CITY OF BALTIMORE
2024 OPEN ENROLLMENT

RETIREE
BENEFITS PROGRAM BOOK
OCTOBER 2 -18, 2023

"A HEALTHIER YOU, TAKING CONTROL OF YOUR HEALTH"

FOR MORE INFORMATION CONTACT

410-396-5830

OPENENROLLMENT@BALTIMORECITY.GOV

DHR
CITY OF BALTIMORE
DEPARTMENT OF HUMAN RESOURCES

CITY OF BALTIMORE
2024 OPEN ENROLLMENT

October 2023

Dear City of Baltimore Retirees,

Welcome to the PY2024 Benefits Booklet. For retirees, this year's open enrollment is passive. Meaning that current benefit elections will roll over if you do not make any changes.

The City of Baltimore is committed to providing you with a comprehensive benefits package that meets your needs. We encourage you to take this opportunity to review your benefits and make any necessary changes to ensure that you have the coverage you need. The City of Baltimore Benefits Team is always available to assist you if there are questions or concerns.

This year's theme is ***"A Healthier You, Taking Control of Your Health".*** By taking control of your health, you are embracing a holistic approach that encompasses nourishing your body, nurturing your mind, and cherishing your soul.

Remember, you are not alone on this path. A community of like-minded individuals, passionate professionals, and dedicated supporters stands ready to cheer you on, offer guidance, and celebrate your achievements. By working together, we create a dynamic network of support where we share knowledge, celebrate victories, and overcome challenges.

As you navigate through this exciting journey, embrace the small victories along the way. Celebrate the healthy choices you make, the positive changes you witness in yourself. We commend you for prioritizing and being proactive in your well-being. May this begin a remarkable chapter, filled with radiant health, boundless energy, and a strong sense of fulfillment.

Once again, welcome to a world where you are the protagonist of your health journey. Together, let us celebrate ***"A Healthier You, Taking Control of Your Health"*** and embrace the extraordinary possibilities that lie ahead.

We remain committed to providing you with a competitive, comprehensive, flexible, and cost-effective benefits plan.

We value your feedback and ideas. Kindly reach out to us at openenrollment@Baltimorecity.gov to share your comments and suggestions.

Sincerely,

Quinton Herbert
Director, Department of Human Resources

TABLE OF CONTENTS

NEED HELP SELECTING YOUR BENEFITS?

Jelly Vision is here to help during the Open Enrollment period as well as ongoing enrollment when applicable. Active employees and retirees can always interact online with Alex, the virtual benefits counselor. You can access Alex by visiting: http://start.myalex.com/cityofbaltimore

Alex will help you make smarter healthcare decisions that may save you time and money by answering a series of health-related questions.

RESOURCES

Medical Plan	BlueChoice Advantage (PPO) (Non-Medical Retirees/Retirees pending CMS approval)	Call: (800) 535-2292 www.carefirst.com
Medical Plan	Aeta Medicare Advantage Plan (MAPD) with Prescription Drug Benefits (CMS approved Retirees)	Call: (855) 3351407 (TTY 711) www.aetnaretireeplans.com Visit: Link for drug formulary
Medical Plan	Aetna Open Choice (PPO) Non-Medicare Retiree/Dependents (CMS approved Medicare Retirees	Call: (877) 440-4711 www.aetna.com
Medical Plan	Kaiser Permanente (HMO) Non-Medicare Retirees and Dependents	Call: 1-866-248-0715 www.kaiserpermanente.org
Medical Plan	Kaiser Medicare Advantage Plan (MAPD) with Prescription drug Benefits and Dependents	Call: (866) 248-0715 www.kaiserpermanente.org www.kp.org/seniorrx (for drug formulary)
Prescription Drug	CVS Caremark Prescription Plan (Non- Medicare Retirees/Retirees pending CMS approval)	Call: (866) 234-6781 www.Caremark.com
Vison	NVA-National Vision Administrators	Call: (800) 672-7723 www.e-nva.com
Dental	United Concordia (HMO/PPO)	Call: (866) 851-7568 www.unitedconcordia.com/cityofbaltimore
Life Insurance	MetLife – Optional Life and AD&D	Call: (866) 492-6983 www.metlife.com/mybenefits
Baltimore City Retirement System (ERS)	Baltimore City Employee (ERS)	Call: (877) 273-7136 www.bcers.org
Fire & Police Retirement System	Fire & Police (FPR)	Call: (888) 410-1600 www.bcfpers.org
Maryland State Retirement (MSRP)	Maryland State Retirement (MSRP)	Call: (800) 492-5909 https://sra.maryland.gov/
CMS	Centers for Medicare & Medicaid	Call:1 (800) MEDICARE/ (800) 633- 4227 TTY: (877) 486-2048 https://www.medicare.gov/ https://www.cms.gov/
SSA	Social Security Administration	Call: (800) 772-1213; YYT: (800) 325-0778 https://www.ssa.gov/
Employee Benefits	Office of Employees Benefits	Call: 410-396-5830 Openenrollment@Baltimorecity.gov

CITY OF BALTIMORE

ACTIVE EMPLOYEES & RETIREES

2024 OPEN ENROLLMENT

"A HEALTHIER YOU, TAKING CONTROL OF YOUR HEALTH"

VIRTUAL BENEFITS FAIR

OCTOBER 2, 6, 10, 13, and 17 2023
10:00 AM - 3:00 PM

Attend this Virtual Fair to speak with:

- City of Baltimore Benefits Team
- Health Care Benefits Vendors

To attend:

Visit www.COBBenefitFair.com

Take a moment to watch the Mayor's Welcome Video. Then follow the prompts to see the Benefits Fair Schedule and Agenda.

For more information contact:
(410) 396-5830 or
openenrollment@baltimorecity.gov

DHR
CITY OF BALTIMORE
DEPARTMENT OF HUMAN RESOURCES

YOUR FY2024 BENEFITS AT-A-GLANCE

Non-Medicare Medical Plans/MAPD Plan	BlueChoice Advantage (PPO) (Non-Medicare Retirees/Retirees *pending CMS approval) Aetna Medicare Advantage Plan (MAPD) with Prescription Drug Benefits (CMS approved Retirees) Aetna Open Choice (PPO) (Non-Medicare Retiree/Dependent of CMS approved Medicare Retirees) Kaiser Permanente (HMO) (Non-Medicare Advantage Plan (MAPD) with Prescription Drug Benefits (CMS approved Retirees)
Dental Plan	United Concordia (HMO/PPO)
Vision	National Vision Administrators (NVA)
Prescription	CVS Caremark Prescription Plan (Non-Medicare Retirees/Retirees pending CMS approval)
MetLife Insurance	Optional Life and AD&D

BENEFIT OPEN ENROLLMENT 2024

CURRENT RETIREES

Open Enrollment will run from October 2, 2023, through October 18, 2023.

Changes will become effective January 1, 2024.

This year, Baltimore City enrollment process will be passive. This means that if a retiree does not make any benefit and/or dependent changes during Open Enrollment, there will be no need to complete or return the 2024 Benefits Enrollment Form (this can be retained for your reference.

- Retirees enrolled in the Aetna Medicare Advantage Plan (MAPD) or the Kaiser Medicare Advantage Plan (MAPD) as of Open Enrollment will remain enrolled unless the retiree requests to change their City of Baltimore Medicare plan, opt out of their City Medicare plan or select another non-Medicare plan. If the retiree requests to opt out of coverage during Open Enrollment, they are removed from City Medical and Rx coverage for the complete 2024 plan year. Please keep in mind that in the event of an opt-out request, any enrolled covered dependents will be removed from the City's health plans.
- If you are enrolled in either the Aetna MAPD plan or the Kaiser MAPD plan, your dependents who are not eligible for Medicare will automatically be enrolled in the Aetna Open Choice (PPO) plan or the Kaiser HMO plan. This will continue until they become eligible for Medicare Part A and Part B or until the retiree chooses to cancel their coverage.
- Both the Aetna MAPD and Kaiser MAPD plans offer prescription coverage. The premium amount listed includes both medical and prescription drug coverage.

Retirees may elect health benefits online through Workday at:

https://workday.baltimorecity.gov/login.

If you gain access to the Workday system, please, take the time to review all your personal information and benefit options.

- Retirees that choose to elect health benefits using an Enrollment Form, must return the signed and completed form along with all required documents (if adding or removing a dependent) with a postmark no later than **October 17, 2023**, to:

DHR, Office of Employee Benefits
7 E. Redwood Street, 20th Floor
Baltimore, Maryland 21202

NOTE: A Benefit Partner will process all Open Enrollment elections effective January 1, 2024. If you need assistance making any corrections to your benefits plan, contact the Office of Employee Benefits at 410-396-5830.

Remember all address changes must be updated by your retirement agency. The Office of Employee Benefits cannot make any address changes.

New Membership ID Cards - Membership ID cards will only be issued for enrollment in new plans, new enrollment, and coverage level changes.

HOW TO ENROLL – NEW RETIREE

INITIAL ELIGIBILITY

New retirees have sixty (60) days from their retirement date to enroll in health benefits. Once the Office of Employee Benefits is notified of the retirement, a "New Retiree" packet is mailed to the address on file with the retirement agency. New retirees have three options to enroll:

1. Complete the “New Retiree” enrollment event in Workday and, if applicable, upload the required documentation for each eligible dependent you are electing to enroll (https://workday.baltimorecity.gov/login); or
2. Complete an enrollment form and required dependent documentation and email to Openenrollment@Baltimorecity.gov; or
3. Complete an enrollment form and required dependent documentation and mail to:

DHR, Office of Employee Benefits
7 E. Redwood Street, 20th Floor
Baltimore, Maryland 21202

If the new retiree does not enroll in health benefits within 60 days of retirement, all benefit elections will default to "No Coverage" at the end of the enrollment period.

ENROLLING ELIGIBLE DEPENDENTS

Dependent children are eligible for benefits until the end of the calendar year that they reach age 26, regardless of student status. If you are adding a "NEW" dependent during Open Enrollment or throughout the 2024 plan year, you have two options to submit required documentation:

1. If you are enrolling through Workday, you can upload dependent documentation directly into Workday. **IMPORTANT NOTE**: "Adding" your dependent to your Workday record, does not automatically "enroll" that dependent into your health benefits coverage. If you need guidance on how to enroll dependents in Workday, please utilize Workday job aids at:

   https://humanresources.baltimorecity.gov/benefits-enrollment-cy-2024

2. If you are not enrolling through Workday, you must complete the Required Documentation form, attaching all required dependent documentation and submit all paperwork to the Office of Employee Benefits at:

   DHR, Office of Employee Benefits

   7 E. Redwood Street, 20th Floor Baltimore, Maryland 21202

   OpenEnrollment@baltimorecity.gov

   IMPORTANT: You must submit documentation for each dependent you wish to enroll for coverage to verify that eligibility requirements are met.

3. If you do not provide all the required documentation by the deadline, coverage may be terminated. You will be required to wait until the next annual Open Enrollment period to enroll new dependents or to make any changes to your enrollment.

Duplicate Coverage: If you, your spouse, or your dependent child are City employees/ retirees, you cannot enroll each other or the same eligible dependents on your medical, dental, vision and/or prescription plan during the same coverage period. You will be notified to adjust duplicate coverage, if applicable.

The chart on the following page will provide guidance of documentation required for adding dependents and family status changes. This chart also lists eligible dependents and the document required to verify eligibility. Photocopies are acceptable, provided any seal or official certification can be seen clearly.

If you have any questions, contact the Office of Employee Benefits at (410) 396-5830.

DOCUMENTATION FOR NEWLY ADDED DEPENDENTS & FAMILY STATUS CHANGES

Legal Spouse

Dependent Eligibility Criteria	*Documentation for Verification of Relationship (Provide Copy Of)*
Legally married as recognized by the laws of the State of Maryland or in a jurisdiction where such marriage is legal	Official Court-Certified State Marriage Certificate (must be certified and dated by the appropriate state or County official, such as the Clerk of the Court): • From the court in the County or City where the marriage took place; or • From the Maryland Department of Health - Maryland Vital Statistics Administration at https://health.maryland.gov/vsa/Pages/Home.aspx or www.vitalchek.com

Children

Dependent Eligibility Criteria	*Documentation for Verification of Relationship (Provide Copy Of)*
• Children covered due to birth, adoption, or stepchildren are covered until the end of the year they reach age 26. They may be married or unmarried. • Grandchildren are covered until the end of the year they reach 26, must reside in your home, and must have 100% economic support. • Disabled Children over age 26 must be incapable of self-support due to mental or physical incapacity incurred before age 26 and are required to reside in your home.	• **Birth:** Official State Birth Certificate with the name of employee/retiree as the child's parent • **Adoption:** Official Court Documents & Official State Birth Certificate • **Stepchild:** Official Court-Certified State Marriage Certificate & Official State Birth Certificate with the name of the spouse of employee/retiree as the child's parent • **Permanent Guardianship:** Official Court Documents signed by a judge & Official State Birth Certificate • **Grandchild:** Official State Birth Certificate of your child and grandchild showing the line of relationship, recent Income Tax Return claiming grandchild, and the "Certification of Economic Support for Grandchildren Form" • **Medical Child Support Order:** Official Medical Child Support Order requiring employee/retiree to provide health coverage signed by the child support officer or judge. • **Disabled Child:** Original Disability Questionnaire Form

TERMINATION OF COVERED DEPENDENTS DUE TO A FAMILY STATUS CHANGE

Reason for Termination of Dependents	Copy of Required Documentation
Death of Spouse or Child	Death Certificate
Divorce	Divorce Decree
Gain Other Coverage (Employee, Retiree, Spouse, or Child)	Letter from employer or medical plan
Reason for Coverage Change	**Copy of Required Documentation**
Loss of Coverage (Employee, Retiree, Spouse, or Child)	Letter from employer or medical plan

NOTE: Eligible dependents only include Legal spouse, natural child, stepchild, permanent guardianship of a child, grandchild, medical child support order, disabled child (see chart).

QUALIFYING LIFE EVENTS AND STATUS CHANGE
(MAKING CHANGES DURING THE PLAN YEAR)

The coverage you elect during Open Enrollment will be effective as of January 1, 2023, through December 31, 2023. There are several life events that allow you to make changes to your level of coverage or your ability to enroll or cancel your insurance during the plan year. You have **60 days**, immediately following that family status change, to make changes to your benefits. The changes that you may make must be consistent with the family status change you have experienced (i.e., adding a dependent to your coverage for the birth/adoption of a child, reducing coverage due to divorce). Family Status Changes include:

- Birth, adoption or placement for adoption of a child;
- Death of a dependent;
- Marriage (legally married spouse), divorce or court-ordered separation;
- Loss of other coverage; employment change for spouse (going from part-time to full-time or the reverse);
- Changes in entitlement to Medicare or Medicaid for you, your spouse or dependent;
- Significant change in the cost or condition of your spouse's health care coverage related to your spouse's employment that affects you.

If a retiree experiences a qualifying life event (marriage, birth, death, etc.), they may process the benefit changes via Workday or utilize an Enrollment Form which may be found at https://humanresources.baltimorecity.gov/benefits-enrollment-cy-2024 or by contacting the Office of Employee Benefits between 8:30 a.m. and 4:30 p.m. on (410) 396-5830, or via email at Openenrollment@Baltimorecity.gov When adding dependents to coverage, the retiree must upload the required supporting documentation in Workday, email, or mail the completed Enrollment Form and required dependent documentation before the enrollment deadline to:

DHR, Office of Employee Benefits, 7 East Redwood Street, 20th Floor, Baltimore, MD 21202
OpenEnrollment@baltimorecity.gov

If an Enrollment Form along with required documentation is not completed and returned to the Office of Employee Benefits within sixty (60) days of the QLE date, the retiree will have to wait until the next annual Open Enrollment period to make the benefit changes.

Special Enrollment Rights

If you or any of your dependents have health plan coverage and choose not to enroll in this plan, you may still be able to enroll later if you lose your current coverage or if your employer stops contributing to it. To do so, you need to request enrollment within sixty (60) days after your current coverage ends or contributions cease for you, your spouse, or your dependents.

If you recently gained a dependent due to marriage, birth, adoption, or placement for adoption, you may be eligible to enroll yourself, your spouse, and your dependents. Just remember to request enrollment within 60 days of the marriage, birth, adoption, or placement for adoption.

CITY OF BALTIMORE
DEPARTMENT OF HUMAN RESOURCES
Employee Benefits
7 E. Redwood Street | 20th Floor
Baltimore, MD 21202
T (410) 396-5830 | TTY 711 | F (410) 396-5216

DEPENDENT & QUALIFIED FAMILY LIFE EVENT

REQUIRED DOCUMENTATION FOR ONGOING ENROLLMENT

Instructions: Documentation is required for newly added dependents and family status changes. Complete this form and attach all required documentation and return all materials within forty-five (45) days of your initial enrollment period, sixty (60) days of your qualified family life event or before the last day of Open Enrollment. Dependents will be removed from coverage if all the required documentation is not received.

EMPLOYEE INFORMATION

First Name: _____ Last Name: _____

Social Security Number (last four digits only): _____ Employee Retiree Date of Birth: _____

Daytime Number: _____ Cell Number: _____

OPTIONS FOR SUBMITTING DOCUMENTATION

Upload documents to Workday: https://workday.baltimorecity.gov/login	Fax documents to: (410) 396-5216	Mail documents to: DHR, Office of Employee Benefits 7 E. Redwood Street | 20th Floor Baltimore, Maryland 21202

NEW DEPENDENT ENROLLMENT

Eligible Dependent Relationships to Employee / Retiree	Dependent Eligibility Criteria	Documentation for Verification of Relationship (Attach a copy of:)
Legal Spouse	Legally married as recognized by the laws of the State or jurisdiction where such marriage is legal	Official Court-Certified State Marriage Certificate (The certificate must be certified and dated by the appropriate State or County official, such as the Clerk of Court.) ***Where can I get a copy of a certificate?*** • From the court in the County or City where the marriage occurred • Maryland: Department of Health Vital Statistics Administration https://health.maryland.gov/vsa/Pages/Home.aspx • Out of State: VitalChek https://www.vitalchek.com/
Children • Birth • Adoption • Stepchild • Permanent Guardianship • Medical Child Support Order • Disabled Child (at age 26 as of December 31st)	• Under age 26 as of December 31st • Required to reside in your home • May be married or unmarried • Provide 100% economic support • Over age 26 and incapable of self-support due to mental or physical incapacity incurred prior to age 26	• Birth: Official State Birth Certificate with name of employee/retiree as child's parent • Adoption: Official court documents and official State Birth Certificate • Stepchild: Official court-certified State Marriage Certificate and official State Birth Certificate with the name of the spouse of the employee/retiree as child's parent • Permanent Guardianship: Official court documents signed by a judge and official State Birth Certificate • Grandchild: Official State Birth Certificate of your child and grandchild showing line of relationship, recent Income Tax Return claiming grandchild and the Certification of Economic Support for Grandchildren Form • Medical Child Support Order: Official Medical Child Support Order requiring employee/retiree to provide health coverage signed by the child support officer or judge • Disable Child: Original Disability Questionnaire Form

ENROLLMENT DUE TO A QUALIFIED LIFE EVENT

Qualified Life Event	Required Documentation (Provide a copy)
Loss of Other Coverage (Employee, Retiree, Spouse, Child)	Letter from Employer or Medical Plan

TERMINATION OF COVERED DEPENDENTS DUE TO A QUALIFIED LIFE EVENT

Qualified Life Event	Required Documentation (Provide a copy)
Death of Spouse or Child	Death Certificate
Divorce	Divorce Decree
Gain of Other Coverage (Employee, Retiree, Spouse, Child)	Letter from Employer or Medical Plan
Marriage of Dependent Child	Official State Marriage Certificate

RETIREE ENROLLMENT/MEDICARE INFORMATION

Important Medicare Notice:

The City of Baltimore **REQUIRES** all members covered under a Baltimore City retiree medical plan to enroll in **Medicare Part B** through Social Security Administration (SSA) at the time they become eligible for **Medicare Part A**. Once enrolled in Part B, they must remain enrolled to receive the maximum possible benefit through the City of Baltimore Retiree benefits.

What if I (or my spouse) am not eligible for Medicare Part A?

- If you (or your spouse) are not eligible for premium-free Medicare Part A because you did not pay enough Medicare taxes while you worked and you are age 65 or older, you will not be eligible to enroll in the City's MAPD plans, but you will have the option to enroll in the Aetna PPO Non-Medicare retiree plan offered by the City at the higher monthly premium. However, you must enroll in Medicare Part B through your local Social Security office at the time you become eligible for Medicare.
- Once you have received your Red, White and Blue Medicare card, please mail a copy of your card (or your spouse's) to DHR, Office of Employee Benefits, 7 E. Redwood Street, 20th floor, Baltimore, MD 21202 so we may update your information and begin the enrollment process with the Medicare Advantage Plan of your choice (Kaiser or Aetna). You will receive a Medical ID card from the plan, once enrolled, and your medical premium deduction will be changed to reflect the change in your health plan coverage. Medicare requires both Parts A and Parts B to be enrolled in a Medicare Advantage Plan with Part D Prescription (MAPD).

I am a new retiree but not 65 yet, what are my plan options?

- New retirees who are pre-Medicare age (prior to age 65), at the time of retirement, their medical enrollment options would be Kaiser HMO, BlueCross Advantage PPO and CVS Caremark prescription drug plan, United Concordia and National Vision administrator (MAPS, Fire and Police only).
- New retirees who are post Medicare (age 65 or older), at the time of retirement, their medical enrollment options would be Aetna PPO, Kaiser HMO and CVS Caremark prescription drug plan, United Concordia (Non-Medicare participants only) and National Vision administrator (MAPS, Fire and Police only) until they become eligible and enrolled in a MAPD plan. Retirees cannot enroll directly into a Medicare sponsored plan like the City's Kaiser MAPD or the Aetna MAPD plans, the retiree must be approved and accepted by CMS first. Retirees must be Medicare eligible with both Parts A and B Medicare to be enrolled in the MAPD plans.
- The retiree is required to provide a copy of their Red, White and Blue Medicare card and the MBI# at the same time the enrollment form is completed or at the time the retiree becomes Medicare eligible, whichever comes first.
- In plan year 2023, if the retiree does not have both parts of Medicare Part A and Part B, that retiree will not be considered for enrollment in the Aetna MAPD plan or the Kaiser MAPD plan. That retiree and or dependent without both parts of Medicare can only be placed in the Aetna PPO plan or the Kaiser HMO plan which requires separate prescription coverage in addition to the medical coverage and a higher monthly premium. The retiree and or dependent will remain in the Aetna PPO plan or Kaiser HMO plan until which time both Medicare Part A and B coverage is obtained or until the retiree cancels their coverage with the City of Baltimore.

RETIREE ENROLLMENT/MEDICARE INFORMATION (continued)

I am retired and already enrolled in a medical plan, what happens when I turn 65?

- Retirees that elected or are enrolled in the BlueChoice Advantage PPO High/Standard Option Plan or the Kaiser HMO plan and become eligible for Medicare Parts A & Part B due to attaining age 65 or as a disabled retiree will be included in the "Age-in to Medicare process". The Age-ins and new retirees are different, the age-ins are those who have already retired (or the dependent of a retiree) but are now becoming Medicare eligible. During the Age-in to Medicare process, the retiree and dependents remain in the BlueChoice Advantage PPO High/ Standard Option Plan or the Kaiser HMO plan until they are accepted by CMS and allowed enrollment into the Aetna or the Kaiser MAPD plan. If the retiree is aware that they are NOT eligible for either Part A or that they did not elect Part B Medicare when they were eligible, the retiree must notify the Office of Employee Benefits immediately. Failure to timely notify the Office of Employee Benefits could result in incorrect premium deductions from your pension check.

- Age-in enrollment is not instant, Medicare requires that the retirees be given the option to "opt out" if they do not want the plan. First the retiree must be sent the opt out kit which allows the retiree 21 days to decide if they want to be enrolled in the MAPD plan before the retiree is submitted to CMS for enrollment. At the time of submission, CMS will notify the plan if the retiree is eligible for both parts of Medicare. The submission of the Medicare card does not prove the retiree is eligible for both Part A and Part B, only CMS can verify the eligibility and enrollment. Once confirmed, the ID cards will be generated and mailed to the retiree's home address on file. The enrollment date could be 2 months out from the Medicare eligibility date. Once the Benefits Office is notified of the enrollment into the MAPD plan via the Aetna and Kaiser files, the retiree's plan option is changed on Workday that will reflect the change in the premium deduction. If there is a non-Medicare dependent of that age-in Medicare retiree, that dependent will remain or be moved to the Aetna PPO plan or Kaiser HMO plan at the same time the Retiree is moved to the MAPD plan.

- If there is a non-Medicare retiree that has an age-in Medicare dependent, that Retiree will remain or be moved to the Aetna PPO plan or Kaiser HMO at the same time the dependent is moved to the MAPD plan.

What should I do if I am eligible for Medicare due to a disability?

- Once you (or your spouse or child) have enrolled in Medicare Part A & Part B due to a disability determined by Social Security Administration and have received your Medicare card, you must notify the Office of Employee Benefits. Please provide your Medicare MBI# and Medicare Part A & Part B effective dates as soon as you receive your card. If you are enrolled in health benefits, your medical and prescription plan options will change.

What should I do if I am still actively working when I turn age 65?

- If you are still employed and enrolled in the group health benefits with the City of Baltimore (COB) as an active full-time employee when you (or your spouse) turn age 65, you should contact Social Security Administration (SSA) three months before you (or your spouse) turn age 65 to discuss your enrollment in Medicare Part A and Part B.
- If you decide to remain employed as an active full-time employee with the COB beyond age 65 and you (and your spouse) remain enrolled in COB group health benefits, you (or your spouse) may consider delaying your enrollment in Medicare Part B through SSA without a late- enrollment penalty. Contact your local Social Security Administration office to discuss your options and for more information.

RETIREE ENROLLMENT/MEDICARE INFORMATION (continued)

Who do I contact if I have any questions?

- If you have any questions regarding your Baltimore City medical plan coverage, contact the Office of Employee Benefits office on 410-396-5830/TTY 711 (Maryland).
- If you have any questions regarding Medicare enrollment in Part A and Part B, contact the Social Security Administration on 1-800-772-1213 or online www.SSA.Gov. If you have any questions regarding Medicare benefits, contact Medicare on 1- 800-633-4227 or online www.Medicare.Gov.

MEDICARE BENEFICIARY IDENTIFIER (MBI#)

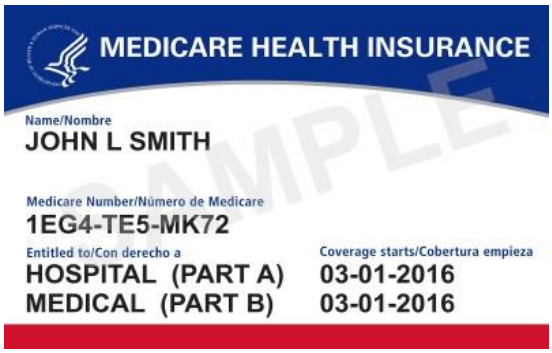
Once you (or your spouse) have enrolled in Medicare Part A & Part B due to attaining age 65 or to a disability, the City requests a copy of the Red, white and blue Medicare Card received from the Social Security Administration. The City will use your Medicare card to update your MBI# and your Part A and Part B effective dates on the Workday system.

Please note: a copy of the retiree's Medicare card does not automatically enroll you in the Aetna or Kaiser MAPD plan. CMS must verify your entitlement before this can take place.

Once the Office of Employee Benefits (OEB) receives your Medicare card/MBI# you will be submitted to CMS for approval to be enrolled in the AETNA or Kaiser MAPD Plan with prescription drug coverage. If you should decide that you do not want to be enrolled in the MAPD plans, then you must notify the OEB immediately by calling 410-396-5830. You may also submit your request to opt out in writing to the:

Office of Employee Benefits
7 E. Redwood Street, 20th Floor
Baltimore, MD 21202
Or via email: Openenrollment@Baltimorecity.gov.

Your new card should look like this:



If you are currently a Medicare member and have not received your new Medicare card, please check your current address listed with the Social Security Administration (SSA). You may review and change your address with the SSA online by using "my Social Security account" at the following link https://www.ssa.gov/myaccount/ or you may call 1 (800)772-1213 or 1(800) Medicare. The new card will automatically come to each Medicare member as long as the address is up to date with the Social Security Administration.

SUMMARY OF HEALTH INFORMATION

As a retiree, the health benefits available to you represent a significant component of your retirement benefit with the City of Baltimore. They also provide important protection for you and your family in case of illness or injury.

The City of Baltimore offers a series of coverage options. Choosing the correct medical plan is an important decision.

This Benefits Book provides the Open Enrollment information and a summary of all other available benefits for the full plan year. This Book describes and compares the plans to help you decide which plans are best for you.

MEDICARE SECONDARY PAYER (MSP) MANDATORY REPORTING

Under the Medicare Secondary Payer (MSP) Mandatory Reporting, Federal law requires the mandatory collection and reporting of social security numbers for all covered participants including employees, retirees, and their dependents through employer group health benefits.

Noncompliance may result in the loss of coverage for participants with invalid or missing social security numbers.

RETIREMENT SAVINGS PLAN (RSP)

The City of Baltimore has determined that employees who choose the Retirement Savings Plan ("RSP") Non-Hybrid retirement option will be eligible to receive retiree health care benefits when they terminate City employment commensurate with their employment years of service.

The RSP Board desires to establish the following age and length- of- service criteria to govern Non-Hybrid eligibility.

- The RSP Board has determined that for a Non-Hybrid member to be considered retirement eligible, he/she needs to reach the earliest ERS retirement age and service, which is at least age fifty-five (55) with at least five (5) years of service. Once deemed retirement eligible, a Non-Hybrid member would be eligible to receive retiree health care benefits based on the Graduated Retiree Contribution Schedule.
  A record for each member's years of City service, including hire dates and termination dates, will be maintained by the ERS/RSP to determine tiered eligibility for retiree health benefits.

MEDICAL PLAN COMPARISON CHART
NON-MEDICARE

The following charts are a summary of generally available benefits and do not guarantee coverage. Check each carrier's website to determine if your providers and the facilities in which your providers work are included in the various plan networks. To ensure coverage under your plan, contact the plan before receiving services or treatment to obtain more information on coverage limitations, exclusions, determinations of medical necessity, and preauthorization requirements.

2024 RETIREE BENEFIT PLAN (WITHOUT MEDICARE)

*Any out-of-network provider can balance bill the difference between the allowed amount and charges

	BlueChoice Advantage PPO Standard Option		BlueChoice Advantage PPO High Option		Kaiser HMO
	In-Network	Out-of-Network*	In-Network	Out-of-Network*	
Out-of-Pocket Maximum	$1,500 per individual $3,000 per family	$3,000 per individual $6,000 per family	$1,000 per individual $2,000 per family	N/A	$1,100 / $3,600
Deductible	$250 per individual $500 per family	$500 per individual $1,000 per family	N/A	N/A	N/A
Are Referrals Required?	No	No	No	No	Yes
Plan Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Routine & Preventive Services					
Routine Office Visit (Annual Physical)	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit	80% allowed benefit	Covered in full
Routine GYN (Annual)	100% allowed benefit	100% allowed benefit	100% allowed benefit	80% allowed benefit	Covered in full
Immunizations	100% allowed benefit	100% allowed benefit	100% allowed benefit	80% allowed benefit	Covered in full
Well Baby/Child Care	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit	Covered in full
Mammography, Colorectal Screening, Prostate Screening	100% allowed benefit	100% allowed benefit	100% allowed benefit, yearly after age 40	80% allowed benefit, yearly after age 40	Covered in full

2024 RETIREE BENEFIT PLAN (WITHOUT MEDICARE)

*Any out-of-network provider can balance bill the difference between the allowed amount and charges

	BlueChoice Advantage PPO Standard Option		BlueChoice Advantage PPO High Option		Kaiser HMO
	In-Network	Out-of-Network*	In-Network	Out-of-Network*	
Physician Office Visits (Non-Routine)					
Physician's Office Visit	$25 Copay	80% of allowed benefit after deductible	$5 copay per visit	80% allowed benefit	$5 copay per visit
Specialist Office Visit	$40 Copay	80% allowed benefit after deductible	$5 copay per visit	80% allowed benefit	$5 copay per visit
Hearing Exams One exam every 36 months; Routine exams excluded)	90% of allowed benefit after deductible	70% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit	$5 copay per visit
Emergency Room and Urgent Care Services					
Ambulance Service (Based on medical necessity)	90% allowed benefit after deductible (Ground Only)	90% allowed benefit after deductible (Ground Only)	100% of allowed benefit (Ground Only)	100% of allowed benefit (Ground Only)	Covered in full
Emergency Room (Copay waived if admitted)	90% allowed benefit after deductible	90% allowed benefit after deductible	$50 copay	100% of allowed benefit $50 copay	$50 copay
Urgent Care	$25 Copay, 90% allowed benefit	$25 Copay, 90% allowed benefit	$5 copay per visit	100% of allowed benefit	$5 copay per visit
Hospital Inpatient Services					
Anesthesia	90% allowed benefit after deductible	70% allowed benefit after deductible	100% allowed benefit	80% allowed benefit	Covered in full
Hospital Services, Including Room, Board & General Nursing Services (Preauthorization required)	90% allowed benefit after deductible	70% allowed benefit after deductible	100% allowed benefit, preauthorization required	$100 deductible per admission, then plan pays 80% up to $1,500 out-of-pocket maximum per admission, then 100% allowed benefit	Covered in full

2024 RETIREE BENEFIT PLAN (WITHOUT MEDICARE)

*Any out-of-network provider can balance bill the difference between the allowed amount and charges

	BlueChoice Advantage PPO Standard Option		BlueChoice Advantage PPO High Option		Kaiser HMO
	In-Network	Out-of-Network*	In-Network	Out-of-Network*	
Hospital Inpatient Services continued					
Medical Surgical Physician Services	90% allowed benefit after deductible	70% allowed benefit after deductible	100% allowed benefit	80% allowed benefit	Covered in full
Organ Transplant (Pre-authorization required)	90% allowed benefit after deductible	70% allowed benefit after deductible ($30,000 limit per Transplant)*	100% allowed benefit (Pre-Authorization Required)	100% allowed benefit (Pre-Authorization Required)	Covered in full for non-experimental transplants
Acute Inpatient Rehab	90% of allowed benefit after deductible	70% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit	Covered in full
Miscellaneous Supplies & Services					
Nutrition Counseling & Health Education	90% allowed benefit, after deductible	70% allowed benefit after deductible	100% allowed benefit after $5 copay	80% allowed benefit	$5 copay per visit
Diabetic Supplies (Insulin & Syringes are covered by the RX plan)	90% allowed benefit, after deductible	70% allowed benefit, after deductible	100% allowed benefit, including lancets, test strips and glucometers	100% allowed benefit, including lancets, test strips and glucometers	Covered in full
Durable Medical Equipment	90% allowed benefit, after deductible	70% allowed benefit, after deductible	100% allowed benefit	80% allowed benefit	Covered in full
Private Duty Nursing (Pre-authorization required)	90% allowed benefit, after deductible (outpatient only)	70% allowed benefit, after deductible (outpatient only)	100% allowed benefit (outpatient only)	80 % allowed benefit (outpatient only)	Covered in full
Inpatient Hospice Care (Pre-authorization required)	90% allowed benefit, after deductible	70% allowed benefit, after deductible	100% allowed benefit	100% allowed benefit	Covered in full for members with life expectancy of less than six months

2024 RETIREE BENEFIT PLAN (WITHOUT MEDICARE)

*Any out-of-network provider can balance bill the difference between the allowed amount and charges

	BlueChoice Advantage PPO Standard Option		BlueChoice Advantage PPO High Option		Kaiser HMO
	In-Network	Out-of-Network*	In-Network	Out-of-Network*	
Miscellaneous Supplies & Services cont.					
Outpatient Hospice Care (Pre-authorization required)	90% allowed benefit, after deductible	70% allowed benefit, after deductible	100% allowed benefit	100% allowed benefit	Covered in full for members with life expectancy of less than six months
Prosthetic Devices (Such as artificial limbs)	90% allowed benefit, after deductible	70% allowed benefit, after deductible	100% allowed benefit	80% allowed benefit	Covered in full
Major Medical					
Major Medical Annual Deductible	N/A	N/A	N/A	N/A	N/A
Major Medical Yearly Out-of-Pocket Maximum Costs	N/A	N/A	N/A	N/A	N/A
Outpatient Services					
Physical, Speech & Occupational Therapy	90% allowed benefit (after deductible) - limit 60 visits combined yearly	70% Allowed benefit (after deductible) - limit 60 visits combined yearly	100% allowed benefit -100 combined visits per calendar year	80% allowed benefit-100 combined visits per calendar year	Covered in full (call plan for visit limits)
Chemotherapy & Radiation	90% allowed benefit, after deductible	70% allowed benefit, after deductible	100% allowed benefit	80% allowed benefit	$5 copay per visit
Renal Dialysis	90% allowed benefit, after deductible	70% allowed benefit, after deductible	100% allowed benefit	80% allowed benefit	$5 copay per visit
Diagnostic Lab Work & X-rays	90% allowed benefit, after deductible	70% allowed benefit, after deductible	100% allowed benefit	80% allowed benefit	Covered in full
Outpatient Surgery	90% allowed benefit, after deductible	70% allowed benefit, after deductible	100% allowed benefit	80% allowed benefit	$5 copay per visit

2024 RETIREE BENEFIT PLAN (WITHOUT MEDICARE)					
*Any out-of-network provider can balance bill the difference between the allowed amount and charges					
	BlueChoice Advantage PPO Standard Option		BlueChoice Advantage PPO High Option		Kaiser HMO
	In-Network	Out-of-Network*	In-Network	Out-of-Network*	
Outpatient Services cont.					
Cardiac Rehab	90% allowed benefit, after deductible	90% allowed benefit, after deductible	100% allowed benefit	80% allowed benefit	Covered at 100%, if medically necessary
Allergy Services					
Allergy Testing	90% allowed benefit, after deductible	70% allowed benefit, after deductible	100% allowed benefit	80% allowed benefit	$5 copay per visit
Allergy Serum	90% allowed benefit, after deductible, no maximum	70% allowed benefit, after deductible, no maximum	100% allowed benefit, no maximum	80% allowed benefit, no maximum	Covered in full
Maternity					
Pre & Post-Natal Physician Services	100% allowed benefit	80% allowed benefit, after deductible	100% allowed benefit	80% allowed benefit	Copays, deductibles, or co-insurance may apply depending on services rendered
Delivery (Inpatient)	100% allowed benefit	80% allowed benefit	100% allowed benefit initial & discharge	80% allowed benefit initial & discharge	Covered in full
Newborn Care (Inpatient)	100% Allowed benefit	80% allowed benefit	100% allowed benefit initial & discharge	80% allowed benefit initial & discharge	Covered in full
Fertility Testing & Family Planning					
Fertility Testing & Family Planning	90% allowed benefit	70% allowed benefit	100% allowed benefit	80% allowed benefit	$5 copay per visit for family planning. Fertility testing office visit and any other fertility services covered at 50%

2024 RETIREE BENEFIT PLAN (WITHOUT MEDICARE)

*Any out-of-network provider can balance bill the difference between the allowed amount and charges

	BlueChoice Advantage PPO Standard Option		BlueChoice Advantage PPO High Option		Kaiser HMO
	In-Network	Out-of-Network*	In-Network	Out-of-Network*	
Fertility Testing & Family Planning cont.					
In-Vitro Fertilization (Pre-authorization required)	90% allowed benefit after deductible up to $100,000 Lifetime Maximum	70% allowed benefit after deductible up to $100,000 Lifetime Maximum	100% allowed benefit, up to $100,000 Lifetime Maximum	80% allowed benefit, up to $100,000 Lifetime Maximum	50% of allowable charges; $100,000 maximum lifetime benefit for up to 3 attempts per live birth
Mental Health & Substance Abuse					
Inpatient Mental Health/Alcohol & Substance Abuse Benefits (Pre-authorization required)	90% allowed benefit after deductible	70% allowed benefit after deductible	100% allowed benefit	$100 deductible per admission, then plan pays 80% of allowed benefit up to $1,500 out-of-pocket maximum per admission, then 100% allowed benefit	Covered in full
Outpatient Mental Health/ Alcohol & Substance Abuse Benefits	$25 Copay	80% allowed benefit after deductible	100% allowed benefit after $5 copay	80% allowed benefit	$5 copay per visit

2024 DEPENDENT BENEFIT PLAN (WITHOUT MEDICARE OF A RETIREE WITH MEDICARE)

*Any out-of-network provider can balance bill the difference between the allowed amount and charges

	Aetna PPO (Only offered to Non-Medicare Dependents of Medicare Participants enrolled in the Aetna MAPD plan.)	
	In-Network	**Out-of-Network***
Out-of-Pocket Maximum	$1,000 per individual $2,000 per family	N/A
Deductible	N/A	N/A
Are Referrals Required?	No	No
Plan Lifetime Maximum	Unlimited	Unlimited
Routine & Preventive Services		
Routine Office Visit (Annual physical)	100% of allowed benefit	80% allowed benefit
Routine GYN (Annual)	100% allowed benefit	80% allowed benefit
Immunizations	100% allowed benefit	80% allowed benefit
Well Baby/Child Care	100% of allowed benefit	80% of allowed benefit
Mammography, Colorectal Screening, Prostate Screening	100% allowed benefit, yearly after age 40	80% allowed benefit, yearly after age 40
Physician's Office Visit	$5 copay per visit	80% allowed benefit
Specialist Office Visit	$5 copay per visit	80% allowed benefit
Hearing Exams (One exam every 36 months; routine exams excluded)	100% of allowed benefit	80% of allowed benefit
Emergency Room and Urgent Care Services		
Ambulance Service (Based on medical necessity)	100% of allowed benefit (Ground, Air, and Water)	100% of allowed benefit (Ground, Air, and Water)
Emergency Room (Copay waived if admitted)	$50 copay	100% of allowed benefit $50 copay
Urgent Care	$5 copay per visit	$5 copay, then 100% of allowed benefit
Hospital Inpatient Services		
Anesthesia	100% allowed benefit	80% allowed benefit
Hospital Services, Including Room, Board & General Nursing Services (Pre-authorization required)	100% allowed benefit	$100 copay per admission, then 100% allowed benefit
Medical-Surgical Physician Services	100% allowed benefit	80% allowed benefit

2024 DEPENDENT BENEFIT PLAN (WITHOUT MEDICARE OF A RETIREE WITH MEDICARE)

*Any out-of-network provider can balance bill the difference between the allowed amount and charges

	Aetna PPO (Only offered to Non-Medicare Dependents of Medicare Participants enrolled in the Aetna MAPD plan.)	
	In-Network	**Out-of-Network***
Organ Transplant (Pre-authorization required)	100% allowed benefit	100% allowed benefit
Acute Inpatient Rehab	100% allowed benefit	80% allowed benefit
Miscellaneous Supplies and Services		
Nutritional Counseling & Health Education	100% of allowed benefit after $5 copay	80% allowed benefit
Diabetic Supplies (Insulin & Syringes are covered by the RX plan)	100% allowed benefit, including lancets, test strips and glucometers.	100% allowed benefit, including lancets, test strips and glucometers.
Durable Medical Equipment	100% allowed benefit	80% allowed benefit
Private Duty Nursing (Pre-authorization required)	100% of allowed benefit (outpatient only)	80% of allowed benefit (outpatient only)
Inpatient Hospice Care (Pre-authorization required)	100% allowed benefit	100% allowed benefit
Outpatient Hospice Care (Pre-authorization required)	100% allowed benefit	100% allowed benefit
Prosthetic Devices (Such as artificial limbs)	100% allowed benefit	80% allowed benefit
Outpatient Services		
Physical, Speech & Occupational Therapy	100% allowed benefit – 100 combined visits per calendar year	80% allowed benefit – 100 combined visits per calendar year
Chemotherapy & Radiation	$5 copay, 100% allowed benefit, based on place of service	80% allowed benefit
Renal Dialysis	$5 copay, 100% allowed benefit, based on place of service	80% allowed benefit
Diagnostic Lab Work & X-rays	100% allowed benefit	80% allowed benefit
Outpatient Surgery	100% allowed benefit	80% allowed benefit
Cardiac Rehab	$5 copay, 100% allowed benefit, based on place of service	80% allowed benefit
Allergy Services		
Allergy Testing	100% allowed benefit	80% allowed benefit
Allergy Serum	100% allowed benefit	80% allowed benefit
Maternity		
Pre & Post-Natal Physician Services	100% allowed benefit	80% allowed benefit

2024 DEPENDENT BENEFIT PLAN (WITHOUT MEDICARE OF A RETIREE WITH MEDICARE)

*Any out-of-network provider can balance bill the difference between the allowed amount and charges

	Aetna PPO (Only offered to Non-Medicare Dependents of Medicare Participants enrolled in the Aetna MAPD plan.)	
	In-Network	Out-of-Network*
Maternity (continued)		
Delivery (Inpatient)	100% allowed benefit initial & discharge	80% allowed benefit initial & discharge
Newborn Care (Inpatient)	100% allowed benefit initial & discharge	80% allowed benefit initial & discharge
Fertility Testing & Family Planning		
Fertility Testing & Family Planning	100% allowed benefit	80% allowed benefit
In-Vitro Fertilization (Pre-authorization required)	100% allowed benefit, $100,000 Maximum lifetime benefit; up to 6 attempts per live birth combined with ART, AI & AO.	80% allowed benefit, $100,000 Maximum lifetime benefit; up to 6 attempts per live birth combined with ART, AI & AO.
Mental Health & Substance Abuse		
Inpatient Mental Health/Alcohol & Substance Abuse Benefits (Pre-authorization required)	100% allowed benefit	$100 copay per admission, then 100% allowed benefit
Outpatient Mental Health/ Alcohol & Substance Abuse Benefits	100% allowed benefit	80% allowed benefit

MEDICAL PLAN COMPARISON CHART
MEDICARE

The following charts are a summary of generally available benefits and do not guarantee coverage. Check each carrier's website to determine if your providers and the facilities in which your providers work are included in the various plan networks. To ensure coverage under your plan, contact the plan before receiving services or treatment to obtain more information on coverage limitations, exclusions, determinations of medical necessity, and preauthorization requirements.

2024 RETIREE BENEFIT PLANS (WITH MEDICARE)		
*Any out-of-network provider can balance bill the difference between the allowed amount and charges		
	Aetna MAPD	**Kaiser MAPD**
Are Referrals Required?	No	Yes
Plan Lifetime Maximum Benefit	Unlimited	Unlimited
Deductible/Out-of-Pocket Maximums		
Deductible	None	N/A
Out-of-Pocket Maximum	$1,500	N/A
Routine & Preventive Services		
Physician's Office Visit	$5 copay per visit	$5 copay per visit
Specialist Office Visit	$5 copay per visit	$5 copay per visit
Routine GYN Examination	Covered in Full, one routine visit and pap smear every 24 months	Covered in full
Hearing Exams	$5 copay per visit, one exam every 12 months	$5 copay, hearing aids not covered
Immunizations	Medicare Covered immunizations covered in full	Office visit copay may apply, then covered in full for influenza, pneumococcal and Hepatitis B vaccine
Mammography, Colorectal Screening, Prostate Screening	Covered in Full (One baseline mammogram for members age 35-39; and one annual mammogram for members age 40 & over) (Prostrate screening for males age 50 and over, every 12 months)	Covered in full
Routine Physical	Covered in Full, once every 12 months	Covered in full
Well Baby/Child Care	No Benefit	Covered in full
Emergency Room and Urgent Care Services		
Ambulance Service	Covered in Full, prior authorization or physician's order may be required	Covered in full according to Medicare guidelines
Emergency Room (Copay waived if admitted)	$50 copay, worldwide	$50 copay

2024 RETIREE BENEFIT PLANS (WITH MEDICARE)

*Any out-of-network provider can balance bill the difference between the allowed amount and charges

	Aetna MAPD	Kaiser MAPD
Emergency Room and Urgent Care Services cont.		
Urgent Care	$5 copay per visit	$5 copay per visit
Hospital Inpatient Services		
Anesthesia	Covered in full, prior authorization may be required	
Hospital Services, including Room, Board & General Nursing Services	Covered in Full, prior authorization or physician's order may be required.	Covered in full for pre-authorized hospitalization or emergency admission
Diagnostic Lab Work & X-rays	Covered in Full, prior authorization or physician's order may be required.	Covered in full
Medical Surgical Physician Services	Covered in Full, prior authorization or physician's order may be required.	Covered in full
Physical, Speech & Occupational Therapy	Covered in Full, prior authorization or physician's order may be required.	Covered in full (call plan for limits)
Organ Transplant (Pre-authorization required)	Covered in Full, prior authorization or physician's order may be required.	Covered in full when authorized, according to Medicare guidelines
Acute Inpatient Rehab	Covered in full when authorized, according to Medicare guidelines	Covered in full
Outpatient Services		
Cardiac Rehabilitation	Covered in full	Covered at 100% if medically necessary
Chemotherapy & Radiation	$5 copay per visit	$5 copay per visit
Renal Dialysis	Covered in Full, prior authorization or physician's order may be required.	Covered in full for out-patient dialysis within the service area
Diagnostic Lab Work & X-rays	Covered in Full, prior authorization or physician's order may be required.	Covered in full
Outpatient Surgery	Covered in Full	Covered in full
Physical, Speech & Occupational Therapy	$5 copay per visit, prior authorization or physician's order may be required.	$5 copay per visit, Medicare guidelines apply for medical necessity and length of treatment
Allergy Testing	$5 copay per visit	$5 copay per visit
Allergy Serum	$5 copay per visit	$5 copay per visit
Maternity		
Pre/Post-Natal Physician Services	No benefit	Copays, deductibles, or co-insurance may apply depending on services rendered

2024 RETIREE BENEFIT PLANS (WITH MEDICARE)

*Any out-of-network provider can balance bill the difference between the allowed amount and charges

	Aetna MAPD	Kaiser MAPD
Maternity cont.		
Delivery (Inpatient)	No benefit	Covered in full
Newborn Care (Inpatient)	No benefit	Covered in full
Fertility Testing & Family Planning		
Fertility Testing & Family Planning	No benefit	$5 copay per visit- infertility 50% of allowable charges for testing, lab and x-ray charges
In-Vitro Fertilization	No benefit	50% of allowable charges; $100,000 maximum lifetime benefit for up to 3 attempts per live birth
Mental Health & Substance Abuse		
Inpatient Mental Health Benefits/Alcohol & Substance Abuse	Covered in Full, prior authorization or physician's order may be required	Covered in full
Outpatient Mental Health Benefits/Alcohol & Substance Abuse	$5 copay per visit, prior authorization or physician's order may be required	$5 copay per visit
Miscellaneous Supplies & Services		
Nutrition and Health Education	Covered in Full	Unlimited visits
Diabetic Supplies	Covered in Full, prior authorization or physician's order may be required. Includes supplies to monitor your blood glucose from LifeScan.	$5 copay per visit for Medicare covered self-monitoring training; covered in full for lancets, test strips & glucometers
Home Health Care	Covered in Full, prior authorization or physician's order may be required.	Covered in full according to Medicare guidelines
Extended Care Facility/Skilled Nursing Facilities	Covered in Full, up to 100 days per Medicare benefit period.	Covered in full for up to 100 days per benefit period
Hospice Care	Covered by Original Medicare at Medicare certified hospice	Covered in full
Prosthetic Devices (Such as artificial limbs)	Covered in Full, prior authorization or physician's order may be required.	Covered in full according to Medicare guidelines

HEALTH INSURANCE PREMIUM RATES

2024 Retiree Medical Plan Monthly Deduction Rate Chart

(15 or more city service years)

Effective January 1, 2024

All Members Non-Medicare Only			BlueChoice Adv (High Option)	BlueChoice Adv (Standard Option)	Aetna	Kaiser HMO
Level Code	Number of Members	Coverage Level Description	Your Cost	Your Cost	Your Cost	Your Cost
I	1	Retiree Only	$549.37	$449.75	N/A	$469.08
P	2	Retiree Plus Dependent Child	$1,070.70	$876.54	N/A	$867.52
H	2	Retiree Plus Spouse	$1,231.94	$1,008.14	N/A	$910.75
F	3 or More	Retiree Plus Two or More Dependents	$1,343.19	$1,100.29	N/A	$1,687.69
All Members with Medicare A & B Only			BlueChoice Adv (High Option)	BlueChoice Adv (Standard Option)	Aetna	Kaiser HMO
Level Code	Number of Members	Coverage Level Description	Your Cost	Your Cost	Your Cost	Your Cost
1	1	Retiree With Medicare A & B	N/A	N/A	$154.32	$166.47
2	2 or More	Two or More With Medicare A & B	N/A	N/A	$308.64	$332.94
Two Members: One Non-Medicare Member & One Member with Medicare A & B			BlueChoice Adv (High Option)	BlueChoice Adv (Standard Option)	Aetna	Kaiser HMO
Level Code	Number of Members	Coverage Level Description	Your Cost	Your Cost	Your Cost	Your Cost
I1	2	One Non-Medicare Member and One Member with Medicare A & B	N/A	N/A	$703.69	$491.61
Three or More Members With At Least One Member With Medicare A & B Only			BlueChoice Adv (High Option)	BlueChoice Adv (Standard Option)	Aetna	Kaiser HMO
Level Code	Number of Members	Coverage Level Description	Your Cost	Your Cost	Your Cost	Your Cost
F1	3 or More	Three or More Members With At Least One Member with Medicare A & B Only	N/A	N/A	$948.14	$1,174.43
Combination of Medicare Part B or A Only & Medicare A & B Members			BlueChoice Adv (High Option)	BlueChoice Adv (Standard Option)	Aetna	Kaiser HMO
Level Code	Number of Members	Coverage Level Description	Your Cost	Your Cost	Your Cost	Your Cost
S	1	Retiree With Medicare B or A Only	N/A	N/A	$452.97	N/A
SS S1	2	Two Members with Medicare B or A Only or One Member with Medicare B or A Only & One Member with Medicare A & B	N/A	N/A	$905.94	N/A
Combination of Medicare B or A Only & Non Medicare Members			BlueChoice Adv (High Option)	BlueChoice Adv (Standard Option)	Aetna	Kaiser HMO
Level Code	Number of Members	Coverage Level Description	Your Cost	Your Cost	Your Cost	Your Cost
IS	2 or more	Two or More Members With At Least One Member with Medicare B Only & Non-Medicare Members	N/A	N/A	$980.46	N/A

HEALTH INSURANCE PREMIUM RATES

2024 Retiree Medical Plan Monthly Deduction Rate Chart

(10 to 14 city service years)

Effective January 1, 2024

All Members Non-Medicare Only			BlueChoice Adv (High Option)	BlueChoice Adv (Standard Option)	Aetna	Kaiser HMO
Level Code	Number of Members	Coverage Level Description	Your Cost	Your Cost	Your Cost	Your Cost
I	1	Retiree Only	$853.62	$754.01	N/A	$773.33
P	2	Retiree Plus Dependent Child	$1,663.35	$1,469.18	N/A	$1,460.17
H	2	Retiree Plus Spouse	$1,917.58	$1,693.79	N/A	$1,596.39
F	3 or More	Retiree Plus Two or More Dependents	$2,081.36	$1,838.46	N/A	$2,425.86
All Members with Medicare A & B Only			BlueChoice Adv (High Option)	BlueChoice Adv (Standard Option)	Aetna	Kaiser HMO
Level Code	Number of Members	Coverage Level Description	Your Cost	Your Cost	Your Cost	Your Cost
1	1	Retiree With Medicare A & B	N/A	N/A	$219.20	$235.63
2	2 or More	Two or More With Medicare A & B	N/A	N/A	$438.40	$471.26
Two Members: One Non-Medicare Member & One Member with Medicare A & B			BlueChoice Adv (High Option)	BlueChoice Adv (Standard Option)	Aetna	Kaiser HMO
Level Code	Number of Members	Coverage Level Description	Your Cost	Your Cost	Your Cost	Your Cost
I1	2	One Non-Medicare Member and One Member with Medicare A & B	N/A	N/A	$1,072.82	$691.17
Three or More Members With At Least One Member With Medicare A & B Only			BlueChoice Adv (High Option)	BlueChoice Adv (Standard Option)	Aetna	Kaiser HMO
Level Code	Number of Members	Coverage Level Description	Your Cost	Your Cost	Your Cost	Your Cost
F1	3 or More	Three or More Members With At Least One Member with Medicare A & B Only	N/A	N/A	$1,446.94	$1,862.20
Combination of Medicare Part B or A Only & Medicare A & B Members			BlueChoice Adv (High Option)	BlueChoice Adv (Standard Option)	Aetna	Kaiser HMO
Level Code	Number of Members	Coverage Level Description	Your Cost	Your Cost	Your Cost	Your Cost
S	1	Retiree With Medicare B or A Only	N/A	N/A	$724.75	N/A
SS S1	2	Two Members with Medicare B or A Only or One Member with Medicare B or A Only & One Member with Medicare A & B	N/A	N/A	$1,449.50	N/A
Combination of Medicare B or A Only & Non Medicare Members			BlueChoice Adv (High Option)	BlueChoice Adv (Standard Option)	Aetna	Kaiser HMO
Level Code	Number of Members	Coverage Level Description	Your Cost	Your Cost	Your Cost	Your Cost
IS	2 or more	Two or More Members With At Least One Member with Medicare B Only & Non-Medicare Members	N/A	N/A	$1,568.73	N/A

HEALTH INSURANCE PREMIUM RATES

2024 Retiree Medical Plan Monthly Deduction Rate Chart

(5 to 9 city service years)

Effective January 1, 2024

All Members Non-Medicare Only			BlueChoice Adv (High Option)	BlueChoice Adv (Standard Option)	Aetna	Kaiser HMO
Level Code	Number of Members	Coverage Level Description	Your Cost	Your Cost	Your Cost	Your Cost
I	1	Retiree Only	$1,054.98	$955.36	N/A	$974.68
P	2	Retiree Plus Dependent Child	$2,055.96	$1,861.80	N/A	$1,852.79
H	2	Retiree Plus Spouse	$2,366.74	$2,142.94	N/A	$2,045.55
F	3 or More	Retiree Plus Two or More Dependents	$2,575.66	$2,332.76	N/A	$2,920.16
All Members with Medicare A & B Only			BlueChoice Adv (High Option)	BlueChoice Adv (Standard Option)	Aetna	Kaiser HMO
Level Code	Number of Members	Coverage Level Description	Your Cost	Your Cost	Your Cost	Your Cost
1	1	Retiree With Medicare A & B	N/A	N/A	$274.00	$294.54
2	2 or More	Two or More With Medicare A & B	N/A	N/A	$548.00	$589.08
Two Members: One Non-Medicare Member & One Member with Medicare A & B			BlueChoice Adv (High Option)	BlueChoice Adv (Standard Option)	Aetna	Kaiser HMO
Level Code	Number of Members	Coverage Level Description	Your Cost	Your Cost	Your Cost	Your Cost
I1	2	One Non-Medicare Member and One Member with Medicare A & B	N/A	N/A	$1,328.98	$970.37
Three or More Members With At Least One Member With Medicare A & B Only			BlueChoice Adv (High Option)	BlueChoice Adv (Standard Option)	Aetna	Kaiser HMO
Level Code	Number of Members	Coverage Level Description	Your Cost	Your Cost	Your Cost	Your Cost
F1	3 or More	Three or More Members With At Least One Member with Medicare A & B Only	N/A	N/A	$1,794.68	$2,314.17
Combination of Medicare Part B or A Only & Medicare A & B Members			BlueChoice Adv (High Option)	BlueChoice Adv (Standard Option)	Aetna	Kaiser HMO
Level Code	Number of Members	Coverage Level Description	Your Cost	Your Cost	Your Cost	Your Cost
S	1	Retiree With Medicare B or A Only	N/A	N/A	$905.94	N/A
SS S1	2	Two Members with Medicare B or A Only or One Member with Medicare B or A Only & One Member with Medicare A & B	N/A	N/A	$1,811.88	N/A
Combination of Medicare B or A Only & Non Medicare Members			BlueChoice Adv (High Option)	BlueChoice Adv (Standard Option)	Aetna	Kaiser HMO
Level Code	Number of Members	Coverage Level Description	Your Cost	Your Cost	Your Cost	Your Cost
IS	2 or more	Two or More Members With At Least One Member with Medicare B Only & Non-Medicare Members	N/A	N/A	$1,960.92	N/A

PRESCRIPTION DRUG BENEFITS

2024 RX COPAYS (CVS CAREMARK) (HIGH OPTION PHARMACY PROGRAM)		
Retirees without Medicare – $0 Deductible		
Plan Feature	**Amount You Pay**	**Notes**
Deductible	None	Your plan does not have a deductible.
Preventive Drugs (Up to a 31-day supply at retail)	$0	A preventive drug is a prescribed medication or item on CVS Caremark's Preventive Drug List. *
Generic Drugs (Tier 1) (Up to a 31-day supply at retail)	$5	Generic drugs are covered at this copay level.
Preferred Brand Drugs (Tier 2) (Up to a 31-day supply at retail)	$30	All preferred brand drugs are covered at this copay level.
Non-preferred Brand Drugs (Tier 3) (Up to a 31-day supply at retail)	$50	All non-preferred brand drugs on this copay level are not on the Preferred Drug List. * Discuss using alternatives with your physician or pharmacist.
Retail Pharmacy Maintenance Drugs (Up to a 90-day supply)	Generic: $12.50 Preferred Brand: $75 Non-preferred Brand: $125	Maintenance drugs of up to a 90-day supply are also available at the retail pharmacy.
Mail Order Maintenance Drugs (Up to a 90-day supply)	Generic: $12.50 Preferred Brand: $75 Non-preferred Brand: $125	Maintenance drugs of up to a 90-day supply are only available through Mail Service Pharmacy.
Mandatory Generic Substitution	If a provider prescribes a non-generic drug when a generic is available, you will pay the non-generic applicable copay PLUS the cost difference between the generic non-generic up to the cost of the prescription. If a generic version is not available, you will only pay the applicable copay.	

PRESCRIPTION DRUG BENEFITS (CONTINUED)

2024 RX COPAYS CVS CAREMARK STANDARD OPTION PHARMACY PROGRAM		
Retirees without Medicare - $50 Deductible		
Plan Feature	**Amount You Pay**	**Notes**
Deductible	$50	If you meet your deductible, you will pay a different copay or coinsurance depending on the drug tier. Drugs not subject to any medical or drug deductibles are noted below.
Preventive Drugs (Up to a 31-day supply at retail)	$0	A preventive drug is a prescribed medication or item on CVS Caremark's Preventive Drug List. *
Generic Drugs (Tier 1) (Up to a 31-day supply at retail)	$5	Generic drugs are covered at this copay level.
Preferred Brand Drugs (Tier 2) (Up to a 31-day supply at retail)	$30	All preferred brand drugs are covered at this copay level.
Non-preferred Brand Drugs (Tier 3) (Up to a 31-day supply at retail)	$50	All non-preferred brand drugs on this copay level are not on the Preferred Drug List.* Discuss using alternatives with your physician or pharmacist.
Retail Pharmacy Maintenance Drugs (Up to a 90-day supply)	Generic: $10 Preferred Brand: $60 Non-preferred Brand: $100	Maintenance drugs of up to a 90-day supply are also available at the retail pharmacy.
Mail Order Maintenance Drugs (Up to a 90-day supply)	Generic: $10 Preferred Brand: $60 Non-preferred Brand: $100	Maintenance drugs of up to a 90-day supply are only available through Mail Service Pharmacy.
Mandatory Generic Substitution	If a provider prescribes a non-generic drug when a generic is available, you will pay the non-generic applicable copay PLUS the cost difference between the generic non-generic up to the cost of the prescription. If a generic version is not available, you will only pay the applicable copay.	

PRESCRIPTION DRUG BENEFITS (CONTINUED)

2024 RX COPAYS (AETNA AND KAISER MAPD)

MEDICARE PART D OPTION PHARMACY PROGRAM PREMIUM IS INCLUDED IN THE MAPD PREMIUM

Retirees with Medicare – $100 Deductible

Plan Feature	Amount You Pay	Notes
Deductible	$100	If you meet your deductible, you will pay a different copay or coinsurance depending on the drug tier. Drugs not subject to any medical or drug deductibles are noted below.
Preventive Drugs (Up to a 31-day supply at retail)	$0	A preventive drug is a prescribed medication or item on your Medicare Advantage Plan's Preventive Drug List. *
Generic Drugs (Standard) (Up to a 31-day supply at retail)	$5	Generic drugs are covered at this copay level.
Preferred Brand Drugs (Up to a 31-day supply at retail)	$30	All preferred brand drugs are covered at this copay level.
Non-preferred Brand Drugs (Up to a 31-day supply at retail)	$50	All non-preferred brand drugs on this copay level are not on the Preferred Drug List. * Discuss using alternatives with your physician or pharmacist.
Retail Pharmacy Maintenance Drugs - Standard (Up to a 90-day supply)	Generic: $15.00 Preferred Brand: $90 Non-preferred Brand: $150	Maintenance drugs of up to a 90-day supply are also available at the retail pharmacy for Medicare retirees.
Mail Order Maintenance Drugs - Preferred (Up to a 90-day supply)	Generic: $12.50 Preferred Brand: $75 Non-preferred Brand: $125	Maintenance drugs of up to a 90- day supply are available through Mail Service Pharmacy.
Mandatory Generic Substitution	If a provider prescribes a non-preferred brand drug when a generic is available, you will pay the non-preferred brand copay PLUS the cost difference between the generic and brand drug up to the cost of the prescription. If a generic version is not available, you will only pay the copay.	

Visit https://www.aetna.com and https://www.kaiserpermanente.org for the most up-to-date drug lists, including the prescription guidelines. Prescription guidelines indicate drugs that require your doctor to obtain prior authorization before they can be filled and drugs that can be filled in limited quantities.

This plan summary is for comparison purposes only and does not create rights not given through the benefit plan.

PRESCRIPTION DRUG BENEFITS COST

2024 Monthly Prescription Drug Costs for Retirees (High Option & Standard Option Plans)

Retirees & Dependents Enrolled in Rx (Non-Medicare) & MRx (Medicare D) Plans (NOTE: Will Be Combined with Your Medical Cost As A Single Payroll Deduction)

A	Retirees & Dependents (All Members Non-Medicare) Prescription Drug Plan (Rx)	Rx Level Tiers	High Option Your Cost Per Pension Check	Standard Option Your Cost Per Pension Check
	Participant Only	1	$63.51	$53.09
	Participant + Child	2	$123.85	$103.54
	Participant + Spouse	3	$142.68	$119.28
	Participant + Family	4	$154.87	$129.48

B	Non-Medicare Dependent(s) Of Retirees Enrolled In MAPD	Rx Level Tiers	High Option Your Cost Per Pension Check	Standard Option Your Cost Per Pension Check
	Spouse	9	$63.51	$53.09
	Spouse + One Child	10	$123.85	$103.54
	Spouse + Two or More Children	11	$154.87	$129.48
	One Child Only	12	$60.35	$50.45
	Two Or More Children Only	13	$91.37	$76.38

Key:

Rx Plan = Non-Medicare retirees and dependents enrolled in the CVS Caremark Rx Plan

MRx Plan = Medicare retirees and dependents enrolled in the Aetna or Kaiser MAPD Rx Plan

How To Determine Your Monthly Prescription Cost

To determine your prescription drug cost in the City's (High Option or Standard Option) prescription drug plan, read the following categories along with the costs displayed on the front of this notice and complete the worksheet below. Choose the High Option or Standard Option column based on your medical plan enrollment option. If you enroll in the BlueChoice Advantage PPO Standard Option Medical Plan, then you can only elect the Standard Option Rx Plan. All other Medical Plan enrollment options are linked to the High Option Rx Plan.

Refer to Table A if you and all of your family members are non-Medicare. Example: Your family unit includes you and two dependents (spouse and children) all members are (Non-Medicare – Table A – Rx Level Tier 4 – Family). Your Rx cost for you and your family members will be $129.48 if you enroll in the Standard Option Rx Plan. Your total prescription drug cost of $129.48 will be combined with your medical cost as a single payroll deduction from your monthly pension check.

Refer to Table B if you (the retiree) are Medicare eligible enrolled in the Aetna or Kaiser MAPD plan and your family members (dependents) are Non-Medicare enrolled in the Aetna PPO or Kaiser HMO. You will have to add the cost of Rx from Tables B to arrive at your total prescription drug cost that will be combined with your medical cost as a single payroll deduction from your monthly pension check.

Worksheet:

Table A All Members Non-Medicare Level Tier Code:_____ Rx Cost: $_____

Table B Dependents of Retirees in MAPD Level Tier Code: _____ Rx Cost: $_____

Total Prescription Drug Cost Per Pension Check: $_____

VISION BENEFITS

2024 NATIONAL VISION ADMINISTRATORS (NVA) VISION SCHEDULE OF BENEFITS (RETIREES OF MAPS, POLICE & FIRE ONLY)			
	If services are provided by a Participating Provider	If services are provided by a Non-Participating Provider	
	Plan Pays	Plan Pays	You Pay
Vision Covered Service (Note: Plan allows one vision exam, per member, once per calendar year.)			
Exam	100% after $5 copay	up to $38.00	$0
Glasses Covered Service (Note: Plan allows one pair of glasses, per member, once per calendar year.)			
Lenses			
Single Vision	100% after $15 copay	up to $41.50	Balance
Bifocal	100% after $15 copay	up to $67.00	Balance
Trifocal	100% after $15 copay	up to $89.50	Balance
Lenticular (Cataract)	100% after $15 copay	up to $100.50	Balance
Lenses Options			
Solid Tints	Covered 100%	up to $10	Balance
Fashion Gradient Tint	Covered 100%	up to $12	Balance
Standard Progressive	Covered 100%	up to $50	Balance
Frames			
Frames Per Pair	Covered up to $75 retail allowance (20% discount off remaining balance over $75 allowance)	up to $29.50	Balance
Contact Lenses (Note: Plan allows one pair of contacts, per member, once per calendar year.)			
Medically Necessary	Covered 100%	up to $221	Balance
Elective not Medically Necessary	Covered up to $100 retail allowance 15% discount (conventional) or 10% discount (disposable) off remaining balance over $100 allowance	up to $100	Balance

NOTE: The only Retirees eligible for the City Vision Benefits are MAPS, Fire & Police.

DENTAL COVERAGE

IMPORTANT: Residential information

- The **United Concordia Dental DHMO** plan is for the non-Medicare retirees who ***resides within Maryland and Pennsylvania***.
- The **United Concordia Dental DPPO** plan is for the non-Medicare retirees who ***resides Outside of Maryland and Pennsylvania.***
- Kaiser Permanente Dental HMO plan for non-Medicare retirees **(Dental coverage provided by Kaiser Only)**

Once the retirees enrolled in BlueChoice PPO and Aetna PPO are enrolled in Medicare, their dental coverage will be terminated.

Under the DHMO plan, you must select a dentist, or one will be automatically assigned to you. To find a dentist in your area please visit the United Concordia website at:
http://www.unitedconcordia.com/cityofbaltimore

Retirees enrolled in Kaiser's Medicare Advantage Plan are eligible to continue dental coverage once on Medicare. Please contact Kaiser for more information on their dental plan.

2024 UNITED CONCORDIA DENTAL HMO

(NON-MEDICARE RETIREES THAT LIVE IN MARYLAND AND PENNSYLVANIA)

Under this DHMO plan, you'll have your choice of skilled primary care dentists from the United Concordia network. Select a primary care dentist, who will then coordinate any needed referrals to a specialist. Covered services provided by your dentist have preset copayments (dollar amounts), which are listed below and in your plan booklet. There are no maximums or deductibles.

COPAYMENTS FOR COMMON DENTAL SERVICES

Code	Description of Service	Enrollee Pays
D0100-D0999 I. Diagnostic		
D0120	Periodic oral evaluation – established patient	$5.00
D0140	Limited oral evaluation - problem focused	$5.00
D0150	Comprehensive oral evaluation - new or established patient	$5.00
D0210	Intraoral - complete series of radiographic images	$25.00
D0220	Intraoral - periapical first radiographic image	$4.00
D0230	Intraoral - periapical each additional radiographic image	$3.00
D0272	Bitewings - two radiographic images	$5.00
D0274	Bitewings - four radiographic images	$7.00
D0330	Panoramic radiographic image	$20.00
D1000-D0999 II. Preventive		
D1110	Prophylaxis – adult	$10.00
D1120	Prophylaxis – child	$10.00
D1208	Topical application of fluoride (prophylaxis excluded) - through age 18	$5.00
D1351	Sealant - per tooth	$5.00
D2000-D2999 III. Restorative		
D2140	Amalgam - one surface, primary or permanent	$28.00
D2150	Amalgam - two surfaces, primary or permanent	$35.00
D2160	Amalgam - three surfaces, primary or permanent	$45.00

DENTAL COVERAGE (CONTINUED)

Code	Description of Service	Enrollee Pays
D2000-D2999 III. Restorative cont.		
D2161	Amalgam - four or more surfaces, primary or permanent	$55.00
D2330	Resin-based composite - one surface, anterior	$35.00
D2331	Resin-based composite - two surfaces, anterior	$45.00
D2332	Resin-based composite - three surfaces, anterior	$55.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$80.00
D2391	Resin-based composite - one surface, posterior	$40.00
D2392	Resin-based composite - two surfaces, posterior	$50.00
D2750	Crown - porcelain fused to high noble metal	$390.00
D2752	Crown - porcelain fused to noble metal	$380.00
D2790	Crown - full cast high noble metal	$390.00
D2792	Crown - full cast noble metal	$380.00
D2920	Re-cement crown	$25.00
D2950	Core buildup, including any pins	$60.00
D2954	Prefabricated post and core in addition to crown	$70.00
D3000-D3999 IV. Endodontics		
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$200.00
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	$300.00
D3330	Endodontic therapy, molar (excluding final restoration)	$425.00
D4000-D4999 V. Periodontics		
D4341	Periodontal scaling and root planting - four or more teeth per quadrant	$60.00
D4910	Periodontal maintenance	$50.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$35.00
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$60.00
D7000-D7999 VI. Oral and Maxillofacial Surgery		
D7230	Removal of impacted tooth - partially bony	$110.00
D7240	Removal of impacted tooth - completely bony	$150.00
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$10.00
D9230	Inhalation of Nitrous Oxide/Anxiolysis Analgesia	$28.00

NOTE: THIS IS ONLY A BRIEF SUMMARY OF THE PLAN. The Group Dental Service Contract must be consulted to determine the exact terms and conditions of coverage.

DENTAL COVERAGE (CONTINUED)

2024 UNITED CONCORDIA DENTAL PPO

(NON-MEDICARE RETIREES THAT LIVE OUTSIDE MARYLAND AND PENNSYLVANIA)

This preferred provider plan offers the convenience and flexibility of visiting any licensed dentist, anywhere. Covered services are paid based on a percentage—if, for example, fillings are covered at 40%, you pay the remaining 60%. Get the most plan value by choosing a United Concordia PPO dentist. PPO network dentists complete claim forms for you and can help advise you on questions regarding your share of the payment.

Benefit Category 1	In-Network 2	Non- Network 2
Class I – Diagnostic/Preventive Services		
Exams (2 per calendar year MARYLAND GROUP)	60%	60%
X-rays (Full Mouth 1 per 60 months)		
Cleanings (2 per calendar year MARYLAND GROUP)		
Fluoride Treatments (1 per calendar year under age 14 MARYLAND GROUP)		
Sealants (1 per tooth per 36 months to age 16 on permanent first and second molars)		
Class II – Basic Services		
Basic Restorative	40%	40%
Simple Extractions		
Complex Oral Surgery		
General Anesthesia		
Class III – Major Services		
Repairs of Crowns, Inlays, Onlays, Bridges & Dentures (1 in any 12-month period per specific area of appliance)	30%	30%
Endodontics		
Non-surgical Periodontics (Scaling & Root Planing 1 per 36 months, per quadrant)		
Surgical Periodontics		
Inlays, Onlays, Crowns (1 per 60 months)		
Maximums & Deductibles (Applies to the combination of services received from network and non-network dentists.)		
Calendar Year Program Deductible (per member/per family) January 1 – December 31	$75 / $225 Excludes Class I	
Calendar Year Program Maximum (per member) January 1 – December 31	$1,000	
Lifetime Orthodontic Maximum (per child dependent)	N/A	

- Dependent children covered to age 26
- Reimbursement is based on our schedule of maximum allowable charges (MACs). Network dentists agree to accept our allowances as payment in full for covered services. Out-of-Network dentists may bill the member for any difference between our allowances and their fee. United Concordia Dental's standard exclusions and limitations apply.

METLIFE INSURANCE – BASIC LIFE

MetLife requires a valid beneficiary designation on file.

How to designate your beneficiary online!

1. Log on to metlife.com/mybenefits and enter '**City of Baltimore**' in the Company Name field.
2. On the '**Welcome to MyBenefits**' page you can register as a new user or if you have already registered, enter your username and password.
3. Once you log into **MyBenefits**, select the '**Group Life Insurance**' link.
4. Click on '**Beneficiaries**' at the top of the page and follow the instructions.

Changes to your beneficiary are effective immediately. Beneficiaries can be added or changed at any time throughout the year. You can also print a paper copy for your records.

The Life Insurance beneficiaries can only be designated through MetLife. The beneficiary is not designated on Workday.

Retirees without computer access may call MetLife at 1 (866) 492-6983 to request a new beneficiary designation form if needed or if they cannot remember previous designations. **MetLife will not identify current beneficiaries over the phone due to HIPAA.**

If you are not sure, complete a new form!

Once you have requested and completed the beneficiary designation form, please mail it or fax it back to MetLife for processing, please use the address provided on the form.

What happens if I do not designate a beneficiary?

If you do not name a beneficiary, or if you are not survived by your named beneficiary, benefits will be paid according to the plan provisions listed in MetLife's certificate of group coverage.

RETIREE LIFE INSURANCE AMOUNTS BY UNION	
Union	**Benefit Amount**
MAPS	$10,000
Fire	$7,000
Police	$7,000
AFSCME Local 558 (Nurses)	$1,500
AFSCME Local 2202	$5,000
AFSCME Local 44	$5,000
CUB	$5,000

The Life Insurance Beneficiaries can only be designated through MetLife. The beneficiary is not designated on Workday. Please go to http://www.metlife.com/mybenefits or call 1 (866) 492-6983 to request a new beneficiary form. Once you have completed the form, send it back to MetLife for processing.

METLIFE INSURANCE – BASIC LIFE

How to register on MetLife, My Benefits

METLIFE: HOW TO REGISTER ON MYBENEFITS

Website: https://online.metlife.com/edge/web/public/benefits

Step 1: Provide your group name and click to select it and then click "Next"

Step 2: The login screen. To begin accessing personal plan information, click on **"Log In"** at the top-middle of the page and on the next screen select **"Create New Account"** and complete the registration process.

Step 3: Enter personal information. Enter your first and last name, identifying data and e-mail address.

Step 4: Establish account credentials. You will need to create a unique username and password for future access to **MyBenefits**. You will also need to choose and answer three identity verification questions, to be used in the event you forget your password. In addition to reading and agreeing to the website's Term of Use, you will be asked to opt into electronic consent.

Step 5: Process complete. Now you will be brought to the "Thank You" page.

GLOSSARY OF TERMS

Premium	The amount you pay through payroll deduction for coverage
Copay	A flat dollar amount you pay each time you receive a particular service under the Plan
Coinsurance	Your percentage of the charge when you and the Plan each pay a percentage
Deductible	In the Standard Option only. This is the amount you must pay before the plan pays any benefit under the terms of the Plan.
Formulary	A list of covered drugs that includes both generic and brand name medications that have been chosen as both medically necessary and cost effective.
Term Life	Life insurance payable to a beneficiary only when an insured person dies within a specific period; premiums are age based; there are no benefits such as cash loan value

SUMMARY BENEFITS AND COVERAGE (SBC)

The Patient Protection and Affordable Care Act (PPACA) requires health plans and health insurance issuers to provide a Summary of Benefits and Coverage (SBC) to applicants and enrollees. The SBC is a concise document providing simple and consistent information about health plan benefits and coverage. Its purpose is to help health plan consumers better understand the coverage they have and to help them make easy comparisons of different options when shopping for new coverage. The City of Baltimore will post this document on the City of Baltimore's webpage at https://humanresources.baltimorecity.gov/hr-divisions/benefits

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2023. Contact your State for more information on eligibility.

ALABAMA Medicaid	ALASKA Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS Medicaid	**CALIFORNIA Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA Medicaid	INDIANA Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA Medicaid and CHIP (Hawki)	**KANSAS Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-766-9012
KENTUCKY Medicaid	**LOUISIANA Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE Medicaid	**MASSACHUSETTS Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
MINNESOTA Medicaid	**MISSOURI Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA Medicaid	**NEBRASKA Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA Medicaid	NEW HAMPSHIRE Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY Medicaid and CHIP	**NEW YORK Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA Medicaid	**NORTH DAKOTA Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA Medicaid and CHIP	**OREGON Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA Medicaid and CHIP	**RHODE ISLAND Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA Medicaid	**SOUTH DAKOTA Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS Medicaid	**UTAH Medicaid and CHIP**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT Medicaid	**VIRGINIA Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON Medicaid	**WEST VIRGINIA Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN Medicaid and CHIP	**WYOMING Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services **www.cms.hhs.gov**
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

The City of Baltimore Health and Welfare Benefit Plan

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

YOUR INFORMATION. YOUR RIGHTS. THE PLAN'S RESPONSIBILITIES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violate

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

The Plan may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Privacy Contact for questions about the Plan's Health Information Privacy Practices:

Chief Ray Gulhar, Office of Employee Benefits 410-396-5830

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

(CONTINUED)

Introduction

The health plans sponsored by the City of Baltimore (referred to in this Notice as the "Plan") may use or disclose health information about participants and their covered dependents as required for purposes of administering the Plan. Some of these functions are handled directly by The City of Baltimore, while other functions are performed by other service providers under contract with the Plan or by insurance carriers.

This Notice applies to each health Plan sponsored by the City of Baltimore, including plans that provide medical, vision, prescription drug, dental, and health care flexible spending account benefits. However, for benefits that are provided through insurance contracts, you will receive a separate notice, similar to this one, from the insurer and only that notice will apply to the insurer's uses or disclosures of your health information.

The Plan is required by law to abide by the terms of this Notice while it is in effect. This Notice is effective beginning January 1, 2020, and will remain in effect until it is revised.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information the Plan has about you. Ask us how to do this.
- The Plan will provide a copy or a summary of your health and claims records, usually within 30 days of your request. The Plan may charge a reasonable, cost-based fee.
- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- The Plan may say "no" to your request, but we'll tell you why in writing within 60 days.
- Request confidential communications.
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a Different address.
- The Plan will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations
- The Plan is not required to agree to your request, and we may say "no" if it would affect the administration of the Plan.
- Get a list of those with whom we've shared information
- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

(CONTINUED)

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- The Plan will make sure the person has this authority and can act for you before we take any action

File a complaint if you feel your rights are violate
- You can complain if you feel the Plan has violated your rights by contacting us using the information above.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- The Plan and the City of Baltimore, will not retaliate against you for filing a complaint

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear Preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. The Plan may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission.
- Marketing purposes
- Sale of your information

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

(CONTINUED)

Our Uses and Disclosures

How does the Plan typically use or share your health information?

The Plan typically uses or shares your health information in the following ways.

Help manage the health care treatment you receive

The Plan can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services

Run our organization

- The Plan can use and disclose your information to allow The City of Baltimore to review, design and maintain the Plan and may contact you when necessary.
- The Plan is not allowed to use genetic information to decide whether you are eligible for coverage and the price of that coverage.

Example: *We use health information about you to develop better benefits for you*

Pay for your health services

The Plan can use and disclose your health information as it pays for your health services.

Example: The Plan processes your health care claims to coordinate payment to providers or to reimburse you for eligible expenses you have paid.

Administer the Plan

The Plan may disclose your health information to your health plan sponsor for plan administration.

Example: The Plan can provide The City of Baltimore with certain statistics to help determine the amounts charged for coverage.

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

(CONTINUED)

How else can the Plan use or share your health information?

The Plan is allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. The Plan must meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/ consumers/index.html

Help with public health and safety issues

The Plan can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
The Plan can use or share your information for health research.

Comply with the law
The Plan will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that the Plan is complying with federal privacy law

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- The Plan can share health information about you with organ procurement organizations
- The Plan can share health information with a coroner, medical examiner, or funeral director when an individual dies

Address workers' compensation, law enforcement, and other government requests

The Plan can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective service

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

(CONTINUED)

Respond to lawsuits and legal actions

The Plan can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- The Plan is required by law to maintain the privacy and security of your protected health information.
- The Plan will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- The Plan must follow the duties and privacy practices described in this notice and give you a copy of it.
- The Plan will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.htm**

Changes to the Terms of this Notice

The Plan can change the terms of this notice, and the changes will apply to all information the Plan has about you. The new notice will be available upon request, on our website, and we will provide a copy to you.

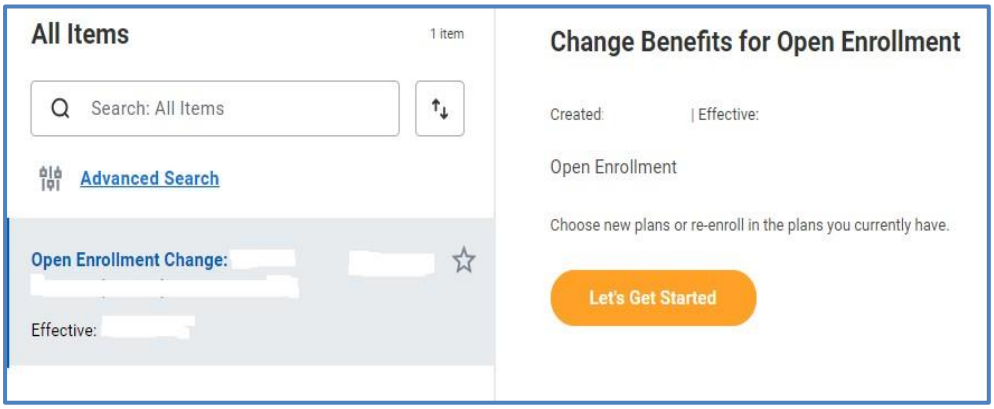
OPEN ENROLLMENT - RETIREE BENEFITS SELECTION INSTRUCTIONS

Once a year, open enrollment will allow you to make changes to your benefits in Workday as a City of Baltimore Retiree.
Follow the instructions below to modify your benefits plans elections, such as medical, prescription and dental plans, add dependents and include supporting documentation.

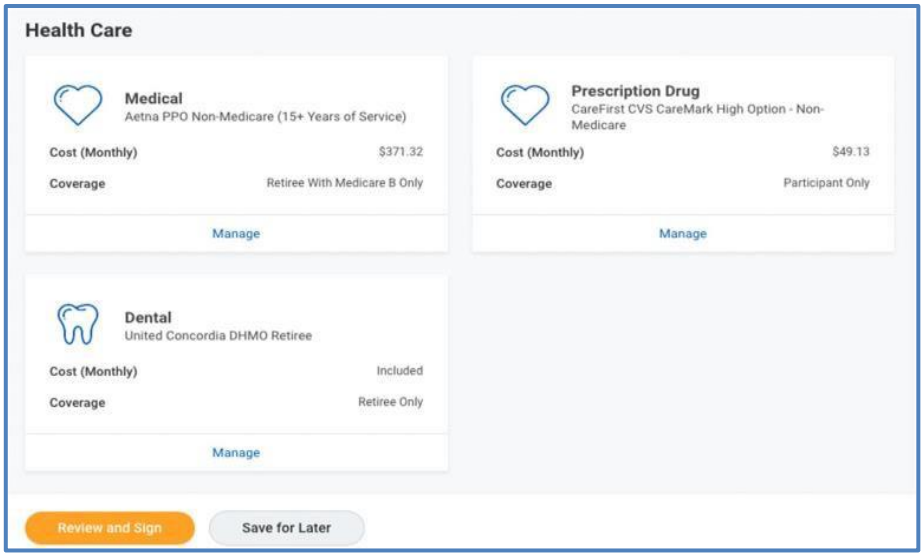
MODIFYING AND/OR ENROLLING IN BENEFITS

1. Log into your Workday Retiree account.
2. During open enrollment period, you will receive a task in your **My Tasks** box.

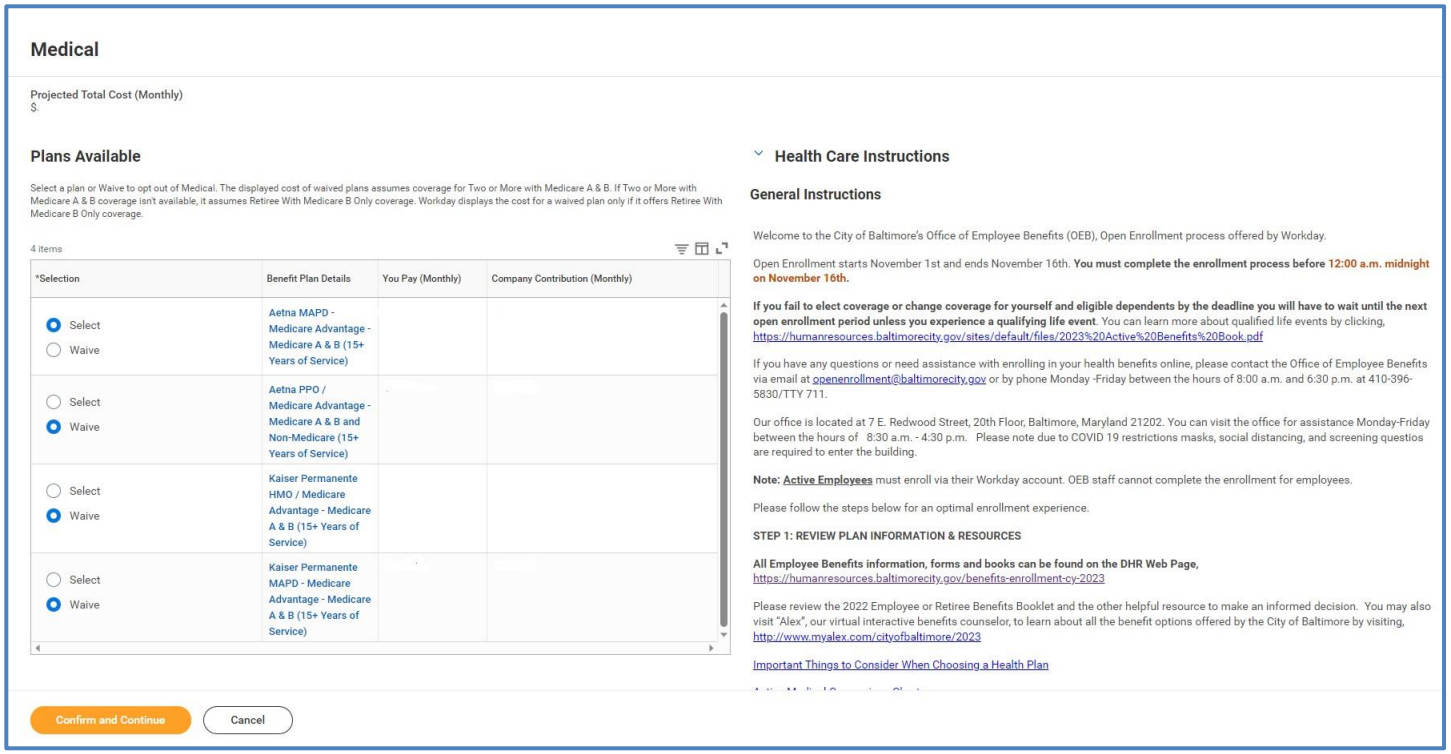
   Click the **My Tasks** icon in your homepage to review the task.
3. Click the **Open Enrollment Change** task.



4. Click **Let's Get Started**.
5. At first glance you will see your current enrolled benefit plans. Click on **Manage** to update your medical elections, or **Enroll** to view your enrollment option, if applicable.

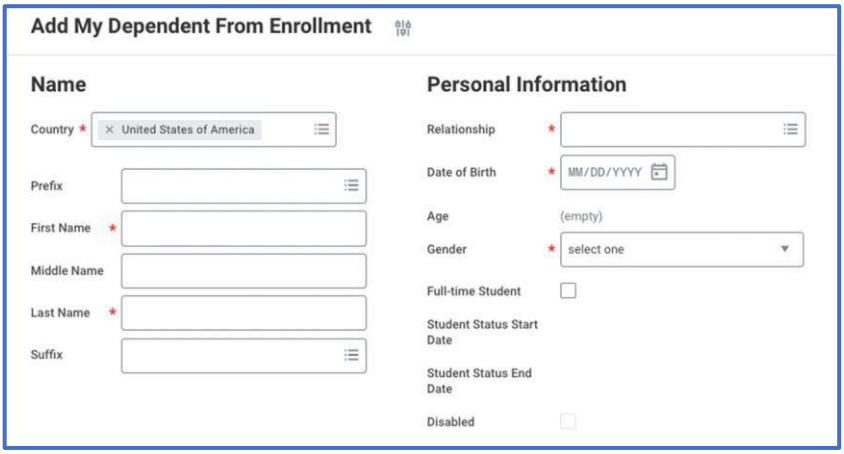


6. Your current elections will appear as default. Prior to moving forward, please ensure that you have read the **Health Care Instructions** information. Review all available plans and choose **Select** or **Waive** for each election.

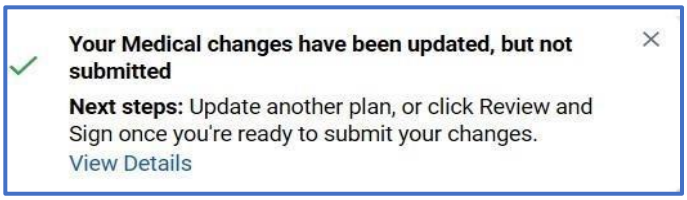


7. Complete modifying your coverage as needed. Once you have made your selections, click **Confirm and Continue.**
8. On the next page you will be prompted to add your dependents.

   If you are not adding dependents to your benefits plans, please proceed to step number 12.
9. Click the **Add New Dependent** button and on the next page review the "**Add My Dependent For Enrollment"** instructions.
10. Click the **Ok** button if you are ready to proceed.
11. Complete all required fields with your dependent information and click **Save.**

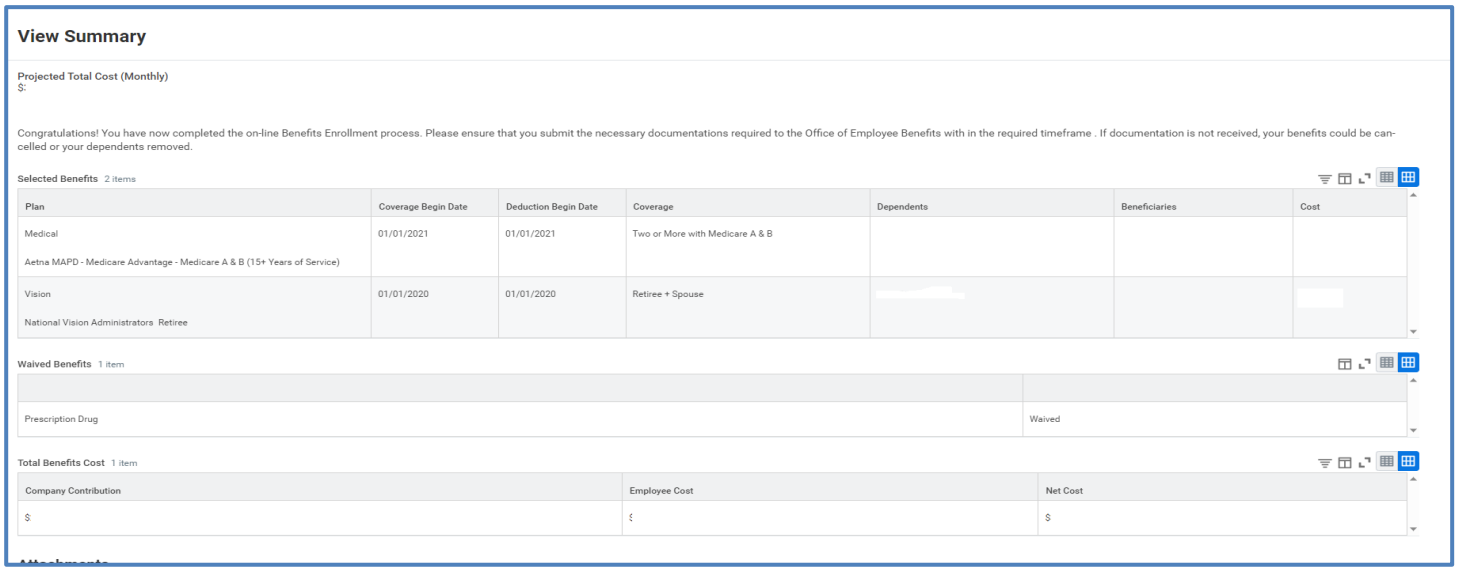


12. After you complete selecting your benefits elections and adding your dependents (if applicable), you will be notified with the following message.



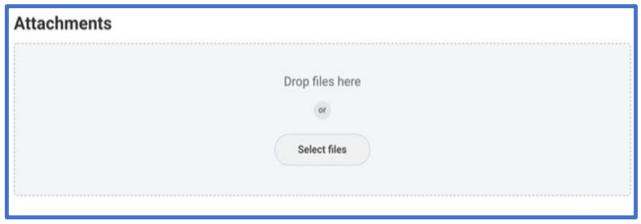
13. Repeat this process for all available benefits plans.
14. To finalize your benefits plans elections, click on the **Review and Sign** button. If you are not ready to proceed, click the **Save for Later** button to complete the process in the future.

15. This will take you to a Summary Page where you can review all your benefit plans elections before attaching any supporting documentation and proceeding with final submission.

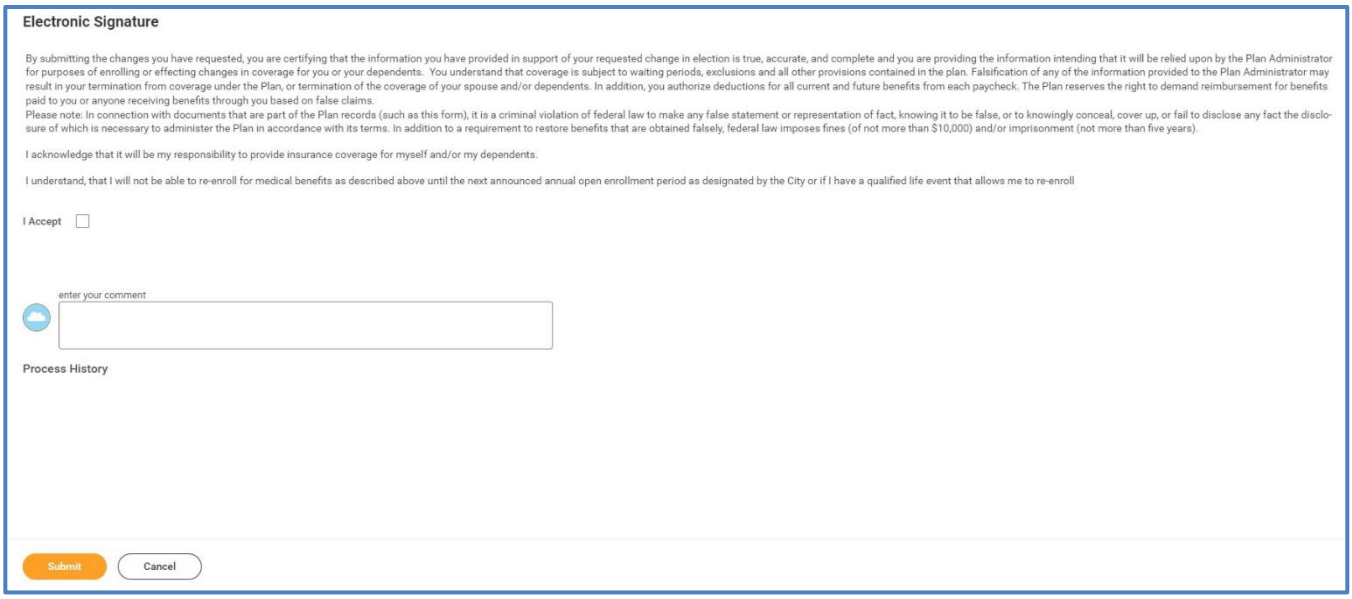


16. Scroll down to the bottom of the page and proceed to attach any supporting documentation, if applicable. Documentation is required for all newly added dependents.

    Please review the Required Documentation Form for more information.



17. Your benefits are not confirmed until you select the final **Submit** button at the bottom of the page. Before proceeding, review the **Electronic Signature"** information and mark the **I Accept** box. *Optional:* Add comments in the **Comment** field if desired.



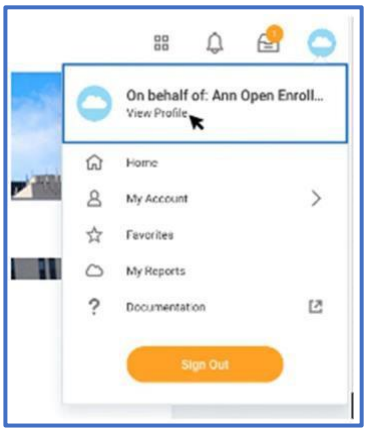
18. Click the **Submit** button to submit your benefit plans elections. If you are not ready to submit your benefits plans elections, click the **Save for Later** button to complete the process in the future. Click **Cancel** if you do not want to submit or save your benefits plans elections at this time.

19. A confirmation page will display. You have now completed and submitted your benefits plans elections for Open Enrollment

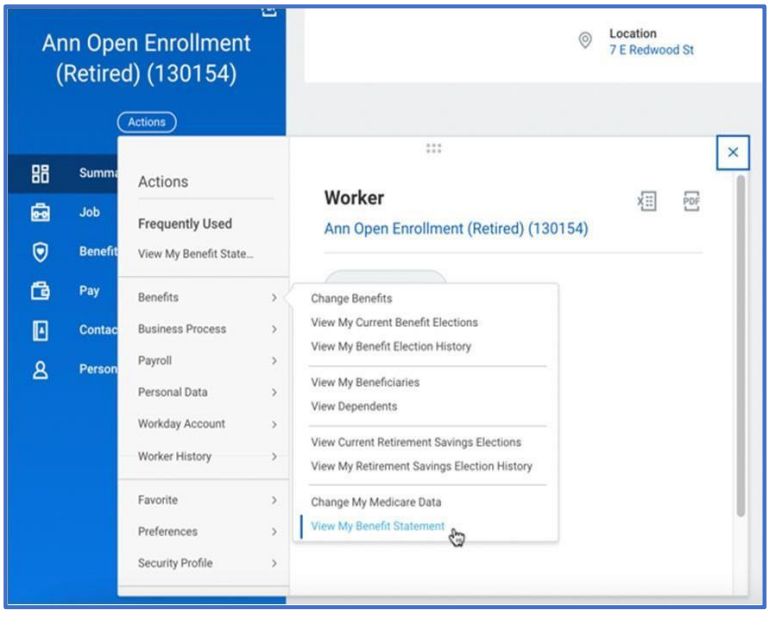
PRINTING YOUR BENEFITS PLANS STATEMENT

Once you have submitted your benefits plans elections you can print a Benefits Statement for your records. To print your Benefits Statement:

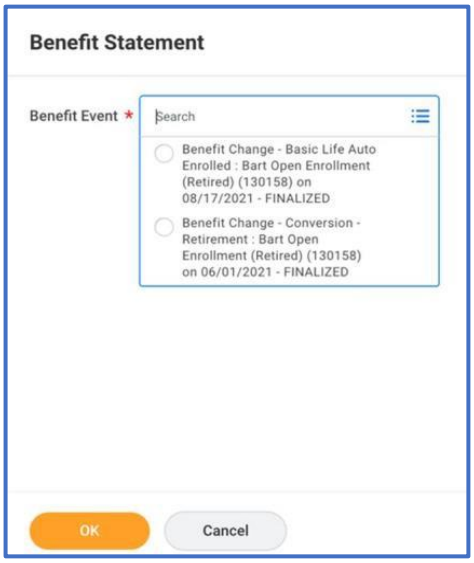
1. Click the **Profile** icon in your Home Page and select **View Profile.**



2. Click on the **Action** button below your name.
3. Select **Benefits > View My Benefit Statement**.



4. Click the **Benefit Event** field, select the desired benefit event you would like to view and print, and click **Ok.**



5. The selected benefit event statement will appear.
6. Click the **Print** button. The benefit event statement will open as a PDF document, which can be saved and printed.

STILL HAVE QUESTIONS ABOUT YOUR BENEFITS OR WORKDAY?

For additional support or log in and/or password reset issues:

- If your email address ends with @baltimorecity.gov or @baltimorepolice.org, reference the guide posted at https://bcitguide.baltimorecity.gov/Default.aspx?p=9
- For all other email addresses, please call the BCIT service desk at 410-396-6648 for assistance.

For questions related to your benefits plans:

Please contact the Employee Benefits team at (410) 396-5830.

City of Baltimore
Department of Human Resources Office of Employee Benefits
7 E. Redwood Street, 20th Floor
Baltimore, Maryland 21202
Phone: (410) 396-5830
TTY 711 (Maryland) http://workday.baltimorecity.gov/login
Email: openenrollment@baltimorecity.gov

This book was designed to give you an overview of the general features of the benefits plans at the City of Baltimore. It is not a legal document. If there is a difference between the information in this book and the official plan documents and contracts, the official plan documents and contracts will govern.

An Equal Opportunity Employer