to \$1,500 out of pocket maximum per admission then 100% allowed benefit Pre-authorization required.	covered in full	100% allowed benefit*
Delivery (Inpatient) (Represented)	covered in full	100% allowed benefit*	100% allowed benefit Pre-authorization required	\$100 deductible per admission, then plan pays 80% up to \$1,500 out of pocket maximum per admission then 100% allowed benefit Pre-authorization required.	covered in full	100% allowed benefit*
Newborn Care (inpatient)	covered in full	100% allowed benefit*	100% allowed benefit	80% allowed benefit	covered in full	100% allowed benefit*

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	UnitedHealthcare POS		CareFirst PPN		Aetna PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network**	In-Network	Out-of-Network
Fertility Testing & Family Planning						
Fertility Testing & Family Planning	\$5 copay per visit	\$5 copay per visit; 100% allowed benefit*	100% allowed benefit	80% allowed benefit	Member cost sharing based on type of service performed and place of service where rendered	100% allowed benefit* member cost sharing based on type of service performed and place of service where rendered
In-Vitro Fertilization	100% allowable charges; \$100,000 maximum lifetime benefit; for up to 3 attempts per life birth	100% allowed benefit*; \$100,000 maximum lifetime benefit for up to 3 attempts per life birth	100% allowed benefit*; \$12,000 maximum lifetime. Pre-Authorization Required	80% allowed benefit*; \$12,000 maximum lifetime Pre-Authorization Required	Covered in full; \$100,000 Maximum lifetime benefit; up to 3 attempts per live birth combined with ART, AI and AO	100% allowed benefit* covered in full; \$100,000 Maximum lifetime benefit; up to 3 attempts per live birth combined with Art, AI and AO
Mental Health & Substance Abuse Benefits						
Alcohol & Substance Abuse/Mental Health (Maps & Unrepresented) (Inpatient)	covered in full	100% allowed benefit*	100% allowed benefit preauthorization required (Benefit Provided by Value Options) Pre-Authorization Required	\$100 co-pay per admission, then plan pays 70% up to \$1,500 out of pocket maximum per admission, then 100% allowed benefit. preauthorization required (Benefit Provided by Value Options) Pre-Authorization Required	covered in full	100% allowed benefit*
Alcohol & Substance Abuse/Mental Health (Represented) (Inpatient)	covered in full	100% allowed benefit*	100% allowed benefit preauthorization required (Benefit Provided by Value Options) Pre-Authorization Required	\$100 deductible per admission, then plan pays 80% up to \$1,500 out of pocket maximum per admission, then 100% allowed benefit. preauthorization required (Benefit Provided by Value Options) Pre-Authorization Required	covered in full	100% allowed benefit*
Mental Health/Alcohol & Substance Abuse (Maps & Unrepresented) (Outpatient)	\$5 copay per visit	\$5 copay per visit; 100% allowed benefit*	\$20 copay per visit; 100% allowed benefit. (Benefit provided by Value Options) Pre-Authorization Required	80% allowed benefit. (Benefit provided by Value Options) Pre-Authorization Required	\$5 copay per visit	\$5 copay per visit 100% allowed benefit*
Mental Health/Alcohol & Substance Abuse (Represented) (outpatient)	\$5 copay per visit	\$5 copay per visit; 100% allowed benefit*	\$10 copay per visit; 100% allowed benefit. (Benefit provided by Value Options) Pre-Authorization Required	80% allowed benefit. (Benefit provided by Value Options) Pre-Authorization Required	\$5 copay per visit	\$5 copay per visit 100% allowed benefit*

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	UnitedHealthcare POS		CareFirst PPN		Aetna PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network**	In-Network	Out-of-Network
Miscellaneous Supplies & Services						
Nutrition & Health Education	\$5 copay per visit, Diabetic Nutritional Counseling Only	\$5 copay per visit, Diabetic Nutritional Counseling Only, 100% allowed benefit*	Covered same as any office visit- based on diagnosis. Contact plan for details.	80% allowed benefit, for specific diagnosis only	\$5 copay per visit, Diabetic Nutritional Counseling Only	\$5 copay per visit, Diabetic Nutritional Counseling Only; 100% allowed benefit*
Diabetetic Supplies (Insulin & Syringes Covered by Rx Plan)	covered in full , including lancets, tests strips and glucometers	100% allowed benefit, including lancets, test strips and glucometers	100% allowed benefit, including lancets test strips and glucometers	100% allowed benefit, including lancets, test strips and glucometers	covered in full	100% allowed benefit*
Durable Medical Equipment	covered in full; pre-authorization required	100% allowed benefit; pre-authorization required	major medical benefit subject to deductible and coinsurance if applicable	major medical subject to deductible and coinsurance if applicable	covered in full	100% allowed benefit*
Private duty nursing (pre-authorization required)	covered in full for skilled care when medically necessary with prior plan approval	100% allowed benefit*	based on medical necessity; major medical benefit subject to deductible and coinsurance if applicable	based on medical necessity; major medical benefit subject to deductible and coinsurance if applicable	covered in full	100% allowed benefit *
Inpatient Hospice Care	covered in full; prior plan approval for palliative services required	100% allowed benefit*; prior plan approval for palliative services required	100% allowed benefit - preauthorization required	80% allowed benefit - preauthorization required	covered in full	100% allowed benefit *
Outpatient Hospice Care	covered in full; prior plan approval required (in lieu of hospitalization)	100% allowed benefit*, prior plan approval for palliative services required	100% allowed benefit - preauthorization required	100% allowed benefit - preauthorization required	covered in full	100% allowed benefit *
Prosthetic Devices (Such as artificial limbs)	covered in full after prior plan approval	100% allowed benefit* after prior plan approval	major medical benefit subject to deductible and coinsurance if applicable	major medical benefit subject to deductible and coinsurance if applicable	covered in full	100% allowed benefit *
Major Medical						
Major Medical Annual Deductible (Maps & Unrepresented)	N/a	N/a	Major medical expenses only - \$250 per person per year	Major medical expenses only - \$250 per person per year	N/a	N/a
Major Medical Annual Deductible (Represented)	N/a	N/a	major medical expenses only; \$200 per person per policy year	major medical expenses only; \$200 per person per policy year	N/a	N/a
Major Medical Yearly Out-Of-Pocket Maximum Costs (Maps & Unrepresented)	N/a	N/a	Deductible then 100% first \$30,000, then 50% of allowed benefit	Deductible then 100% first \$30,000, the 50% of allowed benefit	N/a	N/a
Major Medical Yearly Out-Of-Pocket Maximum Costs (Represented)	N/a	N/a	Deductible then 80% of allowed benefit	Deductible then 80% of allowed benefit	N/a	N/a

2012 Active Benefit Plan Comparison Charts

Section 3: HMO

*Allowed Benefit is 50% of R & C ** any out-of-network provider can balance bill the difference between allowed amount and billed amount

	Kaiser HMO	Optimum Choice HMO	Aetna HMO
Are Referrals Required?	Yes	Yes	Yes
Dependent Eligibility	Dependent children, until the end of the calendar year they reach age 26, regardless of student or marital status.		
Plan Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited
Routine & Preventive Services			
Physician's Office Visit	\$5 copay per visit	\$5 copay per visit	\$5 copay per visit
Routine GYN Examination (Limited to one per year)	Covered in full	\$5 copay per visit	\$5 copay per visit
Specialist Office Visit	\$5 copay per visit	\$5 copay per visit	\$5 copay per visit
Hearing Exams	\$5 copay per visit	\$5 copay per visit	\$5 copay per visit
Immunizations	Covered in full	Covered in full when done in conjunction with an office visit	Covered in full
Mammography, Colorectal & Prostate Screening	Covered in full - call plan for details	Covered in full - call plan for details	Covered in full - call plan for details
Routine Physical	Covered in full	\$5 copay per visit	\$5 copay per visit
Well Baby/Child Care	Covered in full for children under age 5	\$5 copay per visit	\$5 copay per visit
Emergency Room and Urgent Care Services			
Ambulance Service (Based on medical necessity)	Covered in full when medically necessary	Covered in full for emergency only	Covered in full for emergency only
Emergency Room (Waived if admitted)	\$50 copay	\$50 copay	\$50 copay
Urgent Care	\$5 copay per visit	\$5 copay per visit	\$5 copay per visit
Hospital Inpatient Services			
Anesthesia	Covered in full	Covered in full	Covered in full
Hospital Services Including Room, Board and General Nursing Services	Covered in full	Covered in full	Covered in full
Diagnostic Lab Work & X-rays	Covered in full	Covered in full	Covered in full
Medical Surgical Physician Services	Covered in full	Covered in full	Covered in full
Physical, Speech & Occupational Therapy	Covered in full	Covered in full	Covered in full
Organ Transplant (Pre-Authorization Required)	Contact plan for details	Covered in full for non-experimental kidney, bone marrow, cornea transplants; liver, heart, heart-lung, or pancreas	Covered in full for non-experimental transplants.

2012 Active Benefit Plan Comparison Charts

Section 3: HMO

*Allowed Benefit is 50% of R & C ** any out-of-network provider can balance bill the difference between allowed amount and billed amount

	Kaiser HMO	Optimum Choice HMO	Aetna HMO
Outpatient Services			
Chemotherapy & Radiation	\$5 copay per visit	\$5 copay per visit	\$5 copay per visit
Renal Dialysis	\$5 copay per visit	covered in full	covered in full
Diagnostic Lab Work & X-rays	covered in full	covered in full	covered in full
Outpatient Surgery	\$5 copay per visit	covered in full	covered in full
Physical, Speech & Occupational Therapy	\$5 copay per visit call plan for visit limits	\$5 copay per visit 90 visits per therapy type per year.	\$5 copay per visit Call plan for visit limits
Pre-Admission Testing	\$5 copay per visit	covered in full	covered in full
Allergy Testing	\$5 copay per visit	\$5 copay per visit	\$5 copay per visit
Allergy Serum	covered up to \$200 maximum per year	covered up to \$200 maximum per year	\$5 copay per visit
Maternity			
Pre and Post-Natal (Physician Services)	\$5 copay for initial visit to determine pregnancy then covered in full	\$5 copay for initial visit to determine pregnancy then covered in full	\$5 copay for the first visit only, then covered in full
Delivery (Inpatient)	covered in full	covered in full	covered in full
Newborn Care (Inpatient)	covered in full	covered in full	covered in full
Fertility Testing & Family Planning			
Fertility Testing & Family Planning	\$5 copay per visit for family planning. Fertility testing office visit and any other fertility services covered at 50%	\$5 copay per visit for family planning and fertility testing; other fertility services 50%	Member cost sharing based on type of service performed and place of service where rendered
In-Vitro Fertilization	50% of allowable charges; \$100,000 maximum lifetime benefit for up to 3 attempts per live birth	50% of allowable charges; \$100,000 maximum lifetime benefit for up to 3 attempts per live birth	Call plan for specific state mandated benefits
Mental Health & Substance Abuse Benefits			
Mental Health/Alcohol & Substance Abuse (Inpatient)	covered in full	covered in full	covered in full
Mental Health/Alcohol & Substance Abuse (Outpatient)	\$5 copay per visit	\$5 copay per visit	\$5 copay per visit
Miscellaneous Supplies & Services (NOTE: Major Medical Does Not Apply to HMO Plans)			
Nutrition & Health Education	\$5 copay per visit	\$5 copay per visit, Diabetic Nutritional Counseling only	\$5 copay per visit, Diabetic Nutritional Counseling Only
Diabetic Supplies (Insulin & Syringes Covered by Rx plan)	Covered in full	Lancets & test strips, generic covered by a \$5 copay and brand covered by a \$20 copay. Glucometers covered in full with pre-authorization.	Covered in full
Durable Medical Equipment	Covered in full	Covered in full after pre-authorization	Covered in full
Private Duty Nursing (Pre-authorization required)	Covered in full	Not covered	Not covered
Inpatient Hospice Care	Covered in full	Covered in full	Covered in full
Outpatient Hospice Care	Covered in full	Covered in full	Covered in full
Prosthetic Devices (Such As Artificial Limbs)	Covered in full after pre-authorization	Covered in full after pre-authorization	Covered in full, pre-certification required

Section 4: Medical Rates, Prescription Copays, Dental Benefits, Vision Benefits and Life/AD&D Insurance

Plan	Individual			Parent & Child			Husband & Wife			Family		
	Bi-Weekly	Weekly	21 Pay	Bi-Weekly	Weekly	21 Pay	Bi-Weekly	Weekly	21 Pay	Bi-Weekly	Weekly	21 Pay
CareFirst PPN	\$49.51	\$24.76	\$61.30	\$95.92	\$47.96	\$118.75	\$110.53	\$55.27	\$136.85	\$120.45	\$60.22	\$149.13
UnitedHealthcare POS	\$46.01	\$23.00	\$56.96	\$87.41	\$43.71	\$108.23	\$96.62	\$48.31	\$119.62	\$138.02	\$69.01	\$170.88
Aetna PPO	\$45.47	\$22.73	\$56.29	\$89.78	\$44.89	\$111.15	\$99.36	\$49.68	\$123.02	\$139.73	\$69.86	\$173.00
Kaiser Permanente HMO	\$18.08	\$9.04	\$22.38	\$34.35	\$17.17	\$42.53	\$37.97	\$18.98	\$47.01	\$54.24	\$27.12	\$67.15
Optimum Choice HMO	\$23.35	\$11.68	\$28.91	\$42.43	\$21.22	\$52.53	\$46.56	\$23.28	\$57.64	\$53.17	\$26.58	\$65.83
Aetna HMO	\$22.73	\$11.36	\$28.14	\$41.50	\$20.75	\$51.38	\$45.54	\$22.77	\$56.38	\$52.01	\$26.00	\$64.39

Express Scripts Copays for Active Employees			
Maps & Unrepresented			
	Generic	Formulary	Non-Formulary
Retail (30 Day Supply)	\$15	\$30	\$40
Mail (90 Day Supply)	\$20	\$40	\$60
Represented			
	Generic	Formulary	Non-Formulary
Retail (30 Day Supply)	\$10	\$20	\$30
Mail (90 Day Supply)	\$15	\$25	\$35

2012 CareFirst Dental PPO Rates

Tier	Bi-Weekly	Weekly	21- Pay
Individual	\$8.99	\$4.49	\$11.13
Parent & Child	\$15.27	\$7.63	\$18.90
Husband & Wife	\$17.97	\$8.99	\$22.25
Family	\$25.15	\$12.57	\$31.14

Dental Comparison Chart

ADA Procedure Code	Description	DHMO*	Dental PPO In-Network**	Dental PPO Out-Of Network***
120	Periodic Oral Evaluation -once per 6 months	\$5.00	\$0.00	\$0.00
272	Bitewings- Two Films	\$5.00	\$0.00	\$0.00
330	Panoramic Film	\$20.00	\$0.00	\$0.00
1110	Prophylaxis (cleaning) -Adult once per 6 months	\$10.00	\$0.00	\$0.00
1120	Prophylaxis (cleaning) -Child once per 6 months	\$10.00	\$0.00	\$0.00
1351	Sealants - Per Tooth	\$5.00	\$0.00	\$0.00
2140	Amalgam- One Surface, Permanent	\$28.00	\$9.90	\$24.40
2160	Amalgam- Three Surface, Permanent	\$45.00	\$15.12	\$38.20
2330	Resin- Based Composite, One Surface Anterior	\$35.00	\$12.34	\$29.00
2332	Resin- Based Composite, Three Surface Anterior	\$55.00	\$18.80	\$44.40
2750	Crown- Porcelain/High Noble Metal	\$390.00	\$230.04	\$400.80
3330	Molar Root Canal	\$425.00	\$219.00	\$365.60
4260	Osseous Surgery	\$450.00	\$238.96	\$386.40
4341	Periodontal Scaling and Root Planning- Quad	\$60.00	\$48.40	\$92.00
5110	Complete Denture - upper	\$350.00	\$267.48	\$620.00
6010	Implant Body	Not Covered	\$543.32	\$751.60
7140	Extraction, Erupted Tooth or Exposed Root	\$35.00	\$13.86	\$30.20
7210	Surgical Extraction of Erupted Tooth	\$60.00	\$24.84	\$50.80
7240	Removal of Impacted Tooth- Complete Bony	\$150.00	\$45.18	\$89.80
8080	Comprehensive Orthodontic Treatment- Adolescent	\$2,220.00	\$1,480.50	\$3,786.00
9110	Palliative Treatment	\$10.00	\$0.00	\$0.00

*Benefits are available in-network only. ** Member estimated out-of-pocket expense when services are rendered by a CareFirst Preferred Participating Dentist without consideration of deductible or annual benefit maximum. *** Member estimated out-of-pocket expense based upon dentist fee at 80th percentile of 2007 NDAS schedule without consideration of deductible or annual benefit maximum. Member subject to Balance billing over and above this amount.

CareFirst Select Vision- Schedule of Benefits

If you go to a

		Participating Provider	Non-Participating Provider		
Covered Service (Note: Plan allows one pair of glasses or contacts, per member, in a 24 month period.)					
Vision Exam	Plan Pays 100% of Allowed Benefit.		Plan Pays 100% of allowed Benefit; you pay the balance.		
Glasses		Plan pays up to:		Plan pays up to:	You Pay:
	Single Vision	\$41.50	Single Vision	\$41.50	Balance
	Bifocal	\$67.00	Bifocal	\$67.00	Balance
	Trifocal	\$89.50	Trifocal	\$89.50	Balance
	Double Bifocal	\$100.50	Double Bifocal	\$100.50	Balance
	Cataract (Aphakic)	\$156.50	Cataract (Aphakic)	\$156.50	Balance
Frames Per Pair	Plan Pays up to \$29.50 and you pay \$0 for select frames. (If you select more expensive frames then you pay the balance.)		Plan pays up to \$29.50; you pay the balance.		
Contact Lenses**	Covered only if medically necessary or instead of glasses				
	Medically Required*	Plan pays up to \$221.	Plan pays up to \$221; you pay the balance.		
	Not Medically Required. Single Vision.**	Plan pays up to \$71.	Plan pays up to \$71; you pay the balance.		
	Not Medically Required. Bifocal **	Plan pays up to \$96.50.	Plan pays up to \$96.50; you pay the balance.		
* Following cataract surgery or when visual acuity of at least 20/70 in the better eye is possible with the use of contact lenses.					
** In place of glasses (frames and lenses)					

Important Information About Your Life and AD&D Insurance:
Effective January 1, 2012 The City of Baltimore Will Have A New Life Insurance Vendor:
Minnesota Life
Phone Number: 1-888-658-0193 (Claims)
Website: www.lifebenefits.com/plandesign/baltimorecity

Active Basic Life/AD&D Coverage	
Employment	
Union	Benefit Amount
CUB	1 x Annual Salary, Minimum \$17,630
AFSCME Local 2202	1 x Annual Salary, Minimum \$15,000
AFSCME Local 44	1 x Annual Salary, Minimum \$15,000
AFSCME Local 558	1 x Annual Salary, Minimum \$15,000
Fire	1 x Annual Salary + \$1,500
Police	1 x Annual Salary
MAPS	2 1/2 x Annual Salary to a maximum of \$100,000

Optional Life Premium	
Age	Cost Per \$1,000 of Coverage
Under 30	\$0.57
30-34	\$0.064
35-39	\$0.074
40-44	\$0.110
45-49	\$0.177
50-54	\$0.299
55-59	\$0.464
60-64	\$0.742
65-69	\$1.298
70-74	\$2.534
75 & over	\$3.440
Optional AD&D Premium	
\$0.023 Per \$1,000 of Coverage Per Month	

New Beneficiary forms are available on the City of Baltimore Enrollment website:
www.baltimorecity.essbenefits.com

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