

2012 Medical Plans Comparison Chart

Benefit	BlueChoice (HMO)	BlueChoice Triple Option Plan		
		Level 1	Level 2	Level 3
Acupuncture Services	Discount program available through CareFirst Options Program.	Not covered	\$15 co-pay	80% Allowed Benefit after deductible
Chiropractic Services	\$10 co-pay, 20 visits per calendar year	\$10 co-pay (limited to 20 visits per year)	\$15 co-pay (unlimited visits)	80% Allowed Benefit after deductible (unlimited visits)
Dental Services as a result of an accidental injury	\$10 co-pay – Covered for accidental bodily injury or to correct congenital anomalies	\$10 co-pay covered for accidental bodily injury or to correct congenital anomalies	90% Allowed Benefit after deductible covered for accidental bodily injury or to correct congenital anomalies	80% Allowed Benefit after deductible
Diagnostic, Lab Services, X-ray	Covered in full for x-rays and lab services. Diagnostic – \$10 co-pay	Diagnostic \$10 co-pay, Lab no co-pay (Lab Corp only)	\$15 co-pay	80% Allowed Benefit after deductible
Durable Medical Equipment	Covered in full	No co-pay	90% Allowed Benefit after deductible	80% Allowed Benefit after deductible
Emergency Room Visits	Medical Emergency – \$50 co-pay, waived if admitted Urgent Care Centers – \$10 co-pay	\$50 co-pay (waived if admitted) Urgent Care Centers – \$10 co-pay	Considered under Level 1. If Benefits are not available under Level 1, benefits may be payable under the appropriate level.	
			Urgent Care Centers – \$15 co-pay	80% Allowed Benefit after deductible
Family Planning/Fertility	Infertility Counseling & Testing – \$10 co-pay Artificial Insemination – covered at 50% of the plan allowance; IVF – covered at 50% of the plan allowance <i>(limited to 3 attempts per live birth, lifetime maximum benefit \$100,000)</i>	50% Allowed Benefit (subject to state mandate)	90% Allowed Benefit after deductible (subject to state mandate)	80% Allowed Benefit after deductible (subject to state mandate)
Hearing Exams/Hearing Aids	Hearing exam – no co-pay. No co-pay per aid per ear, benefit once every 36 months.	Hearing exam – no co-pay. No co-pay per aid per ear, benefit once every 36 months.	Hearing exam – \$15 co-pay. 100% of Allowed Benefit every 36 months per aid per ear.	Hearing exam – 80% of Allowed Benefit, after deductible. 100% of Allowed Benefit every 36 months per aid per ear.
Hospitalization (Inpatient)/ Surgery	Covered in full	No co-pay	90% Allowed Benefit after deductible	80% Allowed Benefit after deductible
Inpatient Nervous and Mental; Alcohol/Substance Abuse	Contact Magellan Behavioral Health for pre-authorization at 1-800-245-7013.	Contact Magellan Behavioral Health for pre-authorization at 1-800-245-7013.	Contact Magellan Behavioral Health for pre-authorization at 1-800-245-7013.	Contact Magellan Behavioral Health for pre-authorization at 1-800-245-7013.
Outpatient Nervous and Mental; Alcohol/Substance Abuse	No pre-authorization required. Contact Magellan Behavioral Health for provider network information at 1-800-245-7013. \$5 co-pay per visit.	No pre-authorization required. Contact Magellan Behavioral Health for provider network information at 1-800-245-7013. \$10 co-pay per visit.	No pre-authorization required. Contact Magellan Behavioral Health for provider network information at 1-800-245-7013. \$10 co-pay per visit.	No pre-authorization required. Contact Magellan Behavioral Health for provider network information at 1-800-245-7013. Deductible and co-insurance applies.
Maternity Care	\$5 co-pay PCP/\$10 co-pay specialist per visit, not to exceed \$100 per pregnancy	\$10 co-pay not to exceed \$100 per pregnancy	90% Allowed Benefit after deductible	80% Allowed Benefit after deductible
Outpatient Surgery	\$5 co-pay PCP; \$10 co-pay specialist	\$10 co-pay	\$15 co-pay	80% Allowed Benefit after deductible
Physical Therapy	\$10 co-pay; 30 visits/per condition/per calendar year. PCP referral required.	\$10 co-pay (limited to 30 visits/per condition/per year)	\$15 co-pay (limited to 100 visits per year)	80% Allowed Benefit after deductible (limited to 100 visits per year)
Prescription Drug Card (CVS CAREMARK)	RETAIL: \$5 generic/\$15 preferred brand/\$25 non-preferred brand MAIL ORDER or CVS RETAIL MAINTENANCE CHOICE: \$10 generic/\$20 preferred brand/\$40 non-preferred brand			
Routine Physicals	No co-pay	No co-pay	No co-pay	80% Allowed Benefit, no deductible
Vision Care	\$10 co-pay through Davis Vision Providers – Optometrists or Ophthalmologists. Limited to one examination per calendar year. Discounts on glasses and contact lenses from participating Davis Vision Providers. You may also use your Vision Option 1 or 2 Plans.	\$10 co-pay at Plan-designated Vision Care Centers (Davis Vision Providers). Discounts on glasses and contact lenses from Davis Vision Providers. You may also use your Vision Option 1 or 2 Plans.	Not Covered - refer to Level 1 benefits or Vision Option 1 and 2 plans.	
Well Child Care	No co-pay	No co-pay	No co-pay	80% Allowed Benefit, no deductible
Additional Program Benefits	Discount program for alternative therapies. Magellan Behavioral Health	Disease Management/Case Management Magellan Behavioral Health	Disease Management/Case Management Magellan Behavioral Health	Disease Management/Case Management Magellan Behavioral Health
Primary Care Office Visit Co-pays/ Specialist Office Visit Co-pays	\$5 co-pay \$10 co-pay	\$10 co-pay \$10 co-pay	\$15 co-pay \$15 co-pay	80% Allowed Benefit, after deductible
Calendar Year Deductible	N/A	Individual/family – \$0	Individual = \$200; family = \$400	Individual = \$300; family = \$600
Co-insurance	100%	100%	90%	80%
Out-of-Pocket Maximum	N/A	Individual/family-none	\$500/\$1,000	\$1,000/\$2,000
Calendar Year Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Lifetime Maximum	Unlimited, except for fertility services	Unlimited, except for fertility services	Unlimited, except for fertility services	Unlimited, except for fertility services

- Dependents must be added within 31 days of becoming eligible or wait until the next open enrollment period.
- Dependents are covered until end of the month in which they turn 26.
- *This chart is for comparison purposes only. Please consult each plan benefit summary (available on-line) for full details.*

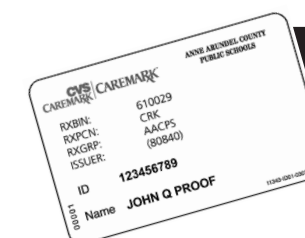
Benefit	CareFirst/BCBS Preferred Provider Network (PPN)	
	In-Network	Out-of-Network
Acupuncture Services	Only covered with certain diagnosis. Contact BCBS to verify. \$15 co-pay for participating provider.	Only covered with certain diagnosis. Contact BCBS to verify. 80% of Allowed Benefit, after deductible.
Chiropractic Services	\$15 co-pay in-network. See BCBS Summary.	Benefit paid at 80% of Allowed Benefit after deductible. See BCBS Summary.
Dental Services as a result of an accidental injury	Restorative services for accidental injury to natural teeth—100% of Allowed Benefit	Restorative services for accidental injury to natural teeth—100% of Allowed Benefit
Diagnostic, Lab Services, X-ray	100% of Allowed Benefit	80% of Allowed Benefit after deductible
Durable Medical Equipment	100% of Allowed Benefit	80% of Allowed Benefit after deductible
Emergency Room Visits	\$25 co-pay or if admitted 100% of Allowed Benefit. Urgent Care Centers – \$15 co-pay	\$25 co-pay or if admitted 100% of Allowed Benefit. Urgent Care Centers – \$15 co-pay
Family Planning/Fertility	Plan of treatment required – Subject to State Mandate; Artificial Insemination – 100% of allowed mandate, some services may require co-pay; IVF – 100% of Allowed Benefit, some services may require co-pay (limited to 3 attempts per live birth, lifetime maximum benefit \$100,000)	Plan of treatment required – Subject to State Mandate; Artificial Insemination – 80% of allowed benefit after deductible; IVF – 80% of Allowed Benefit after deductible (limited to 3 attempts per live birth, lifetime maximum benefit \$100,000)
Hearing Exams/Hearing Aids	Hearing exam – \$15 co-pay. 100% of Allowed Benefit every 36 months per aid per ear.	Hearing exam – 80% of Allowed Benefit, after deductible. 100% of Allowed Benefit every 36 months per aid per ear.
Hospitalization (Inpatient)/ Surgery	100% up to 365 days	80% after deductible/365 days
Inpatient Nervous and Mental; Alcohol/Substance Abuse	Contact Magellan Behavioral Health for pre-authorization at 1-800-245-7013.	
Outpatient Nervous and Mental; Alcohol/Substance Abuse	No pre-authorization required. Contact Magellan Behavioral Health for provider network information at 1-800-245-7013. \$15 co-pay per visit	No pre-authorization required. Contact Magellan Behavioral Health for provider network information at 1-800-245-7013. Deductible and co-insurance applies.
Maternity Care	100% of Allowed Benefit	80% of Allowed Benefit after deductible
Outpatient Surgery	100% of Allowed Benefit	80% after deductible
Physical Therapy	100 visits per year with \$15 co-pay per office visit. See BCBS Summary.	Deductible, then 80% of Allowed Benefit for 100 visits per calendar year. See BCBS Summary.
Prescription Drug Card (CVS CAREMARK)	RETAIL: \$5 generic/\$15 preferred brand/\$25 non-preferred brand MAIL ORDER or CVS RETAIL MAINTENANCE CHOICE: \$10 generic/\$20 preferred brand/\$40 non-preferred brand	
Routine Physicals	No co-pay	80% of Allowed Benefit, after deductible
Vision Care	Not included in medical benefit See CareFirst BCBS Summary Dental and Vision Plans.	Not included in medical benefit See CareFirst BCBS Summary Dental and Vision Plans.
Well Child Care	No co-pay	80% of Allowed Benefit, after deductible
Additional Program Benefits	Case Management/Disease Management – Magellan Behavioral Health	
Primary Care Office Visit Co-pays/ Specialist Office Visits	100% of Allowed Benefit after \$15	80/20 after deductible
Co-pays	100% of Allowed Benefit after \$15	
Calendar Year Deductible	N/A	\$200 individual/\$400 family
Co-insurance	100%	80/20
Out-of-Pocket Maximum	\$1,200 individual/\$2,400 family	\$1,200 individual/\$2,400 family
Calendar Year Benefit Max.	Unlimited	Unlimited
Lifetime Maximum	Unlimited, except for fertility services	Unlimited, except for fertility services

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Active Employees



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New 3 Tier Prescription Plan for 2012

Our goal...to educate all employees so they can make an informed healthcare decision.