Baltimore City Public Schools
Health Plan Comparison Chart
Benefits Effective January 1, 2019

About this chart: This chart is to be used as a guide only and does not contain all details or exclusions.

Actual benefits will be governed by the terms and conditions of the master contract.

All benefits are subject to change due to Healthcare Reform Legislation.

Benefits Summary	BlueChoice Point-of-Service 1-800-648-5285 www.carefirst.com		Kaiser Permanente HMO 1-800-777-7902 www.kp.org	CareFirst Blue Cross Blue Shield Preferred Provider Plan 1-800-648-5285 www.carefirst.com	
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HOSPITAL – INPATIENT SERVICES					
Anesthesia	10% allowed benefit	30% allowed benefit	Covered in full	0% allowed benefit (acute inpatient rehabilitation not covered)	20% allowed benefit (acute inpatient rehabilitation not covered)
Diagnostic Lab Work and X-rays, Hospital Services, Medical/ Surgical Physician Services, Operating Room Expenses, Physical and Rehabilitation Therapy, and Room, Board, and General Nursing Services	10% allowed benefit; pre-authorization required	30% allowed benefit; pre-authorization required	Covered in full	0% allowed benefit, 365 inpatient days (acute inpatient rehabilitation not covered); pre-authorization required	$100 deductible per admission, then you pay 20% up to $1,500 out of pocket maximum per admission, then 0% allowed benefit, 365 inpatient days (acute inpatient rehabilitation not covered); pre-authorization required
Organ Transplant	10% allowed benefit for non-experimental transplants; pre-authorization required	30% allowed benefit for non-experimental transplants; pre-authorization required	Covered in full for non-experimental kidney, bone marrow, and cornea transplants; for liver, heart, heart-lung, or pancreas, pre-authorization required	0% allowed benefit for kidney, bone marrow, and cornea transplants; for liver, heart, heart-lung, or pancreas, pre-authorization required	20% allowed benefit to $1,500, then 0% allowed benefit for non-experimental transplants; pre-authorization required with a maximum of $1 million per transplant
HOSPITAL – OUTPATIENT SERVICES					
Chemotherapy	$10 copay per visit	$10 copay per visit, 30% allowed benefit	$10 copay per visit	0% allowed benefit	20% allowed benefit
Colonoscopy	10% allowed benefit	30% allowed benefit	Covered in full	0% allowed benefit	20% allowed benefit
Diagnostic Lab Work and X-rays	10% allowed benefit	30% allowed benefit	Covered in full	0% allowed benefit	20% allowed benefit

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HOSPITAL – OUTPATIENT SERVICES (continued)					
Outpatient Surgery	10% allowed benefit	30% allowed benefit	Covered in full	0% allowed benefit	20% allowed benefit
Physical & Rehabilitation Therapy	$20 copay per visit; combined maximum 60 visits per injury or illness per year for short term care	$20 copay per visit; 30% allowed benefit, combined maximum 60 visits per injury or illness per year for short term care	$10 copay per visit, 90 visits per therapy type per injury, incident, or condition per year	0% allowed benefit for 100 visits per calendar year for physical, speech, and occupational therapies combined; pre-certification required after first 10 visits	20% allowed benefit for 100 visits per calendar year for physical, speech, and occupational therapies combined; pre-certification required after first 10 visits
Pre-admission Testing	10% allowed benefit	30% allowed benefit	$10 copay per visit	0% allowed benefit	20% allowed benefit
Radiation Therapy	$20 copay per visit – office only; facility paid in full	$20 copay per visit, 30% of allowed benefit	$10 copay per visit	0% allowed benefit	20% allowed benefit
COMMON AND PREVENTIVE SERVICES					
Doctor's Office Visits	$10 copay per visit	$10 copay per visit, 30% of allowed benefit	$5 copay per visit	$10 copay per visit	$10 copay per visit then 20% of allowed benefit
Specialist Office Visits	$20 copay per visit	$20 copay per visit, 30% of allowed benefit	$10 copay per visit	$20 copay per visit	$20 copay per visit then 20% of allowed benefit
Routine GYN Examinations (one per year)	Covered in full	$20 copay per visit, 30% of allowed benefit	Covered in full	0% allowed benefit	$10 copay per visit then 20% allowed benefit
Chlamydia Screening	Covered in full	30% allowed benefit	Covered in full	0% allowed benefit	20% allowed benefit
Hearing Exams	Covered in full (PCP) (screening only)	$10 copay per visit (PCP), 30% allowed benefit	$5 copay for hearing exam (PCP) Hearing screening for newborns covered in full as preventive care services	$10 copay per visit then 100% allowed benefit with medical diagnosis; one exam every 36 months (routine exams excluded)	$10 copay per visit then 20% allowed benefit with medical diagnosis; one exam every 36 months (routine exams excluded)
Immunizations	Covered in full	30% allowed benefit	Covered in full when done in conjunction with an office visit	Included in well baby visits Hepatitis B vaccination covered in full	Included in well baby visits Hepatitis B vaccination covered in full

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COMMON AND PREVENTIVE SERVICES (continued)					
Mammography	Covered in full	30% allowed benefit	Covered in full	0% allowed benefit	20% allowed benefit
Prostate Screening	Covered in full	30% allowed benefit	Covered in full	0% allowed benefit	20% allowed benefit
Routine Physical	Covered in full; one per year	$10 copay per visit; 30% allowed benefit; one per year	Covered in full; limit one per year	0% allowed benefit; limit one per year	$10 copay per visit, 20% allowed benefit
Well Baby Care	Covered in full	$10 copay per visit, 30% allowed benefit	Covered in full	0% allowed benefit	$10 copay per visit, 20% allowed benefit
EMERGENCY TREATMENT					
Ambulance Service	Covered in full, if emergency	30% allowed benefit, if emergency only	Covered in full, if medically necessary	0% allowed benefit (air transport not covered)	100% allowed benefit (air transport not covered)
Emergency Room	$100 copay (waived if admitted)	$100 copay (waived if admitted)	$100 copay (waived if admitted)	$100 copay (waived if admitted) then 0% allowed benefit	$100 copay (waived if admitted) then 0% allowed benefit
Urgent Care Facility	$10 copay per visit	$10 copay per visit	$10 copay per visit	$10 copay; 0% allowed benefit	$10 copay; 20% allowed benefit
MATERNITY					
Pre- and Post-Natal Care	Covered in full	$20 copay for initial visit to determine pregnancy, then 30% allowed benefit	$10 copay for initial visit to determine pregnancy, then covered in full	0% allowed benefit	$20 copay per visit then 20% allowed benefit
Delivery (inpatient)	Covered in full	30% allowed benefit	Covered in full	0% allowed benefit	20% allowed benefit
Newborn Care (inpatient)	Covered in full	30% allowed benefit	Covered in full	0% allowed benefit, initial visit	20% allowed benefit, initial visit

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MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS – INPATIENT					
Alcohol and Substance Abuse Care	10% allowed benefit; pre-authorization required	30% allowed benefit; pre-authorization required	Covered in full	0% allowed benefit; pre-certification required	$100 deductible per admission, then 20% up to $1,500 inpatient out-of-pocket limit maximum per admission then 0% allowed benefit, 365 inpatient days; pre-certification required
Mental Health Benefits	10% allowed benefit; pre-authorization required	30% allowed benefit; pre-authorization required	Covered in full	0% allowed benefit; pre-certification required	$100 deductible per admission, then 20% up to $1,500 inpatient out-of-pocket limit maximum per admission, then 0% allowed benefit, 365 inpatient days; pre-certification required
MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS – OUTPATIENT					
Alcohol and Substance Abuse Care (office only)	$10 copay per visit	30% allowed benefit	$5 copay per visit; pre-authorization required	$10 copay per visit	20% allowed benefit
Alcohol and Substance Abuse Care (all other outpatient services)	$10 copay per visit	30% allowed benefit	$5 copay per visit	$10 copay per visit	20% allowed benefit

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MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS – OUTPATIENT (continued)					
Mental Health Benefits (office only)	$10 copay per visit	30% allowed benefit	$5 copay per visit (no pre-authorization required for outpatient mental health)	$10 copay	20% allowed benefit
Mental Health Benefits (all other outpatient services)	Covered in full	30% allowed benefit	$5 copay per visit	0% allowed benefit	20% allowed benefit
OTHER SERVICES AND SUPPLIES					
Allergy Serum	10% allowed benefit	30% allowed benefit	Covered in full	Covered under prescription drug plan	Covered under prescription drug plan
Diabetic Supplies	10% allowed benefit	30% allowed benefit, including lancets, test strips, and glucometers	Covered in full, including lancets, test strips, disposable insulin needles, and glucometers	0% allowed benefit, including lancets, test strips, and glucometers	0% allowed benefit, including lancets, test strips, and glucometers
Insulin	Insulin and needles covered in full under prescription drug plan after copay				
Family Planning and Fertility Testing	$20 copay per visit; office visits and diagnostics covered as any other service	$20 copay per visit; 30% allowed benefit	$10 copay per visit for family planning and fertility testing; 50% for other fertility services; IVF limited to 3 attempts per live birth and $100,000 maximum benefit per lifetime	$20 copay per visit then 0% allowed benefit	$20 copay per visit then 20% allowed benefit
	In-vitro fertilization and related outpatient services are covered with the following restrictions: • Limited to 3 attempts per live birth • Coverage is provided same as physician office services, professional fees, outpatient diagnostic, and therapeutic services • Artificial insemination is covered; maximum of 6 cycles per live birth • Limited to $100,000 per lifetime • Pre-authorization required				

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OTHER SERVICES AND SUPPLIES (continued)					
Home Health Care	10% allowed benefit after prior plan approval	90 days of unlimited visits; 30% allowed benefit after prior plan approval	Covered in full	90 days of unlimited visits; 0% allowed benefit with pre-authorization	90 days of unlimited visits; 0% allowed benefit with pre-authorization
Private Duty Nursing (outpatient only)	10% allowed benefit for skilled care when medically necessary; prior plan approval required	30% allowed benefit; prior plan approval required	Covered in full for skilled care when medically necessary; prior plan approval required	Mandatory pre-certification and medical necessity; 0% allowed benefit	Mandatory pre-certification and medical necessity; 20% allowed benefit
Durable Medical Supplies (such as crutches and wheelchairs)	10% allowed benefit after prior plan approval	30% allowed benefit; pre-authorization required	Covered in full; pre-authorization required	0% allowed benefit	20% allowed benefit
Hospice Care (inpatient)	10% allowed benefit limited to 30 days	30% allowed benefit	Covered in full	0% allowed benefit; pre-authorization required	0% allowed benefit; pre-authorization required
Hospice Care (outpatient)	10% allowed benefit; pre-authorization required (in lieu of hospitalization)	30% allowed benefit; pre-authorization required (in lieu of hospitalization)	Covered in full; pre-authorization required (in lieu of hospitalization)	0% allowed benefit; pre-authorization required	0% allowed benefit; pre-authorization required
Podiatry Services (non-routine)	$20 copay per visit	30% allowed benefit	$10 copay per visit	$20 copay per visit then 0% allowed benefit	$20 copay per visit then 20% allowed benefit
Prosthetic Devices (such as artificial limbs)	10% allowed benefit after prior plan approval	30% allowed benefit	Covered in full; prior authorization required, except artificial limbs and artificial eyes; Artificial limbs and artificial eyes $5 per device; prior authorization required	0% allowed amount	20% allowed amount
Second Surgical Opinions	$20 copay per visit	30% allowed benefit	$10 copay per visit	$20 copay per visit then 0% allowed benefit	$20 copay per visit then 0% allowed benefit

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OTHER PLAN FEATURES					
Annual Deductible (plan year)	N/A	N/A	N/A	N/A	N/A
Yearly Out-of-Pocket Maximum (excluding mental and nervous coverage)	Individual: $1,000 Family: $2,000	N/A	Individual: $1,100 Family: $3,600 Includes mental and nervous coverage. The following services do not apply to out-of-pocket maximum: • Outpatient drugs, supplies, and supplements, including blood, blood products, and medical foods • Inpatient and outpatient infertility services	$400	Individual: $2,000 Family: $4,000
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Are referrals required in this plan?	No	No	Referrals from PCPs are required except: standing referrals for certain conditions; no referrals required for Outpatient Mental Health, OB/GYN, and eye refraction provided by an Optometrist	No	No
Dependent Eligibility	Dependent children until the end of the month they reach age 26, regardless of student status	Dependent children until the end of the month they reach age 26, regardless of student status	Dependent children until the end of the month they reach age 26, regardless of student status	Dependent children until the end of the month they reach age 26, regardless of student status	Dependent children until the end of the month they reach age 26, regardless of student status

Please note: If you plan to travel overseas, call your health plan for coverage information.