2010 Baltimore City
Active Employee Benefit Plan Comparison Guide

- Aetna Open Choice PPO & HMO
- United Healthcare POS
- CareFirst Blue Cross Blue Shield PPN
- Kaiser Permanente HMO
- Optimum Choice HMO
- Express Scripts, Inc. (Prescription Drug Coverage)
- CareFirst Dental PPO
- The Dental Network (Dental HMO)
- CareFirst Select Vision

EXPRESS SCRIPTS PRESCRIPTION DRUG PLAN: REPRESENTED

	Generic	Formulary	Non-Formulary
Mail (90-Day Supply)	**$ 15**	**$ 25**	$ 35
Retail (30-day Supply)	**$ 10**	**$ 20**	$ 30

EXPRESS SCRIPTS PRESCRIPTION DRUG PLAN: MAPS/UNREPRESENTED

	Generic	Formulary	Non-Formulary
Mail (90-Day Supply)	**$ 20**	**$ 40**	$ 60
Retail (30-day Supply)	**$ 15**	**$ 30**	$ 40

CAREFIRST SELECT VISION - SCHEDULE OF BENEFITS

If you go to a						
Covered Service	Participating Provider			Non-participating Provider		
Vision Exam	Plan pays 100% of allowed benefit; you pay $0.			Plan pays 100% of allowed benefit; you pay the balance.		
Glasses						
Lenses (per pair)		**Plan pays up to:**	**You pay:**		**Plan pays up to:**	**You pay:**
	Single Vision	41.50	0.00	Single Vision	41.50	Balance
	Bifocal	67.00	0.00	Bifocal	67.00	Balance
	Trifocal	89.50	0.00	Trifocal	89.50	Balance
	Double Bifocal	100.50	0.00	Double Bifocal	100.50	Balance
	Cataract (aphakic)	156.50	0.00	Cataract (aphakic)	156.50	Balance
Frames (per pair)	Plan pays up to $29.50 and you pay $0 (for selected frames; if you choose more expensive frames, you pay the balance.)			Plan pays up to $29.50; you pay the balance.		
Contact Lenses (covered only if medically required or instead of glasses						
Medically required*	Plan pays up to $221; you pay $0.			Plan pays up to $221; you pay the balance.		
NOT medically required. Single vision.**	Plan pays up to $71; you pay $0.			Plan pays up to $71; you pay the balance.		
NOT medically required. Bifocal**	Plan pays up to $96.50; you pay $0.			Plan pays up to $96.50; you pay the balance.		

** Following cataract surgery or when visual acuity of a least 20/70 in the better eye is possible only with use of contact lenses.*
*** In place of glasses (frames and lenses)*

2010 CAREFIRST DENTAL PPO RATES

Tier Level	Bi-Weekly Employee Cost	Weekly Employee Cost	21-Pay Employee Cost
Individual	9.46	4.73	11.71
Parent & Child	16.08	8.04	19.90
Husband & Wife	18.92	9.46	23.43
Family	26.48	13.24	32.79

DENTAL COMPARISON CHART

ADA PROCEDURE CODE	DESCRIPTION	DHMO*	PPO** IN-NETWORK	PPO*** OUT-NETWORK
120	Periodic Oral Evaluations (once per 6 months)	5.00	0.00	0.00
272	Bitewings - Two Films	5.00	0.00	0.00
330	Panoric 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	12.24	29.00
2332	Resin-Based Composite, Three Surface, Anterior	55.00	18.54	44.40
2750	Crown - Porcelain/High Noble Metal	390.00	230.04	411.20
2751	Crown - Porcelain/Noble Metal	370.00	230.04	400.80
3330	Molar Root Canal	425.00	211.32	365.60
4260	Osseous Surgery	450.00	237.60	386.40
4341	Periodontal Scaling and Root Planning - Quad	60.00	23.22	46.00
5110	Complete Denture - Upper	350.00	267.48	620.00
6010	Implant Body	Not Covered	460.08	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 - Completely Bony	150.00	45.18	89.80
8080	Comprehensive Orthodontic Treatment - Adolescent	2200.00	1480.50	3786.00
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 frr 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.*

2010 BENEFIT PLAN COMPARISON CHART EFFECTIVE JANUARY 1, 2010

*** Non-network benefit based on allowed benefit. Allowed benefit is 50% of R & C ** Any out-of-network provider can balance bill the difference between allowed amount and billed amount**

BENEFITS SUMMARY	AETNA PPO (New for 2010) OPEN CHOICE PPO www.aetna.com 1-800-900-7562			CAREFIRST BLUE CROSS BLUE SHIELD PREFERRED PROVIDER www.carefirst.com 1-800-535-2292			UNITEDHEALTHCARE POINT-OF-SERVICE www.myuhc.com 1-877-462-5027			AETNA (New for 2010) HMO www.aetna.com 1-877-440-4711			KAISER PERMANENTE HMO www.kaiserpermanente.org 1-866-248-0715			OPTIMUM CHOICE HMO www.myuhc.com 1-800-815-8958		
EMPLOYEE CONTRIBUTIONS BY PAY CYCLE	WKLY	BI-WKLY	21-PAY	WKLY	BI-WKLY	21-PAY	WKLY	BI-WKLY	21-PAY	WKLY	BI-WKLY	21-PAY	WKLY	BI-WKLY	21-PAY	WKLY	BI-WKLY	21-PAY
Individual	20.76	41.52	51.41	23.67	47.34	58.61	20.49	40.99	50.75	9.95	19.90	24.64	7.50	15.01	18.58	10.40	20.81	25.76
Parent & Child	40.99	81.99	101.51	45.84	91.69	113.52	38.94	77.88	96.42	18.17	36.34	44.99	14.26	28.52	35.31	18.90	37.80	46.81
Husband & Wife	45.37	90.74	112.34	52.83	105.66	130.82	43.04	86.09	106.58	19.94	39.87	49.37	15.76	31.52	39.02	20.74	41.48	51.36
Family	63.80	127.61	157.99	57.58	115.16	142.58	61.49	122.97	152.25	22.77	45.54	56.38	22.51	45.03	55.75	23.68	47.37	58.65

	AETNA PPO IN-NETWORK	AETNA PPO OUT-OF-NETWORK	CAREFIRST PREFERRED	CAREFIRST NON-PREFERRED***	UNITEDHEALTHCARE IN-NETWORK	UNITEDHEALTHCARE OUT-OF-NETWORK	AETNA HMO	KAISER PERMANENTE HMO	OPTIMUM CHOICE HMO
Are referrals required?	No	No	No	No	No	No	Yes	Yes	Yes
Dependent Eligibility	Unmarried dependent children are covered until the end of the calendar year they reach age 25 regardless of student status.								
Plan Lifetime Maximum Benefit	$2 M combined in and out of network	$2 M combined in and out network	Unlimited	Unlimited	$2 M combined	$2 M combined	Unlimited	Unlimited	Unlimited
ROUTINE & PREVENTIVE SERVICES									
Physician's Office Visits	$5 co-pay per visit	$5 co-pay per visit 100% allowed benefit*	**REPRESENTED:** $10 co-pay per visit 100% allowed benefit **MAPS/UNREPRESENTED**: $20 co-pay per visit 100% allowed benefit	80% allowed benefit	$5 co-pay per visit	$5 co-pay per visit 100% allowed benefit*	$5 co-pay per visit	$5 co-pay per visit	$5 co-pay per visit
Specialist Office Visits	$5 co-pay per visit	$5 co-pay per visit 100% allowed benefit*	**REPRESENTED:** $15 co-pay per visit 100% allowed benefit **MAPS/UNREPRESENTED:** $25 co-pay per visit 100% allowed benefit	80% allowed benefit	$5 co-pay per visit	$5 co-pay per visit 100% allowed benefit*	$5 co-pay per visit	$5 co-pay per visit	$5 co-pay per visit
Routine GYN Examinations (limited 1 per year)	$5 co-pay per visit	$5 co-pay per visit 100% allowed benefit*	**REPRESENTED:** $15 co-pay per visit 100% allowed benefit **MAPS/UNREPRESENTED:** $5 co-pay per visit 100% allowed benefit	80% allowed benefit	$5 co-pay per visit	$5 co-pay per visit 100% allowed benefit*	$5 co-pay per visit (referral is not needed from primary care physician)	Covered in full; limited 1 per year; referral not needed from primary care physician.	$5 co-pay per visit (referral is not needed from primary care physician)
Mammography, Colorectal Screening, Prostate Screening	Covered in full. Call plan for frequency limits	100% allowed benefit* Call plan for frequency limits	100% allowed benefit; eligibility based on age (contact plan for details)	80% allowed benefit; eligibility based on age (contact plan for details)	Covered in full; call plan for frequency limits	Covered in full 100% allowed benefit*; call plan for frequency limits	Covered in full; call plan for frequency limits	Covered in full; call plan for frequency limits	Covered in full; call plan for frequency limits
Routine Physical	$5 co-pay per visit	$5 co-pay per visit 100% allowed benefit*	**REPRESENTED:** $10 co-pay per visit; 100% allowed benefit * (includes all related services, limited to one physical every 36 months) **MAPS/UNREPRESENTED:** $5 co-pay per visit; 100% allowed benefit * (includes all related services, limited to one physical every 36 months)	80% allowed benefit (includes all related services, limited to one physical every 36 months)	$5 co-pay per visit	$5 co-pay per visit 100% allowed benefit*	$5 co-pay per visit	Covered in full	$5 co-pay per visit
Well Baby Care/ Child Care	$5 co-pay per visit	$5 co-pay per visit 100% allowed benefit*	100% of allowed benefit after $10 co-pay per visit; frequency of visits based on age of child	80% allowed benefit; after $10 co-pay per visit; frequency of visits based on age of child	$5 co-pay per visit	$5 co-pay per visit 100% allowed benefit*	$5 co-pay per visit	Covered in full for children under the age of 5	$5 co-pay per visit
EMERGENCY ROOM AND URGENT CARE SERVICES									
Ambulance Service (based on medical necessity)	Covered in full when medically necessary	100% allowed benefit*	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, if emergency only	100% allowed benefit*, if emergency only	Covered in full when medically necessary	Covered in full when medically necessary	Covered in full for emergency only
Emergency Room (co-pay waived if admitted)	$50 co-pay	$50 co-pay	$50 co-pay	$50 co-pay	$50 co-pay	$50 co-pay	$50 co-pay	$50 co-pay (waived if admitted)	$50 co-pay
Urgent Care	$5 co-pay per visit	$5 co-pay per visit	$10 co-pay per visit	These services are for specific providers and none are out of network	$5 co-pay	$5 co-pay 100% allowed benefit*	$5 co-pay per visit	$5 co-pay per visit	$5 co-pay per visit

HOSPITAL INPATIENT SERVICES									
Anesthesia	Covered in full	100* allowed benefit*	100% allowed benefit	80% allowed benefit	Covered in full	100% allowed benefit*	Covered in full	Covered in full	Covered in full
Hospital Services, Room, Board & General Nursing Services	Covered in full	100% allowed benefit*	**REPRESENTED:** 100% allowed benefit pre-authorization required (acute inpatient rehabilitation not covered) **MAPS/UNREPRESENTED:** 80% allowed benefit up to $1000 annual out-of-pocket max, then paid at 100% allowed benefit per individual; family maximum not to exceed $3000 per year; pre-authorization required (acute inpatient rehabilitation not covered)	**REPRESENTED:** $100 deductible per admission, then plan pays 80% up to $1500 out-of-pocket maximum per admission then 100% allowed benefit; pre-authorization required (acute inpatient rehabilitation not covered) **MAPS/UNREPRESENTED:** $100 deductible per admission, then plan pays 70% up to $1500 out-of-pocket maximum per admission; then 100% allowed benefit.; pre-authorization required (acute inpatient rehabilitation not covered)	Covered in full	100% allowed benefit*	Covered in full	Covered in full	Covered in full
Diagnostic Lab Work & X-rays	Covered in full	100% allowed benefit*	100% allowed benefit	80% allowed benefit	Covered in full	100% allowed benefit*	Covered in full	Covered in full	Covered in full
Medical Surgical Physician Services	Covered in full	100% allowed benefit*	100% allowed benefit	80% allowed benefit	Covered in full	100% allowed benefit*	Covered in full	Covered in full	Covered in full
Physical, Speech & Occupational Therapy	Covered in full	100% allowed benefit*	100% allowed benefit	80% allowed benefit	Covered in full	100% allowed benefit*	Covered in full	Covered in full	Covered in full
Organ Transplant (Pre-Authorization Required)	Covered in full for non-experimental transplants; no maximum	No coverage	Kidney, bone marrow, cornea transplants, liver, heart, heart-lung or pancreas - 100% allowed benefit; $1M per transplant	Kidney, bone marrow, cornea transplants, liver, heart, heart-lung or pancreas - 100% allowed benefit; $1M per transplant	Covered in full for non-experimental transplants	100% allowed benefit*; limited to $30,000 per transplant for non-experimental transplants	Covered in full for non-experimental transplants	Contact plan for details	Covered in full for non-experimental kidney, bone marrow, cornea transplants, liver, heart, heart-lung or pancreas
OUTPATIENT SERVICES									
Chemotherapy & Radiation	$5 co-pay per visit	$5 co-pay per visit, 100% allowed benefit*	100% allowed benefit	80% allowed benefit	$5 co-pay per visit	$5 co-pay per visit 100% allowed benefit*	$5 co-pay per visit	$5 co-pay per visit	$5 co-pay per visit
Renal Dialysis	Covered in full	100% allowed benefit*	100% allowed benefit	80% allowed benefit	Covered in full	100% allowed benefit*	Covered in full	$5 co-pay per visit	Covered in full
Diagnostic Lab Work & X-rays	Covered in full	100% allowed benefit*	100% allowed benefit	80% allowed benefit	Covered in full	100% allowed benefit*	Covered in full	Covered in full	Covered in full
Outpatient Surgery	Covered in full	100% allowed benefit*	100% allowed benefit	80% allowed benefit	Covered in full	100% allowed benefit*	Covered in full	$5 co-pay per visit	Covered in full
Physical , Speech & Occupational Therapy	$5 co-pay per visit call plan for visit limits	$5 co-pay per visit, 100% allowed benefit*, call plan for visit limits	REPRESENTED: $10 co-pay per visit MAPS/UNREPRESENTED: 100% allowed benefit for 100 visits per calendar year for physical, speech and occupational therapies combined; pre-certification required after 10 visits.	80% allowed benefit for 100 visits per calendar year for physical, speech and occupational therapies combined; pre-certification required after first 10 visits.	$5 co-pay per visit; combined maximum 60 visits per year for short term care	$5 co-pay per visit; 100% allowed benefit* combined maximum 60 visits per year for short term care	$5 co-pay per visit; Call plan for visit limits	$5 co-pay per visit; call plan for visit limits	$5 co-pay per visit; 90 visits per therapy type per year
Pre-Admission Testing	Covered in full	100% allowed benefit*	100% allowed benefit	80% allowed benefit	$5 co-pay per visit; testing covered in full	$5 co-pay per visit; 100% allowed benefit*	Covered in full	$5 co-pay per visit	covered in full
Allergy Testing/Allergy Serum	$5 co-pay per visit for both	$5 co-pay per visit, 100% allowed benefit* for both	Allergy Testing: 100% allowed benefit; Allergy Serum: not covered; see pharmacy benefits	Allergy Testing: 80% allowed benefit; Allergy Serum: not covered; see pharmacy benefits	Covered in full/covered up to a $200 maximum per year	100% allowed benefit*/ covered up to a $200 maximum per year	$5 co-pay per visit for both	$5 co-pay per visit/covered up to $200 maximum per year	Covered in full/covered up to $200 maximum per year
MATERNITY									
Pre and Post Natal Care (Physician Services)	$5 co-pay for the first visit only, then covered in full	$5 co-pay for the first visit only, then covered in full; 100% allowed benefit*	100% allowed benefit	80% allowed benefit	$5 co-pay for initial visit to determine pregnancy, then covered in full	$5 co-pay for initial visit to determine pregnancy, then 100% allowed benefit*	$5 co-pay for the first visit only, then covered in full	$5 co-pay for initial visit to determine pregnancy then covered in full	$5 co-pay for initial visit to determine pregnancy then covered in full
Delivery (Inpatient)	Covered in full	100% allowed benefit*	REPRESENTED: 100% allowed benefit MAPS/UNREPRESENTED: 80% allowed benefit up to $1000 annual out-of-pocket maximum then paid at 100% allowed benefit per individual family maximum not to exceed $3000 per year	REPRESENTED: 80% allowed benefit MAPS/UNREPRESENTED: $100 deductible per admission, then plan pays 70% up to $1,500 out-of-pocket maximum per admission then 100% allowed benefit	Covered in full	100% allowed benefit*	Covered in full	Covered in full	Covered in full
Newborn Care (Inpatient)	Covered in full	100% allowed benefit*	100% allowed benefit	80% allowed benefit	Covered in full.	100% allowed benefit*	Covered in full	Covered in full	Covered in full

FERTILITY TESTING & FAMILY PLANNING									
Fertility Testing & Family Planning	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	100% allowed benefit	80% allowed benefit	$5 co-pay per visit	$5 co-pay per visit; 100% allowed benefit*	Member cost sharing based on type of service performed and place of service where rendered	$ 5 co-pay per visit for family planning, fertility testing office visits and any other fertility services covered at 50%	$5 co-pay per visit for family planning and fertility testing, other fertility services 50%
In-Vitro Fertilization	Covered in full; $100,000 maximum lifetime benefit; up to 3 attempts per live birth combined with ART, AI and OI	100% allowed benefit* covered in full; $100,000 maximum lifetime benefit; up to 3 attempts per live birth combined with ART, AI and OI	100% allowed benefit up to $12,000 lifetime maximum; pre-authorization required	80% allowed benefit up to $12,000 lifetime maximum, pre-authorization required.	100% allowable charges $100,000 maximum lifetime benefit for up to 3 attempts per live birth	100% allowed benefit*	Call plan for specific state mandated benefits	50% allowable charges; $100,000 maximum lifetime benefit for up to 3 attempts per live birth	50% allowable charges; $100,000 maximum lifetime benefit for up to 3 attempts per live birth
MENTAL HEALTH & SUBSTANCE ABUSE BENEFITS (INPATIENT)									
Alcohol & Substance Abuse/Mental Health Benefits	Covered in full	100% allowed benefit*	**REPRESENTED:** 100% allowed benefit pre-authorization required **MAPS/UNREPRESENTED:** 80% allowed benefit up to $1000 annual out-of-pocket max, then paid at 100% allowed benefit per individual; family maximum not to exceed $3000 per year; pre-authorization required	**REPRESENTED:** $100 deductible per admission, then plan pays 80% up to $1500 out-of-pocket maximum per admission then 100% allowed benefit; pre-authorization required **MAPS/UNREPRESENTED:** $100 deductible per admission, then plan pays 70% up to $1500 out-of-pocket maximum per admission; then 100% allowed benefit.; pre-authorization required	Covered in full	100% allowed benefit*	Covered in full	Covered in full	Covered in full
MENTAL HEALTH & SUBSTANCE ABUSE BENEFITS (OUTPATIENT)									
Alcohol & Substance Abuse/Mental Health Benefits	$5 co-pay per visit	$5 co-pay per visit 100% allowed benefit*	**REPRESENTED:** $15 co-pay per visit; 100% allowed benefit; pre-authorization required by 8th visit **MAPS/UNREPRESENTED:** $25 co-pay per visit allowed; benefit pre-certification required; pre-authorization required by 8th visit	80% allowed benefit; pre-authorization required by 8th visit	$5 co-pay per visit	100% allowed benefit*	$5 co-pay per visit	$5 co-pay per visit	$5 co-pay per visit
MISCELLANEOUS SUPPLIES & SERVICES									
Nutrition & Health Education	$5 co-pay per visit, diabetic nutritional counseling only	$5 co-pay 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 co-pay per visit; diabetic nutritional counseling Only	$5 co-pay per visit; diabetic nutritional counseling Only, 100% allowed benefit*	$5 co-pay per visit, diabetic; nutritional counseling only	$5 co-pay per visit	$5 co-pay per visit, diabetic nutritional counseling only
Diabetic Supplies (insulin & Syringes covered by RX plan)	Covered in full	100% allowed benefit*	100% allowed benefit, including lancets, test strips and glucometers	100% allowed benefit, including lancets, test strips and glucometers	Covered in full, including lancets, test strips and glucometers	100% allowed benefit*, including lancets test strips and glucometers	Covered in full	Covered at 80% of allowable charges, including lancets, test strips and glucometers	Lancets and test strips, generic covered by a $5 co-pay and brand covered by a $20 co-pay, glucometers covered in full with pre-authorization
Durable Medical Equipment	Covered in full	100% allowed benefit*	Major medical benefit subject to deductible and coinsurance if applicable	Major medical subject to deductible and coinsurance if applicable	Covered in full; pre-authorization required	100% allowed benefit*; pre-authorization required	Covered in full	Covered in full	Covered in full after pre-authorization
Private Duty Nursing (Pre-Authorization Required)	Covered in full	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 for skilled care when medically necessary with prior plan approval	100% allowed benefit*	Not covered	Covered in full	No benefit
Inpatient Hospice Care	Covered in full	100% allowed benefit*	100% allowed benefit up to $20,000 lifetime maximum per person; unlimited days, pre-authorization required.	80% allowed benefit up to $20,000 lifetime maximum per person; unlimited days, pre-authorization required.	Covered in full; prior plan approval fro palliative services required	100% allowed benefit*; prior plan approval for palliative services required	Covered in full	Covered in full	Covered in full
Outpatient Hospice Care	Covered in full	100% allowed benefit*	100% allowed benefit up to lifetime maximum of $20,000 unlimited days; pre-authorization required	100% allowed benefit up to lifetime maximum of $20,000 unlimited days, pre-authorization required	Covered in full; prior plan approval required (in lieu of hospitalization)	100% allowed benefit*; prior plan approval for palliative services required	Covered in full	Covered in full	Covered in full

MAJOR MEDICAL	AETNA		CAREFIRST PPO		UNITEDHEALTHCARE POS		AETNA HMO	KASIER HMO	OPTIMUM CHOICE HMO
Major Medical Annual Deductible	n/a	n/a	Major medical expenses only; $250 per person per policy per year	Major medical expenses only; $250 per person per policy per year	n/a	n/a	n/a	n/a	n/a
Major Medical Yearly Out-Of-Pocket Maximum Costs	n/a	n/a	After deductible is satisfied 80% of the allowed benefit up to the lifetime maximum ($225,000)	After deductible is satisfied 80% of the allowed benefit up to the lifetime maximum ($225,000)	n/a	n/a	n/a	n/a	n/a

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.