

2010 Baltimore City Retiree w/o Medicare Benefit Plan Comparison Guide

- Aetna Open Choice PPO
 - CareFirst Blue Cross Blue Shield PPN
 - United Healthcare POS
 - CareFirst Blue Cross Blue Shield Traditional
 - Kaiser Permanente HMO
 - Optimum Choice HMO
 - Express Scripts, Inc. (Prescription Drug Coverage)
 - CareFirst Select Vision (MAPS, Fire, Police)
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EXPRESS SCRIPTS PRESCRIPTION DRUG PLAN

| | Generic | Formulary | Non-Formulary |
|------------------------|---------|-----------|---------------|
| Mail (90-Day Supply) | \$ 20 | \$ 40 | \$ 60 |
| Retail (30-day Supply) | \$ 10 | \$ 20 | \$ 30 |

CAREFIRST SELECT VISION - SCHEDULE OF BENEFITS (MAPS, Fire, Police)

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: |
| | 41.50 | 0.00 |
| Single Vision | 41.50 | Balance |
| Bifocal | 67.00 | Balance |
| Trifocal | 89.50 | Balance |
| Double Bifocal | 100.50 | Balance |
| 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 RETIREE WITHOUT MEDICARE 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 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 | | CAREFIRST BLUE CROSS BLUE SHIELD TRADITIONAL www.carefirst.com 1-800-535-2292 | KAISER PERMANENTE HMO www.kaiserpermanente.org 1-866-248-0715 | OPTIMUM CHOICE HMO www.myuhc.com 1-800-815-8958 |
|---|---|---|---|--|---|---|--|---|--|
| | IN-NETWORK | OUT-OF-NETWORK | PREFERRED | NON-PREFERRED** | IN-NETWORK | OUT-OF-NETWORK | | | |
| Are referrals required? | No | No | No | No | No | No | No | 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 | \$2M combined in and out of network | \$2M combined in and out of network | Unlimited | Unlimited | \$2M combined in and out-of-network | \$2M combined in and out-of-network | Unlimited | Unlimited | Unlimited |
| COMMON AND PREVENTIVE SERVICES | | | | | | | | | |
| Physician's Office Visits | \$5 co-pay per visit | \$5 co-pay per visit; 100% allowed benefit* | 100% of allowed benefit after \$20 co-pay per medical office visit to a primary care physician | 80% allowed benefit | \$5 co-pay per visit | \$5 co-pay per visit; 100% allowed benefit* | Major medical subject to deductible and coinsurance if applicable | \$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* | 100% allowed benefit after \$25 co-pay | 80% allowed benefit | \$5 co-pay per visit | \$5 co-pay per visit; 100% allowed benefit* | 100% allowed benefit | \$5 co-pay per visit | \$5 co-pay per visit |
| Routine GYN Examinations (1 per year) | \$5 co-pay per visit | \$5 co-pay per visit; 100% allowed benefit* | 100% allowed benefit after \$5 co-pay; one per year | 80% allowed benefit; one per year | \$5 co-pay per visit | \$5 co-pay per visit; 100% allowed benefit* | No benefit | Covered in full | \$5 co-pay per visit |
| 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 | 100% allowed benefit*; call plan for frequency limits | 100% allowed benefit; eligibility based on age (contact plan for details) | 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* | \$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* | No benefit | 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 \$5 co-pay per visit; frequency of visits based on age of child | 80% allowed benefit; frequency of visits based on age of child | \$5 co-pay per visit | \$5 co-pay per visit; 100% allowed benefit* | No benefit | Covered in full for children under 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 for emergency only | 100% allowed benefit*; for emergency only | Major medical subject to deductible and coinsurance, if applicable | Covered in full | Covered in full |
| Emergency Room (co-pay waived if admitted) | \$50 co-pay | \$50 co-pay | 100% allowed benefit; \$50 co-pay | 100% allowed benefit; \$50 co-pay | \$50 co-pay | \$50 co-pay | 100% allowed benefit | \$50 co-pay | \$50 co-pay |
| Urgent Care | \$5 co-pay per visit | \$5 co-pay per visit | \$10 co-pay per visit | Will be handled as in-network benefit | \$5 co-pay per visit | \$5 co-pay per visit; 100% allowed benefit* | Covered by major medical | \$5 co-pay per visit | \$5 co-pay per visit |
| HOSPITAL (INPATIENT SERVICES) | | | | | | | | | |
| Anesthesia | Covered in full | 100% allowed benefit* | 100% allowed benefit | 100% allowed benefit | Covered in full | 100% allowed benefit* | 100% allowed benefit | Covered in full | Covered in full |
| Hospital Services, Including Room, Board & General Nursing Services | Covered in full | 100% allowed benefit* | 80% allowed benefit up to \$1,000 individual annual out-of-pocket maximum, then paid at 100% of allowed benefit per individual; \$3,000 annual out-of-pocket maximum per family (acute inpatient rehab not covered) | \$100 deductible per admission, then paid at 70% up to \$1500 individual out-of-pocket maximum per admission, then paid at 100% of allowed benefit (acute inpatient rehab not covered) | Covered in full | 100% allowed benefit* | \$50 deductible per person for first admission in calendar year then covered at 100% allowed benefit (Acute inpatient rehab not covered) | 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* | 100% allowed benefit | 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* | 100% allowed benefit | 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* | Major medical benefit subject to deductible and coinsurance if applicable | 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; \$1 M per transplant | Kidney, bone marrow, cornea transplants, liver, heart, heart-lung or pancreas - 100% allowed benefit; \$1 M per transplant | Covered in full for non-experimental transplants | 100% allowed benefit*; limited to \$30,000 per transplant; non-experimental transplants | Kidney, bone marrow, cornea transplants, liver, heart, heart-lung or pancreas - 100% allowed benefit; \$1M per transplant | Covered in full for non-experimental transplants; heart, heart-lung, liver, kidney, lung, bone marrow, cornea, simultaneous pancreas/kidney | 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* | 100% allowed benefit | \$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* | 100% allowed benefit | \$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* | 100% allowed benefit | 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* | 100% allowed benefit | \$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 | 100% allowed benefit for 100 visits per calendar year combined. Pre-certification required after 10 visits | 80% allowed benefit for 100 visits per calendar year combined. Pre-certification required after 10 visits | \$5 co-pay per visit; combined maximum 60 visits per year for short term care (pre-authorization) | \$5 co-pay per visit 100% allowed benefit*; combined maximum 60 visits per short term care | 100 visits per year - combined, subject to deductible and coinsurance if applicable; pre-certification required | \$5 co-pay per visit; call plan for visit limits | \$5 co-pay per visit; 90 visits per therapy type per year |
| Preadmission 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* | 100% allowed benefit | \$5 co-pay per visit | Covered in full |
| Allergy Testing/Allergy Serum | \$5 co-pay per visit | \$5 co-pay per visit | Allergy testing: 100% allowed benefit; Allergy Serum: not covered | Allergy testing: 80% allowed benefit; Allergy Serum: not covered | Allergy Testing: covered in full/serum; covered up to a \$200 maximum per year | Allergy Testing: 100% allowed benefit*; allergy serum: covered up to a \$200 maximum per year | Allergy Testing: Major medical benefit , subject to deductible and coinsurance if applicable; Serum, not covered. | Allergy Testing: \$5 co-pay per visit; serum covered up to a \$200 maximum per year | Allergy testing: covered in full; serum covered up to a \$200 maximum per year |
| MATERNITY | | | | | | | | | |
| Pre & Post Natal Physician Services | \$5 co-pay for first visit only, then covered in full | \$5 co-pay for 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* | 100% 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 covered in full |
| Delivery | Covered in full | 100% allowed benefit* | 80% allowed benefit, up to \$1,000 annual out-of-pocket maximum then paid at 100% allowed benefit, individual family maximum not to exceed \$3,000 per year | \$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* | \$50 deductible per person for first admission in calendar year then covered at 100% allowed benefit. | Covered in full | Covered in full |
| Newborn Care (Inpatient) | Covered in full | 100% allowed benefit* | 100% allowed benefit initial & discharge | 80% allowed benefit initial & discharge | Covered in full | 100% allowed benefit* | 100% allowed benefit initial & discharge | 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* | 100% allowed benefit | \$5 co-pay per visit for family planning. Fertility testing office visit and any other fertility services covered at 50% | \$5 co-pay for initial 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 & OI | 100% allowed benefit*; covered in full; \$100,000 maximum lifetime benefit; up to 3 attempts per live birth combined with ART, AI & 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*; \$100,000 maximum lifetime benefit; for up to 3 attempts per live birth | 100% allowed benefit; no pre-authorization, \$100,000 lifetime maximum | 50% 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 |

| MENTAL HEALTH & SUBSTANCE ABUSE (INPATIENT) | | | | | | | | | |
|---|--|---|---|--|---|---|---|---|---|
| Alcohol & Substance Abuse/Mental Health Benefits | Covered in full | 100% allowed benefit* | 80% allowed benefit up to \$1000 individual annual out-of-pocket maximum, then paid at 100% of allowed benefit per individual; \$3000 annual out-of-pocket maximum per family | \$100 deductible per admission, then paid at 70% up to \$1500 individual out-of-pocket maximum per admission, then paid at 100% of allowed benefit | Covered in full | 100% allowed benefit* | \$50 deductible per person for first admission in calendar year then covered at 100% allowed benefit. | Covered in full | Covered in full |
| MENTAL HEALTH & SUBSTANCE ABUSE (OUTPATIENT) | | | | | | | | | |
| Alcohol & Substance Abuse/Mental Health Benefits | \$5 co-pay per visit | \$5 co-pay per visit; 100% allowed benefit* | 100% allowed benefit after \$25 co-pay; pre-authorization required | 80% allowed benefit | \$5 co-pay per visit | \$5 co-pay per visit; 100% allowed benefit* | 100% allowed benefit after \$25 co-pay | \$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 at 100% for certain diagnosis; contact plan with questions | Covered at 80% for certain diagnosis; contact plan with questions | \$5 co-pay per visit; diabetic nutritional counseling only | \$5 co-pay per visit; 100% allowed benefit; diabetic nutritional counseling only* | Covered at 100% for certain diagnosis; contact plan with questions | \$5 co-pay per visit | \$5 co-pay per visit (diabetic nutritional counseling only) |
| Diabetic Supplies (insulin & syringes covered by the 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, tests strips and glucometers | 100% allowed benefit*, including lancets, tests strips and glucometers | 100% allowed benefit, including lancets, test strips and glucometers | Covered at 80% of allowable charges, including lancets, test strips and glucometers | Lancets & 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 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 | Major medical subject to deductible and coinsurance if applicable | Covered in full | Covered in full |
| Private Duty Nursing (pre-authorization required) | Covered in full | 100% allowed benefit* | Mandatory pre-certification and medical necessity; major medical benefits subject to deductible and coinsurance if applicable | Mandatory pre-certification and medical necessity; major medical benefits subject to deductible and coinsurance if applicable | Covered in full for skilled care when medically necessary | 100% allowed benefit* for skilled care when medically necessary | Mandatory pre-certification and medical necessity; major medical benefits subject to deductible and coinsurance if applicable | Covered in full | No benefit |
| Inpatient Hospice Care (pre-authorization required) | Covered in full | 100% allowed benefit* | 100% allowed benefit up to \$20,000 lifetime maximum per person, unlimited days | 100% allowed benefit up to \$20,000 lifetime maximum per person, unlimited days | Covered for palliative services only | 100% allowed benefit* for palliative services only | 100% allowed benefit up to \$20,000 lifetime maximum per person, unlimited days | Covered in full for members with life expectancy of less than six months | Covered in full |
| Outpatient Hospice Care (pre-authorization required) | Covered in full | 100% allowed benefit* | 100% allowed benefit up to \$20,000 lifetime maximum per person, unlimited days | 100% allowed benefit up to \$20,000 lifetime maximum per person, unlimited days | Covered in full (in lieu of hospitalization) for palliative services. | 100% allowed benefit* (in lieu of hospitalization) for palliative services | 100% allowed benefit up to \$20,000 lifetime maximum, unlimited days | Covered in full for members with life expectancy of less than six months | Covered in full |

| | AETNA PPO | | CAREFIRST PPN | | UNITEDHEALTHCARE PPN | | CAREFIRST TRADITIONAL | KAISER HMO | OPTIMUM CHOICE HMO |
|--|--------------------------------------|--------------------------------------|--|--|----------------------|----------------|--|----------------|--------------------|
| | In-Network | Out-of-Network | Preferred | Non-preferred** | In-Network | Out-of-Network | | | |
| Major Medical Lifetime Maximum Benefit | Not Applicable | Not Applicable | \$200 per person per policy year | \$200 per person per policy year | Not Applicable | Not Applicable | Major medical expenses only; \$200 per person per policy year | Not Applicable | Not Applicable |
| Major Medical Yearly Out-of-Pocket Maximum Costs | \$2 M combined in and out of network | \$2 M combined in and out of network | \$225,000 lifetime maximum for major medical expenses only; \$30,000 paid at 100% allowed benefit; \$195,000 paid at 50% allowed benefit | \$225,000 lifetime maximum for major medical expenses only; \$30,000 paid at 100% allowed benefit; \$195,000 paid at 50% allowed benefit | Not Applicable | Not Applicable | \$200 deductible per person per year; \$225,000 lifetime maximum for major medical expenses only; \$30,000 paid at 100% allowed benefit; \$195,000 paid at 50% allowed benefit | Not Applicable | Not Applicable |

REMINDER: THE CITY OF BALTIMORE REQUIRES ALL ITS MEMBERS TO ENROLL IN MEDICARE PART B AT THE TIME THEY BECOME ELIGIBLE FOR MEDICARE PART A. ONCE ENROLLED IN MEDICARE PART B, YOU MUST REMAIN ENROLLED IN ORDER TO RECEIVE BENEFITS.

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.