

STATE OF MARYLAND



**Short Plan Year:
July 1, 2013 to
December 31, 2013**

What's New

- 🔥 **Two Open Enrollments in 2013: Spring and Fall**
- 🔥 **FSA maximum election reduced for the short plan year**
- 🔥 **New Life and AD&D carrier**
- 🔥 **Women's preventive healthcare enhancements**

Please read this guide carefully for details on these and many other topics.



EMPLOYEE BENEFITS DIVISION

301 West Preston Street
Room 510
Baltimore, MD 21201

410-767-4775
Fax: 410-333-7104
1-800-30-STATE (1-800-307-8283)
Email us at: ebdmail@dbm.state.md.us
Twitter: MdEBDWWellness



www.dbm.maryland.gov/benefits
(or scan the QR code to the left to go directly to our website)

Plan	Phone	Website
MEDICAL PLANS		
Aetna Select SM EPO, Choice [®] POS II	1-800-501-9837	1-800-501-9837 (TTY/TDD) www.aetnamd.com
CareFirst BlueCross BlueShield EPO, POS, PPO	1-800-225-0131	1-800-735-2258 (TTY) www.carefirst.com/statemd
UnitedHealthcare Select EPO, ChoicePlus POS, Options PPO	1-800-382-7513	1-800-553-7109 (TTY/TDD) www.uhcmaryland.com
BEHAVIORAL HEALTH PLAN (FOR MEMBERS IN PPO AND POS HEALTH PLANS – EPO MEMBERS USE EPO)		
APS Healthcare	1-877-239-1458	www.APSHelpLink.com MD State Code: SOM2002
PRESCRIPTION DRUG PLAN		
Express Scripts, Inc.	1-877-213-3867	www.express-scripts.com
DENTAL PLANS		
United Concordia DHMO and DPPO	1-888-MD-TEETH (1-888-638-3384)	www.unitedconcordia.com/statemd
FLEXIBLE SPENDING ACCOUNTS		
ConnectYourCare	1-866-971-4646	www.connectyourcare.com/statemd
TERM LIFE INSURANCE PLAN		
Minnesota Life	1-866-883-3514	www.LifeBenefits.com/Maryland
ACCIDENTAL DEATH AND DISMEMBERMENT PLAN		
Minnesota Life	1-866-883-3514	www.LifeBenefits.com/Maryland
LONG TERM CARE INSURANCE		
The Prudential Insurance Company of America	1-800-732-0416	www.prudential.com/glwcweb/maryland

HELPFUL CONTACTS

State Retirement Pension System	410-625-5555 or 1-800-492-5909	www.sra.state.md.us
Social Security Administration (Medicare)	1-800-772-1213	www.ssa.gov

Table of Contents

Introduction	i
Healthcare Reform	2
A Word About Program Requirements	3
Benefits Overview	4
Who is Eligible.....	4
When Coverage Begins.....	4
Your Cost.....	4
Duplicate Coverage	4
Tax and Non Tax Favored Dependents	6
Eligibility and Subsidy	7
Required Documentation for Dependents	13
Qualifying Status Changes	15
Removing Dependents who Lose Eligibility.....	15
Making Mid-Year Changes.....	16
When Coverage Ends.....	17
Medical Benefits	18
Your Choices	18
How the Plans Work.....	18
Definitions You'll Need to Know	19
Plans Comparison Charts	
Aetna.....	20
CareFirst.....	25
UnitedHealthcare.....	31
Benefits Chart Footnotes.....	37
Behavioral Health Benefits	38
Your Choices	38
How the Plans Work.....	38
Plan Charts	39
Prescription Drug Benefits	40
How the Plan Works	40
Your Cost at Retail Pharmacies	40
Your Cost through Home Delivery Program.....	41
Prescription Drug Management Programs.....	41
Drug Exclusions	43
Direct Member Reimbursement.....	43

IMPORTANT NOTE:

The Maryland State Employee and Retiree Health and Welfare Benefits Program (the Program) is switching to a **calendar year plan year** starting January 1, 2014. In order to make this switch, there will be a short plan year covering July 1, 2013 to December 31, 2013. There will then be a second Open Enrollment this fall for the new calendar year plan year that begins January 1, 2014. Please review the Short Plan Year Summary of Benefits document in your Enrollment Packet or found online to see how this short plan year affects your benefits.

THIS GUIDE IS NOT A CONTRACT

This guide is a summary of general benefits available to State of Maryland eligible active employees and retirees. Wherever conflicts occur between the contents of this guide and the contracts, rules, regulations, or laws governing the administration of the various programs, the terms set forth in the various program contracts, rules, regulations, or laws shall prevail. Space does not permit listing all limitations and exclusions that apply to each plan. Before using your benefits, call the plan for information. Benefits provided can be changed at any time without the consent of participants.

Table of Contents

Dental Benefits	44
Your Choices	44
Predetermination of Benefits.....	44
How the Plans Work.....	44
DHMO Schedule of Benefits.....	46
Flexible Spending Accounts	47
What is a Flexible Spending Account.....	47
Healthcare Flexible Spending Account.....	47
Dependent Care Flexible Spending Account.....	48
How FSAs Work.....	48
Reimbursement Information	49
Timeline for Using Account Funds.....	49
Covered and Not Covered Expenses	50
Updated IRS Guidance on Healthcare Payment Cards.....	51
Using Your Account	51
Term Life Insurance	52
Life Insurance for Active Employees.....	52
Life Insurance Upon Retirement.....	54
Accidental Death and Dismemberment	55
Long Term Care Insurance	56
Your Choices	57
How the Plan Works.....	57
Important Notices and Information	59
Employee Fraud and Abuse.....	59
Notice About Disclosure and Use of Your Social Security Number.....	59
Leave/Continuation of Coverage/COBRA.....	59
General Notice of Continuation (COBRA) Rights.....	62
Health Insurance Portability and Accountability Act (HIPAA)	66
Notice of Privacy Practices	67
Newborns' and Mothers' Health Protection Act of 1996.....	68
Notice of Women's Health & Cancer Rights Act of 1998	69
Genetic Information Nondiscrimination Act of 2008	69
Medicaid and the Children's Health Insurance Program (CHIP).....	69
Medicare and Your State Benefits	71
Notice of Creditable Prescription Drug Coverage	75
Benefits Appeal Process	77
Definitions	78

Introduction

The State of Maryland provides a generous benefit package to eligible employees and retirees with a wide range of benefit options. The chart on the next page briefly outlines your benefit options for the short plan year July 1, 2013-December 31, 2013. For more details about each plan, review the sections in this guide or refer to the inside of the front cover for phone numbers and websites for each of the plans.

NOTICE TO EMPLOYEES AND THEIR DEPENDENTS

This guide contains several very important Notices for every individual covered through the State Employee and Retiree Health and Welfare Benefits Program (the Program). These Notices inform you of your rights under State and Federal Laws on such important topics as healthcare reform, continuation of coverage (COBRA), the Program's privacy practices, and creditable prescription drug coverage. Please read all the notices carefully.

Plan	Options	Coverage	Who Is Eligible*
Medical	PPO Plans <ul style="list-style-type: none"> ◆ CareFirst BlueCross BlueShield ◆ UnitedHealthcare POS Plans <ul style="list-style-type: none"> ◆ Aetna ◆ CareFirst BlueCross BlueShield ◆ UnitedHealthcare EPO Plans <ul style="list-style-type: none"> ◆ Aetna ◆ CareFirst BlueCross BlueShield ◆ UnitedHealthcare 	<p>Provides benefits for a variety of medical services and supplies. Benefit coverage level, exclusions and limitations, and allowed benefits vary by plan; review the information carefully.</p> <p>None of the medical plans include prescription drug or dental coverage.</p> <p>If you are enrolled in a medical plan, routine vision services are covered and behavioral health coverage is available.</p>	<ul style="list-style-type: none"> ◆ Active State/Satellite employees ◆ Contractual State employees ◆ Less than 50% part-time State employees ◆ State retirees** ◆ ORP retirees**
Prescription Drug (Express Scripts)		Provides benefits for a variety of prescription drugs. Some limitations (quantity limits, prior authorization, and step therapy) may apply for certain drugs.	<ul style="list-style-type: none"> ◆ Active State/Satellite employees ◆ Contractual State employees ◆ Less than 50% part-time State employees ◆ State retirees ◆ ORP retirees
Dental (United Concordia)	<ul style="list-style-type: none"> ◆ DPPO ◆ DHMO 	Provides benefits for a variety of dental services and supplies.	<ul style="list-style-type: none"> ◆ Active State/Satellite employees ◆ Contractual State employees ◆ Less than 50% part-time State employees ◆ State retirees ◆ ORP retirees
Flexible Spending Accounts (ConnectYourCare)	<ul style="list-style-type: none"> ◆ Healthcare Spending Account ◆ Dependent Day Care Spending Account 	Allows you to set aside money on a pre-tax basis to reimburse yourself for eligible healthcare or dependent day care expenses.	<ul style="list-style-type: none"> ◆ Active State/Satellite employees
Term Life (Minnesota Life)	<p>Coverage for you in increments of \$10,000 up to \$300,000 – may be subject to medical review.</p> <p>Coverage for dependents in increments of \$5,000 up to 50% of your coverage (to a maximum of \$150,000) – may be subject to medical review.</p>	Pays a benefit to your designated beneficiary in the event of your death. You are automatically the beneficiary for your dependent's coverage.	<ul style="list-style-type: none"> ◆ Active State/Satellite employees ◆ Contractual State employees ◆ Less than 50% part-time State employees ◆ State retirees*** ◆ ORP retirees***
Accidental Death and Dismemberment (Minnesota Life)	You may choose from three coverage amounts for yourself: \$100,000, \$200,000, or \$300,000. If you choose to cover your dependents, benefits payable will be a percentage of your elected amount.	Pays a benefit to you or your beneficiary in the event of an accidental death or dismemberment. You are automatically the beneficiary for your dependent's coverage.	<ul style="list-style-type: none"> ◆ Active State/Satellite employees ◆ Contractual State employees ◆ Less than 50% part-time State employees
Long Term Care (The Prudential)	<p>You may choose one of the following Facility Daily Benefits:</p> <ul style="list-style-type: none"> ◆ \$100, \$150, \$200 or \$250 <p>Then select a Lifetime Maximum multiplier of:</p> <ul style="list-style-type: none"> ◆ 3 years or 6 years 	Provides benefits for long term care. Long term care is the type of care received, either at home or in a facility, when someone needs assistance with activities of daily living or suffers severe cognitive impairment.	<ul style="list-style-type: none"> ◆ Active State/Satellite employees ◆ State retirees ◆ ORP retirees ◆ Other relatives

* To be eligible, you must meet the eligibility requirements as outlined on pages 7-14 in this guide.

** For retirees and their dependents who are Medicare eligible, all medical plans are secondary to Medicare Parts A & B regardless of whether the individual has enrolled in each.

*** Only retirees who are enrolled in life insurance as an active employee at the time of retirement may continue life insurance coverage.

Healthcare Reform

The Patient Protection and Affordable Care Act (Healthcare Reform)

In March 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA) into federal law. PPACA impacts, among other things, employer-sponsored group health plan design, cost, and eligibility. July 1, 2011 was when the first of those changes went into effect for the State Employee and Retiree Health and Welfare Benefits Program. Below is a summary of the changes effective July 1, 2011 through July 1, 2013.

July 1, 2011: Procedures for Appealing Adverse Claims Decisions by Plans

This process replaced the Benefit Review Committee previously in place for participants wishing to appeal claims denials or reduced payments. Please refer to page 77 of this guide for details.

Flexible Spending Account Limit Reduced

Under PPACA, the annual maximum contribution participants may make is limited to \$2,500 for healthcare flexible spending accounts. The dependent day care flexible spending account maximum annual contribution remains at \$5,000 (\$2,500 if married and both spouses are contributing to a dependent care account).

IMPORTANT NOTE: PLEASE REVIEW THE SHORT PLAN YEAR SUMMARY OF BENEFITS DOCUMENT IN THIS YEAR'S ENROLLMENT PACKET FOR HOW THE SHORT PLAN YEAR AFFECTS YOUR HEALTHCARE FSA LIMIT.

Reporting of Plan Value on W-2

Originally slated to begin with the issuance of the 2011 calendar year W-2s, the Department of Health and Human Services (HHS) delayed the requirement to report the plan value on W-2s until the issuance of the 2012 W-2s. However, HHS indicated that employers could voluntarily provide this information on the 2011 W-2s if so desired. The State Central Payroll Bureau did choose to include this information on the W-2s issued for the 2011 calendar year. The reporting of the plan value on the W-2 is intended to provide information to employees regarding the cost of their healthcare coverage and does not cause this coverage to become taxable.

The amount reported excludes long-term care premiums, flexible spending account contributions, and dental plan premiums for dental plans that are not combined with medical plans. Included in the reporting are medical plan coverage and prescription drug coverage premiums along with vision (included in medical).

Extension of Young Adult Coverage to Age 26

The PPACA extended the eligible age limit of children to age 26. A child is defined as an eligible biological, adopted, or step-child for the purposes of PPACA. PPACA required health plans to change eligibility criteria for adult children in the following ways:

- child does not have to reside in your home;
- child is not required to be a student;
- child does not have to be a tax dependent;
- child may be eligible for coverage under his/her own employer;
- child may be married or unmarried.

PPACA does not require coverage for the child's spouse or children; however, the State of Maryland continues to cover eligible grandchildren.

Elimination of Cost-sharing for Preventive Care Services

Below are several examples of the types of preventive services requiring no copayment under PPACA. For the entire list of required preventive care services with no cost share please refer to www.uspreventiveservicestaskforce.org/recommendations.htm.

- In-network **well child examination** (newborn through 36 months - 12 visits; 3 years through 21 years - one per plan year) covered at 100% of the Plan's allowed benefit with no copayment
- In-network **adult physical examination** (22 years and older) covered one per plan year at 100% of the Plan's allowed benefit with no copayment
- In-network **annual GYN examination** at 100% of Plan's allowed benefit with no copayment (See further expansion of women's preventive care effective July 1, 2013)

- In-network **nutritional counseling** and **health education** for chronic conditions.
- **Annual screening mammograms** – Age 35-39 one baseline screening, age 40+ one per plan year
- **Annual flu vaccine** rendered by in-network provider.

Elimination of Rescission Provisions

The PPACA provides that your coverage can not be terminated retroactively except –

- for failure to pay premiums by due date,
- in the case of fraud, or;
- an intentional misrepresentation of a material fact.

The State is required to send a thirty-day advance notice of the rescission prior to the termination date of your coverage.

July 1, 2013: Summary of Benefits and Coverage

Originally slated to begin in 2012, the federal department of Health and Human Services (HHS) delayed the effective date until March 1, 2013. Plans are required to provide a four-page, double-sided, summary of plan provisions to each participant, customized by plan and coverage tier (i.e. “Employee Only” or “Employee plus Family”) reflecting covered services and out of pocket cost examples.

You can obtain a copy for the plan in which you are enrolled by going to the DBM Health Benefits website at: <http://dbm.maryland.gov/benefits> and clicking on the tab marked Summaries of Benefits and Coverage or you may call the Employee Benefits Division at 410.767.4775 or 800.307.8283 and request that one be mailed to you.

Expanded Preventive Care for Women

Expands the list of preventive services available to women at no copay and includes HIV screening and counseling; contraception and contraceptive counseling; breast feeding support, supplies, and counseling; and domestic violence counseling.

A WORD ABOUT PROGRAM REQUIREMENTS

The State Employee and Retiree Health and Welfare Benefits Program is subject to many federal and state laws and regulations. Complying with these provisions makes it possible for employees to have pre-tax premium deductions in the Program, to have tax-free State subsidies for active employee and retiree coverage, and to offer benefits like the Flexible Spending Account plans.

Section 125 of the Internal Revenue Code has strict regulations and guidelines for administering the Program. As a new employee who is eligible to participate in the State plans, you have 60 days from your hire date to enroll yourself and the eligible dependents you want to cover, and to submit the required documentation. If you do not enroll during this period, you must wait until the annual Open Enrollment period held before the next plan year starts. Once Open Enrollment closes, benefit elections (who is covered, coverage level, and plan) are locked in for the entire plan year. Changes can only be made during Open Enrollment for the next plan year or if you experience a qualified change in status.

Qualified status changes include marriage, birth, adoption, divorce, death of a spouse, death of a dependent, moving outside of the health plan network, loss of other coverage, etc. If you experience one of these events and wish to make a change to your benefit elections, you must contact your Agency Benefit Coordinator or the Employee Benefits Division immediately. Your benefit election changes must be consistent with the status change event. For example, if you get married, you may add your spouse to your medical plan. You must make your changes and submit all required documentation within 60 days of the event.

We must abide by these regulations and cannot allow changes to elections after Open Enrollment closes, or after the 60-day enrollment period for newly eligible members. Please refer to our website for a detailed list of qualified status changes.

Benefits Overview

WHO IS ELIGIBLE

Certain employees and retirees are eligible for coverage. Refer to the charts on the following pages to determine if you are eligible for benefits from the State of Maryland. If you are eligible, you may also cover your eligible dependents for certain benefits.

Who Can be Covered

For plans in which you are enrolled, your dependents must be in one of the categories listed in the table on page 6.

Beneficiaries of deceased State retirees can only cover dependents who would be eligible dependents of the State retiree if he/she were still living.

Refer to the Required Documentation For Dependents section for a list of documentation you must submit for all newly enrolled dependents.

NOTE: It is your responsibility to remove a covered dependent child or spouse immediately when he/she no longer meets dependent eligibility criteria provided on page 6. Children reaching age 26 with no disability certification are removed from coverage automatically at the end of the month in which they reach age 26. A notice is sent to your address on file in advance of the termination of coverage.

WHEN COVERAGE BEGINS

For this short plan year only if you enroll in benefits during this Open Enrollment period, the coverage you elect will begin July 1 of the plan year and remain in effect through December 31, unless you have a qualifying status change that allows you to make a mid-year change in coverage as described under the Qualifying Status Changes section.

Refer to the chart below to see when your coverage begins.

If you are...	Coverage becomes effective...
A new active employee enrolling for the first time	Either the 1st or 16th of the month, based on the pay period in which the first deduction is taken.
An active employee making an authorized mid-year change in coverage	Either the 1st or 16th of the month, based on the pay period in which the first deduction is taken. (Some employees have only one single monthly deduction.)
Newly retired and enrolling for retiree benefits for the first time	1st of the month, based on the month in which the first deduction is taken or when payment is received for direct pay enrollees.
A retiree making an authorized mid-year change in coverage	1st of the month, based on the month in which the first deduction is taken from your retirement allowance or when payment is received for direct pay enrollees.

Retroactive Coverage

You may purchase coverage retroactively to the date you or your dependent(s) became eligible for coverage

or back to the date of the change in circumstances permitting a mid-year change in coverage, whichever is earlier, on a post-tax basis but no more than 60 days in arrears. See your Agency Benefits Coordinator or call the Employee Benefits Division for more information.

New retirees should receive a retroactive adjustment letter from the Employee Benefits Division regarding any missed premiums between their date of retirement and the period covered by their first retiree premium deduction.

You may not retroactively cancel coverage, or retroactively elect to participate in an FSA.

YOUR COST

The amount you pay for benefits coverage depends on several factors, including:

- The benefit plans you choose;
- Whom you choose to cover;
- Your age (for Life Insurance and Long Term Care Insurance only);
- Your Medicare eligibility;
- Your status (full-time active, part-time active, retiree, ORP retiree, etc.); and
- Your amount of service with the State (for retirees and ORP retirees only).

If you are eligible for the maximum State subsidy, you pay the amount shown on the premium rate document at www.dbm.maryland.gov/benefits. However, some individuals will receive no State subsidy or only a percentage of the State subsidy and will be responsible for the amount shown on the premium rate chart plus the difference between the maximum State subsidy and the percentage for which he or she is eligible, if any.

The premiums provided do not apply to Contractual, Part-time (below 50%) employees, Satellite employees, and some State retirees and ORP retirees. Contractual and Part-time employees do not receive any State subsidy of their coverage. Satellite employees receive only the subsidy provided by their employer.

DUPLICATE COVERAGE PROHIBITED

Spouses who are both active State employees and/or retirees may not be enrolled as both an employee/retiree and as a dependent in the same plans nor may they both cover the same children. This is duplicate coverage and is not permitted under the Program. This also applies to Satellite agency dependents. Two State employees and/or retirees may not be covered twice under the coverage of two employees/retirees. It is the employee's/retiree's responsibility to make sure that they and their dependents do not have duplicate State coverage. This includes your children who may also be State employees. Duplicate benefits will not be paid.

Dependent Child to Age 26

- You can cover your eligible dependent child through the end of the month in which they turn age 26. Your dependent child does not need to be a student or disabled to be covered up to age 26. Disability certification is required to cover children beyond age 26.

If the child is 25 or older and not disabled, post-tax deductions and imputed income may apply to any grandchildren or legal wards that you cover under your benefit elections. Please refer to the “July 2013-December 2013 Imputed Income Rates” document at www.dbm.maryland.gov/benefits for additional details.

- You must submit the required dependent documentation and Affidavit for Dependent Eligibility for all newly enrolled dependent children. See pages 13-14 for the required dependent documentation.
- Disabled Eligible Dependent Child:** You are not required to provide Disability Certification until the child reaches age 26. You will then be required to provide continued certification of his/her disability status every two years in order to keep him/her on your coverage.
- Additional rules apply for covered children, see page 14.

Important Information About Covering Your Same Sex Spouse or Same Sex Spouse's Child(ren)

- Post-Tax Benefit Deductions and Imputed Income Taxation of Same Sex Spouse Benefits** – Due to IRS and other federal tax rules and regulations, employers that offer health insurance benefits to same sex spouses and must follow certain rules and regulations regarding pre-tax and post-tax payroll deductions and the calculation of imputed income. Non-dependent same sex spouses and domestic partners (and their dependents) are treated differently under federal tax laws.

Pre vs. Post Tax

Definition: Pre-tax dollars can only be used for dependents that meet the federal definition of a dependent. Post-tax deductions must be taken for dependents covered on your plan who do not meet the federal definition of a dependent.

Application: As an example, if an employee selects Employee+Spouse coverage (where the spouse is a same-sex spouse), the federal tax code does not align with the Maryland definition of a legal spouse and therefore your same-sex spouse is not eligible for pre-tax benefits.

Example Math: For purposes of easy math, assume the Employee-Only deduction is \$50 per pay

period and the Employee+Spouse deduction is \$75 per pay period. Typically, these deduction amounts would be withheld on a pre-tax basis. If the enrolled spouse is a same sex spouse, then the portion of the deduction relating to that spouse is withheld on a post-tax basis. The Employee-Only premium (the cost for one person) is attributed to the same sex spouse, and a \$50 post-tax deduction would appear on your paycheck. The difference between the Employee-Only and Employee+Spouse deductions (\$75-\$50= \$25) is withheld on a pre-tax basis.

- Imputed Income** – For each group health insurance plan where there is an employee contribution and State subsidy in which you enroll your same sex spouse and/or your same sex spouse's eligible dependents, you are subject to tax withholding on the State's contribution toward the coverage for those dependents not qualified as tax dependents under the IRS code.

Definition: Imputed Income is the estimated value of the employer's financial contribution towards health insurance that is provided to same sex spouses and their dependents. The value of this contribution must be reported to the IRS as taxable wages earned.

Application: The employer's financial contribution toward health insurance for a same sex spouse is equal to the state subsidy for Employee-Only (one person) coverage.

Example Math: If the state subsidy for the Employee-Only medical plan in which you are enrolled is \$100 per pay, then \$100 is the value of the benefit provided to you by the State for your same sex spouse health insurance coverage. This \$100 will be added in to your taxable income with the earnings code of “IMP INC”, and is taken back out of your check as an equal deduction with the same code. The result of this equal earnings addition and deduction subtraction is a net zero to you, but allows the state to withhold the necessary federal taxes on the value of the benefit. In this \$100 example, if you were in a 30% tax bracket, you would not see a change to your paycheck of \$100; you would see an increase to your taxes withheld of around \$30 (30% taxes withheld on a \$100 benefit).

For rate information refer to the Same Sex Spouse rate sheet available on the “July 2013-December 2013 Imputed Income Rates” document at www.dbm.maryland.gov/benefits.

Retirees covering a same sex spouse will be billed quarterly for the Medicare taxes applicable to the imputed income and will receive a W-2 each January indicating the imputed income amount for the calendar year to be filed with their tax returns.

How to determine if your dependent is eligible for tax favored treatment

TAX FAVORED DEPENDENTS	NON TAX FAVORED DEPENDENTS (Subject to post-tax deductions/imputed income)
Spouse - Opposite Sex	
Spouse - Same Sex <ul style="list-style-type: none"> ◆ Must permanently reside with you for entire taxable year, and; ◆ For whom you provide more than 50% support for the taxable year 	Spouse - Same Sex <ul style="list-style-type: none"> ◆ Permanently resides with you for entire taxable year, but; ◆ For whom you <u>do not</u> provide more than 50% support for the taxable year
Child <ul style="list-style-type: none"> ◆ Meets all dependent child eligibility criteria as described on page 14, and; ◆ Is your or your spouse's biological child, step-child or adopted child 	Child <ul style="list-style-type: none"> ◆ Meets the eligibility criteria for grandchild or legal ward, and; ◆ Age 25 or older ◆ Biological, step-child, adopted child, grandchild or legal ward of the employee or retiree's Same Sex Spouse who does not fully satisfy one of the tax tests. (See Affidavit for Dependent Eligibility.)

All forms referenced in this guide can be found on
www.dbm.maryland.gov/benefits.

Important: Domestic Partner Coverage

With the passage of the Civil Marriage Protection Act, same sex marriage became legal in Maryland effective January 1, 2013. The Act repeals the reference to marriage between “a man and a woman” and specifies instead that a marriage between “two individuals who are not otherwise prohibited from marrying” is valid in Maryland.

In response to same-sex couples' inability to marry in the State of Maryland, the Program began offering domestic partner benefits to same-sex couples in July 2009. The Act, effective January 1, 2013, now gives same-sex couples the same benefits, protections and obligations as opposite-sex couples, under Maryland law. Therefore, the Program's need to offer domestic partner benefits has been alleviated.

Consistent with proposed changes to regulations governing the State Employee and Retiree Health and Welfare Program, effective January 1, 2014, same sex domestic partners or the children of same sex domestic partners will no longer be eligible dependents covered under the Program. In addition, beginning on July 1, 2013, the Program will not enroll new same sex domestic partners. Same sex domestic partners and/or their children enrolled prior to July 1, 2013 may continue coverage under the Program through December 31, 2013.

Legally married spouses, regardless of gender, and their dependents will continue to be eligible for coverage under the Program.

Due to federal tax regulations, post tax and imputed income rules still apply to same sex spouses and their dependents unless those dependents qualify as federal tax dependents of the employee.

Eligibility	Subsidy Amount	How You Will Pay for Benefits
ACTIVE STATE EMPLOYEES		
<p>You are eligible for benefits if you are:</p> <ul style="list-style-type: none"> ◆ A full-time or part-time active (working 50% or more of the workweek) State employee who is regularly paid salary or wages through an official State payroll center, including but not limited to: <ul style="list-style-type: none"> – Central Payroll Bureau; – Maryland Transit Administration; and – University of Maryland, including graduate assistants and the University's Far East and European Divisions; ◆ An elected State official; ◆ Register of Wills or an employee of the Register of Wills; ◆ Clerk of the Court or an employee of the offices of Clerks of the Court; or ◆ A State Board or Commission member who is regularly paid salary or wages and works at least 50% of the work week. 	Maximum State Subsidy	<p>Through payroll deductions, using pre-tax deductions through the State's cafeteria plan, where pre-tax deductions are permitted.</p> <p>If for any reason you do not receive a payment for a pay period, or if your wages are not enough to cover your deductions, you will be required to pay the State directly for that unpaid amount. Coverage may be cancelled due to non-payment of missed deductions.</p>
SATELLITE EMPLOYEES		
<ul style="list-style-type: none"> ◆ You are eligible for benefits if you are: <ul style="list-style-type: none"> – An employee of a political subdivision which participates in the State's health benefits program with the approval of the governing body; or – An employee of an agency, commission, or organization permitted to participate in the State's health benefits program by law. ◆ All forms are automatically processed based on the current processing date. A letter must be attached with the enrollment form if it needs to be processed based on date of eligibility. 	As determined by the Satellite Employer	As determined by the Satellite Employer
CONTRACTUAL AND PART-TIME (WORKING LESS THAN 50%) EMPLOYEES		
<p>You are eligible to enroll in the same benefits as full-time State employees, with the exception of the Flexible Spending Accounts and Long Term Care Insurance. Contractual and part-time employees must follow the same participation rules as full-time employees, plus:</p> <ul style="list-style-type: none"> ◆ You cannot change the effective date of coverage once the enrollment form has been processed (a letter must be attached with the enrollment form if you are requesting an effective date other than the current processing date). ◆ Changes to coverage cannot be made at the time of an employment contract renewal. ◆ Contractual employees must have a current active contract to enroll. ◆ Graduate students may be considered Contractual Employees. Check with your University Personnel Department to see if this applies. 	No State Subsidy – you pay the full amount	<p>Premiums are paid on a post-tax basis. Monthly payment coupons will be mailed to the address provided on your enrollment form for the first month of coverage through the end of the plan year or the end of your current contract period, whichever comes first.</p> <p>All benefits are inactive and claims will not be processed until the Employee Benefits Division receives payment.</p> <p>Payments must begin with the first coupon received and are due the first of every month, with a 30-day grace period.</p> <p>Missed payments or payments not postmarked within the 30-day grace period will result in the termination of your coverage. You will not be permitted to re-enroll until the next Open Enrollment period.</p> <p>Payment may be made in advance to cover any or all coupons received, but must be made in full monthly increments. Payment deadlines are strictly enforced.</p> <p>If you do not receive payment coupons within one month of submitting your enrollment form, please contact the Employee Benefits Division.</p>

Eligibility	Subsidy Amount	How You Will Pay for Benefits
LONG TERM LEAVE WITHOUT PAY – PERSONAL		
<p>If on approved leave without pay for personal reasons, you may continue any or all of your current health benefit plans, or you may reduce your coverage level while on leave for up to two (2) years.</p>	<p>No State Subsidy – you pay the full amount.</p>	<p>Premiums are paid on a post-tax basis. Monthly payment coupons will be mailed to the address provided on your enrollment form for the first month of coverage through the end of the plan year or the end of your approved leave, whichever comes first.</p> <p>All benefits are inactive and claims will not be processed until the Employee Benefits Division receives payment.</p> <p>Payments must begin with the first coupon received and are due the first of every month, with a 30-day grace period.</p> <p>Missed payments or payments not postmarked within the 30-day grace period will result in the termination of your coverage. You will not be permitted to re-enroll until the next Open Enrollment period.</p> <p>Payment may be made in advance to cover any or all coupons received, but must be made in full monthly increments. Payment deadlines are strictly enforced.</p> <p>If you do not receive payment coupons within one month of submitting your enrollment form, please contact the Employee Benefits Division.</p>
LONG TERM LEAVE WITHOUT PAY – ON THE JOB INJURY		
<p>If on approved leave without pay due to an on-the-job injury, you may continue any or all of your current health benefit plans, or you may reduce your coverage level while on leave for up to two (2) years.</p> <ul style="list-style-type: none"> ◆ First report of injury must be submitted with enrollment form. ◆ Agency Fiscal Officer must complete appropriate section of enrollment form approving payment of state subsidy. 	<p>Maximum State Subsidy</p>	<p>The employee pays their portion of the premiums on a post-tax basis. Monthly payment coupons will be mailed to the address provided on your enrollment form for the first month of coverage through the end of the plan year or the end of your approved leave, whichever comes first.</p> <p>All benefits are inactive and claims will not be processed until the Employee Benefits Division receives payment.</p> <p>Payments must begin with the first coupon received and are due the first of every month, with a 30-day grace period.</p> <p>Missed payments or payments not postmarked within the 30-day grace period will result in the termination of your coverage. You will not be permitted to re-enroll until the next Open Enrollment period.</p> <p>Payment may be made in advance to cover any or all coupons received, but must be made in full monthly increments. Payment deadlines are strictly enforced.</p> <p>If you do not receive payment coupons within one month of submitting your enrollment form, please contact the Employee Benefits Division.</p>

Eligibility	Subsidy Amount	How You Will Pay for Benefits
LEAVE OF ABSENCE – MILITARY (ACTIVE DUTY ONLY)		
<p>If on approved leave of absence for active military duty, you may continue any or all of your current health benefit plan, or you may reduce your coverage level while on leave for up to five (5) years.</p> <p>◆ Agency must submit the LAW – Military Notification Form with the employee's Active Military Orders.</p> <p>Note: A leave of absence for military training does not qualify for a continuation of benefits under Leave of Absence - Military.</p>	<p>◆ Employee and State Subsidy paid by State for medical, prescription and dental</p> <p>◆ Employee responsible for payment of premiums if he/she elects to continue AD&D and Life insurance.</p>	<p>Monthly payment coupons will be mailed to the address provided on your enrollment form for the first month of coverage through the end of the plan year or the end of your approved leave, whichever comes first.</p> <p>All benefits are inactive and claims will not be processed until the Employee Benefits Division receives payment.</p> <p>Payments must begin with the first coupon received and are due the first of every month, with a 30-day grace period.</p> <p>Missed payments or payments not postmarked within the 30-day grace period will result in the termination of your coverage. You will not be permitted to re-enroll until the next Open Enrollment period.</p> <p>Payment may be made in advance to cover any or all coupons received, but must be made in full monthly increments. Payment deadlines are strictly enforced.</p> <p>If you do not receive payment coupons within one month of submitting your enrollment form, please contact the Employee Benefits Division.</p>
FAMILY MEDICAL LEAVE ACT – FMLA		
<p>If you are on approved FMLA, we will maintain your health coverage under our group health plan on the same terms as when you were actively working.</p> <p>If you are on paid leave while on FMLA and receiving a paycheck, we will continue deducting your premiums through pre-tax payroll deductions.</p> <p>If you are on FMLA and do not have paid leave available, you will be responsible for the payment of your share of the premiums payments for your health insurance coverage for the period of time you are on approved FMLA leave. You may choose to submit payment due while on leave or within 30 days upon returning to work.</p>	<p>Maximum State Subsidy</p>	<p>If FMLA leave is unpaid, premiums are paid on a post-tax basis. Biweekly coupons will be mailed to the address on file. You may pay each coupon as it is received, or you may pay all coupons within 30 days upon returning to work.</p> <p>Payments must begin with the first coupon received and are due by the due date indicated on the payment coupon. If payment is not made by the due date indicated, this debt may be forwarded to the State of Maryland's Central Collections Unit. If referred to the Central Collection Unit, a collection fee of 17% will be added to the amount owed. In addition, the Central Collection Unit is authorized to report this debt to consumer reporting agencies. Debts referred to these agencies may affect your credit rating.</p>

Eligibility	Subsidy Amount	How You Will Pay for Benefits
MARYLAND STATE RETIREMENT SYSTEM RETIREES (hired prior to 7/1/11)		
<p>You are eligible for benefits if you are a State retiree who is currently receiving a monthly State retirement allowance and meet one of the following criteria:</p> <ul style="list-style-type: none"> ◆ You left State service with at least 16 years of creditable service; ◆ You retired directly from State service with at least five years of creditable service; ◆ You left State service (deferring your retirement allowance) with at least 10 years of creditable service and within five years of normal retirement age; ◆ You retired from State service with a disability retirement; or ◆ Your State employment ended before July 1, 1984. <p>Note: Retirees of a County that participates with the State Retirement System are not eligible for health benefits coverage through the State Employee and Retiree Health and Welfare Benefits Program. Certain other retirees, such as retirees of the Maryland Environmental Service or the University of Maryland Medical System that receive a State retirement allowance, may be eligible. Contact your Agency Benefits Coordinator or the Employee Benefits Division if you think you may be eligible.</p>	<p>Maximum State Subsidy if:</p> <ul style="list-style-type: none"> ◆ You retire with 16 or more years of creditable service; ◆ You receive a disability retirement; or ◆ You retired from State service before July 1, 1984. <p>Partial State Subsidy if you have at least five years of State creditable service, but less than 16. For example, if you have 10 years of State creditable service, you would receive 10/16 of the maximum State subsidy.</p>	<p>Premiums will be deducted from your monthly retirement allowance. Deductions taken from your retirement allowance are always taken after any taxes have been deducted. If your retirement allowance is not enough to cover all of your monthly plan premiums, you will be billed for the plan premiums that could not be deducted. Only whole plan premiums will be deducted. You will receive coupons for the 6-month period of July-December in August for the premiums that could not be deducted from your monthly retirement allowance.</p> <p>Premium payments are due on the first of every month, with a 30-day grace period (Exception: July premiums are due upon receipt of the coupons, with a 30-day grace period).</p> <p>If payment is not received by the end of the grace period, you will be disenrolled from the plans for which payments were not received and will not be permitted to re-enroll until the next Open Enrollment period.</p>
MARYLAND STATE RETIREMENT SYSTEM RETIREES (hired on or after 7/1/11)		
<p>You are eligible for benefits if you are a State retiree who is currently receiving a monthly State retirement allowance and meet one of the following criteria:</p> <ul style="list-style-type: none"> ◆ You left State service with at least 25 years of creditable service; ◆ You retired directly from State service with at least 10 years of creditable service; ◆ You left State service (deferring your retirement allowance) with at least 10 years of creditable service and within five years of normal retirement age; or ◆ You retired from State service with a disability retirement. <p>Note: Retirees of a County that participates with the State Retirement System are not eligible for health benefits coverage through the State Employee and Retiree Health and Welfare Benefits Program. Certain other retirees, such as retirees of the Maryland Environmental Services or the University of Maryland Medical System that receive a State retirement allowance, may be eligible. Contact your Agency Benefits Coordinator or the Employee Benefits Division if you think you may be eligible.</p>	<p>Maximum State Subsidy if:</p> <ul style="list-style-type: none"> ◆ You retire with 25 or more years of creditable service; or ◆ You receive a disability retirement. <p>Partial State Subsidy if you have at least 10 years of State creditable service, but less than 25. For example, if you have 15 years of State creditable service, you would receive 15/25 of the maximum State subsidy.</p>	<p>Premiums will be deducted from your monthly retirement allowance. Deductions taken from your retirement allowance are always taken after any taxes have been deducted. If your retirement allowance is not enough to cover all of your monthly plan premiums, you will be billed for the plan portion that could not be deducted. Only whole plan premiums will be deducted. You will receive coupons for the 6-month period of July-December in August for the premiums that could not be deducted from your monthly retirement allowance.</p> <p>Premium payments are due on the first of every month, with a 30-day grace period. (Exception: July premiums are due upon receipt of the coupons, with a 30-day grace period).</p> <p>If payment is not received by the end of the grace period, you will be disenrolled from the plans for which payments were not received and will not be permitted to re-enroll until the next Open Enrollment period.</p>
OPTIONAL RETIREMENT PROGRAM (ORP) RETIREES (hired prior to 7/1/11)		
<p>There are special rules governing your eligibility and costs for health benefits if you are a retiree of an Optional Retirement Program (ORP). Current and former ORP vendors include: Teachers Insurance and Annuity Association College Retirement Equities Fund (TIAA-Cref), AIG-Valic, Fidelity, American Century, and ING. You are eligible for benefits with maximum, partial or no State subsidy beginning with the month in which you received a periodic distribution from your Maryland ORP account if you meet one of the criteria found on the next page:</p>	<p>Maximum Individual/No Dependent State subsidy if you:</p> <ul style="list-style-type: none"> ◆ retire directly from a Maryland State institution of higher education and have creditable service equal to at least 16 years but less than 25 years of full-time service with contributions to a Maryland ORP account. 	<p>A letter explaining the payment process will be mailed to the address provided on your enrollment form along with payment coupons for the first month of coverage through the end of the plan year.</p> <p>Payments must begin with the first coupon received and are due the first of every month, with a 30-day grace period.</p>

Be sure to notify the Employee Benefits Division in writing of any address changes in order to receive important information about your benefits from us, as well as the plans to which you are entitled. A Personal Information Change form may be downloaded at www.dbm.maryland.gov/benefits (click on Forms).

Eligibility	Subsidy Amount	How You Will Pay for Benefits
OPTIONAL RETIREMENT PROGRAM (ORP) RETIREES (hired prior to 7/1/11) <i>continued</i>		
<ul style="list-style-type: none"> ◆ You retire directly from a Maryland State institution of higher education with creditable service equal to at least 5 years of full-time employment with continuous contributions to a Maryland ORP account; ◆ You ended service with a Maryland State institution of higher education when you were at least age 57 and had service equal to at least 10 years of full-time employment with continuous contributions to a Maryland ORP account; or ◆ You ended service with a Maryland State institution of higher education with creditable service equaling at least 16 years of full-time employment with continuous contributions to a Maryland ORP account. 	<p>Partial Individual/No Dependent State subsidy if you:</p> <ul style="list-style-type: none"> ◆ retire directly from a Maryland State institution of higher education and have creditable service equal to at least 5 years but less than 16 years of full-time service with contribution to a Maryland ORP account. <p>No Individual or Dependent State subsidy if you:</p> <ul style="list-style-type: none"> ◆ do not retire directly upon ending ORP service with a Maryland State institution of higher education, with the exception noted below. 	<p>All benefits are inactive and claims will not be processed until the Employee Benefits Division receives payment. Missed payments or payments not postmarked within the 30-day grace period will result in the termination of your coverage. You will not be permitted to re-enroll until the next Open Enrollment period.</p> <p>Payment may be made in advance to cover any or all coupons received, but must be made in full monthly increments. Payment deadlines are strictly enforced.</p> <p>If you do not receive payment coupons within one month of submitting your enrollment form, please contact the Employee Benefits Division.</p>
OPTIONAL RETIREMENT PROGRAM (ORP) RETIREES (hired on or after 7/1/11)		
<p>There are special rules governing your eligibility and costs for health benefits if you are a retiree of an Optional Retirement Program (ORP). Current and former ORP vendors include: Teachers Insurance and Annuity Association College Retirement Equities Fund (TIAA-Cref), AIG-Valic, Fidelity, American Century, and ING. You are eligible for benefits with maximum, partial or no State subsidy beginning with the month in which you received a periodic distribution from your Maryland ORP account if you meet one of the criteria below:</p> <ul style="list-style-type: none"> ◆ You retire directly from a Maryland State institution of higher education with creditable service equal to at least 10 years of full-time employment with continuous contributions to a Maryland ORP account; ◆ You ended service with a Maryland State institution of higher education when you were at least age 57 and had service equal to at least 10 years of full time employment with continuous contributions to a Maryland ORP account; or ◆ You ended service with a Maryland State institution of higher education with creditable service equaling at least 25 years of full-time employment with continuous contributions to a Maryland ORP account. 	<p>Maximum Individual/Dependent State Subsidy if you:</p> <ul style="list-style-type: none"> ◆ retire directly from a Maryland State institution of higher education and have creditable service equal to at least 25 years of full-time service with contributions to a Maryland ORP account. <p>Partial Individual/No Dependent State subsidy if you:</p> <ul style="list-style-type: none"> ◆ retire directly from a Maryland State institution of higher education and have creditable service equal to at least 10 years but less than 25 years of full-time service with contribution to a Maryland ORP account. <p>No Individual or Dependent State subsidy if you:</p> <ul style="list-style-type: none"> ◆ do not retire directly upon ending ORP service with a Maryland State institution of higher education, with the exception noted below. 	<p>A letter explaining the payment process will be mailed to the address provided on your enrollment form along with payment coupons for the first month of coverage through the end of the plan year.</p> <p>Payments must begin with the first coupon received and are due the first of every month, with a 30-day grace period.</p> <p>All benefits are inactive and claims will not be processed until the Employee Benefits Division receives payment. Missed payments or payments not postmarked within the 30-day grace period will result in the termination of your coverage. You will not be permitted to re-enroll until the next Open Enrollment period.</p> <p>Payment may be made in advance to cover any or all coupons received, but must be made in full monthly increments. Payment deadlines are strictly enforced.</p> <p>If you do not receive payment coupons within one month of submitting your enrollment form, please contact the Employee Benefits Division.</p>
OPTIONAL RETIREMENT PROGRAM (ORP) RETIREES (regardless of date of hire)		
<p>If you are an ORP retiree with service equal to 25 or more full years of regular employment with the State, in any branch of government, you may be eligible for the maximum State subsidy of the coverage for you and your dependent(s), even if you did not retire directly from a Maryland State institution of higher education.</p> <p>One year of employment at 50% of standard work hours, with contributions to a Maryland ORP, provides six months of applicable ORP service. If you stop receiving a periodic distribution from your Maryland ORP account, you will no longer be eligible for health benefits.</p> <p>Lump sum payments, supplemental retirement accounts, or non-Maryland State institution service do not count for enrollment in, or State subsidy for, retiree health benefits.</p> <p>Although ORP and MSRPS service cannot be combined if they total less than 25 years, if eligibility with State subsidy in the Health Benefits Program is independently supported by your participation in more than one system, the percentage of maximum State subsidy provided by each system may be combined.</p> <p>If coverage in the Program is terminated for an ORP Retiree or Beneficiary for any reason, either voluntarily or involuntarily, documentation confirming the current continuing receipt of a periodic distribution from the Maryland ORP must be provided to qualify for re-enrollment.</p> <p>Required Documentation: Completion of a Retiree Health Enrollment and Change form and a State of Maryland Optional Retirement Program (ORP) Packet. The form and packet are available from your Agency Benefits Coordinator, by mail from the Employee Benefits Division, or from our website at www.dbm.maryland.gov/benefits.</p>		

Eligibility	Subsidy Amount	How You Will Pay for Benefits
BENEFICIARIES OF DECEASED ORP RETIREES		
<p>You are eligible for health benefits coverage if you are the surviving spouse or child of a deceased ORP retiree and:</p> <ul style="list-style-type: none"> ◆ You are receiving a periodic distribution of benefits from the retiree's Maryland ORP; and ◆ You meet the spouse or child dependent eligibility criteria for health benefits. <p>If the surviving spouse is the beneficiary, the spouse may cover himself/herself and any eligible dependent of the deceased ORP retiree. However, only dependents that would be eligible dependents of the deceased ORP retiree if he/she were still living may be covered.</p> <p>If a child is the beneficiary, only the child will be eligible for health benefits as long as he/she meets dependent eligibility requirements for children (see page 6).</p> <p>Required Documentation: Completion of a Retiree Health Benefits Enrollment and Change form and a State of Maryland Optional Retirement Program (ORP) packet. The form and packet are available from an Agency Benefits Coordinator, at a Maryland State institution of higher education, from our website, www.dbm.maryland.gov, or by calling the Employee Benefits Division.</p> <p>If you were enrolled in dependent Term Life Insurance at the time of the retiree's death, that policy must be converted to an individual policy directly through Minnesota Life within 30 days in order to continue Term Life Insurance coverage. Plan phone numbers are located on the inside front cover of this guide.</p>	<ul style="list-style-type: none"> ◆ Maximum State subsidy if the retiree had service equal to 25 or more full years of regular employment with the State in any branch of government; you may be eligible for the maximum State subsidy even if the retiree did not retire directly from a Maryland State institution of higher education. ◆ No State Subsidy if the retiree had less than 25 years of Maryland State service. 	Same as ORP retirees (see pages 10-11).
If coverage in the Program is terminated for an ORP Retiree or Beneficiary for any reason, either voluntarily or involuntarily, documentation confirming the current continuing receipt of a periodic distribution from the Maryland ORP must be provided to qualify for re-enrollment.		
BENEFICIARIES OF DECEASED MARYLAND STATE RETIREMENT SYSTEM RETIREES		
<p>You are eligible for benefits if you are a surviving spouse or child of a deceased State retiree and:</p> <ul style="list-style-type: none"> ◆ Are receiving a monthly State retirement allowance as the surviving beneficiary of a deceased retiree; and ◆ Meet the dependent eligibility criteria for health benefits. <p>If the surviving spouse is the beneficiary, the spouse may cover himself/herself and any eligible dependent children of the deceased retiree. However, he/she may only cover dependents that would be eligible dependents of the deceased retiree if he or she were still living.</p> <p>If the beneficiary is a child, the child will only be eligible for subsidized health benefits as long as he or she meets the dependent eligibility requirements for children (see page 6). When the child no longer meets the dependent eligibility criteria for children, the subsidized health benefits end. Non-subsidized benefits under COBRA may then be available for up to 36 months.</p> <p>If you were enrolled in dependent Term Life Insurance at the time of the retiree's death, that policy must be converted to an individual policy directly through Minnesota Life within 30 days in order to continue Term Life Insurance coverage. Plan phone numbers are located on the inside front cover of this guide.</p>	If you are eligible for coverage as a beneficiary, you will receive the same State subsidy that the retiree was entitled to receive at the time of his or her death. See above section.	Same as Maryland State Retirement System Retirees (see page 10).

FOR MORE INFORMATION

If you have questions regarding your eligibility or State subsidy, see the **Maryland Optional Retirement Program Handbook for Retiree Health Benefits**, available from your Agency or Institution Benefits Coordinator, the Employee Benefits Division, or the Department of Budget and Management website, www.dbm.maryland.gov/benefits.

REQUIRED DOCUMENTATION FOR DEPENDENTS

You are required to submit verifying documentation for each dependent you wish to enroll for coverage. Coverage for your dependent(s) is contingent upon receipt of all required documentation. Should all required documentation not be provided by the stated deadlines, coverage may be terminated and claims payment denied. The following chart lists the documents you must submit to cover an eligible dependent. Photocopies are acceptable provided any seal or official certification can be clearly seen.

TRANSLATION OF FOREIGN DOCUMENT

An official translator other than the employee/retiree or spouse (available at any college or university) must translate foreign documents into English. The translated document must be signed by the translator and notarized.

TAX CONSEQUENCES WHEN DEPENDENTS DO NOT QUALIFY FOR TAX-FREE HEALTH COVERAGE

For purposes of providing health coverage under the State's cafeteria plan, an employee who is covering age 25 grandchildren or legal wards will pay for coverage through an after-tax deduction from the employee's paycheck.

IMPORTANT NOTE ABOUT DOCUMENTATION

Marriage certificates must be signed, dated, and certified by the clerk of the court or other appropriate state or county official. Certificates signed by a clergy, rabbi, etc. are not acceptable.

Birth certificates: Must show lineage from employee or spouse to dependent child.

Balance of page intentionally left blank.

Dependent Relationship	Eligibility Criteria	Required Documentation
Spouse - Opposite Sex/Same Sex	<ul style="list-style-type: none"> ◆ Lawfully married to an employee or retired employee as recognized by the laws of the State of Maryland or in a jurisdiction where such marriage is legal 	<ul style="list-style-type: none"> ◆ Affidavit for Dependent Eligibility** ◆ Official State marriage certificate (must be a certified copy and dated by the appropriate State or County official, such as the Clerk of Court): <ul style="list-style-type: none"> - From the court in the County or City in which the marriage took place; or - From the Maryland Division of Vital Records for marriages that occurred at least six months prior to enrollment; or - From the Department of Health and Mental Hygiene (DHMH) website: www.dhmh.maryland.gov (click Online Services) – also www.vitalchek.com
Children <ul style="list-style-type: none"> ◆ Biological Child ◆ Adopted Child ◆ Step-child ◆ Grandchild* ◆ Legal ward*, Testamentary, or Court appointed guardian (not temporary for less than 12 months) ◆ Step-grandchild or other dependent child relatives* ◆ Child with a mental or physical incapacity incurred prior to age 26 	<ul style="list-style-type: none"> ◆ Under age 26 ◆ Except for grandchildren and legal wards, no requirement to reside in your home ◆ May be eligible for coverage under own employer ◆ May be married or unmarried, or; ◆ Over age 26 and incapable of self-support due to mental or physical incapacity incurred prior to age 26 	<ul style="list-style-type: none"> ◆ Affidavit for Dependent Eligibility** and Biological Child <ul style="list-style-type: none"> ◆ Copy of child's official state birth certificate showing lineage ◆ Adopted Child <ul style="list-style-type: none"> ◆ Pending Adoption: Notice of placement for adoption on adoption agency letterhead or copy of court order placing child pending final adoption ◆ Final Adoption: Copy of final adoption decree signed by a judge or a State-issued birth certificate showing employee/retiree as the parent ◆ Step-child <ul style="list-style-type: none"> ◆ Copy of child's official state birth certificate with name of spouse of employee/retiree as child's parent ◆ Copy of employee/retiree's official state marriage certificate ◆ Legal Ward, Testamentary, or Court appointed guardian (not temporary for less than 12 months) <ul style="list-style-type: none"> ◆ Copy of dependent's official state birth certificate showing lineage ◆ Copy of Legal Ward/Testamentary court document, signed by a judge ◆ Proof of permanent residence with enrolled employee/retiree (one of the following): <ul style="list-style-type: none"> - Valid driver's license; - State-issued identification card; - School records certifying Dependent's address; - Day care records certifying Dependent's address; or - Tax documents certifying address with child's name on document ◆ Grandchild, Step-grandchild or other dependent child relatives <ul style="list-style-type: none"> ◆ Copy of child's official state birth certificate showing lineage ◆ Proof of relation by blood or by marriage ◆ Proof of permanent residence with enrolled employee/retiree (one of the following): <ul style="list-style-type: none"> - Valid driver's license; - State-issued identification card; - School records certifying Dependent's address; - Day care records certifying Dependent's address; or - Tax documents certifying address with child's name on document ◆ Sole Support Affirmation ◆ Child with mental or physical incapacity incurred prior to age 26 <ul style="list-style-type: none"> ◆ Copy of child's disability certification form in addition to applicable documentation above
Medical Child Support Order		<ul style="list-style-type: none"> ◆ Copy of court order requiring Employee/Retiree to provide support and health coverage, signed by the child support officer or judge









* Please refer to the "July 2013-December 2013 Premium Rates" document at www.dbm.maryland.gov/benefits for important tax information when covering these dependents who are age 25 and not disabled.

** This form can be downloaded at www.dbm.maryland.gov/benefits.

QUALIFYING STATUS CHANGES

Regardless of how you pay for your coverage (by automatic deduction from your paycheck, retirement allowance or with payment coupons), the State uses the same rules to permit changes outside of Open Enrollment for all enrollees. IRS regulations for cafeteria plans strictly govern when and how benefits election changes can be made.

You are only permitted to make changes to your coverage during the Open Enrollment period each year. The coverage you elect during the short plan year 2013 Open Enrollment will be in place July 1 to December 31. However, there are some changes in status that permit you to make limited changes during the plan year. Examples of qualifying changes in status include:

-  Birth or adoption/placement for adoption of a child;
-  Death of a dependent;
-  Marriage or divorce;
-  You or your dependent child's loss of SCHIP/Medicaid/Medical Assistance coverage;
-  You or your dependent gain access to a SCHIP/Medicaid subsidy based on your residence in another state;
-  Loss of other coverage, such as if coverage under your spouse's employment ends or your child ceases to be eligible;
-  Gaining eligibility for Medicare (for retirees); or
-  Changes in your other coverage which has a different plan year.

You have 60 days from the date of the qualifying change in status to submit an enrollment form and supporting documentation making changes to your benefits. Any changes submitted after 60 days of the qualifying change in status cannot be accepted and you will have to wait until the next Open Enrollment period to make the desired change.

NOTE: Documentation supporting a qualifying event must be submitted with the enrollment form. For example, requesting to cancel benefits due to obtaining other coverage requires a letter from the employer or insurance provider on company letterhead. The letter must identify all benefits (i.e. medical, dental, life insurance, etc.) for which the person is enrolled, the

names of dependents covered and the effective date of the new coverage.

If you decline to enroll yourself or a dependent because of other coverage, you may be able to enroll in the future if you or your dependent(s) lose that other coverage.

REMOVING DEPENDENTS WHO LOSE ELIGIBILITY

It is your responsibility to submit an enrollment form to remove any dependent as soon as he/she loses eligibility. If you fail to remove the ineligible dependent within 60 days from the date of ineligibility, you will be required to pay the full insurance premium including the State subsidy from the date he/she became ineligible until the date removed. You may face disciplinary action, termination of employment, and/or criminal prosecution for continuing to cover dependents who no longer meet the definition of an eligible dependent noted on pages 13 and 14. In most cases, dependents who lose eligibility are entitled to COBRA/Continuation Coverage for a limited time, which is not subsidized by the State. Please see the COBRA/Continuation of Coverage section for more information.

Ex-Spouse

If you are obligated to continue coverage for a former spouse by terms of the divorce, that coverage can be provided for a **limited time** under COBRA and Maryland law. If COBRA is selected, the ex-spouse will have his/her own account and will be responsible for paying premiums directly. COBRA coverage is not subsidized by the State.

Age 26 Dependent Child

We will automatically remove a dependent child who turns age 26. A COBRA notice will be sent directly to the dependent child.

FOR MORE INFORMATION about enrollment and changes outside of Open Enrollment contact:



- **Your Agency Benefits Coordinator**, if you are an active or Satellite employee; or
- **The Employee Benefits Division**, if you are a retiree or Direct Pay enrollee.
- **For additional information regarding qualifying events**, go to www.irs.gov.

INSTRUCTIONS ON HOW TO MAKE MID-YEAR CHANGES



If You...	Then...
Are rehired or transferred to another state agency within 30 days following termination from previous agency	You will automatically be enrolled into the same elections you had previously upon rehire or transfer.
Are an active State employee enrolling for the first time	You must submit an enrollment form and dependent verification documentation within 60 days of your hire date. Enrollment forms will not be accepted after 60 days. Completed forms and documentation must be given to your Agency Benefits Coordinator who must sign the enrollment form and check the accuracy of the dependent verification documentation before forwarding to the Employee Benefits Division. If you want coverage to begin on your date of hire, you must contact your Agency Benefits Coordinator within 30 days after receiving your first payroll deduction for benefits to request a retroactive adjustment and pay your portion of the back premiums on a post-tax basis.
Are enrolling as a new retiree	You must submit an enrollment form within 60 days of your retirement date. (If your retirement date is retroactive, you must submit an enrollment form within 60 days of receiving your first retirement allowance.) Submit the enrollment form and the required documentation to the Employee Benefits Division. You will receive a retroactive adjustment letter from the Employee Benefits Division regarding how to pay any missed premiums between your retirement date and the period covered by your first retiree premium deduction.
Are an active employee or retiree making a mid-year change in coverage	You must submit an enrollment form and applicable documentation verifying the qualifying change in status within 60 days of the event. Active employees must submit their enrollment form and documentation to their Agency Benefits Coordinator. Retirees must submit their form to the Employee Benefits Division along with the required documentation.
BENEFITS OVERVIEW	Experience a qualifying event In order for your qualifying event to be effective on the earliest effective date following the date of the qualifying event, you must request a retroactive adjustment. A newborn's effective date may go back to the date of birth. For newborns, no retroactive adjustment is required if employee already has family coverage. Your request for a retroactive adjustment must be submitted within 30 days of the first premium deduction reflecting the change. Active employees must contact their Agency Benefits Coordinator for assistance; Retirees must contact the Employee Benefits Division. Only the Employee Benefits Division has authority to modify your requested changes to your health benefits. Flexible Spending Accounts cannot be made effective retroactively.
	Have a newborn child that you want to add to your health benefits You must add your child within 60 days from the date of birth. If a newborn is not added within 60 days of birth, you must wait until the next Open Enrollment period to enroll the child. You must submit an enrollment form along with temporary documentation of the child's birth (such as hospital discharge papers, copy of the child's hospital I.D. bracelet, or footprints). A retroactive adjustment form and payment must also be submitted unless you already have family coverage. An official State birth certificate and the child's social security number must be submitted within 60 days of the date of receipt of the temporary documentation. Active employees with questions should contact their Agency Benefits Coordinator. All other enrollees should contact the Employee Benefits Division for assistance.
	Need to remove an ineligible dependent (e.g., divorced spouse, child no longer eligible, etc.) You must notify the Employee Benefits Division in writing through an enrollment form signed by your Agency Benefit Coordinator. (Retirees must notify the Employee Benefits Division directly.) You must include all necessary documentation with your notification. If you do not remove an ineligible dependent within 60 days of the loss of eligibility, you will be responsible for the total premium cost for coverage of the ineligible dependent, regardless of whether claims were submitted or paid. In addition, keeping an ineligible dependent on your coverage may result in disciplinary action, termination of employment, and/or criminal prosecution. Satellite agency employees must notify their Agency Benefit Coordinator.

WHEN COVERAGE ENDS

You may choose to cancel your coverage during the Open Enrollment period or as a result of having a qualifying status change allowing you to terminate coverage mid-year.

-  If you elect to cancel your coverage during the Open Enrollment period, your coverage will end on June 30.
-  If you end coverage as a result of a qualifying status change, the date your coverage ends will be determined by the time period covered by your last deduction or payment, or the date of the event, whichever is later.

It is your responsibility to verify your benefit deductions on your check or retirement stub and your Benefits Summary Statement to make sure they match the coverage you requested. If there is an error, you should immediately contact:

-  Your Agency Benefits Coordinator, if you are an active, Satellite or Direct Pay employee; or
-  The Employee Benefits Division, if you are a retiree or a COBRA enrollee.

Special Note for Active Employees

Your effective date of coverage depends on the pay period ending date for which the first benefit deduction is taken. The pay period ending date is shown on the check stub of each paycheck. Paychecks are distributed approximately one week after the pay period ending date.





If you miss any premium deductions, you must pay all missed premiums or your coverage will be cancelled for the remainder of the plan year. In some cases, you will be required to pay the subsidy portion as well. Missing one or two pay periods is considered a short term leave of absence. Please review the policy in the Continuation of Coverage section. The Employee Benefits Division will bill you for missed premiums and the payment deadline is strictly enforced.

If you missed deductions because you transferred between two agencies or had a payroll error, please contact your Agency Benefits Coordinator immediately so your Coordinator can calculate your share of the premiums and submit a retroactive adjustment form. This must be done so your benefits continue without interruption for the remainder of the plan year.

If your benefits are cancelled, you will not be permitted to re-enroll until the next Open Enrollment period.

Refunds

Refunds will only be considered when an administrative error by a State agency has occurred. Errors by members will not be considered. The member must submit a request within one calendar year of the administrative error, and a refund will only be approved for up to a one-year period. A refund request for any reason other than an administrative error by a State agency cannot be approved. Examples of refund requests that will be denied include:

-  An incorrect coverage level due to:
 - Dependent no longer being eligible
 - Divorce
-  Incorrect benefits due to errors on your enrollment form.
-  Incorrect deductions for changes that were not made within 60 days of the qualifying change in status.
-  If benefits were used during the period in which a refund is being requested, no refund is permitted.

Medical Benefits (includes routine vision and behavioral health coverage)

NOT SURE WHICH PLAN TO CHOOSE?

Use this link to see how the different plans rate under the Maryland Health Care Commission's Performance report: [http://mhcc.dhmdh.maryland.gov/healthplan/Documents/2012 Health Benefit Plan Performance Report 20130114.pdf](http://mhcc.dhmdh.maryland.gov/healthplan/Documents/2012%20Health%20Benefit%20Plan%20Performance%20Report%2020130114.pdf).

YOUR CHOICES

You have eight medical plans from which to choose. All medical plans have national networks unless otherwise noted.

Preferred Provider Organization (PPO) Plans:

- CareFirst BlueCross BlueShield
- UnitedHealthcare Options PPO

Point-of-Service (POS) Plans:

- Aetna Choice POS II
- CareFirst BlueCross BlueShield (regional network)
- UnitedHealthcare ChoicePlus POS

Exclusive Provider Organization (EPO) Plans:

- Aetna Select EPO
- CareFirst BlueCross BlueShield
- UnitedHealthcare Select EPO

In general, all options under each type of plan (PPO, POS, or EPO) cover the same services. However, the participating provider networks for the plans are different. Be sure to carefully review what is covered by each type of plan, as well as which providers and facilities participate with the various plan networks.

HOW THE PLANS WORK

Once you enroll in a medical plan, you will receive identification cards in the mail. Take these cards with you every time you receive medical services. Depending on what type of medical plan you choose, the way you receive medical services and how much you pay at the time of service will vary. Please review the plans carefully and select the plan that best suits your needs.

PPO and POS plans offer out-of-network benefits. EPO plans do not provide out of network benefits except for true emergencies.

Please refer to the benefit charts on pages 20-36 for more details on each medical plan option.

Allowed Benefit

The plan's allowed benefit refers to the reimbursement amount the plan has contractually negotiated with network providers to accept as payment in full. Non-participating providers (out-of-network) are not obligated to accept the allowed benefit as payment in full and may charge more than the plan's allowed benefit. In the charts that follow, if it indicates the service is covered at 70% out-of-network, it means the plan pays 70% of the allowed benefit. You are responsible for any amount above the plan's allowed benefit when you receive services from non-participating providers.

Standard Benefits for Medical Plans

The following charts are a summary of generally available benefits and do not guarantee coverage. To ensure coverage under your plan, contact the plan before obtaining services or treatment to obtain more information on coverage limitations, exclusions, determinations of medical necessity, and preauthorization requirements. In addition, you will receive a summary of coverage from the plan in which you enroll, providing details on your plan coverage.

Coordination of Benefits

Coordination of Benefits (COB) occurs when a person has healthcare coverage under more than one insurance plan. All plans require information from State employees and retirees on other coverage that they or their dependents have from another health insurance carrier.

If Your Provider Terminates from Your Plan Network

Providers may decide to terminate from a plan network at any time. If your provider terminates from your plan, it is not considered a qualifying event that would allow you to cancel or change your plan election. You will be able to change your plan election during the next Open Enrollment.

NOTE: Outpatient prescription drug benefits are not included under the medical benefits plan and require a separate enrollment election. Please refer to page 40 for details.

- **There are no pre-existing condition limitations for any of the medical plans, but there are other exclusions. Please contact the medical plans for further information on coverage exclusions, limitations, determination of medical necessity, preauthorization requirements, etc.**
- **For a list of participating plan providers, please access carrier websites located on the inside cover of this guide.**

DEFINITIONS YOU'LL NEED TO KNOW

Benefit	PPO In-Network	PPO Out-of-Network	POS In-Network	POS Out-of-Network	EPO In-Network Only
Plan Year Deductible	Deductible – The amount a member is required to pay before payment for services are paid.				
Individual			None	\$250	None
Family	None	\$500	None	\$500	None
Out-of-Pocket Coinsurance and Deductible Maximum	Out-of-Pocket Maximum – This is the most a member will pay out of his or her pocket in coinsurance charges. The deductible is included in the out-of-pocket maximum. Copays are not included in the out-of-pocket maximum.				
Individual				\$3,000	None
Family	\$2,000	\$6,000	\$2,000	\$6,000	None
Any charges above the plan's Allowed Benefit are not counted toward the out-of-pocket maximum.					
Primary Care Physician's Office Visit	\$15 copay	70% of allowed benefit after deductible	\$15 copay	70% of allowed benefit after deductible	\$15 copay
Specialist Office Visit	\$30 copay	70% of allowed benefit after deductible	\$30 copay	70% of allowed benefit after deductible	\$30 copay
Adult Physical Exams & Associated Lab Work	100% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit	Not covered	
One exam per plan year for all members and their dependents age 22 and older					
Well Baby/Child Visits	100% of allowed benefit	70% of allowed benefit	100% of allowed benefit	Not covered	
Inpatient Care	90%	70% of allowed benefit	90% of allowed benefit	70% of allowed benefit after deductible	

Allowed Benefit –
The maximum fee a health plan will pay for a covered service or treatment. Allowed benefit is determined by each health plan.

Coinsurance – Cost sharing between you and the plan for certain services. Expressed in terms of a percentage. Percentage shown is the insurance carrier's payment amount.

allowed benefit

DOING THE MATH – COINSURANCE (example assumes individual coverage)

IN-NETWORK

\$10,000 surgery
 -but-
 \$8,000 is the allowed benefit
 × 10% (patient coinsurance)
\$800 (patient responsibility)
 \$1,000 is the out-of-pocket maximum
 - \$800 patient responsibility 1st surgery
 \$200 maximum coinsurance charge for any other service to which coinsurance applies through the end of the plan year. Your coinsurance responsibility (10%) will never exceed \$1,000.

OUT-OF-NETWORK

\$10,000 surgery
 -but-
 \$8,000 is the allowed benefit
 - \$250 deductible (patient responsibility)
\$7,750
 × 30% patient coinsurance
 \$2,325 patient responsibility (coinsurance)
 +\$250 patient responsibility (deductible)
 \$2,575 total patient responsibility
 \$3,000 is the out-of-pocket maximum
 -\$2,575 paid toward coinsurance & deductible
 \$425 maximum coinsurance charge for any other service to which coinsurance applies through the end of the plan year.

A Note About Out-of-Network Providers

* BEWARE OF BALANCE BILLING *

- The \$10,000 surgery had a maximum allowed benefit of \$8,000.
- This leaves the provider with a difference in his charge and the amount he collects from the insurance company of \$2,000.
- This provider can "Balance Bill" you for this difference.
- This would make total cost to you \$4,575!!

We cannot stress enough how important it is to use In-Network providers in order to receive the best care at the lowest out-of-pocket cost!!



Make the most out of *your* health plan

Taking charge of your health can be challenging these days. You have so many choices, and everything seems more complicated.

Aetna makes it easier for you to get quality health coverage. When you enroll in an Aetna medical plan option, you get comprehensive medical care and a resource to help you:

- Live healthier
- Understand your plan choices in order to get the most out of your health plan
- Make confident decisions about your health, your care, and your finances

Whether it's our Aetna Navigator website, access to Aetna's discount programs, or Aetna's maternity and disease management programs, we are here to help you get the most out of your coverage.

As a benefit-eligible State of Maryland employee, you have access to a national network with coverage in all Maryland counties, as well as in DC, Pennsylvania, and Delaware.

You can choose from two Aetna plans:

- **Aetna POS Plan** – This plan lets you choose from three ways to get care, it's completely your call. You can visit your Primary Care Physician (PCP), visit any network doctor, or visit any out-of-network licensed doctor you choose. You do not need a referral for covered services, and there are no claim forms to fill out when you receive care from an in-network provider.
- **Aetna EPO Plan** – This plan lets you visit any doctor in the Aetna network without a referral; it's entirely up to you. Visit your Primary Care Physician (PCP) or go directly to another network doctor. You do not need a referral for covered services and there are no claim forms to fill out. Keep in mind that with the Aetna EPO Plan, coverage is only provided when you see an in-network provider (except in the case of an emergency).

aetnaSM

AETNA			
Benefit	POS In-Network	POS Out-of-Network	EPO In-Network Only
Short Plan Year Deductible			
Individual	None	\$125	None
Family	None	\$250	None
Short Plan Year Out-of-Pocket Coinsurance & Deductible Combined Maximum			
Individual	\$500	\$1,500	None
Family	\$1,000	\$3,000	None
	Any charges above the plan's Allowed Benefit are not counted toward the out-of-pocket maximum.		
Lifetime Maximum	Unlimited		
National Network	Yes	Yes	Yes
Primary Care Physician Required	No	No	Yes

COMMON AND PREVENTIVE SERVICES			
Primary Care Physician's Office Visit	\$15 copay	70% of allowed benefit after deductible	\$15 copay
Specialist Office Visit	\$30 copay	70% of allowed benefit after deductible	\$30 copay
Adult Physical Exams & Associated Lab Work	100% of allowed benefit	Not covered	100% of allowed benefit
	One exam per plan year for all members and their dependents age 22 and older		
Well Baby/Child Visits	100% of allowed benefit	Not covered	100% of allowed benefit
	Birth through 36 months: 12 visits total / 3 through 21 years: 1 visit per plan year		
	Contact Aetna for further details on eligibility for visits.		
Immunizations* and Vaccines Covered	100% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	Contact Aetna for detailed list.		
Hearing Examinations and Hearing Aids (No exam copay for children when part of a well-child visit)	\$15 copay (primary care physician) or \$30 copay (specialist) for exam 100% of allowed benefit for Basic Model Hearing Aid 1 exam and hearing aid per ear every 3 years for each employee/ retiree and dependent	Not covered, except for hearing aids as mandated for minor children	\$15 copay (primary care physician) or \$30 copay (specialist) for exam 100% of allowed benefit for Basic Model Hearing Aid 1 exam and hearing aid per ear every 3 years for each employee/ retiree and dependent
	Includes benefit for hearing aids for minor children (ages 0-18) as mandated by Maryland law effective 01/01/02.		
Allergy Testing	\$15 copay (primary care physician) or \$30 copay (specialist)	70% of allowed benefit after deductible	\$15 copay (primary care physician) or \$30 copay (specialist)
Nutritional Counseling and Health Education	100% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	Contact Aetna for details.		

Benefit chart footnotes are on page 37.

Active employees represented by Bargaining Unit I (SLEOLA) have a different rate schedule and plan design for medical and prescription drug benefits. Please visit the Employee Benefit Division's website for more information at www.dbm.maryland.gov/benefits.

AETNA

Benefit	POS In-Network	POS Out-of-Network	EPO In-Network Only
WOMEN'S SERVICES			
Well Woman Visits	100% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	One per plan year or as necessary based on a woman's health status, needs, and risk factors. Allows adult women to obtain recommended preventive services that are age and developmentally appropriate including preconception counseling, tobacco cessation counseling, and interpersonal & domestic violence screening & counseling.		
Mammography (Preventive)	100% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Mammography (Diagnostic)	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
In Vitro Fertilization (IVF) and Artificial Insemination (AI)	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	Up to 3 attempts of AI and/or IVF per live birth, lifetime maximum of \$100,000. Contact Aetna for further details and limitations.		
STI Screening & Counseling (Includes HPV DNA and HIV)	100% of allowed benefit	Not covered	100% of allowed benefit
	Counseling and screening for sexually active women as mandated by PPACA.		
Contraception and Contraceptive Counseling	100% of allowed benefit	Not covered	100% of allowed benefit
	Includes pre-conception counseling, IUD insertion and tubal ligation. For information on coverage of prescription contraceptives, please refer to the Prescription Drug section of this guide.		
Family Planning & Fertility Testing	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	Family planning benefits include: sperm count hysterosalpingography, eudiometrical biopsy and vasectomy.		
Prenatal Care	100% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	Routine prenatal obstetrical office visits, all lab services explicitly identified in the health reform law including gestational diabetes screening, tobacco cessation counseling specific to pregnant women, and certain immunizations.		
	Radiology (i.e., obstetrical ultrasounds), and high-risk prenatal services may be subject to coinsurance.		
Maternity Benefits	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	Includes delivery services, hospital stay, and other postnatal care and services.		
Breastfeeding Support, Supplies & Counseling (In conjunction with each birth)	100% of allowed benefit	Not covered	100% of allowed benefit
	Covers the cost for rental of certain breastfeeding equipment. The equipment must be obtained by the member through the insurance carrier's durable medical equipment partner(s).		
THERAPIES (Preauthorization Required)			
Benefit Therapies	\$30 copay	70% of allowed benefit after deductible	\$30 copay
Habilitative Services ^{†††}	Covers children under the age of 19 with congenital or genetic birth defects. Not subject to 50 visit per plan year limit.		
Physical Therapy (PT), Occupational Therapy (OT) and Speech Therapy	PT/OT services must be precertified after the 6th visit, based on medical necessity; 50 visits per plan year combined for PT/OT/Speech Therapy. Speech Therapy must be precertified from the first visit with exceptions and close monitoring for special situations (e.g., trauma, brain injury) for additional visits.		

Active employees represented by Bargaining Unit I (SLEOLA) have a different rate schedule and plan design for medical and prescription drug benefits. Please visit the Employee Benefit Division's website for more information at www.dbm.maryland.gov/benefits.

AETNA			
Benefit	POS In-Network	POS Out-of-Network	EPO In-Network Only
HOSPITAL – INPATIENT SERVICES (Preauthorization Required)			
Inpatient Care	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	Inpatient care primarily for or solely for rehabilitation is not covered.		
Hospitalization	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Anesthesia	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Surgery	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Newborn Care****	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	Contact Aetna to confirm your hospital's Neonatal Unit participates in the plan. If the Neonatal Unit and its physicians do not participate with the plan, you will be responsible for any balances up to the billed charges of the Neonatal Unit's providers. The POS plan will only pay these providers under the out-of-network coverage benefits. There will be no coverage for these providers under the EPO plan.		
Organ Transplant	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	Benefit is per calendar year for cornea, kidney, bone marrow, heart, heart-lung, single or double lung, liver, and pancreas.		
HOSPITAL – OUTPATIENT SERVICES			
Chemotherapy/Radiation	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Outpatient Surgery (Preauthorization Required)	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Anesthesia	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
EMERGENCY TREATMENT			
Urgent Care Centers	\$30 copay	70% of allowed benefit after deductible	\$30 copay
Emergency Room (ER) Services – inside and outside of service area***	\$75 copay for ER Facility plus \$75 copay for ER Physician Services	\$75 copay for ER Facility plus \$75 copay for ER Physician Services	\$75 copay for ER Facility plus \$75 copay for ER Physician Services
	Copays are waived if admitted. If criteria are not met for a medical emergency, plan coverage is 50% of allowed benefit after the two \$75 copays.		
Ambulance Services – Emergency Transport	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit
Ambulance Services – Non-Emergency Transport	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit

Benefit chart footnotes are on page 37.

Active employees represented by Bargaining Unit I (SLEOLA) have a different rate schedule and plan design for medical and prescription drug benefits. Please visit the Employee Benefit Division's website for more information at www.dbm.maryland.gov/benefits.

AETNA			
Benefit	POS In-Network	POS Out-of-Network	EPO In-Network Only
OTHER SERVICES AND SUPPLIES (Preauthorization Required)			
Acupuncture Services for Chronic Pain Management	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Behavioral Health	Covered by APS. See Behavioral Health Benefits section.		Inpatient care: 100% of allowed benefit Outpatient care: \$15 copay
Cardiac Rehabilitation [†]	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Chiropractic Services	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Dental Services	Covered separately from Plan. See Dental Benefits section.		
Diagnostic Lab & X-Ray	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Durable Medical Equipment	90% of allowed benefit	70% of allowed benefit	100% of allowed benefit
	Contact Aetna for details on covered items.		
Extended Care Facility (Medically Necessary)	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	Skilled nursing care and extended care facility benefits are limited to 180 days per plan year as long as skilled nursing care is medically necessary. Inpatient care primarily for or solely for rehabilitation is not covered.		
Home Healthcare	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	Home Healthcare benefits are limited to 120 days per plan year.		
Hospice Care	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Medical Supplies	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	Includes, but not limited to: surgical dressings; casts; splints; syringes; dressings for cancer, burns, or diabetic ulcers; catheters; colostomy bags; oxygen; supplies for renal dialysis equipment and machines; and all diabetic supplies as mandated by Maryland law.		
Outpatient Prescription Drugs	Covered separately from Plan. See Prescription Drug Benefits section.		
Private Duty Nursing	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Second Surgical Opinion (No Preauthorization Required)	90% of allowed benefit	90% of allowed benefit	100% of allowed benefit
Whole Blood Charges (No Preauthorization Required)	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
VISION SERVICES AND SUPPLIES			
Vision – Medical Any services that deal with the medical health of the eye	\$15 copay (primary care physician) or \$30 copay (specialist)	70% of allowed benefit after deductible	\$15 copay (primary care physician) or \$30 copay (specialist)
Vision – Routine Any services that deal with correcting vision.	Exam: Plan pays up to \$45 (available once every plan year) Prescription lenses, frames, contact lenses (per plan year): \$200 every 12 months per member (member pays out-of-pocket and then submits a claim for reimbursement) You may obtain vision services from any licensed vision provider, whether in Aetna's network or not. However, you may have to pay the full cost up front and submit a claim form to Aetna for partial reimbursement. Contact Aetna for more information.		

Active employees represented by Bargaining Unit I (SLEOLA) have a different rate schedule and plan design for medical and prescription drug benefits. Please visit the Employee Benefit Division's website for more information at www.dbm.maryland.gov/benefits.



CareFirst is committed to keeping you healthy and happy.

Over 97% of surveyed State of Maryland members were very satisfied with CareFirst as their carrier and 92% said their claims were processed quickly and correctly.

Plan Options

Preferred Provider Organization (PPO)

- Access to a National network of doctors
- No PCP selection required

Point of Service (POS)

- Access to a regional network, MD, DC and Northern VA with over 26,000 providers
- Choose a PCP that will coordinate the right care for you

Exclusive Provider Organization (EPO)

- Access to a National network of doctors
- The features of a PPO with in-network benefits only
- No PCP selection required

Resources



My Account: www.carefirst.com/statemd

- Review your claims
- Change your PCP
- Check your deductible
- Locate providers

My Care First: www.carefirst.com/mycarefirst

An online directory of Health+Wellness tools



FirstHelp™: (800) 535-9700 24-hour nurse line

Customer Service: (800) 225-0131

Mobile Features



Ready, Step, Go! Pedometer

Count your steps, distance traveled and calories burned!



Symptom Checker

Offers a simple guide to checking your symptoms and choosing the most appropriate level of care.



Facebook

Like us on Facebook and enjoy exclusive access to healthy recipes, wellness tips and fitness challenges—delivered right to you!



Twitter

CareFirst has three Twitter accounts.

CareFirst News is your source for breaking news and CareFirst updates.

CareFirst Dance provides timely information about dance classes and events in your area.

CareFirst Alert posts real time news about CareFirst office closings or emergencies.



CareFirst BlueCross BlueShield is the business name of CareFirst of Maryland, Inc. and an independent licensee of the Blue Cross and Blue Shield Association. ® Registered trademark of the Blue Cross and Blue Shield Association. ® Registered trademark of CareFirst of Maryland, Inc.

CST1729-1P (11/12)

CAREFIRST

Benefit	PPO In-Network	PPO Out-of-Network	POS In-Network	POS Out-of-Network	EPO In-Network Only
Short Plan Year Deductible					
Individual	None	\$125	None	\$125	None
Family	None	\$250	None	\$250	None
Short Plan Year Out-of-Pocket Coinsurance & Deductible Combined Maximum					
Individual	\$500	\$1,500	\$500	\$1,500	None
Family	\$1,000	\$3,000	\$1,000	\$3,000	None
Any charges above the plan's Allowed Benefit are not counted toward the out-of-pocket maximum.					
Lifetime Maximum	Unlimited				
National Network	Yes	Yes	No, Regional Network	Yes	Yes
Primary Care Physician Required	No	No	Yes	No	No

COMMON AND PREVENTIVE SERVICES

Primary Care Physician's Office Visit	\$15 copay	70% of allowed benefit after deductible	\$15 copay	70% of allowed benefit after deductible	\$15 copay
Specialist Office Visit	\$30 copay	70% of allowed benefit after deductible	\$30 copay	70% of allowed benefit after deductible	\$30 copay
Adult Physical Exams & Associated Lab Work	100% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit	Not covered	100% of allowed benefit
One exam per plan year for all members and their dependents age 22 and older.					
Well Baby/Child Visits	100% of allowed benefit	70% of allowed benefit after deductible per visit	100% of allowed benefit	Not covered	100% of allowed benefit
Birth through 36 months: up to 12 visits total / 3 through 21 years: 1 annual visit per plan year					
Contact CareFirst for further details on eligibility for visits.					
Immunizations* and Vaccines Covered.	100% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Contact CareFirst for a detailed list.					
Hearing Examinations and Hearing Aids (No exam copay for children when part of a well-child visit.)	\$15 copay (primary care physician) or \$30 copay (specialist) for exam 100% of allowed benefit for Basic Model Hearing Aid	70% of allowed benefit after deductible for exam 70% of allowed benefit for Basic Model Hearing Aid	\$15 copay (primary care physician) or \$30 copay (specialist) for exam 100% of allowed benefit for Basic Model Hearing Aid	Not covered, except for hearing aids as mandated for minor children	\$15 copay (primary care physician) or \$30 copay (specialist) for exam 100% of allowed benefit for Basic Model Hearing Aid
1 exam and hearing aid per ear every 3 years for each employee/retiree and dependent					
Includes benefit for hearing aids for minor children (ages 0-18) as mandated by Maryland law effective 01/01/02.					
Allergy Testing and Serum	\$15 copay (primary care physician) or \$30 copay (specialist)	70% of allowed benefit after deductible	\$15 copay (primary care physician) or \$30 copay (specialist)	70% of allowed benefit after deductible	\$15 copay (primary care physician) or \$30 copay (specialist)
Nutritional Counseling and Health Education	100% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Contact CareFirst for details.					

Benefit chart footnotes are on page 37.

Active employees represented by Bargaining Unit I (SLEOLA) have a different rate schedule and plan design for medical and prescription drug benefits. Please visit the Employee Benefit Division's website for more information at www.dbm.maryland.gov/benefits.

CAREFIRST					
Benefit	PPO In-Network	PPO Out-of-Network	POS In-Network	POS Out-of-Network	EPO In-Network Only
WOMEN'S SERVICES					
Well Woman Visits	100% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit	Not covered	100% of allowed benefit
	One per plan year or as necessary based on a woman's health status, needs, and risk factors. Allows adult women to obtain recommended preventive services that are age and developmentally appropriate including preconception counseling, tobacco cessation counseling, and interpersonal & domestic violence screening & counseling.				
Mammography (Preventive)	100% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Mammography (Diagnostic)	90% of allowed benefit	70% of allowed benefit after deductible	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
In Vitro Fertilization (IVF) and Artificial Insemination (AI)	90% of allowed benefit	70% of allowed benefit after deductible	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	Up to 3 attempts of AI and/or IVF per live birth, lifetime maximum of \$100,000. Contact CareFirst for further details and limitations.				
STI Screening & Counseling (Includes HPV DNA and HIV)	100% of allowed benefit	Not covered	100% of allowed benefit	Not covered	100% of allowed benefit
	Counseling and screening for sexually active women as mandated by PPACA.				
Contraception and Contraceptive Counseling	100% of allowed benefit	Not covered	100% of allowed benefit	Not covered	100% of allowed benefit
	Includes pre-conception counseling, IUD insertion and tubal ligation. For information on coverage of prescription contraceptives, please refer to the Prescription Drug section of this guide.				
Family Planning & Fertility Testing	90% of allowed benefit	70% of allowed benefit after deductible	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	Family planning benefits include: sperm count hysterosalpingography, eudiometrical biopsy and vasectomy.				
Prenatal Care	100% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	Routine prenatal obstetrical office visits, all lab services explicitly identified in the health reform law including gestational diabetes screening, tobacco cessation counseling specific to pregnant women, and certain immunizations.				
	Radiology (i.e., obstetrical ultrasounds), and high-risk prenatal services may be subject to coinsurance.				
Maternity Benefits	90% of allowed benefit	70% of allowed benefit after deductible	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	Includes delivery services, hospital stay, and other postnatal care and services.				
Breastfeeding Support, Supplies & Counseling (In conjunction with each birth)	100% of allowed benefit	Not covered	100% of allowed benefit	Not covered	100% of allowed benefit
	Covers the cost for rental of certain breastfeeding equipment. The equipment must be obtained by the member through the insurance carrier's durable medical equipment partner(s).				

Active employees represented by Bargaining Unit I (SLEOLA) have a different rate schedule and plan design for medical and prescription drug benefits. Please visit the Employee Benefit Division's website for more information at www.dbm.maryland.gov/benefits.

CAREFIRST

Benefit	PPO In-Network	PPO Out-of-Network	POS In-Network	POS Out-of-Network	EPO In-Network Only
THERAPIES (Preauthorization Required)					
Benefit Therapies	\$30 copay	70% of allowed benefit after deductible	\$30 copay	70% of allowed benefit after deductible	\$30 copay
Habilitative Services†††	Covers children under the age of 19 with congenital or genetic birth defects. Not subject to 50 visit per plan year limit.				
Physical Therapy (PT), Occupational Therapy (OT) and Speech Therapy	PT/OT services must be precertified after the 6th visit, based on medical necessity; 50 visits per plan year combined for PT/OT/Speech Therapy. Speech Therapy must be precertified from the first visit with exceptions and close monitoring for special situations (e.g., trauma, brain injury) for additional visits.				
HOSPITAL – INPATIENT SERVICES (Preauthorization Required)					
Inpatient Care	90% of allowed benefit	70% of allowed benefit after deductible	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	Inpatient care primarily for or solely for rehabilitation is not covered.				
Hospitalization	90% of allowed benefit	70% of allowed benefit after deductible	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Anesthesia	90% of allowed benefit	70% of allowed benefit after deductible	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Surgery	90% of allowed benefit	70% of allowed benefit after deductible	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Newborn Care****	90% of allowed benefit	70% of allowed benefit after deductible	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	Contact CareFirst to confirm your hospital's Neonatal Unit participates in the plan. If the Neonatal Unit and its physicians do not participate with the plan, you will be responsible for any balances up to the charge of the Neonatal Unit's providers. The PPO and POS plans will only pay these providers under the out-of-network coverage benefits. There will be no coverage for these providers under the EPO plan.				
Organ Transplant	90% of allowed benefit	70% of allowed benefit after deductible	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	Benefit is per calendar year for cornea, kidney, bone marrow, heart, heart-lung, single or double lung, liver, and pancreas.				
HOSPITAL – OUTPATIENT SERVICES					
Chemotherapy/ Radiation	90% of allowed benefit	70% of allowed benefit after deductible	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Outpatient Surgery (Preauthorization Required)	90% of allowed benefit	70% of allowed benefit after deductible	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Anesthesia	90% of allowed benefit	70% of allowed benefit after deductible	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit

Benefit chart footnotes are on page 37.

Active employees represented by Bargaining Unit I (SLEOLA) have a different rate schedule and plan design for medical and prescription drug benefits. Please visit the Employee Benefit Division's website for more information at www.dbm.maryland.gov/benefits.

CAREFIRST					
Benefit	PPO In-Network	PPO Out-of-Network	POS In-Network	POS Out-of-Network	EPO In-Network Only
EMERGENCY TREATMENT					
Urgent Care Centers	\$30 copay	70% of allowed benefit after deductible	\$30 copay	70% of allowed benefit after deductible	\$30 copay
Emergency Room (ER) Services – inside and outside of service area***	\$75 copay for ER Facility plus \$75 copay for ER Physician Services	\$75 copay for ER Facility plus \$75 copay for ER Physician Services	\$75 copay for ER Facility plus \$75 copay for ER Physician Services	\$75 copay for ER Facility plus \$75 copay for ER Physician Services	\$75 copay for ER Facility plus \$75 copay for ER Physician Services
	Copays are waived if admitted. If criteria are not met for a medical emergency, plan coverage is 50% of allowed benefit, after the two \$75 copays.				
Ambulance Services – Emergency Transport	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit
Ambulance Services – Non-Emergency Transport	90% of allowed benefit	70% of allowed benefit after deductible	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
OTHER SERVICES AND SUPPLIES (Preauthorization may be required)					
Acupuncture Services for Chronic Pain Management	\$20 copay	70% of allowed benefit after deductible	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Behavioral Health	Covered by APS. See Behavioral Health Benefits section.				Inpatient care: 100% of allowed benefit Outpatient care: \$15 copay
Cardiac Rehabilitation†	90% of allowed benefit	70% of allowed benefit after deductible	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Chiropractic Services	\$20 copay	70% of allowed benefit after deductible	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Dental Services	Covered separately from Plan. See Dental Benefits section.				
Diagnostic Lab & X-Ray	90% of allowed benefit	70% of allowed benefit after deductible	90% of allowed benefit	90% of allowed benefit	100% of allowed benefit
Durable Medical Equipment	90% of allowed benefit	70% of allowed benefit after deductible	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	Contact CareFirst for details on covered items.				
Extended Care Facility	90% of allowed benefit	70% of allowed benefit after deductible	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	Skilled nursing care and extended care facility benefits are limited to 180 days per benefit period as long as skilled nursing care is medically necessary. Inpatient care primarily for or solely for rehabilitation is not covered.				
Home Healthcare	90% of allowed benefit	70% of allowed benefit after deductible	90% of allowed benefit	90% of allowed benefit	100% of allowed benefit
	Home Healthcare benefits are limited to 120 days per plan year. Contact CareFirst for further details.				
Hospice Care	90% of allowed benefit	70% of allowed benefit after deductible	90% of allowed benefit	90% of allowed benefit	100% of allowed benefit
Medical Supplies	90% of allowed benefit	70% of allowed benefit after deductible	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	Includes, but not limited to: surgical dressings; casts; splints; syringes; dressings for cancer, burns, or diabetic ulcers; catheters; colostomy bags; oxygen; supplies for renal dialysis equipment and machines; and all diabetic supplies as mandated by Maryland law.				

Active employees represented by Bargaining Unit I (SLEOLA) have a different rate schedule and plan design for medical and prescription drug benefits. Please visit the Employee Benefit Division's website for more information at www.dbm.maryland.gov/benefits.

CAREFIRST

Benefit	PPO In-Network	PPO Out-of-Network	POS In-Network	POS Out-of-Network	EPO In-Network Only
---------	-------------------	-----------------------	-------------------	-----------------------	---------------------------

OTHER SERVICES AND SUPPLIES (Preauthorization may be required) *continued*

Outpatient Prescription Drugs	Covered separately from Plan. See Prescription Drug Benefits section.				
Private Duty Nursing	90% of allowed benefit	70% of allowed benefit after deductible	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Second Surgical Opinion (No Preauthorization Required)	90% of allowed benefit	90% of allowed benefit	90% of allowed benefit	90% of allowed benefit	100% of allowed benefit
Whole Blood Charges (No Preauthorization Required)	90% of allowed benefit	70% of allowed benefit after deductible	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit

VISION SERVICES AND SUPPLIES

Vision – Medical Any services that deal with the medical health of the eye	\$15 copay (primary care physician) or \$30 copay (specialist)	70% of allowed benefit after deductible	\$15 copay (primary care physician) or \$30 copay (specialist)	70% of allowed benefit after deductible	\$15 copay (primary care physician) or \$30 copay (specialist)
Vision – Routine Any services that deal with correcting vision.	Exam: Plan pays up to \$45 (available once every plan year) Prescription lenses (per pair – available once every plan year): <ul style="list-style-type: none">◆ Single vision: \$28.80◆ Bifocal, single: \$48.60◆ Bifocal, double: \$88.20◆ Trifocal: \$70.20◆ Aphakic – glass: \$54.00◆ Aphakic – plastic: \$126.00◆ Aphakic – aspheric: \$162.00			Frames: Plan pays up to \$45 (available once every plan year) Contacts (per pair, instead of frames and lenses – available once every plan year): <ul style="list-style-type: none">◆ Medically necessary: \$201.60◆ Cosmetic: \$50.40	
You may obtain vision services from any licensed vision provider, whether in the CareFirst network or not. However, you may have to pay the full cost up front and submit a claim form to CareFirst for partial reimbursement. Contact CareFirst for more information.					

Benefit chart footnotes are on page 37.

Active employees represented by Bargaining Unit I (SLEOLA) have a different rate schedule and plan design for medical and prescription drug benefits. Please visit the Employee Benefit Division's website for more information at www.dbm.maryland.gov/benefits.

WELCOME

UnitedHealthcare is committed to giving you access to a better health care experience – from benefits to health and wellness tools that can help support your health goals.



We offer three great plan options - **EPO, POS** and **PPO** - with features that give our plans a clear advantage. Whether you choose the UnitedHealthcare EPO, POS or PPO plan, the same online services, wellness tools and programs will be available to you.

- ▶ **No referrals** – you have the freedom to see any doctor or specialist without a referral.
- ▶ **\$15 Primary Care** and **\$30 Specialist copayment**.
- ▶ **Preventive care covered at 100% (in-network)**.
- ▶ **National network** – our nationwide coverage gives you access to more than 704,900 physicians and health care professionals and 5,580 hospitals, including every hospital in Maryland.

Value-added services

- ▶ **Customer Care 24/7** - 1-800-382-7513.
- ▶ **myuhc.com**[®] – our exclusive member website where you can manage benefits, track claims, use tools and resources, including myHealth Care Cost Estimator, and much more.
- ▶ **uhcmaryland.com** – comprehensive custom website filled with information you need before you enroll.

Mobile tools to help you make the most of your health plan

You might be surprised at how much can be done with just a few simple keystrokes. UnitedHealthcare strives to make it easy to get help, wherever you are.

- ▶ **UnitedHealthcare Health4Me**[™] is your go-to app for your health. You can search for physicians or facilities, view your claims, account balances, health plan ID card and more. It is available for download on the app store for iPhones or Google play for Androids.
- ▶ **DocGPS**[®] will find you a network doctor or hospital wherever you are, give you directions and more.
- ▶ **OptimizeMe**[®] – the UnitedHealthcare social networking application allows you to create or join health related challenges with your friends.



SERVICES



myNurseLineSM

Registered nurses are available to help you anytime – at no extra cost to you. Just call **1-888-315-7257**.



UHC.TVSM

UHC.TV is our new online television network. It presents educational and entertaining programs about good health and living. Visit **www.uhc.tv** to learn more.



Know before you go

It's easier to budget for a medical treatment, if you have an idea of how much it will cost. Our **myHealth Care Cost Estimator** gives you the information you need to help you plan ahead.

- Search and explore cost estimates of different treatments
- Compare network and non-network cost estimates



Discounts for a healthier you

Receive special discounts, ranging from 10 percent to 25 percent on products and services, such as alternative medicine, weight loss programs, fitness clubs and more.* To learn more, go to **myuhc.com**.

*The health discount program is not insurance.

myNurseLine is for informational purposes only. Nurses cannot diagnose problems or recommend specific treatment and are not a substitute for your doctor's care. These services are not an insurance program and may be discontinued at any time.

iPhone is a registered trademark of Apple, Inc. Google is a registered trademark of Google, Inc. Android is a trademark of Google, Inc.

Administrative services provided by UnitedHealthcare Insurance Company, United HealthCare Services, Inc. or their affiliates. Health Plan coverage provided by or through UnitedHealthcare of the Mid-Atlantic, Inc.

© 2012 United HealthCare Services, Inc.



UNITEDHEALTHCARE

Benefit	PPO In-Network	PPO Out-of-Network	POS In-Network	POS Out-of-Network	EPO In-Network Only
Short Plan Year Deductible Individual Family	None None	\$125 \$250	None None	\$125 \$250	None None
Short Plan Year Out-of-Pocket Coinsurance & Deductible Combined Maximum Individual Family	\$500 \$1,000	\$1,500 \$3,000	\$500 \$1,000	\$1,500 \$3,000	None None
	Any charges above the plan's Allowed Benefit are not counted toward the out-of-pocket maximum.				
Lifetime Maximum	Unlimited				
National Network	Yes	Yes	Yes	Yes	Yes
Primary Care Physician Required	No	No	No	No	Yes

COMMON AND PREVENTIVE SERVICES

Primary Care Physician's Office Visit	\$15 copay	70% of allowed benefit after deductible	\$15 copay	70% of allowed benefit after deductible	\$15 copay
Specialist Office Visit	\$30 copay	70% of allowed benefit after deductible	\$30 copay	70% of allowed benefit after deductible	\$30 copay
Adult Physical Exams & Associated Lab Work	100% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit	Not covered	100% of allowed benefit
	One exam per plan year for all members and their dependents age 22 and older				
Well Baby/Child Visits	100% of allowed benefit	70% of allowed benefit after deductible per visit	100% of allowed benefit	Not covered	100% of allowed benefit
	Birth through 36 months: 12 visits total / 3 through 21 years: 1 visit per plan year				
	Contact UHC for further details on eligibility for visits.				
Immunizations* and Vaccines Covered	100% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	Contact UnitedHealthcare for a detailed list.				
Hearing Examinations and Hearing Aids (Requires prior notification if over \$1,000) (No exam copay for children when part of a well-child visit.)	\$15 (PCP), \$30 (Specialist) copay for exam 100% of allowed benefit for Basic Model Hearing Aid 1 exam and hearing aid per ear every 3 years for each employee/retiree and dependent	70% of allowed benefit after deductible for exam 70% of allowed benefit for Basic Model Hearing Aid 1 exam and hearing aid per ear every 3 years for each employee/retiree and dependent	\$15 (PCP), \$30 (Specialist) copay for exam 100% of allowed benefit for Basic Model Hearing Aid 1 exam and hearing aid per ear every 3 years for each employee/retiree and dependent	Not covered, except 70% of allowed benefit after deductible for hearing aids as mandated for minor children	\$15 (PCP), \$30 (Specialist) copay for exam 100% for Basic Model Hearing Aid 1 exam and hearing aid per ear every 3 years for each employee/retiree and dependent
Allergy Testing	\$15 copay (primary care physician) or \$30 copay (specialist)	70% of allowed benefit after deductible	\$15 copay (primary care physician) or \$30 copay (specialist)	70% of allowed benefit after deductible	\$15 copay (primary care physician) or \$30 copay (specialist)
Nutritional Counseling and Health Education	100% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	Contact UHC for details.				

Active employees represented by Bargaining Unit I (SLEOLA) have a different rate schedule and plan design for medical and prescription drug benefits. Please visit the Employee Benefit Division's website for more information at www.dbm.maryland.gov/benefits.

UNITEDHEALTHCARE					
Benefit	PPO In-network	PPO Out-of-Network	POS In-Network	POS Out-of-Network	EPO In-Network Only
WOMEN'S SERVICES					
Well Woman Visits	100% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	One per plan year or as necessary based on a woman's health status, needs, and risk factors. Allows adult women to obtain recommended preventive services that are age and developmentally appropriate including preconception counseling, tobacco cessation counseling, and interpersonal & domestic violence screening & counseling.				
Mammography (Preventive)	100% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Mammography (Diagnostic)	90% of allowed benefit	70% of allowed benefit after deductible	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
In Vitro Fertilization (IVF) and Artificial Insemination (AI)	90% of allowed benefit	70% of allowed benefit after deductible	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	Up to 3 attempts of AI and/or IVF per live birth, lifetime maximum of \$100,000. Contact United Healthcare for further details and limitations.				
STI Screening & Counseling (Includes HPV DNA and HIV)	100% of allowed benefit	Not covered	100% of allowed benefit	Not covered	100% of allowed benefit
	Counseling and screening for sexually active women as mandated by PPACA.				
Contraception and Contraceptive Counseling	100% of allowed benefit	Not covered	100% of allowed benefit	Not covered	100% of allowed benefit
	Includes pre-conception counseling, IUD insertion and tubal ligation. For information on coverage of prescription contraceptives, please refer to the Prescription Drug section of this guide.				
Family Planning & Fertility Testing	90% of allowed benefit	70% of allowed benefit after deductible	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	Family planning benefits include: sperm count hysterosalpingography, eudiometrical biopsy and vasectomy.				
Prenatal Care	100% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	Routine prenatal obstetrical office visits, all lab services explicitly identified in the health reform law including gestational diabetes screening, tobacco cessation counseling specific to pregnant women, and certain immunizations.				
	Radiology (i.e., obstetrical ultrasounds), and high-risk prenatal services may be subject to coinsurance.				
Maternity Benefits	90% of allowed benefit	70% of allowed benefit after deductible	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	Includes delivery services, hospital stay, and other postnatal care and services.				
Breastfeeding Support, Supplies & Counseling (In conjunction with each birth)	100% of allowed benefit	Not covered	100% of allowed benefit	Not covered	100% of allowed benefit
	Covers the cost for rental of certain breastfeeding equipment. The equipment must be obtained by the member through the insurance carrier's durable medical equipment partner(s).				

Benefit chart footnotes are on page 37.

Active employees represented by Bargaining Unit I (SLEOLA) have a different rate schedule and plan design for medical and prescription drug benefits. Please visit the Employee Benefit Division's website for more information at www.dbm.maryland.gov/benefits.

UNITEDHEALTHCARE

Benefit	PPO In-Network	PPO Out-of-Network	POS In-Network	POS Out-of-Network	EPO In-Network Only
THERAPIES (Preauthorization Required)					
Benefit Therapies	\$30 copay	70% of allowed benefit after deductible	\$30 copay	70% of allowed benefit after deductible	\$30 copay
Habilitative Services ^{†††}	Covers children under the age of 19 with congenital or genetic birth defects. Not subject to 50 visit per plan year limit.				
Physical Therapy (PT), Occupational Therapy (OT) and Speech Therapy	PT/OT services must be preauthorized after the 6th visit, based on medical necessity; 50 visits per plan year combined for PT/OT/Speech Therapy. Speech Therapy must be preauthorized from the first visit with exceptions and close monitoring for special situations (e.g., trauma, brain injury) for additional visits.				
HOSPITAL – INPATIENT SERVICES (Preauthorization Required)					
Inpatient Care	90% of allowed benefit	70% of allowed benefit after deductible	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	Inpatient care primarily for or solely for rehabilitation/custodial care is not covered.				
Hospitalization	90% of allowed benefit	70% of allowed benefit after deductible	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Anesthesia	90% of allowed benefit	70% of allowed benefit after deductible	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Surgery	90% of allowed benefit	70% of allowed benefit after deductible	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Newborn Care****	90% of allowed benefit	70% of allowed benefit after deductible	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	Contact UHC to confirm your hospital's Neonatal Unit participates in the plan. If the Neonatal Unit and its physicians do not participate with the plan, you will be responsible for any balances up to the charge of the Neonatal Unit's providers. The PPO and POS plans will only pay these providers under the out-of-network coverage benefits. There will be no coverage for these providers under the EPO plan.				
Organ Transplant	90% of allowed benefit	70% of allowed benefit after deductible	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	Benefit per calendar year for cornea, kidney, bone marrow, heart, heart-lung, single or double lung, liver, and pancreas.				
HOSPITAL – OUTPATIENT SERVICES (Preauthorization Required)					
Chemotherapy/ Radiation	90% of allowed benefit	70% of allowed benefit after deductible	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Outpatient Surgery (Preauthorization Required)	90% of allowed benefit	70% of allowed benefit after deductible	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Anesthesia	90% of allowed benefit	70% of allowed benefit after deductible	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
EMERGENCY TREATMENT					
Urgent Care Centers	\$30 copay	70% of allowed benefit after deductible, plus \$30 copay	\$30 copay	70% of allowed benefit after deductible, plus \$30 copay	\$30 copay
Emergency Room (ER) Services – inside and outside of service area***	\$75 copay for ER Facility plus \$75 copay for ER Physician Services	\$75 copay for ER Facility plus \$75 copay for ER Physician Services	\$75 copay for ER Facility plus \$75 copay for ER Physician Services	\$75 copay for ER Facility plus \$75 copay for ER Physician Services	\$75 copay for ER Facility plus \$75 copay for ER Physician Services
	Copays are waived if admitted. If criteria are not met for a medical emergency, plan coverage is 50% of allowed benefit, after the two \$75 copays.				
Ambulance Services – Emergency Transport	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit
Ambulance Services – Non-Emergency Transport	90% of allowed benefit	70% of allowed benefit after deductible	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit

Active employees represented by Bargaining Unit I (SLEOLA) have a different rate schedule and plan design for medical and prescription drug benefits. Please visit the Employee Benefit Division's website for more information at www.dbm.maryland.gov/benefits.

UNITEDHEALTHCARE					
Benefit	PPO In-Network	PPO Out-of-Network	POS In-Network	POS Out-of-Network	EPO In-Network Only
OTHER SERVICES AND SUPPLIES (Preauthorization may be required)					
Acupuncture Services for Chronic Pain Management	\$20 copay	70% of allowed benefit after deductible	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Behavioral Health	Covered by APS. See Behavioral Health Benefits section.				Inpatient care: 100% of allowed benefit Outpatient care: \$15 copay
Cardiac Rehabilitation†	90% of allowed benefit	70% of allowed benefit after deductible	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Chiropractic Services	\$20 copay	70% of allowed benefit after deductible	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Dental Services	Covered separately from Plan. See Dental Benefits section.				
Diagnostic Lab & X-Ray	90% of allowed benefit	70% of allowed benefit after deductible	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Durable Medical Equipment	90% of allowed benefit	70% of allowed benefit after deductible	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	Preauthorization required if greater than \$1,000. Contact UHC for details on covered items.				
Extended Care Facility	90% of allowed benefit	70% of allowed benefit after deductible	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	Skilled nursing care and extended care facility benefits are limited to 180 days per plan year as long as skilled nursing care is medically necessary. Inpatient care primarily for or solely for rehabilitation/custodial care is not covered.				
Home Health Care	90% of allowed benefit	70% of allowed benefit after deductible	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	Home Healthcare benefits are limited to 120 days per plan year.				
Hospice Care	90% of allowed benefit	70% of allowed benefit after deductible	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Medical Supplies	90% of allowed benefit	70% of allowed benefit after deductible	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	Includes, but not limited to: surgical dressings; casts; splints; insulin syringes; dressings for cancer, burns, or diabetic ulcers; catheters; colostomy bags; oxygen; supplies for renal dialysis equipment and machines; and all diabetic supplies as mandated by Maryland law.				
Outpatient Prescription Drugs	Covered separately from Plan. See Prescription Drug Benefits section.				
Private Duty Nursing	90% of allowed benefit	70% of allowed benefit after deductible	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Second Surgical Opinion (No Preauthorization Required)	90% of allowed benefit	90% of allowed benefit after deductible	90% of allowed benefit	90% of allowed benefit after deductible	100% of allowed benefit
Whole Blood Charges (No Preauthorization Required)	90% of allowed benefit	70% of allowed benefit after deductible	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit

Benefit chart footnotes are on page 37.

Active employees represented by Bargaining Unit I (SLEOLA) have a different rate schedule and plan design for medical and prescription drug benefits. Please visit the Employee Benefit Division's website for more information at www.dbm.maryland.gov/benefits.

UNITED HEALTHCARE

Benefit	PPO In-Network	PPO Out-of-Network	POS In-Network	POS Out-of-Network	EPO In-Network Only
VISION SERVICES AND SUPPLIES					
Vision – Medical Any services that deal with the medical health of the eye	\$15 copay (primary care physician) or \$30 copay (specialist)	70% of allowed benefit after deductible	\$15 copay (primary care physician) or \$30 copay (specialist)	70% of allowed benefit after deductible	\$15 copay (primary care physician) or \$30 copay (specialist)
Vision – Routine Any services that deal with correcting vision.	Exam: Plan pays up to \$45 (available once every plan year) Prescription lenses (per pair – available once every plan year): <ul style="list-style-type: none">◆ Single vision: \$28.80◆ Bifocal, single: \$48.60◆ Bifocal, double: \$88.20◆ Trifocal: \$70.20◆ Aphakic – glass: \$54.00◆ Aphakic – plastic: \$126.00◆ Aphakic – aspheric: \$162.00			Frames: Plan pays up to \$45 (available once every plan year) Contacts (per pair, instead of frames and lenses – available once every plan year): <ul style="list-style-type: none">◆ Medically necessary: \$201.60◆ Cosmetic: \$50.40	
You may obtain vision services from any licensed vision provider, whether in UHC’s network or not. However, you may have to pay the full cost up front and submit a claim form to UHC for partial reimbursement. Contact UHC for more information.					

UNITED HEALTHCARE

Active employees represented by Bargaining Unit I (SLEOLA) have a different rate schedule and plan design for medical and prescription drug benefits. Please visit the Employee Benefit Division's website for more information at www.dbm.maryland.gov/benefits.

BENEFIT CHART FOOTNOTES

* Immunizations: Covered immunizations are determined by following the Immunization Schedules of the Centers for Disease Control and Prevention. Contact your plan for up-to-date information on covered immunizations. The immunization benefit includes Influenza (Flu shots, one per plan year; all ages), Pneumococcal, HPV, Meningitis and Shingles vaccines, immunizations required for participation in college admission, and Lyme Disease immunizations when medically necessary. Travel immunizations are not covered.

*** Emergency services or medical emergency is defined as: healthcare services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in:

- Placing the patient's health in jeopardy;
- Serious impairment of bodily functions; or
- Serious dysfunction of any bodily organ or part.

**** Newborns' and Mothers' Health Protection Act Notice. See page 68.

† Cardiac rehabilitation benefits: 36 sessions in a 12-week period (or on a case-by-case basis thereafter) with physician supervision and in a medical facility. Cardiac rehabilitation must be medically necessary with a physician referral, and patient history of a heart attack in past 12 months; Coronary Artery Bypass Graft (CABG) surgery; angioplasty; heart valve surgery; stable angina pectoris; congestive heart failure; or heart and lung transplants. Inpatient care primarily for rehabilitation is not covered.

†† In-Vitro Fertilization (IVF) and Artificial Insemination (AI) benefits are available for a married (as recognized by the laws of Maryland) woman if:

- She was infertile throughout the most recent two years of marriage to the same man; or
- Her infertility is due to endometriosis, exposure in womb to diethylstilbestrol (DES), or blockage of or surgical removal of one or more fallopian tubes; or
- Male infertility is the documented diagnostic cause.

The patient's oocytes must be fertilized with her spouse's sperm. IVF and AI are covered for a maximum of three attempts per procedure.

- Coverage of the three IVF attempts per live birth will not exceed a maximum expense of \$100,000 per lifetime.
- The AI attempts must be taken, when medically appropriate, before IVF attempts will be covered.

††† Rehabilitative Services, which include occupational therapy, physical therapy, and speech therapy, are covered for children under the age of 19 with congenital or genetic birth defects including but not limited to autism, autism spectrum disorder, and cerebral palsy.

Below are the resources used to determine the list of services that are covered with zero cost-share to our members:

Taken from the Federal Register, a group health plan must provide benefits for and prohibit cost sharing with respect to:

1. Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF).
2. Immunizations that appear on the Immunization Schedules of the Centers for Disease Control and Prevention.
3. With respect to infants, children, adolescents, and women, preventive care and screenings provided for in the guidelines supported by the Health Resources and Services Administration (HRSA).

Behavioral Health Benefits

YOUR CHOICES

You must be enrolled in a State medical plan to have Behavioral Health benefits. If you enroll in a State medical plan, you and your enrolled dependents will automatically receive Behavioral Health coverage. However, the network of providers for these benefits varies depending on the medical plan in which you are enrolled.

If you are enrolled in...	Your Behavioral Health benefits are managed by...
EPO plan	The EPO plan network
PPO or POS plan	APS Healthcare network (APS)





HOW THE PLANS WORK

EPO Plans

Your EPO plan must authorize all of your inpatient Behavioral Health services to be eligible for coverage. Out-of-network services are not covered under any of the EPO plans.



PPO and POS Plans

Your Behavioral Health benefits are managed by APS Healthcare. The following types of services are covered under this plan:

-  Inpatient facility and professional services;
-  Partial hospitalization;
-  Intensive Outpatient Program; and
-  Outpatient facility and professional services.

For a list of participating providers, contact APS at 1-877-239-1458 or visit www.APSHelpLink.com.

Notes about Your Behavioral Health Coverage

-  Inpatient Care – There is no limit to medically necessary preauthorized inpatient days.
-  Outpatient Care – There is no limit on the number of medically necessary/treatable visits per year.





Eligible Behavioral Health services are covered as any other illness. Substance abuse detoxification and

rehabilitation services are covered under inpatient, partial hospitalization, or outpatient services when medically necessary.

If you experience a non-life threatening emergency or crisis, contact the APS Help Line at 1-877-239-1458 for immediate assistance. If you experience a life-threatening emergency, you should seek treatment at the nearest emergency room. You must notify APS within 24 hours of an emergency admission to certify care. APS team members are available 24 hours a day, seven days a week, 365 days a year.

Claims Processing for APS Out-of-Network Services

Your provider may ask you to pay the bill at the time of service. You must pay the provider, then submit a claim form and an itemized bill to APS for reimbursement. The itemized bill should be on the provider's letterhead/stationery and include:

-  Diagnosis and type of treatment rendered (including CPT code);
-  Charges for the services performed;
-  Date of service; and
-  Patient's name and date of birth and employee's or retiree's Social Security number.

The claim form can be found at www.dbm.maryland.gov/benefits, click on Forms.

After you have completed the claim form and attached the itemized bill, mail the information directly to:

APS Healthcare
SOM Claims
P.O. Box 1440
Rockville, MD 20849-1440

APS will send the payment for covered services directly to you at the address on file with the Employee Benefits Division. You will receive an Explanation of Benefits (EOB) any time APS processes a claim. An EOB is not a bill; it is an explanation of how APS processed your claim.

FOR MORE INFORMATION

If you are enrolled in a PPO or POS medical plan and have questions about the Behavioral Health Plan, call APS at 1-877-239-1458 or visit www.APSHelpLink.com Company Code: SOM2002. If you are enrolled in an EPO medical plan, you may call the plan at the number on the inside cover of this guide. You may also contact the Employee Benefits Division at 410-767-4775 or 1-800-30-STATE (1-800-307-8283).

Behavioral Health Coverage for PPO and POS Plan Participants

TYPE OF SERVICE	IN-NETWORK CARE	OUT-OF-NETWORK CARE
Inpatient Facility and Professional Services	90% of allowed benefit when preauthorized by Plan	70% of allowed benefit
Partial Hospitalization Services	90% of allowed benefit	70% of allowed benefit
Residential Crisis Services	90% of allowed benefit when preauthorized by Plan	70% of allowed benefit
Outpatient Facility	90% of allowed benefit	70% of allowed benefit
Office and Professional Services (excluding Intensive Outpatient Services)	\$15 copay	70% of allowed benefit
Intensive Outpatient Services	\$15 copay	70% of allowed benefit
Outpatient Medication Management Services	\$15 copay	70% of allowed benefit
Short Plan Year Deductible Individual Family (Combined with Medical)	None	\$125 \$250
Short Plan Year Out of Pocket Maximum Individual Family (Combined with Medical)	\$500 \$1,000	\$1,500 \$3,000
Lifetime Maximum	Unlimited	

Behavioral Health Coverage for EPO Plan Participants

TYPE OF SERVICE	IN-NETWORK CARE	OUT-OF-NETWORK CARE
Inpatient Facility and Professional Services	100% of the allowed benefit when preauthorized by Plan	No Out-of-Network Coverage
Partial Hospitalization Services and Residential Crisis Services	100% of the allowed benefit	No Out-of-Network Coverage
Outpatient Facility	100% of the allowed benefit	No Out-of-Network Coverage
Office and Professional Services (excluding Intensive Outpatient Services)	\$15 copay	No Out-of-Network Coverage
Intensive Outpatient Services	\$15 copay	No Out-of-Network Coverage
Outpatient Medication Management Services	\$15 copay	No Out-of-Network Coverage
Annual Deductible Individual Family	None	No Out-of-Network Coverage
Annual Out of Pocket Maximum Individual Family	None	No Out-of-Network Coverage
Lifetime Maximum	Unlimited	No Out-of-Network Coverage

Prescription Drug Benefits (Must use in-network pharmacies for coverage)

The State of Maryland's prescription drug plan is administered by Express Scripts. Express Scripts can provide you with additional plan information, participating pharmacy locations, a preferred drug list, prescription costs and other plan information. Please see the inside front cover for Express Scripts' contact information. Outpatient prescription drug coverage is not included in any medical plan coverage. **You must enroll separately in the prescription drug benefits plan; there is a separate premium for this coverage.**

If you or your covered dependents are eligible for Medicare, you may have additional options for prescription drug coverage through Medicare Part D prescription drug plan. Please see the Notice of Creditable Coverage in this guide for more information.

HOW THE PLAN WORKS

Brand Name Versus Generic Medications

The State prescription drug plan only covers up to the cost of a generic medication when a generic is available. If you purchase a brand name medication when a generic medication is available, even if the brand name medication is prescribed by your doctor, you must pay the difference in price, plus the applicable copayment. The plan does not pass judgment on a physician's determination as to the appropriate medication for treatment, but the plan does have limitations as to the types and amounts of reimbursement available. This same rule applies to prescriptions filled either at a retail pharmacy or through home delivery from the Express Scripts PharmacySM.

Express Scripts maintains a preferred list of prescription drugs available at www.dbm.maryland.gov/benefits.



Preferred Brand Name Medications

Preferred brand name medications are those medications that Express Scripts has on its formulary (preferred medication list). This list is subject to change at any time. You can review and/or print the list at www.express-scripts.com. You may also call Express Scripts for a copy.

Express Scripts doctors and pharmacists evaluate the medications approved by the U.S. Food & Drug Administration (FDA). Each prescription medication is reviewed for safety, side effects, efficacy (how well it works), ease of dosage and cost. The medications that are judged best overall are selected as preferred brand name medications. Preferred medications are reviewed throughout the year and are subject to change.

Out-of-Pocket Copay Maximum

The annual out-of-pocket copayment maximum is:

-  Active Employees: \$500 per individual and \$750 per family
-  Retirees: \$750 per individual and \$1,000 per family

This means that when the total amount of copayments you and/or your covered dependents pay during the plan year reaches the annual out-of-pocket copayment maximum, you and your covered dependents will not pay any more copayments for eligible prescriptions for the remainder of the plan year (through December 31).

If you choose to purchase a brand name medication when a generic medication is available, the amount of the copayment will be counted toward your annual out-of-pocket copayment maximum, but the amount of the cost difference between the generic and brand name medication will not.

YOUR COST AT RETAIL PHARMACIES

When you have a prescription filled, your copayment is based on the type of medication and the quantity purchased.

Type of Medication	Prescriptions for 1-45 Days (1 copay)	Prescriptions for 46-90 Days (2 copays)
Generic	\$10	\$20
Preferred brand name	\$25	\$50
Non-preferred brand name	\$40	\$80

Active employees represented by Bargaining Unit I (SLEOLA) have a different rate schedule and plan design for medical and prescription drug benefits. Please visit the Employee Benefit Division's website for more information at www.dbm.maryland.gov/benefits.

YOUR COST THROUGH HOME DELIVERY PROGRAM

Home delivery from the Express Scripts Pharmacy delivers your maintenance medications, the prescription medications you take regularly to treat ongoing conditions, to your home with no cost for standard shipping. You may refill your medications online or by phone.

Visit www.StartHomeDelivery.com or call (877) 213-3867 to get started with home delivery service from the Express Scripts Pharmacy. Your cost for home delivery medications is the same as you would pay at the retail pharmacies, but home delivery offers the convenience of delivery to your home.

PRESCRIPTION DRUG MANAGEMENT PROGRAMS

Zero Dollar Copay for Generics Program

The copayment for specific classes of generic medications is zero dollars (\$0) at both retail and the Express Scripts Pharmacy home delivery program. The five drug classes, including some examples of generic medications covered under this program, are listed in the chart below. Not all generic drugs in these drug classes are covered under the Zero Dollar Copay for Generics Program.

If you are currently taking a brand name medication in one of these drug classes, please consult with your doctor to determine if a generic alternative is appropriate.

ZERO-DOLLAR COPAYMENT FOR GENERICS PROGRAM

Drug Class	Used to Treat	Generic Medication
HHG CoA Reductase Inhibitors (Statins)	High Cholesterol	simvastatin (generic Zocor) pravastatin (generic Pravachol)
Angiotensin Converting Enzyme Inhibitors (ACEIs)	High Blood Pressure	lisinopril (generic Zestril) lisinopril/HCTZ (generic Zestoretic) enalapril (generic Vasotec) enalapril/HCTZ (generic Vaseretic)
Proton Pump Inhibitors (PPIs)	Ulcer/GERD	omeprazole (generic Prilosec)
Inhaled Corticosteroids	Asthma	budesonide (generic Pulmicort Respules)
Selective Serotonin Reuptake Inhibitors (SSRIs)	Depression	fluoxetine (generic Prozac) paroxetine (generic Paxil) sertraline (generic Zoloft) citalopram (generic Celexa)
Contraception Methods	Prevention of Pregnancy	Oral Contraceptives, Diaphragm, Levonorgestrel (Generic Plan B)
Tobacco Cessation	Smoking	Bupropion (generic Zyban)

*The standards of quality are the same for generics as brand name. The FDA requires that all medications be safe and effective. When a generic medication is approved and on the market, it has met the rigorous standards established by the FDA with respect to identification, strength, quality, purity and potency.

Specialty Drug Management Program

CuraScript®, the Express Scripts specialty pharmacy, ensures the appropriate use of specialty medications. Many specialty medications are biotech medications that may require special handling and may be difficult to tolerate.

The specialty medications included in this program may be used for the treatment of rheumatoid arthritis, multiple sclerosis, blood disorders, cancer, hepatitis C or osteoporosis. Specialty medications will be automatically reviewed for step therapy, prior authorization and quantity of dosage limits. These specialty medications will be limited to a maximum 30-day supply per prescription per fill. Some of these specialty drugs are listed in the chart below.

NOTE: You will still be limited to paying just two copayments per 90 days of medication. On your first and second fill, you will pay the standard under 46 days fill copay. Your third fill will be at zero cost.

Disease	Specialty Medications in the Specialty Drug Management Program
Rheumatoid Arthritis	Cimzia, Enbrel, Humira, Kineret, Orencia, Orthovisc, Remicade, Euflexxa, Hyalgan, Supartz, Synvisc
Multiple Sclerosis	Avonex, Betaseron, Copaxone, mitoxantrone, Novantrone, Rebif, Acthar, HP, Tysabri
Blood Disorder	Aranesp, Arixtra, Epogen, Fragmin, Innohep, Lovenox, Nplate, Procrit, Leukine, Neulasta, Neupogen, Neumega, Proleukin, anti-hemophiliac agents
Cancer	Afinitor, Gleevec, Iressa, Nexavar, Revlimid, Sprycel, Sutent, Tarcva, Tasigna, Temodar, Thalomid, Treanda, Tykerb, Xeloda, Zolanza, Eligard, Plenaxis, Trelstar, Vantas, Viadur, Zoladex, Thyrogen, Aloxi IV, Anzemet IV, Kytril IV, Zofran IV
Hepatitis C	Alferon N, Copegus, Infergen, Intron A, Pegasys, Peg-Intron, Rebetol, ribasphere, ribavirin, Roferon-A
Osteoporosis	Forteo, Reclast
*This list is subject to change without notice to accommodate new prescription medications and to reflect the most current medical literature.	

CuraScript emphasizes the importance of patient care and quality customer service. As a CuraScript patient, you will have access to a team of specialists including pharmacists, nurse clinicians, social workers, patient care coordinators and reimbursement specialists who will

Active employees represented by Bargaining Unit I (SLEOLA) have a different rate schedule and plan design for medical and prescription drug benefits. Please visit the Employee Benefit Division's website for more information at www.dbm.maryland.gov/benefits.

work closely with you and your doctor throughout your course of therapy. CuraScript also provides an on-call pharmacist 24 hours a day, 7 days a week.

Prior Authorization Medications

Some prescription medications require prior authorization before they can be covered under the prescription drug plan. Your doctor will need to provide more information about why these medications are being prescribed so Express Scripts can verify their medical use (as opposed to being prescribed for cosmetic purposes). Prior authorization medications include, but are not limited to:

 Retin-A (Retin-A micro not covered)

 Dexedrine  Desoxyn

 Growth hormones  Adderall

When you go to the pharmacy to obtain a medication that requires prior authorization, the pharmacist will receive an electronic message from Express Scripts, which states that your medication cannot be covered until more information is sent by your doctor to Express Scripts. An Express Scripts representative will let your doctor know if the medication can be covered by your plan.

If the medication is approved, you and your doctor's office will be notified. Once you are notified of approval, you can return to your pharmacy to pick up your prescription.

If you are not approved for coverage, you may still purchase the medication, but you will pay the entire cost. This amount will not count toward the annual out-of-pocket copayment maximum. Prescription medications requiring prior authorization are subject to change at any time.

Please visit www.express-scripts.com for more information.

Medications with Quantity Limits

Some medications have limits on the quantities that will be covered under the State plan. Quantity limits are placed on prescriptions to make sure you receive the medication you need in the quantity considered safe. That is, you get the right amount to take the daily dose recommended by the FDA and medical studies.

Some medications with quantity limits include, but are


not limited to:

 Erectile Dysfunction medications

 Proton pump inhibitors

 Sedatives

 Hypnotics (e.g., sleeping pills)

 Nasal inhalers


When you go to the pharmacy for a prescription medication with a quantity limitation, your copayment will only cover the quantity allowed by the plan. You may still purchase the additional quantities, but you will pay the full cost. The cost of the additional quantities will not count toward your annual out-of-pocket copayment maximum.


The list of quantity limitation medications is subject to change at any time and is available by visiting www.express-scripts.com.

Step Therapy

Step therapy is a process for finding the best treatment while ensuring you are receiving the most appropriate medication therapy and helping to reduce prescription drug costs. Step therapy medications include Celebrex, Sporonox, and various Leukotriene Modifiers such as Singulair, Acculate, and ZyFlow.

Medications are grouped into two categories:

 **First-Line Medications:** These are the medications recommended for you to take first — usually generics, which have been proven safe and effective. You pay the lowest copayment for these.

 **Second-Line Medications:** These are brand name medications. They are recommended for you only if a first-line medication does not work. You almost always pay more for brand name medications.

These steps follow the most current and appropriate medication therapy recommendations.




Express Scripts will review your records for step therapy medications when you go to the pharmacy to fill a prescription. If your prescription is for a step therapy medication, the computer will search your prescription records for use of a first-line alternative.

If prior use of a first-line medication is not found, the second-line medication will not be covered. You will be

required to obtain a new prescription from your doctor for one of the first-line alternatives, or have your doctor request a prior authorization for coverage to receive benefits coverage.

DRUG EXCLUSIONS





Some medications are excluded from coverage, including, but not limited to:

-  Weight-loss medications
-  Vitamins and minerals (except for prescription pre-natal vitamins)
-  Prescription medications that are labeled by the FDA as “less than effective”




Refer to the Express Scripts’ State of Maryland website for a full list of excluded medications.

DIRECT MEMBER REIMBURSEMENT

If you or your covered dependent purchase a covered prescription medication without using your prescription drug card and pay the full cost of the medication, you must do the following for your out-of-pocket expenses to be considered for reimbursement:

-  Complete the Prescription Drug Claim Form. Forms may be obtained by calling Express Scripts (877) 213-3867 or by going to www.dbm.maryland.gov/benefits, click on Forms.
-  Attach a detailed pharmacy receipt. This includes medication dispensed, quantity and cost.
-  Send the information to Express Scripts by mail to the address listed on the bottom of the form.
-  If the amount you paid is equal to or less than your copayment, it is not necessary to send in claims for reimbursement. The copayment is the responsibility of the member and will not be reimbursed. However, if you have reached the annual out-of-pocket maximum, the copayment (or smaller) amount will be reimbursable.



NOTE:

-  All reimbursements are subject to plan terms and conditions and therefore may not be eligible for reimbursement.
-  All claims must be submitted within one year of the prescription fill date.
-  Please allow 2 to 6 weeks for your reimbursement check to arrive at your address on file.

Dental Benefits

YOUR CHOICES

Dental coverage is available to all individuals who are eligible for State health benefits. United Concordia offers two dental plans from which to choose:

-  **Dental Health Maintenance Organization (DHMO) plan**
-  **Dental Preferred Provider Organization (DPPO) plan**

HOW THE PLANS WORK

The DPPO Plan

Under this plan, you do not have to select a Primary Dental Office (PDO). You may receive services from any dentist of your choice when you need care. If you use an out-of-network dentist, you will need to submit a claim form for reimbursement and may be billed for the amount charged that exceeds the allowed benefit. No referrals are needed for specialty care. Orthodontia services are only covered for eligible dependent children (not employees) age 26 and younger.

When you use an in-network DPPO dentist, the in-network dentist will directly bill the plan for the amount the plan will pay, and will bill you for the amount you are required to pay under the plan.

You can access all of your dental information online any time on **My Dental Benefits**:

- Visit www.UnitedConcordia.com/statemd,
- Select **My Dental Benefits** and sign in or create an account, then
- View all your Explanations of Benefits (EOBs) under **Claims & Deductibles**.

For all claims that are covered in full, you will not receive an EOB in the mail from United Concordia.

For all claims not covered in full or if you are owed a reimbursement, you will receive an EOB in the mail.

The DHMO Plan

To enroll in the DHMO plan, you must reside within the Maryland service area (MD, DC, VA, DE, WV, or

PA). If you live outside of or move outside of the Maryland service area, please contact United Concordia to determine other plan options. In addition, you may request that the plan evaluate the dentist of your choice for inclusion in the network. However, there is no guarantee that a provider that you request will agree to participate in the plan network. In the DHMO plan, you can only receive coverage for services from a DHMO plan provider.

If you enroll in the DHMO plan, you must select a Primary Dental Office (PDO) from the United Concordia DHMO network of participating dentists. The DHMO allows you to select a different PDO for each member of your family. Your PDO will provide, or coordinate, all of your dental care services, including referrals to specialists.

You may change your PDO selection at anytime during the plan year by contacting United Concordia. The DHMO plan will only pay benefits for in-network coverage, unless it is an out-of-area emergency.

NOTE: It is strongly recommended that you contact your dental provider before enrolling in dental benefits and before each annual Open Enrollment period to be sure he/she still participates in the plan you have selected. The State cannot guarantee the continued participation of a particular provider in any of the benefit plans. If your dentist discontinues participation in the plan, is terminated from the network, or closes his/her practice to new patients, you will not be allowed to change your plan or withdraw from the plan until the next Open Enrollment period. If this happens, contact your dental plan to select another provider.

Out-of-Area Emergencies

The United Concordia DHMO will pay a maximum of \$50, subject to your fee schedule, for emergency dental services when you are traveling out of the area (more than 50 miles from your dentist's office). To receive payment for out-of-area emergency care, you must submit a bill itemizing the charges and services performed, and forward the claim to United Concordia for processing.

FOR MORE INFORMATION

If you have questions about the dental plans, refer to the inside cover of this book for phone numbers and websites of United Concordia.

Both the DHMO and DPPO plans offer a preventive benefit called The Smile for Health® Maternity Dental Benefit. This benefit provides pregnant women with an additional cleaning during the course of pregnancy, regardless of whether they have met the cleaning limitation. This benefit helps control periodontal disease, which has been linked to premature births and low birthweight babies and also helps address a common condition known as pregnancy gingivitis.

PREDETERMINATION OF BENEFITS







There is no requirement for you or your dentist to seek predetermination of benefits before treatment starts. However, you are encouraged to do so for major dental procedures so you and your dentist will know exactly what will be covered and what you will need to pay out-of-pocket.

What's Covered – DPPO Plan

Plan exclusions and limitations may apply. For more details visit My Dental Benefits at www.unitedconcordia.com/statemd.

Feature	Benefit Coverage (In-Network and Out-of-Network Services)
Short Plan Year deductible	\$25 per individual; \$75 per family Only applies to Class II and Class III services
Short Plan Year Out-of-Pocket Maximum	\$750 per participant; only applies to Class II and Class III services
Class I: Preventive services , initial periodic and emergency examinations, radiographs, prophylaxis (adult and child), fluoride treatments, sealants, emergency palliative treatment	Plan pays 100% of allowed benefit
Class II: Basic Restorative services , including composite/resin fillings, inlays, endodontic services, periodontal services, oral surgery services, general anesthesia, prosthodontic maintenance, relines and repairs to bridges, and dentures, space maintainers	Plan pays 70% of allowed benefit after deductible
Class III: Major services , including crowns and bridges, dentures (complete and partial), fixed prosthetics, implants	Plan pays 50% of allowed benefit after deductible
Class IV: Orthodontia (for eligible child(ren) only, age 26 or younger), diagnostic, active, retention treatment	Plan pays 50% of allowed benefit, up to \$2,000 lifetime maximum

What's Covered – DHMO Plan

-  No annual deductible or annual maximum.
-  The schedule of benefits on page 46 provides a list of common procedures covered by your Plan. For procedures that require a copayment the amount to be paid is shown in the column titled "Member Pays \$." You pay these copayments to the dental office at the time of service.
-  You must select a United Concordia Primary Dental Office (PDO) to receive Covered Services. Your PDO will perform the procedures or refer you to a Specialty Care Dentist for further care. Treatment by an out-of-network dentist is not covered, except as described in the Certificate of Coverage.
-  Only procedures listed on the Schedule of Benefits are Covered Services. For services not listed (not covered), you are responsible for the full fee charged by the dentist. Procedure codes and member copayments may be updated to meet American Dental Association (ADA) Current Dental Terminology (CDT) in accordance with national standards.
-  For a complete description of your Plan, please refer to the Certificate of Coverage and the Schedule of Exclusions and Limitations. Full list is available at www.dbm.maryland.gov/benefits.
-  If you have any questions about your United Concordia Dental Plan, please call their Customer Service Department toll free at 1-888-638-3384 or access Our Website at www.unitedconcordia.com/statemd.

DHMO – Common Services Fee Schedule

ADA CODE	ADA DESCRIPTION	MEMBER PAYS \$
0120	Periodic oral evaluation - established patient	0
0140	Limited oral evaluation - problem focused	0
0150	Comprehensive oral evaluation - new or established patient	0
0210	Intraoral - complete series of radiographic images	0
0220	Intraoral - periapical first radiographic image	0
0230	Intraoral - periapical each additional radiographic image	0
0272	Bitewings - two radiographic images	0
0274	Bitewings - four radiographic images	0
0330	Panoramic radiographic image	0
1110	Prophylaxis - adult	0
1120	Prophylaxis - child	0
1206	Topical application of fluoride varnish	0
1208	Topical application of fluoride (prophylaxis excluded) - through age 18	0
1351	Sealant - per tooth	0
2140	Amalgam - one surface, primary or permanent	0
2150	Amalgam - two surfaces, primary or permanent	0
2160	Amalgam - three surfaces, primary or permanent	0
2161	Amalgam - four or more surfaces, primary or permanent	0
2330	Resin-based composite - one surface, anterior	0
2331	Resin-based composite - two surfaces, anterior	0
2332	Resin-based composite - three surfaces, anterior	0
2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	70
2391	Resin-based composite - one surface, posterior	40
2392	Resin-based composite - two surfaces, posterior	60
2750	Crown - porcelain fused to high noble metal	276
2752	Crown - porcelain fused to noble metal	270
2790	Crown - full cast high noble metal	228
2792	Crown - full cast noble metal	264
2920	Recement crown	15
2950	Core buildup, including any pins	100
2954	Prefabricated post and core in addition to crown	108
3310	Endodontic therapy, anterior tooth (excluding final restoration)	108
3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	144
3330	Endodontic therapy, molar (excluding final restoration)	198
4341	Periodontal scaling and root planing - four or more teeth per quadrant	60
4910	Periodontal maintenance	30
7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	20
7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	27
7230	Removal of impacted tooth - partially bony	55
7240	Removal of impacted tooth - completely bony	65
9110	Palliative (emergency) treatment of dental pain - minor procedure	15
9220	Deep sedation/general anesthesia - first 30 minutes	205

PLEASE REFER TO THE DBM Website for a complete DHMO Copay Schedule at www.dbm.maryland.gov/benefits.

Flexible Spending Accounts (Active Employees only)

What is a Flexible Spending Account?

A Flexible Spending Account (FSA) is an account that allows you to set aside pre-tax dollars to pay for qualified healthcare or dependent day care expenses. This plan is administered by ConnectYourCare. You choose how much money you want to contribute to an FSA at the beginning of each plan year and can access these funds throughout the plan year. There are two types of FSAs, a Healthcare FSA and a Dependent Day Care FSA.

All FSA contributions are pre-tax, which means you save money by not paying taxes on the amount you set aside to pay for eligible healthcare and dependent day care expenses.

There are hundreds of eligible expenses for your FSA funds, including prescriptions, doctor office copays, health insurance deductibles and coinsurance for you, your spouse or eligible dependents, and day care for your eligible dependents while you work.

Claims for Same Sex Spouses and the dependent child(ren) of same sex spouses are not eligible for FSA reimbursement of claims or services for them unless they are your tax dependents as defined by the Internal Revenue Service (IRS).

This plan is intended not to discriminate in favor of highly compensated employees as to eligibility to participate, contribution and benefits in accordance with applicable provisions of the Internal Revenue Code. The Plan Administrator must take such actions as excluding certain highly compensated individuals from participation in the plan or limiting the contributions made with respect to certain highly compensated participants if, in the Plan Administrator's judgment, such actions serve to assure that the plan does not violate applicable nondiscrimination rules.

TAX SAVINGS WITH AN FSA

An FSA lets you set money aside for eligible healthcare and dependent day care expenses before taxes are taken from your paycheck. This means the amount of income you pay taxes on is reduced, and, as a result, you save money.

Let's look at how much the average State of Maryland employee saves with an FSA. This example below illustrates what your coworkers saved with an FSA last year.

	With FSA	Without FSA
Average employee pre-tax contribution to FSA	\$1,535	\$0
Tax savings from FSA contributions*	\$460	\$0
Average savings your coworkers enjoyed from their 2012 FSA	=\$460	=\$0

* Assuming 30% tax rate. Actual savings will vary based on your individual tax situation; please consult a tax professional for more information.

HEALTHCARE FLEXIBLE SPENDING ACCOUNT

You can use the Healthcare Flexible Spending Account to pay eligible healthcare expenses for yourself, your spouse, and your dependent children (as defined by the IRC Section 152 to include biological child, step-child, adopted child, eligible grandchild) who have not obtained age 27 by the end of the taxable year. You and your dependents(s) do not have to be covered under the State's other health plans to participate in an FSA. Same qualifying event rules apply to Healthcare Flexible Spending Accounts as medical plans.

The Healthcare Flexible Spending Account is used for your out-of-pocket healthcare expenses not paid by insurance, including deductibles, copays or coinsurance for eligible medical, prescription, dental, vision and certain eligible over-the-counter (OTC) items. There is a sample list of eligible expenses on page 50 of this guide.

You may contribute between \$60 and \$1,250 for this **Short Plan Year on a pre-tax basis** to your healthcare FSA to use for eligible out-of-pocket healthcare expenses. IRS regulations do not allow Healthcare FSA funds to roll over from one year to the next, so be sure to plan carefully when deciding how much to contribute.



Healthcare FSA	Minimum	Maximum
Annually	\$60.00	\$1,250.00
6 pay period deductions	\$10.00	\$208.33
12 pay period deductions	\$5.00	\$104.16
9 Pay Faculty Scheduled deduction*	\$6.66	\$138.88
* 9 pay faculty members must contact the Personnel Office of their respective institution to determine their pay schedule for the multiple deduction pay periods. Multiple deduction schedules differ by institution.		

SPECIAL NOTICE: FSA Distributions for Reservists

The Heroes Earning Assistance and Relief Tax Act of 2008 (HEART Act) allows plans to offer “qualified reservist distributions” of unused amounts in healthcare flexible spending accounts (FSAs) to reservists ordered or called to active duty for at least 180 days or on an indefinite basis. An Employee must request a qualified reservist distribution on or after the date of the order or call to active duty, and before the last day of the plan year (or grace period, if applicable) during which the order or call to active duty occurred. The Employee Benefits Division must receive a copy of the order or call to active duty (or extension thereof) to confirm compliance with the 180-day/indefinite requirement. To request a distribution of unused amounts contributed to the Health FSA, submit your request in writing along with a copy of your orders to the Employee Benefits Division before the last day of the plan year (December 31).

DEPENDENT DAY CARE FLEXIBLE SPENDING ACCOUNT

You can use the Dependent Day Care FSA to pay eligible expenses for the care of:

-  Your dependent children under age 13; and
-  A person of any age whom you claim as a dependent on your federal income tax return and who is mentally or physically incapable of caring for himself or herself.

The Dependent Day Care FSA covers dependent day care expenses that allow you (or you and your spouse, if

married) to work or look for work, or allow you to work and your spouse to attend school full-time. The care may be provided inside or outside of your home and may include things like day care, before- and after-school programs, summer day camp and pre-school tuition. You may only submit claims for dependent day care services already provided.

You may contribute between \$60 and \$2,500 for this Short Plan Year on a pre-tax basis (or between \$60 and \$1,250 a year pre-tax if married and filing separately), to your Dependent Day Care FSA to pay for eligible dependent day care expenses. IRS regulations do not allow Dependent Day Care FSA funds to roll over from one year to the next, so be sure to plan carefully when deciding how much to contribute.

Dependent Day Care FSA	Minimum	Maximum
Annually	\$60.00	\$2,500.00
6 pay period deductions	\$10.00	\$416.66
12 pay period deductions	\$5.00	\$208.33
9 Pay Faculty Scheduled deduction*	\$6.66	\$277.77
* 9 pay faculty members must contact the Personnel Office of their respective institution to determine their pay schedule for the multiple deduction pay periods. Multiple deduction schedules differ by institution.		

How FSAs Work

FSAs are very easy to use. Simply:

1. Decide how much to contribute to your FSA(s). This amount will be deducted from your paycheck throughout the plan year.
2. Use your healthcare payment card to pay for eligible Healthcare FSA expenses, or pay out of pocket and submit a reimbursement request. For Dependent Day Care FSA expenses, you will always pay out of pocket and submit a reimbursement request. Reimbursement requests for either FSA can be submitted online or by using the mobile app. Always keep your itemized receipts for all purchases! ConnectYourCare may request copies of receipts to verify/validate your claims at any time.





3. For easy reimbursement, sign up to receive all reimbursements through direct deposit to your checking or savings account on the ConnectYourCare website.
4. Check online or via the mobile app to see your balance(s) and to see if additional documentation is needed!

It's that easy!

You may be reimbursed from your Healthcare FSA at any time throughout the plan year for expenses up to the annual amount you elected to contribute. This means you have your full contribution amount available to you on the first day of the plan year. However, you may only be reimbursed from the Dependent Day Care FSA up to the amount contributed to that point. If you submit a reimbursement request for more than your current balance, it will be held until additional contributions have been added to your account during subsequent payroll deductions.

REIMBURSEMENT REQUESTS

For the Healthcare FSA, the easiest way to pay for eligible expenses is by using the healthcare payment card. But, when you are not able to use your card for Healthcare FSA purchases, and for all Dependent Day Care FSA purchases, you may pay out of pocket and then submit a reimbursement request.

-  First, when you pay for an eligible expense, keep your itemized receipt as documentation.*
-  Submit a claim online at www.connectyourcare.com/statemd or using the mobile application. (If you do not have web or mobile access, you may contact Customer Service to request a paper claim form.)
-  Click Add New Claim, and follow onscreen prompts to enter information about your claim.
-  Continue through the screens and submit the required documentation via the online upload feature, or by printing the Claim Submission form and submitting via fax or postal mail. If using CYC Mobile, you can submit documentation using your mobile device's camera!

*Important Documentation Information

In order to meet IRS regulations, documentation for FSA claims must contain five key pieces of information:

1. Who - Patient/Dependent's Name
2. What - Description of Service
3. When - Service Date(s)
4. Where - Provider Name
5. How Much - Payment Amount

Always remember to save your itemized receipts for all account purchases. Cancelled checks, credit card receipts or balance forward statements are not acceptable.

TIMELINE FOR USING ACCOUNT FUNDS

You must use all of your FSA funds by the date below or **remaining funds will be forfeited, in accordance with IRS regulations.** Be sure to plan carefully so you contribute the right amount.

Deadline for Eligible Expenses

You have until **March 15, 2014** to incur eligible expenses for your Healthcare FSA.

You have until **December 31, 2013** to incur eligible expenses for your Dependent Day Care FSA.

Deadline for Submitting Reimbursement Requests

For both the Healthcare FSA and the Dependent Day Care FSA, **you have until April 15, 2014 to submit claims for eligible expenses.** Remember, even though you have until April 15, 2014 to submit the claim, the service dates must be on or before the dates listed above.

HEALTHCARE ACCOUNT – ELIGIBLE EXPENSES

Sample eligible expenses include:

- ◆ Copays, coinsurance, and deductibles (but not premiums);
- ◆ Acupuncture;
- ◆ Birth control pills;
- ◆ Breast pumps and lactation devices;
- ◆ Childbirth classes;
- ◆ Chiropractic visits;
- ◆ Dental care;
- ◆ Diabetic supplies;
- ◆ Eye exams, glasses, and contacts;
- ◆ Hearing aids;
- ◆ Laser eye surgery;
- ◆ Orthodontia;
- ◆ Over-the-counter items*;
- ◆ Physical therapy;
- ◆ Prescription drugs;
- ◆ Psychotherapy;
- ◆ Smoking cessation programs;
- ◆ Speech therapy;
- ◆ Sterilization surgery; and
- ◆ Well-baby and well-child care.

* OTC items that contain a drug or medication require a prescription. Insulin, medical monitoring and testing devices, and other non-medicinal health items are eligible without a prescription.

HEALTHCARE ACCOUNT – WHAT IS NOT COVERED

Sample ineligible expenses include:

- ◆ Cosmetic procedures (unless required to restore appearance or function due to disease or illness);
- ◆ Expenses you claim on your income tax return;
- ◆ Expenses reimbursed by other sources, such as insurance plans;
- ◆ Fitness programs (unless medically necessary);
- ◆ Hair transplants;
- ◆ Illegal treatments, operations, or drugs;
- ◆ Insurance premiums, including COBRA;
- ◆ Prescription drug discount fees; and
- ◆ Weight loss programs for general well-being.

This is a sample list of OTC items that **may not be reimbursed under any circumstances**. These items are likely to be primarily for general health.

- ◆ Toothpaste, toothbrushes, dental floss;
- ◆ Make-up, lipstick, eye cream;
- ◆ Face cream, moisturizers;
- ◆ Perfume, body sprays, deodorants;
- ◆ Shampoos and soaps;
- ◆ Acne treatments (rarely reimbursable);
- ◆ Foot-care products;
- ◆ Hair loss treatments; and
- ◆ Dietary supplements and replacements (vitamins).

DEPENDENT DAY CARE ACCOUNT – ELIGIBLE EXPENSES

Sample eligible expenses include:

- ◆ Care of a child under age 13 at a day camp, nursery school, or by a private sitter for a child that lives in your home at least eight hours a day;
- ◆ Before- and after-school care (must be kept separate from tuition expenses);
- ◆ Care of an incapacitated adult who lives with you at least eight hours a day; and
- ◆ Expenses for a housekeeper whose duties include caring for an eligible dependent.

DEPENDENT DAY CARE ACCOUNT – WHAT IS NOT COVERED

Eligible dependent day care services cannot be provided by a person you are claiming as your dependent. You will need the Social Security or tax identification number of the person or facility that provides the care.

Sample ineligible expenses include:

- ◆ Education and tuition fees;
- ◆ Late payment fees;
- ◆ Overnight camps (in general);
- ◆ Sports lessons, field trips, clothing; and
- ◆ Transportation to and from a dependent day care provider.

HEALTHCARE PAYMENT CARD FREQUENTLY ASKED QUESTIONS

For your convenience, the Healthcare FSA comes with a healthcare payment card, providing you a convenient way to access funds and minimizing the hassle of submitting claim forms. Sometimes called an FSA debit card, this payment card allows you to directly access funds in your account. The card may be used for the Healthcare FSA only.

How does the payment card work?

The payment card is like a credit card, and it allows you to access your FSA funds quickly and easily. At many retailers, doctors' offices, vision centers, hospitals, pharmacies and grocery stores (for eligible over-the-counter items), your charges may be automatically verified as an eligible expense, reducing the need for you to submit receipts. You may still have to submit receipts for some of your purchases (per IRS regulations), **so you will need to keep your itemized receipts.**

When will my payment card expire?

Your card will remain active for three years from the date of issue; it is good through the last day of the month shown on

your card. Be sure to keep your card (even after your funds are depleted) for future plan years. When your card is nearing its expiration date, a new card will automatically be mailed to the address on file approximately two weeks before your current card expires.

What types of items may I purchase using my payment card?

Most eligible expenses can be paid for using the card, including prescriptions and certain over-the-counter items at most retailers, and doctors' charges at offices that accept major credit cards. Dependent Day Care FSA funds cannot be accessed using the card. Your card will not work at retail locations that do not offer healthcare items or medical services.

What if I am not able to use my card or forget to use it?

You may easily submit claims for reimbursement, either online or by using a paper form. This process will be necessary for all dependent day care expenses.







UPDATED IRS GUIDANCE ON THE USE OF HEALTHCARE PAYMENT CARDS FOR OVER-THE-COUNTER (OTC) MEDICINES

Due to healthcare reform, all OTC items containing a drug or medication, like cold medicine, allergy treatment, and pain relievers, now require prescriptions for reimbursement. Some retailers will accept your OTC prescriptions at the point of sale and will allow you to use your healthcare payment card for these items. However, for many of these purchases, you will have to pay out of pocket and submit an online or paper claim for reimbursement. Be sure to include a valid prescription along with your receipt in order to be reimbursed. Please refer to www.ConnectYourCare.com/statemd for more details.

USING YOUR ACCOUNT

www.ConnectYourCare.com/statemd




The FSA comes with an online account feature. Use your online account for the following features:




-  Get Account Balance
-  View Payment Card Charges
-  Enter a New Claim
-  View Claim Status
-  Find Answers to Frequently Asked Questions
-  Access WebMDSM Health Education Tools



CYC Mobile

ConnectYourCare's secure mobile application, CYC Mobile allows you to access all your healthcare account information from your mobile device. CYC Mobile allows you to:

-  View account balance, account alerts, and transaction history
-  View all claims
-  Submit a new claim

-  Photograph and upload claim documentation
-  Receive push notifications
-  View FAQs and click to call Customer Service

24/7 dedicated Customer service

You may also obtain your account balance using the automated telephone service. Simply call the Customer Service Center at 866-971-4646. However, if you ever need more information, customer service representatives are available 24 hours a day, seven days a week.

LEARN MORE!

Use the links or QR codes below to access quick and informative videos.

Want to better understand how FSAs provide tax savings?



Scan here with your smart phone or tablet or visit www.connectyourcare.com/fsasavings

Want to learn more about the FSA solution and features?



Scan here with your smart phone or tablet or visit www.connectyourcare.com/fsavideo

Love the idea of account access anytime, anywhere? Watch a quick demo of CYC Mobile.



Scan here with your smart phone or tablet or visit www.connectyourcare.com/mobilevideo

FOR MORE INFORMATION

If you have questions about the FSAs, call ConnectYourCare at 1-866-971-4646 or visit www.ConnectYourCare.com/statemd for a comprehensive list of eligible health and dependent day care expenses.

Term Life Insurance – New Carrier

Minnesota Life Insurance Company is the provider of your group life insurance program. Group Term Life insurance provides a base level of protection that can be enhanced by personal savings, individual life insurance and Social Security benefits. This coverage will help protect your family against the unexpected loss of your life and income during your working years. Remember, Term Life insurance has no cash value.

A life insurance policy pays at your death, but it's purchased to protect the life of someone you love. Take a moment to consider how much your family depends on your income, and secure their life by insuring yours.

LIFE INSURANCE CHOICES FOR ACTIVE EMPLOYEES

Coverage for Yourself

If you are a newly eligible employee you may elect coverage in \$10,000 increments up to a maximum of \$300,000.


If you are a public safety employee who performs scuba diving, or flying in or piloting helicopters as part of your job you may elect coverage in \$10,000 increments up to a maximum of \$500,000. You may choose up to \$50,000 guaranteed coverage without completing an EOI form. Guaranteed coverage must be elected within 60 days of your start date. If you select coverage greater than \$50,000 for yourself, or for coverage elected after your initial eligibility you must complete and submit an EOI form to Minnesota Life. Amounts over \$50,000 will not be in effect until Minnesota Life approves the additional coverage.





Coverage for Your Dependents

You may Elect coverage in a \$5,000 increment to a maximum of \$150,000. Coverage may not exceed half your life insurance amount. You may elect coverage up to the guaranteed coverage amount of \$25,000 for your Spouse and up to \$25,000 for your eligible child(ren), not to exceed half your life insurance amount, without providing EOI. If total coverage is greater than \$25,000, EOI will be required.

If electing coverage greater than the guaranteed maximums or after your initial eligibility, EOI is required.

PLEASE NOTE:

-  Dependent eligibility requirements for term life insurance are the same as the requirements for all other plans.

-  Dependents with life insurance who become ineligible may contact the plan for information to convert to an individual life insurance policy within 31 days. Please contact Minnesota Life at 1-866-883-3514.
-  Evidence of Insurability (EOI) forms can be found at www.LifeBenefits.com/Maryland
-  Rates change at the start of the plan year (July 1) when you reach the next age level.
-  The life insurance offered to you and your dependents is term life coverage. This type of life insurance has no cash value.

How the Plan Works During Active Employment

New Enrollment

For new enrollment in Group Term Life Insurance plan offered through the State to begin, you must be actively at work, employed by the State of Maryland, and performing services for compensation on regularly scheduled working days. Regularly scheduled working days do not include holidays, non-work days, vacations, or other scheduled leaves. Actively at work means that you have worked at least 20 hours over the last seven consecutive calendar days at either your usual place of employment or away from your usual place of employment at the agency's convenience, and that you are not currently on sick leave or other type of scheduled leave. If you do not enroll when first eligible, you will have to wait until the next Open Enrollment period.

Changing Coverage and When Coverage is Effective

If you are currently enrolled in the plan, you may continue at your current coverage level each plan year without medical review. If your election requires proof of good health, you must submit the Evidence of Insurability (EOI) form directly to Minnesota Life. Your increased coverage amount will become effective when you pay increased premiums on the later of:

- The first day of the new plan year;
- The date Minnesota Life approves your Evidence of Insurability; or
- The date you return to active service if you are out on paid or unpaid leave.





If your request for increased coverage is denied, your coverage will remain at your previous amount.

FOR MORE INFORMATION

If you have questions about how to report a death claim, portability/conversion requests or beneficiary information, please contact Minnesota Life at 1-866-883-3514 for more details.

ADDITIONAL BENEFITS

Access to the following services are available to all employees insured under the Minnesota Life group life insurance program, their spouses and dependent children. No additional premium or enrollment is required. Just access these resources as you need them.

-  **Legal Services** – Ceridian provides employees and their dependents telephone access to a national network of 22,000+ accredited attorneys for consultation on simple wills, estate planning documents and other legal issues. Discounts are available for participating attorneys. Contact Ceridian at 1-877-849-6034 or visit LifeWorks.com (user name: *will* password: *preparation*).
-  **Travel Assistance Services** – Global Rescue provides travel assistance services to all active U.S. employees covered under the group life insurance program and their spouses and dependents. The services are available 24/7/365 for emergency assistance and transport services when traveling 100 or more miles away from home. Pre-trip resources are also available. For more information, including program terms and conditions, visit LifeBenefits.com/travel or call 1-855-516-5433 in the U.S. and Canada. From other locations, you can call collect to +1-617-426-6603.
-  **Beneficiary Financial Counseling** – Beneficiaries who receive at least \$25,000 in policy benefits may choose to use independent beneficiary counseling services from PricewaterhouseCoopers LLP.
-  **Legacy Planning Services** – Active and retired employees, spouses and dependents can access resources designed to help individuals and families work through end-of-life issues when dealing with the loss of a loved one or planning for their own passing. These resources are available at LegacyPlanningServices.com.

Please note: Services provided by Ceridian, Europ Assistance USA, Global Rescue LLC, and PricewaterhouseCoopers LLP are their sole responsibility. The services are not affiliated with Minnesota Life or its group contracts and may be discontinued at any time. Certain terms, conditions and restrictions may apply when utilizing the services.

PLAN FEATURES

Accelerated Benefit

An Accelerated Benefit is available in the event of a terminal illness. An insured employee, spouse or child has the option for early access of up to 100% of the face amount of the insurance coverage, if the insured

person is medically certified by Minnesota Life to be terminally ill with less than 12 months to live, and has at least \$10,000 in coverage. (Active employees only.)

Waiver of Premium During Total Disability

If you become totally disabled before you reach age 60 and are enrolled in the term life insurance plan as an active State employee on your date of disability, you may be entitled to a waiver of premium after nine months of total disability. To apply for a waiver of premium, you must submit a waiver of premium application to Minnesota Life on the ninth month of your total disability. If approved, your premiums will be waived.

Once you are approved for a waiver of premium, life insurance coverage for you and your covered dependents will be directly through Minnesota Life. The coverage will end when you reach age 65 or when you are no longer disabled, whichever comes first. When your waiver of premium ends you will be eligible to convert your coverage to an individual life insurance policy by contacting Minnesota Life (Active employees only).

Conversion and Portability of Coverage

If you are no longer eligible for coverage as an active employee, you may port your Group Term Life insurance as well as your in force dependent life insurance (portable coverage ends at age 70) or you may convert your and your dependents life coverage to an individual life insurance policy. Premiums may be higher than those paid by active employees.

Please contact Minnesota Life at 1-866-883-3514.

Note: You only have 31 days from your termination date to select one of these options.

Learn more about your life insurance!

Discover life insurance

Learn how life insurance can protect your financial future.



Scan here with your smart phone or tablet or visit www.LifeBenefits.com/videos/term

Do you have enough life insurance?



Scan here with your smart phone or tablet or visit www.LifeBenefits.com/insuranceneeds to estimate your coverage needs.

No Duplication of Benefits or Enrollment

You cannot have duplicate life insurance coverage under the State plan. If you and your spouse are both State employees and/or retirees, and you cover yourself for life insurance, you cannot be covered as a dependent of your spouse. Also, children of State employees and retirees cannot have duplicate coverage under both parents. Minnesota Life will only pay benefits under one policy.

Beneficiaries

Minnesota Life requires a valid beneficiary designation on file. 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 default listed in Minnesota Life's certificate of group coverage. Benefits will be paid in equal shares to the first surviving class of the following:

- ✎ Your lawful spouse;
- ✎ Your natural and adopted children;
- ✎ Your parents;
- ✎ Your siblings; or
- ✎ Your estate.

Beneficiaries can be changed at any time throughout the year. Beneficiary designation forms are available from Minnesota Life's web site, www.LifeBenefits.com/Maryland.

plan while you were an active employee.

Your dependent's life insurance can never be more than half of your life insurance coverage amount.

Spouse or children who had life insurance as the dependent of a deceased retiree can only continue life insurance coverage through a conversion policy.

Automatic Reduction of Benefits for You and Your Dependents

Life Insurance benefits for you and your dependents will reduce automatically based on your age, according to the chart below. New retirees who are at least 65 at the time of retirement, and their covered dependents, will have an immediate reduction of benefits at the time of their retirement. The premiums are based on the reduced level of coverage and the current age bracket of each covered member. The benefit amount lost at the time of the reduction can be converted to an individual whole life insurance policy within 31 days of the reduction of coverage by calling Minnesota Life at 1-866-883-3514. The reduction schedule is as follows:

At Age...	Benefits Reduce To...
65	65% of your or your dependent's original amount
70	45% of your or your dependent's original amount
75	30% of your or your dependent's original amount
80	20% of your or your dependent's original amount

LIFE INSURANCE CHOICES UPON RETIREMENT

Coverage for Yourself

As of January 1, 1995, State retirees who retire directly from State service may:

- ✎ Continue life insurance at the same coverage level, subject to the age-related reduction schedule;
- ✎ Reduce life insurance coverage to a minimum of \$10,000, also subject to the age-related reduction;
- ✎ Cancel life insurance coverage; or
- ✎ Convert to an individual policy.

You cannot increase your life insurance coverage or add new dependents to your life insurance coverage upon retirement or at any time after retirement. If you choose to reduce or cancel life insurance coverage, you will not be permitted to increase coverage or re-enroll in the State Life Insurance plan in the future.

There can not be a break in life insurance coverage between active employment and retirement.

Coverage for Your Dependents

As a retiree, you may also choose to continue, reduce, or cancel your dependent life insurance coverage for any dependents who were covered under the life insurance

FOR MORE INFORMATION

If you have questions about conversion policies, limitations, definitions, restrictions, terminating events, or exclusions, please call Minnesota Life at 1-866-883-3514. Minnesota Life also has a dedicated website for the State of Maryland's Group Term Life Insurance Plan. The website address is www.LifeBenefits.com/Maryland. On this website, you can find beneficiary designation and change forms, as well as Evidence of Insurance forms.

Accidental Death and Dismemberment – New Carrier

Accidental Death and Dismemberment (AD&D) is available to all active employees and their dependents who are eligible for health benefits with the State. AD&D is offered through Minnesota Life Insurance Company. AD&D insurance provides beneficiaries with additional financial protection if an insured's death or dismemberment is due to a covered accident, whether it occurs at work or elsewhere. Evidence of insurability is not required.

You can choose individual or family coverage in an amount equal to:

 \$100,000  \$200,000  \$300,000

If you choose family coverage, your dependents are covered for a percentage of your benefit amount, as listed below:

NOTE: There is a maximum benefit of \$50,000 per covered dependent child.

Dependent	Benefit
Spouse (if you have children)	55% of your principal benefit amount
Spouse (if no eligible dependent children)	65% of your principal benefit amount
Eligible dependent children (if you have a spouse)	15% of your principal benefit amount
Eligible dependent children (if no spouse)	25% of your principal benefit amount

How the Plan Works

Benefits will be paid within 365 days of the date of an accident. The plan will pay a percentage of the principal benefit amount, depending on whether there is a loss of life or some type of dismemberment. If more than one covered loss is sustained during one accident, the plan will pay all losses up to the principal sum.

AD&D provides other benefits in the event of a covered loss. Additional benefits include:

- Exposure and disappearance;
- Education;
- Day care;
- Common disaster;
- Air Bag; Seat belt; Brain Damage; Coma;
- Common Carrier;
- Hospital Confinement.

ADDITIONAL BENEFITS

Access to the following services are available to all employees insured under the Minnesota Life group life insurance program, their spouses and dependent

AD&D Benefits Chart	
EMPLOYEE LOSS	BENEFIT AMOUNT
Loss of life	100%
Both hands or both feet	100%
Entire sight of both eyes	100%
One hand and one foot	100%
One hand and entire sight of one eye	100%
Speech and hearing (both ears)	100%
Quadriplegia	100%
Paraplegia	75%
One Arm	75%
One Leg	75%
One hand or one foot	50%
Entire sight of one eye	50%
Speech or hearing	50%
Hemiplegia	50%
Thumb and index finger of same hand	25%

children. No additional premium or enrollment is required. Just access these resources as you need them.

-  **Legal Services** – Ceridian provides employees and their dependents telephone access to a national network of 22,000+ accredited attorneys for consultation on simple wills, estate planning documents and other legal issues. Discounts are available for participating attorneys. Contact Ceridian at 1-877-849-6034 or visit LifeWorks.com (user name: will password: preparation).
-  **Travel Assistance Services** – Global Rescue provides travel assistance services to all active U.S. employees covered under the group life insurance program and their spouses and dependents. The services are available 24/7/365 for emergency assistance and transport services when traveling 100 or more miles away from home. Pre-trip resources are also available. For more information, including program terms and conditions, visit LifeBenefits.com/travel or call 1-855-516-5433 in the U.S. and Canada. From other locations, you can call collect to +1-617-426-6603.
-  **Beneficiary Financial Counseling** – Beneficiaries who receive at least \$25,000 in policy benefits may choose to use independent beneficiary counseling services from PricewaterhouseCoopers LLP.
-  **Legacy Planning Services** – Active and retired employees, spouses and dependents can access resources designed to help individuals and families work through end-of-life issues when dealing with the loss of a loved one or planning for their own passing. These resources are available at LegacyPlanningServices.com.

FOR MORE INFORMATION

If you have questions about coverage, conversion policies, limitations, definitions, restrictions, terminating events, or exclusions, please call Minnesota Life at 1-866-883-3514. Minnesota Life also has a dedicated website for the State of Maryland's Group Term Life Insurance Plan. The website address is: www.LifeBenefits.com/Maryland. On this website, you can find a AD&D beneficiary designation forms, as well as information about the plan.

Long Term Care Insurance

Long Term Care (LTC) is help or supervision provided for someone with severe cognitive impairment or the inability to perform the Activities of Daily Living, including bathing, dressing, eating, toileting, transferring, and continence. Services may be provided at home or in a facility and care may be provided by a professional or informal caregiver, such as a friend or family member.

The Long Term Care (LTC) Insurance plan is offered through The Prudential Insurance Company of America (Prudential LTC).

Commonly Asked Questions

Why do I need LTC Insurance?

Your odds of needing Long Term Care Insurance may be greater than you think. More than 2 in 5 people over the age of 65 will require nursing home care at some time in their lives.¹ It could be the result of spinal cord injury, heart attack, stroke, or age-related illness such as Parkinson's Disease or Alzheimer's Disease.

How expensive is LTC?

In Maryland, it can cost over \$87,600 a year for nursing home care alone.² When people suddenly find themselves the primary caregiver for a loved one, the responsibility could result in a huge financial and emotional burden.

Isn't care covered by other insurance?

Disability income insurance provides no benefits for the services covered by LTC insurance – while Medicaid and Medicare have significant limitations.

Am I too young for LTC insurance coverage?

It's never too early to purchase coverage. You may be surprised to learn that 40% of LTC insurance benefit recipients are under the age of 65.³ And the younger you are when you first purchase Long Term Care Insurance, generally the lower your premium for the life of your plan, regardless of your age or health status in later years.

What happens to my coverage if I leave employment with or retire from the State of Maryland?

The LTC Insurance plan is portable. If you leave employment with or retire from the State, you can take your LTC Insurance coverage with you. (Premiums and coverage will not change, but payment must be made directly to Prudential.)

Are LTC premiums pre-tax deductions?

No. Under Federal guidelines, LTC premiums cannot be pre-tax deductions.

Can retirees and family members enroll in LTC insurance coverage?

Yes. State retirees and family members must provide medical history to be approved for coverage and payments are made directly to Prudential.

Guaranteed Issue for Actively-at-Work Employees Who Enroll Within 60 Days of Their Date of Hire

If you are a new, permanent, actively-at-work State of Maryland/Satellite Account employee who works at least 20 hours per week, you can receive guaranteed issue coverage if you enroll within 60 days of your date of hire. That means you do not have to provide medical history to be approved for coverage. Employees enrolling with guaranteed issue must be actively at work on coverage effective date. Current State employees, State retirees and all family members covered by active employees or retirees who do not enroll when first hired must provide medical history to be approved for coverage.

¹ "Long Term Care Insurance: Who Really Needs It?", Journal of Financial Planning, Sept. 2004

² Long Term Care Cost Study, Prudential Research Report, 2010

³ Americans for Long-Term Care Security (ALTCS), "Did You Know," 2005, www.ltcweb.org/learn.html#di

YOUR CHOICES

LTC Insurance is available to all actively at work full-time and part-time State of Maryland/Satellite Account employees working at least 20 hours per week, State retirees, and their family members. Unlike other plans outlined in this guide, coverage may be elected for more than you and your dependents. Coverage under the LTC plan is offered to:

- 🔥 Legal Spouses;
- 🔥 Parents (in-laws included);
- 🔥 Grandparents (in-laws included);
- 🔥 Children age 18 or older and their spouses; and
- 🔥 Siblings of Employees and their Spouses.

For each individual you choose to cover, you must select one of the plans listed below.

Plan Option	Nursing Home Care & Assisted Living Facility Daily Maximum*	Home & Community-Based Care Daily Maximum	Lifetime Maximum**
Plan 1	\$100	\$50	\$109,500
Plan 2	\$150	\$75	\$164,250
Plan 3	\$200	\$100	\$219,000
Plan 4	\$250	\$125	\$273,750
Plan 5	\$100	\$50	\$219,000
Plan 6	\$150	\$75	\$328,500
Plan 7	\$200	\$100	\$438,000
Plan 8	\$250	\$125	\$547,500

* Benefits are paid up to the daily maximum.

** All benefits paid will be deducted from the lifetime maximum, except for Private Care Management.

HOW THE PLAN WORKS

In order to receive benefits, you must be confirmed as having a chronic illness or disability by a licensed healthcare practitioner.

A qualifying chronic illness or disability is one in which there is:

- 🔥 A loss of the ability to perform, without substantial assistance, at least two of the Activities of Daily Living (ADLs). This loss must be expected to continue for at least 90 days. ADLs are bathing, continence, dressing, eating, toileting, and transferring; or
- 🔥 A severe cognitive impairment, which requires substantial supervision to protect you from threats to your health and safety.

Benefit Waiting/Elimination Period

Before you can receive benefits, you must satisfy the 90-day benefit waiting/elimination period. This period is counted in calendar days and begins on the date you are assessed, if you are determined to be eligible for benefits. You do not need to receive formal LTC services to satisfy the waiting period, and this waiting period only needs to be satisfied once during the period you are covered by the Prudential LTC plan.

There is no waiting period for hospice care, Home Support Services, respite care, information and referral services, or private care management.

Guaranteed Purchase Option

As part of the plan, you may increase your coverage on a periodic basis without submitting any additional health information. Inflation protection will be offered every three years to individuals who do not elect the optional automatic inflation protection feature.



FOR MORE INFORMATION

For more information, to enroll, or to download enrollment forms:

- Visit www.prudential.com/gltcweb/maryland
- Call 1-800-732-0416, Monday through Friday, 8:00 a.m. to 8:00 p.m., ET.

Optional Features

You may customize your plan to meet your needs and the needs of your family members by choosing either of these optional features:

-  Automatic inflation protection – coverage amounts increased at least 5% per year, compounded annually
-  Non-forfeiture shortened benefit period – allows you to retain access to a portion of the benefits if you stop paying premiums (after at least three years)

Keep in mind that choosing optional features will increase your premium amount.

Additional Benefits

The LTC Insurance plan through Prudential also offers these additional benefits:

-  Bed reservation;
-  Hospice care;
-  Respite care;
-  Home Support Services;
-  Informal care;
-  Information and referral services;
-  Private care management;
-  Alternate plan of care;
-  Death benefit;
-  Cash alternative;
-  International coverage benefit; and
-  Marriage discount.

Coverage Exclusions

Your Coverage is designed to provide benefits to pay for your Qualified Long-Term Care Services. Your Coverage does not provide benefits for any of the following.

- 1) Work-connected Conditions Charge. A charge covered by a worker's compensation law, occupational disease law or similar law.
- 2) Illness, treatment or medical conditions arising out of
 - a) War or an act of war, whether declared or undeclared, while you are insured; or
 - b) Your participation in a felony, riot or insurrection; or
 - c) Alcoholism and drug addiction.

- 3) Treatment provided in a government facility, unless payment of the charge is required by law or services provided by any law or governmental plan under which you are covered. This does not apply to a state plan under Medicaid, to services paid for or provided by the Maryland Department of Health and Mental Hygiene, or to any law or plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program.
- 4) Charges for services or supplies for which no charge would be made in the absence of insurance.
- 5) Charges for care or treatment provided outside the United States except as described in the International Coverage benefit.
- 6) Charges arising from intentionally self-inflicted injury or attempted suicide.
- 7) Prohibited Practitioner Referral. Payment of any claim bill or demand or request for payment for healthcare services that the appropriate regulatory board determine were made as a result of a prohibited referral.

Non-Duplication of Medicare Benefits

Benefits under your Coverage are not payable for expenses for Qualified Long-Term Care Services to the extent that:

- 1) Such expenses are reimbursable under Medicare; or
- 2) Such expenses would be reimbursable under Medicare but for the application of a deductible or coinsurance amount.

This provision does not apply if following situations apply.

- 1) Such expenses are reimbursable by Medicare as a secondary payer.
- 2) Claim is under the Cash Alternative Benefit, Cash Benefit or Flexible Cash Benefit, if any.

Important Notices and Information

Employee Fraud and Abuse

Fraud, abuse and unethical conduct in connection with the benefits provided through the State Employee and Retiree Health and Welfare Benefits Program is a serious issue. Fraud and abuse can take many forms, including:

- Adding a dependent to your coverage who you know is not eligible for coverage;
- Submitting false or altered affidavits or documentation as part of adding or removing a dependent;
- Letting someone else who is not covered under your enrollment use your insurance card to get health benefits or services;
- Lying to get coverage or access to health benefits (such as prescription drugs or treatments) that are not medically necessary;
- Giving or selling your prescriptions to another person; or
- Submitting reimbursement requests for health benefits or services that were not provided.

The Department of Budget and Management Employee Benefits Division must investigate allegations of fraud and abuse; each plan and benefit option has programs to look for and eliminate fraud and abuse. If fraud or abuse is determined to have taken place, there can be serious consequences, including:

- Lock-down of your prescription benefits to only one doctor or pharmacy;
- Termination of coverage; or
- Seeking repayment or reimbursement of any claims or premiums for benefits that were inappropriately paid.

There may also be serious criminal or civil consequences.

Notice About Disclosure and Use of Your Social Security Number

A federal mandatory reporting law (Section 111 of Public Law 110-173) requires group health plans to report, as directed by the Secretary of the Department of Health and Human Services, information that the Secretary requires for purposes of coordination of benefits. Two key elements that will be required to be reported are social security numbers (SSNs) of covered individuals (or HICNs) and the plan sponsor's employer identification number (EIN). In order for Medicare to properly coordinate Medicare payments with other insurance and/or workers' compensation benefits, Medicare relies on the collection of both the SSN or HICN and the EIN, as applicable. As a member (or spouse or family member of a member) covered by a group health plan arrangement, your SSN and/or HICN will likely be requested in order to meet the requirements of this law. To get more information about the mandatory reporting requirements under this law,

visit the CMS website at www.cms.hhs.gov/MandatoryInsRep.

In addition, because of the tax benefits of employer-sponsored health benefits coverage, we need your SSN to make sure your income tax and other employment-related taxes are calculated and withheld from your paycheck properly.

LEAVE/CONTINUATION OF COVERAGE/COBRA

While on Leave of Absence

If you take a Leave of Absence Without Pay (LAW) you may continue the same health benefits coverage by electing to enroll and paying the full cost of your premiums.

If you take a leave of absence pursuant to the **Family Medical Leave Act (FMLA)**, special rules govern the continuation of your health benefits. You have several options to consider for your health benefits coverage while you are on FMLA leave, including whether to keep your coverage in place or drop it and how to pay for health benefits coverage while you are on FMLA leave. You should review the options and make an informed decision. Contact your Agency Benefits Coordinator for details and visit the Employee Benefits Division website.

Short-Term LAW

If you are on short-term LAW (two pay periods or less for employees who are paid bi-weekly; up to 28 days), and it is neither FMLA leave nor due to a job-related accident or injury (LAW-OJI), you must pay the full cost (both employee share and State subsidy) of all missed premiums. You will receive a "No Pay" bill from the Employee Benefits Division for your missed premiums. Deductions may resume if you return to work before the due date on the "No Pay" bill. However, payment for the missed premiums is still due as you are not allowed to have a break in your benefits coverage. If you do not pay by the due date on the "No Pay" bill, your benefits coverage may be cancelled for the rest of the plan year.

If your short term LAW is due to a job-related accident or injury (LAW-OJI), or an approved FMLA leave, you are entitled to the maximum State subsidy and are responsible for the employee's share of the premium only. When you receive your bill, please contact your Agency Benefits Coordinator, who will complete a retroactive adjustment form and collect your portion of the premiums. You must make up missed premiums within the requested timeframe or your benefits coverage will be cancelled. Payment deadlines are strictly enforced.

Long-Term LAW

If you are on a leave of absence without pay for more than two bi-weekly pay periods (more than 28 days), your leave is considered a long-term LAW. If you are on an approved long-term LAW, you may elect to continue or discontinue health insurance for the duration of the LAW. You may elect to continue your benefits during long-term LAW for up to two years.

You must notify the Employee Benefits Division of your coverage election within 60 days of beginning your long-term LAW. You cannot retroactively terminate benefits and you may be required to pay the full premium for any period of coverage during your long-term LAW that has elapsed prior to your notification to terminate benefits during your long-term LAW.

If you wish to continue your coverage, you must complete a Direct Pay enrollment form and submit it to your Agency Benefits Coordinator. This enrollment form should be completed as soon as you know you will miss two pay periods or more. The enrollment form will not be accepted any later than 60 days after the effective date of the LAW.

You may continue any or all of your current health benefit plans, or you may reduce your coverage level when enrolling for LAW benefits. **However, you may not change plans until the next Open Enrollment period or within 60 days of a qualifying event, the same as an active employee.**

Once enrolled in coverage while on LAW, you are responsible for the full premium cost unless the LAW is due to a job-related accident or injury or an approved FMLA leave. If you are entitled to the State subsidy, your Agency Benefits Coordinator must have the Agency Fiscal Officer complete the applicable section of the Direct Pay enrollment form. The Employee Benefits Division will bill you for the appropriate amount due.

Coupons and Payments

All State employees who are on a Leave of Absence without Pay will be mailed payment coupons to the address on file. If paying via check or money order, the payment coupon must be included with your payment and mailed to the address indicated on the payment coupon cover letter. You also have the option to pay online by going to www.dbm.maryland.gov/benefits click on "Pay Your Direct Pay Coupons Here." Your benefits will be effective as of the date noted on your payment coupon cover letter, but no claims will be paid until the Employee Benefits Division receives your payment. Payments are due the first of every month with a 30-day grace period.

All benefits are inactive until payment is received for each month. Payment may be made in advance to cover any or all coupon(s) received, but must be made in full monthly increments. If payment is not received by the end of the 30-day grace period, your coverage will be cancelled. There will be a break in your coverage until you return to work and request re-enrollment in health benefits. This request

for re-enrollment must be made through your Agency Benefits Coordinator within 60 days of your return to work.

Payment deadlines are strictly enforced. If you do not receive these coupons within one month of signing your enrollment form or if you change your mailing address, please contact your Agency Benefits Coordinator or the Employee Benefits Division immediately.

Leave of Absence – Military

Employees on Active Duty

In recognition of the tremendous service of our employees who serve as members of the armed forces, the State of Maryland permits employees on active military duty to elect to continue their medical, dental, and prescription benefits at the same coverage level in effect prior to the start of their military duty. The State will pay the full cost of coverage, both the employee and State share of premiums. State employees on active military duty may elect to continue coverage for accidental death and dismemberment insurance, life insurance, or flexible spending accounts by remitting payment for this coverage directly to the Employee Benefits Division. If elected, the employees will be sent payment coupons to the address on file.

To continue your benefits under due to being on active military duty, please see your Agency Benefits Coordinator to complete the LAW-Military Notification Form. Please provide a copy of your active military orders to your Agency Benefits Coordinator to be submitted with the LAW-Military Notification Form. If these orders expire, you will need to provide your Agency Benefits Coordinator with updated orders in order to continue Active Military Leave coverage with the State of Maryland.

If you have questions concerning your benefits while on active military leave, please contact your Agency Benefits Coordinator.

Employees Returning from Active Duty

When an employee is returning from active duty, he/she should contact his/her Agency Benefits Coordinator to complete an Active enrollment form. The completed enrollment form should be sent to the Employee Benefits Division along with the employee's discharge paperwork.

COBRA and Continuation of Coverage

You and/or your dependents may elect to continue your Health, Prescription Drug, Dental, and Healthcare Spending Account participation, using post-tax premium payments, for a timeframe determined in accordance with Federal regulations.

If you or one of your dependents experiences a COBRA or Continuation of Coverage qualifying event (as described on the chart on page 61), you or your dependent may be eligible to continue the same health benefits that you or

(continued on pg. 62)

NOTE: Loss of coverage through an Open Enrollment transaction in and of itself is not a qualifying event. You must have a qualifying event listed below to enroll in continuation coverage.

Summary of Continuation of Coverage Conditions		
QUALIFYING EVENT	PERSON AFFECTED	LENGTH OF CONTINUATION COVERAGE
Termination of employment (other than for gross misconduct), including layoff or resignation of employee	<ul style="list-style-type: none"> ◆ Employee ◆ Spouse ◆ Dependent Child(ren) 	18 months or until eligible for coverage elsewhere, including Medicare*, whichever occurs first
Dependent child(ren) of an employee or retiree no longer meets the dependent eligibility requirements	◆ Dependent Child(ren)	36 months or until eligible for coverage elsewhere, including Medicare*, whichever occurs first
Death of employee or retiree	<ul style="list-style-type: none"> ◆ Spouse ◆ Dependent Child(ren) 	36 months or until eligible for coverage elsewhere, including Medicare*, whichever occurs first
Divorce, limited divorce/legal separation NOTE: A legally separated spouse who is still legally married to the employee remains eligible for coverage.	<ul style="list-style-type: none"> ◆ Former Spouse ◆ Step-child(ren) of employee or retiree 	Indefinitely or until remarriage or until eligible for coverage elsewhere, including Medicare, whichever occurs first COBRA coverage includes the ability to enroll with dependents that meet the eligibility criteria. If enrolled separately, 36 months or until eligible for coverage elsewhere, including Medicare*, whichever occurs first
Qualifying Events After the Start of COBRA (Second Qualifying Events)		
QUALIFYING EVENT	PERSON AFFECTED	LENGTH OF CONTINUATION COVERAGE
Divorce or legal separation from COBRA participant	<ul style="list-style-type: none"> ◆ Spouse ◆ Step-child(ren) of participant 	36 months from the original qualifying event or until eligible for coverage elsewhere, including Medicare*, whichever occurs first
Dependent child(ren) of a COBRA participant who no longer meets the dependent eligibility requirements	◆ Child(ren)	36 months from the original qualifying event or until eligible for coverage elsewhere, including Medicare*, whichever occurs first
Total and Permanent Disability of the employee or retiree (as defined by the Social Security Act) within the first 60 days of COBRA coverage	<ul style="list-style-type: none"> ◆ Employee ◆ Spouse ◆ Dependent Child(ren) 	The 18 months can be extended to 29 months at increased premiums equal to 150% of usual premiums for the additional 11 months.

* If you are enrolled in Medicare Parts A & B before leaving State service, you are entitled to elect continued coverage at the full COBRA rate. If you become entitled to Medicare while on COBRA, you will not be able to continue your medical coverage after your Medicare entitlement date. You may, however, continue your prescription drug and dental coverage as desired. If you have dependents on your COBRA coverage when you become entitled to Medicare, your dependents may elect to continue their coverage on COBRA.

your dependents were enrolled under at the time of the qualifying event.

If coverage is continued under these provisions, you and/or your dependents will be responsible for paying 100% of the premiums, plus an additional 2% of the premium to defray administrative costs. If payment is not received by the end of the grace period, your benefits will be terminated. If your enrollment is cancelled because you did not make the required payment, you will not have the opportunity to enroll again.

Coupons and Payments

All COBRA or Continuation of Coverage enrollees will be mailed payment coupons to the address on file. If paying via check or money order, the payment coupon must be included with your payment and mailed to the address indicated on the payment coupon cover letter. You also have the option to pay online by going to www.dbm.maryland.gov/benefits click on "Pay Your Direct Pay Coupons Here." Your benefits will be effective as of the date noted on your payment coupon cover letter, but no claims will be paid until the Employee Benefits Division receives your payment. Payments are due the first of every month with a 30-day grace period.

All benefits are inactive until payment is received for each month. Payment may be made in advance to cover any or all coupon(s) received, but must be made in full monthly increments. If payment is not post-marked by the end of the 30-day grace period, your COBRA coverage will be cancelled and you will not be permitted to re-enroll.

Payment deadlines are strictly enforced. If you do not receive these coupons within one month of signing your enrollment form, or you change your mailing address, please contact the Employee Benefits Division immediately.

The following memorandum entitled General Notice of COBRA and Continuation of Coverage Rights reviews your rights and responsibilities. It is important for you to review it carefully with all covered dependents. If you have questions about a qualifying event or continuation of coverage, please contact the Employee Benefits Division.

GENERAL NOTICE OF CONTINUATION OF COVERAGE (COBRA) RIGHTS

The Employee Benefits Division has processed an enrollment for you as the employee/retiree, spouse, or covered dependent in the State Employee and Retiree Health and Welfare Benefits Program. This notice on possible future group health insurance continuation coverage rights applies individually to the active member (employee or retiree), the member's spouse and all covered dependent child(ren) enrolled under the State's benefits program. It is important that all covered individuals take the time to read this notice

carefully and become familiar with its contents. If you are the employee, and if there is a covered dependent whose legal residence is not yours, please provide written notification of that covered dependent's address to the Employee Benefits Division so a notice can be sent to that covered dependent as well.

You are receiving this notice because you have health benefits coverage under the State Employee and Retiree Health and Welfare Benefits Program (the Program). The Department of Budget and Management Employee Benefits Division administers the Program. The Program sponsored by the State of Maryland is a governmental group health plan covered by the Public Health Service Act, which includes the COBRA continuation of coverage provisions described in this Notice. This Notice explains continuation coverage rights for only these health benefits offered through the Program: the medical PPO, the medical POS, the medical EPO, the prescription plan, the dental PPO, the dental HMO and the Healthcare Flexible Spending Account. You may be enrolled in one or more of these benefits. This Notice does not apply to any other benefits offered by the State of Maryland or through the Program, such as the Dependent Day Care Flexible Spending Account, life insurance benefit, long term care benefit, or accidental death and dismemberment insurance benefit.

Under federal law, group health plans like the Program must offer covered employees and covered family members the opportunity for a temporary extension of health coverage (called COBRA) at group rates when coverage under the health plan would otherwise end due to certain qualifying events. In this Notice, the term "covered employee" also means "covered retiree." This Notice is intended to inform all plan participants of potential future options and obligations related to COBRA. Should an actual qualifying event occur in the future, the State of Maryland would send you additional information and the appropriate election notice at that time. Please take special note, however, of your notification obligations, highlighted in this Notice on page 61.

Who is Entitled to Elect COBRA Continuation Coverage?

Qualifying Events For Covered Employee

If you are the covered employee, you may have the right to elect COBRA coverage if you lose group health coverage because of the following qualifying events: termination of your employment (for reasons other than gross misconduct on your part), resignation, layoff, or a reduction in your hours of employment.

Qualifying Events For Covered Spouse

If you are the covered spouse of an employee, you may have the right to elect COBRA coverage for yourself if you lose group health coverage under the Program because of any of the following qualifying events:

- ◆ A termination of your spouse's employment, including resignation and layoff, (for reasons other than gross misconduct);
- ◆ A reduction in your spouse's hours of employment;
- ◆ The death of your spouse;
- ◆ Divorce from your spouse. If your spouse (the employee or retiree) reduces or eliminates your group health coverage in anticipation of your divorce and your divorce happens soon after that, then the divorce may be considered a qualifying event for you even though you lost coverage earlier than the date of the divorce. The rules of Program do not require you to lose coverage if you and your spouse are legally separated if you are still legally married to the employee or retiree.

Qualifying Events For Covered Dependent Children

If you are the covered dependent child of an employee, you may have the right to elect COBRA coverage for yourself if you lose group health coverage under the Program because of any of the following qualifying events:

- ◆ A termination of the employee's employment (for reasons other than gross misconduct);
- ◆ A reduction in the employee's hours of employment;
- ◆ The death of the employee;
- ◆ Parent's divorce or, if applicable, legal separation;
- ◆ You cease to be a "dependent child" under the terms of the Program.

Special Rule for newly born or adopted children: If a covered employee qualified beneficiary has or adopts a child during a period of COBRA continuation coverage, the new child may be eligible for COBRA continuation coverage that runs for the same period as your coverage. The child must meet the eligibility requirements of the Program.

Other important points: The plan administrator reserves the right to verify eligibility status and to terminate continuation coverage retroactively if a qualified beneficiary is determined to be ineligible or if there has been a material misrepresentation of the facts.

A qualified beneficiary does not have to show they are insurable to elect COBRA or Continuation of Coverage. However, they must have been covered by the Program on the day before the event to be eligible for continuation coverage.

When is COBRA or Continuation of Coverage available?

Coverage starts from the day you lose coverage due to a qualifying event – usually the end of the payroll deduction period in which the qualifying event occurred. When the qualifying event is the end of employment, reduction of employment hours or death of the employee, the Program will offer this coverage to qualified beneficiaries. Qualified beneficiaries are the employee, the spouse and the dependent children who lost group health coverage as a

result of the qualifying event. You will not need to notify the Employee Benefits Division of any of these three qualifying events because your employing agency should notify the Employee Benefits Division of those events. You will need to notify the Employee Benefits Division of any other qualifying event.

Important: Notifications Required By the Employee, Spouse and Dependent

For the other qualifying events (divorce, and a covered dependent ceasing to meet the definition of a "dependent" under the Program's rules), you must notify the Employee Benefits Division within 63 days of the later of these two dates: (1) the date of the event or (2) the date on which health plan coverage would be lost under the terms of the Program because of the qualifying event. If you do not notify the Employee Benefits Division of the qualifying event within 63 days, you will lose the right to elect COBRA or Continuation of Coverage. Under federal law, this is the responsibility of all employees, spouses and covered dependent children (or the parent of covered dependent children).

To provide the required notification, you must contact the Employee Benefits Division and request that a Direct Pay Enrollment form be mailed to you. You then fill out the form, attach documentation of the qualifying event (e.g. copy of divorce decree), and mail to: Employee Benefits Division, 301 West Preston Street, Room 510, Baltimore, Maryland 21201.

If this notification is not completed according to these procedures and within the required 63-day notification period, rights to continuation coverage will be forfeited. Carefully read the dependent eligibility rules contained in this benefit guide so all covered members are familiar with when a dependent ceases to be a dependent under the terms of the plan. **Copies of the Direct Pay Enrollment form may also be obtained from www.dbm.maryland.gov/benefits.**

How much does COBRA coverage cost?

A qualified beneficiary will have to pay the entire applicable premium plus a 2% administration charge for continuation coverage. The State of Maryland does not subsidize COBRA coverage. These premiums will be adjusted during the continuation period if the applicable premium amount changes. In addition, if continuation coverage is extended from 18 months to 29 months due to Social Security disability, the State of Maryland can charge up to 150% of the applicable premium during the extended coverage period for the disabled beneficiary.

Qualified beneficiaries are required to pay on a monthly basis. Premiums are due on the first day of every month. There will be a maximum grace period of thirty (30) days for the regularly scheduled monthly premiums.

How Do I Elect COBRA or Continuation of Coverage?

Each qualified beneficiary will have an independent right to elect COBRA or Continuation of Coverage; parents may elect COBRA coverage on behalf of minor children who were covered dependents. The Employee Benefits Division will send you an Election Notice outlining your rights to COBRA or Continuation of Coverage after it receives notification of a qualifying event from you or the employee's agency.

Each qualified beneficiary has 63 days from the date of the Election Notice (or the date the health plan coverage was lost, if later) to elect COBRA or Continuation of Coverage. This is the maximum period allowed to elect continuation coverage. If a qualified beneficiary does not elect continuation coverage within this election period, then rights to continue health insurance will end and the individual will cease to be a qualified beneficiary.

Each qualified beneficiary has the right to elect COBRA or Continuation of Coverage in the group health benefits the qualified beneficiary had on the last day of coverage in the Program. For example, if the qualified beneficiary is enrolled in a medical POS plan and the prescription plan but not a dental plan on the last day of coverage before the qualifying event, the qualified beneficiary may elect to continue coverage in that medical POS plan and in the prescription plan but may not add coverage under a dental plan during the COBRA Election Period.

COBRA or Continuation of Coverage is required to be identical to the coverage provided under the plan to similarly situated non-COBRA participants and/or covered dependents. Should coverage change or be modified for non-COBRA participants the change and/or modification will be made to your COBRA coverage as well.

How long does COBRA or Continuation of Coverage last?

COBRA coverage is a temporary continuation of coverage. Depending on the nature of the qualifying event that caused the loss of coverage, COBRA coverage may last a maximum of 18 months or 36 months, except in the case of COBRA continuation coverage in a healthcare flexible spending arrangement. If you are participating in a healthcare flexible spending account at the time of the qualifying event, you will only be allowed to continue the healthcare flexible spending account on a post tax basis until the end of the current plan year in which the qualifying event occurs. See below for a description of how COBRA continuation coverage may end earlier than these maximum periods.

Length of Continuation Coverage – 18 Months

If the event causing the loss of coverage is a termination of employment (other than for reasons of gross misconduct, resignation or layoff) or a reduction in work hours, each

qualified beneficiary will have the opportunity to continue coverage for 18 months from the date of the qualifying event. This 18-month coverage may be extended only in limited situations: (1) when the qualified beneficiary receives a Social Security disability determination, (2) when a second qualifying event occurs during COBRA continuation coverage, and (3) when the employee had become eligible for Medicare within 18 months before the termination of employment or reduction in hours (see below for explanation). You must notify the Employee Benefits Division in writing within 63 days of these events in order to be eligible for an extension of the maximum coverage period. Failure to do so could mean that you cannot extend your coverage period.

Social Security Disability

The 18 months of continuation coverage can be extended for an additional 11 months of coverage, to a maximum of 29 months, for all qualified beneficiaries if the Social Security Administration determines a qualified beneficiary was disabled according to Title II or XVI of the Social Security Act on the date of the qualifying event or at any time during the first 60 days of coverage. The disability must last during the entire 18 months of continuation coverage. It is the qualified beneficiary's responsibility to obtain this disability determination from the Social Security Administration and provide a copy of the determination to the Employee Benefits Division within 60 days of the later of: (1) the date of the determination, (2) the date of the termination of employment or reduction in hours, or (3) the date the original 18-month coverage period expires. This notice must be provided no later than the date the original 18-month coverage period expires. If you do not notify the Employee Benefit Division in writing within the time frame, you may lose the ability to extend this coverage.

This extension applies separately to each qualified beneficiary. If the disabled qualified beneficiary chooses not to continue coverage, all other qualified beneficiaries are still eligible for the extension. If coverage is extended, and the disabled qualified beneficiary has elected the extension, the applicable rate is 150% of the premium rate. If only the non-disabled qualified beneficiaries extend coverage, the premium rate will remain at 102%. It is also the qualified beneficiary's responsibility to notify the Employee Benefits Division within 30 days if a final determination has been made that they are no longer disabled.

Secondary Qualifying Events

Extension of the 18 or 29-month continuation period could occur, if during the 18 or 29 months of continuation coverage, a second event takes place (divorce, legal separation, death, or a dependent child ceasing to be a dependent) that would have caused the qualifying beneficiary to lose coverage under the Program if the first

qualifying event (termination of employment or reduction of hours) had not occurred. If a second event occurs, the original 18 or 29 months of continuation coverage can be extended to 36 months from the date of the original qualifying event date for eligible dependent qualified beneficiaries. If a second event occurs, it is the qualified beneficiary's responsibility to notify the Employee Benefits Division in writing within 60 days of the second event and within the original 18 or 29 month continuation period. In no event, however, will continuation coverage last beyond 36 months from the date of the first qualifying event that originally made the qualified beneficiary eligible for continuation coverage. A reduction in hours followed by a termination of employment is not a second qualifying event.

Length of Continuation Coverage - 36 Months

If the original event causing the loss of coverage was the death of the employee, or a dependent child ceasing to be a dependent child, each qualified beneficiary of the employee will have the opportunity to continue coverage for 36 months from the date of the qualifying event. When the employee had become entitled to Medicare benefits less than 18 months before the termination of employment or reduction in work hours, the covered spouse and covered dependent qualifying beneficiaries may be entitled to continued coverage for up to 36 months. This extension does not apply to the employee, who will only have a maximum of 18 months of COBRA coverage unless a secondary qualifying event occurs. The 36-month coverage period cannot be extended.

Length of Continuation Coverage – Indefinitely

If the original event causing the loss of group health coverage was a divorce from the employee, the qualified beneficiary will have the opportunity to continue coverage indefinitely under Maryland law. This indefinite period of coverage will end when any of the following happens: (1) Program coverage for the employee terminates, (2) the qualified beneficiary obtains coverage elsewhere (including Medicare), or (3) the qualified beneficiary spouse remarries. This indefinite period of continuation coverage is a result of a Maryland state law that is similar to COBRA and does not apply to healthcare flexible spending arrangements. However, the dependent child qualified beneficiary will also lose coverage when the child does not meet Program eligibility requirements under standard COBRA rules. Former stepchildren of the covered employee do not gain access to indefinite continuation coverage under these provisions of Maryland law.

Potential Conversion Rights: At the end of the 18, 29, or 36 months of continuation coverage, a qualified beneficiary will be allowed to enroll in an individual conversion health plan if an individual conversion plan is available at that time.

Early Termination of Continuation Coverage

The time frames described above are only potential maximum periods for COBRA or Continuation of Coverage. COBRA coverage can end before those periods finish. The law provides that your continuation coverage will end prior to the maximum continuation period for any of the following reasons:

- ◆ State of Maryland ceases to provide any group health plan to any of its employees;
- ◆ Any required premium for continuation coverage is not paid in a timely manner;
- ◆ A qualified beneficiary first becomes, after the date of COBRA election, covered under another group health Plan that does not enforce any exclusion or limitation with respect to any preexisting condition(s) of the beneficiary;
- ◆ A qualified beneficiary first becomes, after the date of COBRA election, entitled to Medicare;
- ◆ A qualified beneficiary extended continuation coverage to 29 months due to a Social Security disability and a final determination has been made that the qualified beneficiary is no longer disabled;
- ◆ A qualified beneficiary notifies the State of Maryland, Employee Benefits Division they wish to cancel continuation coverage;
- ◆ For cause, on the same basis that the plan terminates coverage of similarly situated non-COBRA participants.

Is COBRA continuation coverage for my Healthcare Flexible Spending Account Different?

Yes. COBRA continuation coverage for the Healthcare Flexible Spending Account (HCFSA) will be offered only to qualified beneficiaries losing coverage through the end of the plan year in which the qualifying event occurs. FSA continuation coverage is never offered to same sex spouses or same sex spouse's children. This coverage cannot be extended beyond the end of the plan year, regardless of the qualifying event or whether a second qualifying event occurs. The use it or lose it rule will still apply so any unused amounts will be forfeited at the end of the plan year and COBRA coverage will terminate at the end of the plan year. You must pay a premium for continued HCFSA coverage that includes a 2% administrative charge for the coverage. Unless otherwise elected, all qualified beneficiaries who were covered under the HCFSA will be covered together for HCFSA COBRA coverage. However, each qualified beneficiary could elect to exercise HCFSA COBRA election rights individually to cover the qualified beneficiary only, with a separate HCFSA limit and a separate premium.

Notification of Address Change

To ensure all covered individuals receive information properly and timely, you are required to notify the State of Maryland Employee Benefits Division of any address change as soon as possible. The Employee Benefits Division must have your current address at all times. A Personal Information Change form is available on-line at www.dbm.maryland.gov/benefits, click on Forms. Instructions for completing and filing the form are at the bottom of the form. Failure on your part to follow the instructions will result in delayed notifications or a loss of continuation coverage options.

How do I notify the Employee Benefits Division if this Notice advises I must provide notification to protect my rights?

In every instance that you must provide notice to the Employee Benefits Division in order to protect your rights, whether the notice is of a first or second qualifying event, Social Security disability, or the addition of a new qualified beneficiary, you must provide written notice to the Employee Benefits Division at the address at the bottom of this Notice. You may be asked to complete a form and provide additional documentation. Failure to provide notice to the Employee Benefits Division within the required time period may cause you to lose your COBRA rights.

Any Questions?

Remember, except for notifying you of your responsibilities to notify the Employee Benefits Division of a divorce, or a dependent child ceasing to meet Program eligibility requirements, this notice is simply a summary of your potential future options. Should an actual qualifying event occur and it is determined you are eligible for continuation; you will be notified of your actual rights at that time as part of the COBRA Election Notice. If any covered individual does not understand any part of this summary notice or has questions regarding the information or your obligations, please contact the State of Maryland Employee Benefits Division at 410-767-4775. In addition, you can find more information about COBRA continuation coverage on the internet at

www.dbm.maryland.gov/benefits.

The Program name and address is:

The State of Maryland Employee and Retiree Health and Welfare Benefits Program
c/o Employee Benefits Division
301 West Preston Street, Room 510
Baltimore, Maryland 21201

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Certificates of Coverage and the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

A Federal law, HIPAA, requires employers to provide certificates of coverage to all former employees, who then can give the certificates to their new employers. If you or your dependents obtain new employment, you may request a certificate of coverage from the State, which describes the length and types of benefits coverage (e.g., medical, dental, etc.) you and your dependents had under the State Program. You may request a HIPAA Certificate of Coverage by writing to the Department of Budget and Management (DBM), Employee Benefits Division, at the address on the inside front cover of this guide. The medical plans offered through the State will mail one to you automatically when your coverage with them ends.

Notice of Privacy Practices and HIPAA Authorization Form

The State conforms to Federal HIPAA and State regulations regarding the privacy of your health information. The Notice of Privacy Practices describes the privacy practices of the State Employee and Retiree Health and Welfare Benefits Program.

HIPAA and State regulations require your written authorization to disclose certain health information to other people. If your written authorization is needed, you may use the HIPAA authorization form to provide the needed authorization. This form is located on our website, www.dbm.maryland.gov/benefits, click on Forms. Assigned HIPAA authorizations remain in effect unless you change or revoke the authorization.

NOTICE OF PRIVACY PRACTICES – THE STATE EMPLOYEE AND RETIREE HEALTH AND WELFARE BENEFITS PROGRAM

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.

Under Federal and State law, DBM administers the State Employee and Retiree Health and Welfare Benefits Program (the Program) and protects the privacy of your protected health information. DBM takes steps to ensure that your protected health information is kept secure and confidential and is used only when necessary to administer the Program. DBM is required to give you this notice to tell you how DBM and your Healthcare Flexible Spending Account (HCFSAs) may use and give out (“disclose”) your protected health information held by DBM and your HCFSAs. This information generally comes to DBM when you enroll in the Program, from your plan administrator as part of administration of the health plan, and to your HCFSAs when you submit requests for reimbursement. DBM and the HCFSAs abide by the terms of this Notice.

Your health plan in the Program (for example, the CareFirst BlueCross BlueShield PPO) will also protect, use, and disclose your personal health information. For questions about your health information held by your health plan, please contact your health plan directly. The plans in the Program all follow the same general rules that DBM and the HCFSAs follow to protect, use, and disclose your protected health information. Each plan will use and disclose your protected health information for payment purposes, for treatment purposes, and for administration purposes.

DBM has the right to use and disclose your protected health information to administer the Program. For example, DBM will use and disclose your protected health information:

- ◆ To communicate with your Program health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue. DBM may need written authorization from you for your health plan to discuss your case.
- ◆ To determine your eligibility for benefits and to administer your enrollment in your chosen health plan.
- ◆ For payment related purposes, such as to pay claims for services provided to you by doctors, hospitals, pharmacies, and others for services delivered to you that are covered by your health plan, to coordinate

your benefits with other benefit plans (including Workers’ Compensation plans or Medicare) to reimburse you from your HCFSAs, or to make premium payments.

- ◆ To collect payment from you when necessary, such as copayments, premiums or other contributions.
- ◆ For treatment related purposes, such as to review, make a decision about, or litigate any disputed or denied claims.
- ◆ For healthcare operations, such as to conduct audits of your health plan’s quality and claims payments, to procure health benefits offered through this Program, to set premiums, and to investigate potential fraudulent claims. However, note that federal law prohibits the use and disclosure of genetic information about an individual, including for underwriting purposes. The group health plan benefits options and the HCFSAs offered through the Program do not use genetic information for underwriting (or for any other) purposes.

DBM and/or your HCFSAs will also use and disclose your protected health information:

- ◆ To you or someone who has the legal right to act for you (your personal representative). To authorize someone other than you to discuss your protected health information, please contact DBM to complete an authorization form.
- ◆ To law enforcement officials when investigating and/or processing alleged or ongoing civil or criminal actions.
- ◆ Where required by law, such as to the Secretary of the U.S. Department of Health and Human Services, to the Office of Legislative Audits, or in response to a subpoena.
- ◆ For healthcare oversight activities (such as mandatory reporting, and fraud and abuse investigations).
- ◆ To avoid a serious and imminent threat to health or safety.

DBM must have written permission (an “authorization”) from you, or your dependents over the age of 18 years, to use or give out your protected health information to other persons or organizations. An authorization is good for only one year. You may revoke an authorization at any time by written notice.

DBM and your HCFSAs do not use your protected health information for fundraising or marketing purposes. DBM and your HCFSAs do not and are prohibited from selling your protected health information. However, we can request payment for treatment or coverage provided to you, for services provided in connection with the health plan (such as processing claims), and for copying costs when you ask for copies of records we have containing your information.

By law, you have rights related to protected health information about you. These include your rights to:

- ◆ Make a written request and see or get a copy of your protected health information held by DBM, the HCFSa, or a plan in the Program. If DBM or your HCFSa use Electronic Health Records, you can ask for a copy of that EHR. We do not use EHRs currently.
- ◆ Amend any of your protected health information created by DBM or the HCFSa if you believe it is wrong or if information is missing, and DBM agrees. If DBM or the HCFSa disagrees, you may have a statement of your disagreement added to your protected health information.
- ◆ Ask in writing for a listing of those receiving your protected health information from DBM or your HCFSa for up to six years prior to your request. The listing will not cover your protected health information that was used or disclosed for treatment, healthcare operations or payment purposes, given to you or your personal representative, disclosed pursuant to an authorization, or disclosed prior to April 14, 2003. If DBM or your HCFSa begins to use EHRs, you could ask for a copy of EHR disclosures over the most recent three years for healthcare operations, treatment, and payment purposes as well.
- ◆ Ask DBM or your HCFSa in writing to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address) if using your address on file creates a danger to you.
- ◆ Ask DBM or your HCFSa in writing to limit how your protected health information is used or given out. However, DBM or your HCFSa may not be able to agree to your request if the information is used for treatment, payment, or to conduct operations in the manner described above, or if a disclosure is required by law. If you wish to exercise these rights in connection with the Program or a health plan, you may contact DBM at the address below.
- ◆ Get a separate paper copy of this notice. If you wish to exercise any of these rights in connection with your HCFSa, you can contact the FSA Administrator at the address listed on the inside front cover or you can contact DBM for assistance. You may also contact your dental plan, medical PPO, medical POS, or medical EPO or long term care plan directly.

DBM cannot disclose protected health information to an employer for employment-related actions or personnel transactions without authorization.

For more information on exercising your rights in this notice, visit the DBM website: www.dbm.maryland.gov/

benefits. You may also call 410-767-4775 or 1-800-30-STATE (1-800-307-8283) and ask for DBM's HIPAA Privacy Official. If you believe DBM has violated your privacy rights, you may submit a written complaint with DBM at the following address:

Department of Budget and Management
Employee Benefits Division
301 West Preston Street
Room 510
Baltimore, MD 21201
ATTN: HIPAA Privacy Officer

Filing a complaint will not affect your benefits under the HIPAA. You also may submit a complaint with the Secretary of the U.S. Department of Health and Human Services at:

Department of Health and Human Services
Office of Civil Rights
150 South Independence Mall West, Suite 372
Public Ledger Building
Philadelphia, PA 19106-9111

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse, midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other healthcare provider obtain authorization for prescribing a length of stay up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information, contact your plan administrator.

NOTICE OF WOMEN'S HEALTH & CANCER RIGHTS ACT OF 1998

As required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, the group health plan benefits options offered here provide coverage for:

- ◆ All stages of reconstruction of the breast on which the mastectomy has been performed;
- ◆ Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- ◆ Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter. Contact your plan administrator, the State of Maryland Employee Benefits Division, for more information.

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to any request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

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 are eligible for health coverage from your employer, your State may have a premium assistance

program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed on the next page, you can 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, you can 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, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not 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, you can contact the Department of Labor electronically at www.askebsa.gov or by calling toll-free 1-866-444-EBSA (3272).

Additional information on the next page.

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 July 31, 2012. You should contact your State for further information on eligibility.

ALABAMA – Medicaid

Website: <http://www.medicaid.alabama.gov>
Phone: 1-855-692-5447

ALASKA – Medicaid

Website: <http://health.hss.state.ak.us/dpa/programs/medicaid/>
Phone (Outside of Anchorage): 1-888-318-8890
Phone (Anchorage): 1-907-269-6529

ARIZONA – CHIP

Website: <http://www.azahcccs.gov/applicants>
Phone (Outside of Maricopa County): 1-877-764-5437
Phone (Maricopa County): 602-417-5437

COLORADO – Medicaid

Medicaid Website: <http://www.colorado.gov/>
Medicaid Phone (In state): 1-800-866-3513
Medicaid Phone (Out of state): 1-800-221-3943

FLORIDA – Medicaid

Website: <https://www.flmedicaidtplrecovery.com/>
Phone: 1-877-357-3268

GEORGIA – Medicaid

Website: <http://dch.georgia.gov/>
Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)
Phone: 1-800-869-1150

IDAHO – Medicaid and CHIP

Medicaid Website: www.accesstohealthinsurance.idaho.gov
Medicaid Phone: 1-800-926-2588
CHIP Website: www.medicaid.idaho.gov
CHIP Phone: 1-800-926-2588

INDIANA – Medicaid

Website: <http://www.in.gov/fssa>
Phone: 1-800-889-9949

IOWA – Medicaid

Website: www.dhs.state.ia.us/hipp/
Phone: 1-888-346-9562

KANSAS – Medicaid

Website: <https://www.kdheks.gov/hcf/>
Phone: 1-800-792-4884

KENTUCKY – Medicaid

Website: <http://chfs.ky.gov/dms/default.htm>
Phone: 1-800-635-2570

LOUISIANA – Medicaid

Website: <http://www.lahipp.dhh.louisiana.gov>
Phone: 1-888-695-2447

MAINE – Medicaid

Website: <http://www.maine.gov/dhhs/ofi/public-assistance/index.html>
Phone: 1-800-977-6740
TTY: 1-800-977-6741

MASSACHUSETTS – Medicaid and CHIP

Website: <http://www.mass.gov/MassHealth>
Phone: 1-800-462-1120

MINNESOTA – Medicaid

Website: <http://www.dhs.state.mn.us/>
Click on Health Care, then Medical Assistance
Phone: 1-800-657-3629

MISSOURI – Medicaid

Website: <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>
Phone: 1-573-751-2005

MONTANA – Medicaid

Website: <http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml>
Telephone: 1-800-694-3084

NEBRASKA – Medicaid

Website: <http://www.ACCESSNebraska.ne.gov>
Phone: 1-800-383-4278

NEVADA – Medicaid

Medicaid Website: <http://dwss.nv.gov/>
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 1-603-271-5218

NEW JERSEY – Medicaid and CHIP

Medicaid Website: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>
Medicaid Phone: 1-800-356-1561
CHIP Website: <http://www.njfamilycare.org/index.html>
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid

Website: http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: <http://www.ncdhs.gov/dma>
Phone: 1-919-855-4100

NORTH DAKOTA – Medicaid

Website: <http://www.nd.gov/dhs/services/medicalserv/medicaid/>
Phone: 1-800-755-2604

OKLAHOMA – Medicaid and CHIP

Website: <http://www.insureoklahoma.org>
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP

Website: <http://www.oregonhealthykids.gov>
<http://hijossaludablesoregon.gov>
Phone: 1-877-314-5678

PENNSYLVANIA – Medicaid

Website: <http://www.dpw.state.pa.us/hipp>
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid

Website: www.ohhs.ri.gov
Phone: 1-401-462-5300

SOUTH CAROLINA – Medicaid

Website: <http://www.scdhhs.gov>
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid

Website: <http://dss.sd.gov>
Phone: 1-888-828-0059

TEXAS – Medicaid

Website: <https://www.gethipptexas.com/>
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Website: <http://health.utah.gov/upp>
Phone: 1-866-435-7414

VERMONT – Medicaid

Website: <http://www.greenmountaincare.org/>
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Medicaid Website: <http://www.dmas.virginia.gov/rcp-HIPP.htm>
Medicaid Phone: 1-800-432-5924
CHIP Website: <http://www.famis.org/>
CHIP Phone: 1-866-873-2647

WASHINGTON – Medicaid

Website: <http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm>
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid

Website: <http://www.dhhr.wv.gov/bms/>
Phone: 1-877-598-5820, HMS Third Party Liability

WISCONSIN – Medicaid

Website: <http://www.badgercareplus.org/pubs/p-10095.htm>
Phone: 1-800-362-3002

WYOMING – Medicaid

Website: <http://www.health.wyo.gov/healthcarefin/equalitycare>
Telephone: 1-307-777-7531

To see if any more States have added a premium assistance program since July 31, 2012, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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, Ext. 61565

MEDICARE AND YOUR STATE BENEFITS

Medicare Parts A & B

Retirees and/or their dependents enrolled in the State Health Benefits Program must enroll in both Parts A & B to have full coverage as soon as they are eligible, either due to age or disability. The State plan will cover only the portion of hospital and medical bills not covered by Medicare. If you and/or your covered dependents are eligible for, but not enrolled in both Parts A & B, you will become responsible for the claims costs that Medicare would have paid.

Active employees and their covered dependents do not have to sign up for Medicare Parts A & B when they become eligible because of age or disability as long as they continue to be active employees. Their State benefits coverage will continue as primary coverage, as long as they are active employees. However, retirees and dependents of retirees must enroll in both Medicare Parts A & B as soon as they are eligible (due to age or disability) to have full claims coverage. If you are a retiree or a covered dependent of a retiree and you are eligible for Medicare, Parts A & B become your primary insurance and the State health plan becomes a supplemental policy to Medicare. Medicare Part A helps pay for hospital care, some skilled nursing facility care, and hospice care; Medicare Part B helps pay for physician charges and other medical services.

If you are an employee, retiree, or a covered dependent that has Medicare entitlement because of End Stage Renal Disease (ESRD), see the ESRD rules that follow.

Age: Even If You Are Not Collecting

For most individuals who are not disabled, Medicare eligibility begins on the first day of the month in which they reach age 65. However, if you were born on the first day of a month, your Medicare eligibility begins on the first day of the month prior to the month in which you reach age 65. In order to have full coverage, retirees and their covered dependents must enroll in Parts A & B at age 65, regardless of what the Social Security Administration determines to be your full retirement age.

Even if you do not wish to start receiving your Social Security retirement benefit, you must still enroll in Medicare Parts A & B. You will be billed directly by the Social Security Administration for your Part B premium. For information on how to enroll in Medicare, call the Social Security Administration at 1-800-772-1213.

Disability

Persons who are certified as being disabled by the Social Security Administration become eligible for Medicare two years (24 months) after their disability determination date. Retirees and their covered dependents enrolled in the State's benefits program **MUST** enroll in Medicare Parts A & B if eligible due to disability, regardless of their age, in order to receive the maximum coverage available. If Social Security denies Medicare coverage, you must provide a copy of the Social Security's denial to the Employee Benefits Division. If your Medicare entitlement is due to disability and the Social Security Administration determines that your disability status ends, please provide the

Employee Benefits Division documentation from the Social Security Administration stating when Medicare entitlement ended. It is your responsibility to notify the Employee Benefits Division of Medicare entitlement due to disability.

If the retiree and covered dependents fail to enroll in Medicare Parts A & B, the member will be responsible for the Medicare portion (about 80%) of all eligible services. The State will only pay as Medicare Supplemental Coverage (about 20%) towards eligible services.

End Stage Renal Disease (ESRD)

The information in this section only pertains to individuals who, according to the Centers for Medicare and Medicaid Services, are eligible for Medicare based on ESRD, not based on age or disability.

Individuals who have ESRD may be eligible for coverage under Medicare Parts A and B. It is strongly recommended that all employees, retirees, and their covered dependents who have ESRD read the Centers for Medicare and Medicaid Services publication, *Medicare Coverage for Kidney Dialysis and Kidney Transplant Services* before making any decisions about whether or not to enroll in Medicare Part A and/or Part B. To obtain a copy of this publication, visit a local Social Security office, call toll-free to 1-800-772-1213, or visit the website www.socialsecurity.gov and select *Other Medicare Information* (under the heading, *Medicare*), then select *More Medicare Publications* and finally, select *Medicare Coverage of Kidney Dialysis and Kidney Transplant Services*.

The information below regarding the Coordination of Benefits (COB) for Medicare due to End Stage Renal Disease (ESRD) pertains to individuals enrolled in an active employee group only.

During the 30-Month COB Period

When Medicare entitlement due to ESRD begins, there is a 30-month COB period (determined by Social Security) during which active employee group coverage remains the primary insurer, regardless of whether or not the individual is enrolled in Medicare Part A and/or Part B. Employees should never change their coverage level in the State health plan to a Medicare coverage level during their 30-month COB period.

After the 30-Month COB Period

NOTE: Individuals enrolled in a medical plan under the State's program and whose coverage is in an active employee group are not required to enroll in Medicare. However, if the individual chooses to enroll in Medicare Part A only, or both Parts A and B due to an ESRD entitlement (determined by Social Security), their claims will be processed according to the COB regulations provided below.

After a successful kidney transplant

Three years after a successful kidney transplant, Medicare is no longer the primary insurer. If Medicare eligibility ends, the employee should contact the SSA to confirm that both Part A and Part B have been cancelled. When the employee receives a cancellation letter from the SSA, if the employee is enrolled in a State medical plan with a Medicare coverage level, an active employee enrollment form should be submitted to change to a non-Medicare coverage level.

The following link is for the Social Security publication titled “Medicare Coverage of Kidney Dialysis and Kidney Transplant Services”:

www.medicare.gov/Publications/Pubs/pdf/10128.pdf

Active employees and their dependents covered by a State medical plan who are eligible for Medicare due to ESRD will have their claims processed as follows.

Active employees/dependents enrolled in both Medicare Part A & B:

- ◆ The State plan will remain the primary insurer for a 30-month coordination of benefits period determined by SSA; your coverage level in the State plan should not be changed to reflect Medicare enrollment until Medicare becomes the primary insurer.
- ◆ At the end of the 30-month coordination period, Medicare will become the primary insurer and the State plan will be the secondary insurer. At that time, you should complete an Active Employee Health Benefits enrollment form to change your State plan coverage level accordingly.

Active employees/dependents enrolled in Medicare Part A, but not Part B:

- ◆ The State plan will remain the primary insurer for the 30-month coordination of benefits period; your coverage level in the State plan should not be changed to reflect Medicare enrollment.
- ◆ At the end of the 30-month coordination period, Medicare Part A will become the primary insurer for Part A (hospital) claims. In order for the State plan to remain the primary insurer for Part B (medical) claims, your coverage level in the State plan should not be changed to reflect Medicare enrollment.

Active employees/dependents not enrolled in Medicare Part A or Part B:

- ◆ There will be no coordination of benefits and no change in the way the State plan processes claims.

If you/your dependent are no longer eligible for Medicare due to ESRD, you should contact the Social Security Administration to request a cancellation of both Medicare Parts A & B, as applicable. When you receive your cancellation letter from the SSA, if your coverage level in the State plan reflects Medicare enrollment, you should submit a copy of the SSA letter along with an Active Employee Health Benefits enrollment form requesting a coverage level reflecting “no Medicare” to your Agency Benefits Coordinator in your Human Resources office.

Retirees and their dependents covered by a State medical plan who are eligible for Medicare due to ESRD (and not for any other reason) will have claims their processed as follows.

Retirees/dependents enrolled in both Medicare Part A & B:

- ◆ The State plan will remain the primary insurer for a 30-month coordination of benefits period determined by SSA; your coverage level in the State plan should not be changed to reflect Medicare enrollment until Medicare becomes the primary insurer.
- ◆ At the end of the 30-month coordination period, Medicare will become the primary insurer and the State plan will be the secondary insurer. This is a qualifying

event and you should complete a Retiree Health Benefits enrollment form to change your State plan coverage level accordingly (i.e., from “Individual & Spouse” to “Individual & One, One with Medicare”).

Retirees/dependents enrolled in Medicare Part A, but not Part B:

- ◆ The State plan will remain the primary insurer for the 30-month coordination of benefits period; your coverage level in the State plan should not be changed to reflect Medicare enrollment.
- ◆ At the end of the 30-month coordination period, your coverage level should be changed to reflect Medicare eligibility. At that time, Medicare Part A will become the primary insurer for Part A (hospital) claims. The State plan will cover only the portion of Part B claims that Medicare would not have covered if the retiree/dependent was enrolled in Part B; the retiree/dependent will become responsible for the claims costs that Medicare Part B would have covered.

Retirees/dependents not enrolled in Medicare Part A or Part B:

- ◆ The State plan will remain the primary insurer for the 30-month coordination of benefits period; your coverage level in the State plan should not be changed to reflect Medicare enrollment.
- ◆ At the end of the 30-month coordination period, Medicare will become the primary insurer. At that time, you should complete a Retiree Health Benefits enrollment form to change your State plan coverage level accordingly (i.e., from “Individual & Spouse” to “Individual & One, One with Medicare”). The State plan will cover only the portion of claims that Medicare would not have covered if the retiree/dependent was enrolled in Parts A & B; the retiree/dependent will become responsible for the claims costs that Medicare would have covered.

If you/your dependent are no longer eligible for Medicare, you should contact the Social Security Administration to request a cancellation of both Medicare Parts A & B, as applicable. When you receive your cancellation letter from the SSA, if your coverage level in the State plan reflects Medicare enrollment, you should submit a copy of the SSA letter along with a Retiree Health and Welfare Benefits enrollment form requesting the appropriate coverage level to the Employee Benefits Division at the address on the inside front cover of this guide.

Medicare Coordination of Benefits (COB)

If you have questions about your coverage level in the State Retiree Health and Welfare Benefits Program, contact the Employee Benefits Division. If you have questions about claims payments and how your plan coordinates with Medicare, contact your Medical Plan.

Initial, Special, and General Enrollment Periods for Medicare Parts A & B

When you reach age 65, if your health benefits coverage is under a retiree’s policy and you do not enroll in both Medicare Parts A & B, you will not have full claims coverage and your Part B premium may be penalized when you enroll later.

If your health benefits coverage is under an active employee's policy when you reach age 65, you do not have to enroll in Medicare until you retire, unless your employment or coverage under an Active employee's policy will end during your initial enrollment period. See the Special Enrollment Period information table on the right.

Initial Enrollment Period is the seven-month period for Medicare due to reaching age 65, as follows:

- ◆ If you reach age 65 on the 1st day of the month – Medicare eligibility begins the 1st day of the previous month; *Example: If your birthday is January 1st, you are eligible for Medicare on December 1st.*
- ◆ If you reach age 65 on the 2nd day through the last day of the month – Medicare eligibility begins the 1st day of the month you turn 65; *Example: If your birthday is January 2nd – 31st, you are eligible for Medicare on January 1st.*

Your Initial Enrollment Period begins three months prior to the month you are eligible for Medicare and ends three months after the month you are eligible for Medicare. The chart on the right shows the schedule for an Initial Enrollment Period and a sample schedule for a birth date of April 2nd – 30th.

Special Enrollment Period is an eight-month period beginning the month your group coverage ends or the month employment ends, whichever comes first. If you were eligible for Medicare, but didn't enroll because you had health benefits under an active employee's policy, you

can enroll during your Special Enrollment Period without penalty to your Part B premium. **Special enrollment period rules don't apply if employment or active employee group coverage ends during your initial enrollment period.**

General Enrollment Period is a three month "Open Enrollment" period for Medicare each year from January 1st through March 31st for Part B coverage to start on July 1st of the same year. If you were eligible but not enrolled in Medicare and you did not have health benefits coverage under an active employee's policy, your Part B premium will be penalized 10% for every 12 months you were entitled to Part B but not enrolled.

If your Initial Enrollment Period or Special Enrollment Period enrollment falls between January 1st and March 31st, it is extremely important that you make it clear to the Social Security Administration representative you have an initial or special enrollment period. Otherwise, you may be enrolled as a general enrollment and your Part B coverage will not start until July 1st and your Part B premium may be penalized.

Medicare Due to Disability

The same rules apply if you are entitled to Medicare due to a disability. If you have health benefits coverage under an active employee's policy, you do not have to enroll in Medicare. **However, when your employment or active employee coverage ends, you must apply for Medicare Parts A & B in order to have full claims coverage.**

Otherwise, you will be responsible for the portion of claims that Medicare would have paid, had you been enrolled.

Initial Enrollment Period Schedule		Sample Initial Enrollment Period for Individuals with birth dates between April 2nd and 30th	
MONTH ENROLLED	PART B COVERAGE STARTS	MONTH ENROLLED	PART B COVERAGE STARTS
1st month	1st day of the month you reach age 65*	January	April 1st
2nd month	1st day of the month you reach age 65*	February	April 1st
3rd month	1st day of the month you reach age 65*	March	April 1st
4th month	One month delay	April	May 1st
5th month	Two month delay	May	July 1st
6th month	Three month delay	June	September 1st
7th month	Three month delay	July	October 1st

To find your Initial Enrollment Period, circle the month you turn 65 and the three months before and after.

*If you were born on the first day of the month, move your schedule back one month.

January	February	March	April	May	June	July	August	September	October	November	December
---------	----------	-------	-------	-----	------	------	--------	-----------	---------	----------	----------

If your employment or your health benefits coverage under an active employee's policy ends during your initial enrollment period, special enrollment period rules do not apply.

Special Enrollment Period Schedule		Sample Initial Enrollment Period for someone retiring on April 1st	
MONTH ENROLLED	PART B COVERAGE STARTS	MONTH ENROLLED	PART B COVERAGE STARTS
1st month	You choose: 1st day of month enrolled or 1st day of following three months	March	March 1st, April 1st, May 1st or June 1st
2nd month	You choose: 1st day of month enrolled or 1st day of following three months	April	April 1st, May 1st, June 1st or July 1st
3rd month	1st day of the month after enrollment	May	June 1st
4th month	1st day of the month after enrollment	June	July 1st
5th month	1st day of the month after enrollment	July	August 1st
6th month	1st day of the month after enrollment	August	September 1st
7th month	1st day of the month after enrollment	September	October 1st
8th month	1st day of the month after enrollment	October	November 1st

General Enrollment Period Schedule	
ENROLLMENT DATE	PART B COVERAGE STARTS
January 1st – March 31st	July 1st

Important Notice From the State of Maryland About Prescription Drug Coverage and Medicare - PART D

NOTICE OF CREDITABLE COVERAGE

Please read this notice carefully and keep it where you can find it. This notice applies to all State of Maryland employees, retirees, and dependents who are entitled to Medicare and are enrolled in the current prescription drug plan through the State Employees and Retirees Health Benefits Program (“our Program”) and has information about our Program’s prescription drug coverage. It also explains the options you have under Medicare Part D prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

IMPORTANT POINTS TO REMEMBER

- ◆ Medicare prescription drug coverage (“Medicare Part D”) became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- ◆ The State of Maryland has determined that the prescription drug coverage offered through our Program is **creditable coverage**. **Creditable coverage** means that, on average for all plan participants, our Program is expected to pay out as much or more than the standard Medicare Part D prescription drug coverage will pay. It also means that **if you keep our Program’s coverage and do not enroll in a Medicare prescription plan now, you will not pay extra if you later decide to enroll in a Medicare prescription drug plan, so long as you do not have a break in coverage of 63 continuous days or more.**
If you go 63 continuous days or longer without prescription drug coverage that is at least as good as Medicare’s prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.
- ◆ Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from October 15th through December 7th. In addition, if you cancel or lose coverage with our Program, you may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the Medicare prescription drug plans in your area. Remember, our Program will only cover eligible dependents in a plan in which you are enrolled as well.

If you are eligible for Medicare prescription drug coverage, you have the right to:

- ◆ Keep our Program’s coverage and not enroll in a Medicare prescription drug plan;
- ◆ Enroll in a Medicare prescription drug plan and drop our Program’s coverage; or
- ◆ Enroll in a Medicare prescription drug plan and keep our Program’s coverage.*

* If your coverage in our Program is as a retiree or a covered dependent of a retiree, your Medicare prescription drug plan will be your primary coverage.

- ◆ If you decide to enroll in a Medicare prescription drug plan and drop your prescription drug coverage through our Program, you may not be able to get our Program coverage back until our next Open Enrollment period or when you cancel or lose your Medicare prescription drug coverage. If you lose or cancel Medicare Part D prescription drug coverage, you may be able to re-enroll in our Program before the next annual Open Enrollment period if you request re-enrollment with the employee Benefits Division within 60 days **and** you have had a change in circumstances that permits a mid-year change in enrollment. See the annual Benefits Guide section entitled “Qualifying Status Changes” on page 15 for more information. If you drop our Program coverage for prescription benefits, your dependent(s) will also lose coverage under our Program’s prescription plan.

If you cancel your coverage under our Program’s prescription drug plan, you are still eligible for enrollment in our Program’s other types of coverage, such as health and dental plans. Prescription coverage is elected separately from these other coverages.

- ◆ **Keep this notice with your important papers.** If you enroll in one of the Part D plans approved by Medicare that offer prescription drug coverage, you may need to give a copy of this notice when you join to show that you are not required to pay a higher premium amount.

For more information about this notice or your current prescription drug coverage: Contact the Employee Benefits Division for further information at 410-767-4775 or

1-800-307-8283. More information can also be found by going to our website, www.dbm.maryland.gov/benefits. NOTE: A copy of this Notice will appear in our Program’s annual Open Enrollment guide each year. You also may request a paper copy at any time.

For more information about your options under Medicare prescription drug coverage:

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. If you are enrolled in Medicare, you will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug plans:

- ◆ Visit www.medicare.gov;
- ◆ Call your State Health Insurance Assistance Program (see your copy of the “Medicare & You” handbook or visit www.mdoa.state.md.us for the telephone number of the local office in your area); or
- ◆ Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit the SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date: 07/01/12, **Name of Entity/Sender:** State of Maryland, **Contact Office:** Employee Benefits Division, **Address:** 301 W. Preston Street, Room 510, Baltimore, Maryland 21201, **Phone Number:** 410-767-4775 or toll-free 1-800-307-8283.

Remember: Keep this notice. If you enroll in one of the prescription drug plans approved by Medicare, you may be required to provide a copy of this notice when you join to determine whether or not you are required to pay a higher premium amount.

BENEFITS APPEAL PROCESS

Important Information about Your Health Benefits Claims Review and Appeal Rights

Internal Appeals: If a healthcare claim you will be incurring or have incurred has been denied, you may contact your insurance carrier using the contact information on your Explanation of Benefits (EOB) form or on the back of your insurance identification card for information on filing an internal appeal. This must be done within 180 days (six months) from the date the claim was denied. If your insurance carrier upholds the denial, you have the right to request an external review (external appeal) of the denial by the Maryland Insurance Administration.

External Appeals: For a claim denied because the service was considered not medically necessary, medically inappropriate or is considered cosmetic or experimental or investigational, you, your representative or a healthcare provider acting on your behalf, may be entitled to request an independent, external review within 120 days (four months) from the date the claim was denied. If you request an external review, the Maryland Insurance Administration (MIA) will review and provide a final, written determination. If MIA decides to overturn the insurance carrier's decision, we will instruct the insurance carrier to provide coverage or payment for your healthcare item or service. For questions on your rights to external review contact:

Maryland Insurance Administration
Attn: Appeals and Grievance Unit
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202
Telephone: (410) 468-2000
Toll-free: 1-800-492-6116
Facsimile: (410) 468-2270
TTY: 1-800-735-2258

If a claim is denied because the service was not a covered service and is not eligible for an independent, external review, but you still disagree with the denial, you may contact the Employee Benefits Division for additional review at the following:

Employee Benefits Division
Attn: Adverse Determinations
301 West Preston Street, Room 510
Baltimore, MD 21201
Telephone: (410) 767-4775
Toll-free: 1-800-307-8283
Facsimile: (410) 333-7104

Urgent Care Request: If your situation meets the definition of urgent care under the law, a review of your claim will be conducted as expeditiously as possible. An urgent care situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on the external review of your claim. If you believe your situation is urgent, you may request an expedited review process by contacting your plan at the phone number listed on the back of your insurance identification card, or you may contact the Maryland Insurance Administration (see above).

Assistance resources: For questions about your rights or for assistance in filing an appeal, you can contact:

Office of Health Insurance Consumer Assistance
Maryland Office of Attorney General
Health Education and Advocacy Unit
200 St Paul Place, 16th Floor
Baltimore, MD 21202
Telephone: (877) 261-8807
<http://www.oag.state.md.us/Consumer/HEAU.htm>
heau@oag.state.md.us

OR

Employee Benefits Security Administration
1-866-444-3272

Definitions

Allowed Benefit: The maximum fee a health plan will pay for a covered service or treatment. The allowed benefit is determined by each health plan.

Cafeteria Plans: Plans under Section 125 of the Internal Revenue Code that allow employees to choose from a menu of one or more qualified benefits and to pay for those qualified benefits on a pre-tax basis.

CMS: Centers for Medicare and Medicaid Services. The agency of the U.S. Department of Health and Human Services that is responsible for administering the Medicare and Medicaid programs.

COB: Coordination of Benefits. If an employee, retiree, or eligible dependents are covered under more than one insurance plan, the insurance plan of the person with the earlier birthday in the calendar year is primary and the other plan is secondary. The employee's or retiree's primary coverage will pay its benefits first, without regard to other coverage.

COBRA: The Consolidated Omnibus Budget Reconciliation Act of 1985. This law amended by ERISA, the PHSA, and the tax code to require employers to offer the option of purchasing continuation coverage to qualified beneficiaries who would otherwise lose group health insurance coverage as the result of a qualifying event. The federal statute which applies to the State of Maryland Health is the Public Health Service Act (PHSA).

Coinsurance: Cost sharing between you and the plan for certain services. It is different for services received from in-network providers and out-of-network providers.

Copayment: The amount an employee, retiree, or covered dependent pays at the time service is rendered. This money goes directly to the healthcare provider. The amount of the copayment varies by type of service.

Deductible: The amount an employee or retiree is required to pay before direct payment or reimbursement is available for out-of-network services.

DHMO: Dental Health Maintenance Organization. A plan similar to a medical HMO, but provides dental services. Participants can use only those designated dental providers approved by and registered with the DHMO.

Emergency services or medical emergency: Healthcare services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in:

- placing the patient's health in jeopardy;
- serious impairment of bodily functions; or
- serious dysfunction of any bodily organ or part.

EPO (Exclusive Provider Organization): An EPO is a type of managed care plan. The EPO utilizes a network made up of providers from a specific network from which members must choose. EPO members are restricted to in-network providers only. Please see specific carrier's benefits on pages 20-36 for more information.

ESRD (End Stage Renal Disease): A medical condition of the kidneys and renal system.

Flexible Spending Account (FSA): A benefit option that reimburses employees for certain expenses from pre-tax deductions taken from the employee's paycheck. These arrangements are regulated by federal tax law and may be used for healthcare expenses or dependent daycare expenses.

FMLA (Family Medical Leave Act): A type of Leave of Absence, as governed by Federal and State statutes, in which an employee may obtain leave due to an individual or family member medical condition or active military leave.

Healthcare Reform: Refers to the federally enacted Patient Protection and Affordable Care Act (PPACA).

HIPAA: Health Insurance Portability and Accountability Act of 1996. A federal law which requires employers to provide certificates of coverage to minimize pre-existing condition exclusions by next employer.

HPV (Human Papillomavirus): A virus which has been currently identified as a possible causal agent for cervical cancer.

Imputed Income: The estimated value of the employer's financial contribution towards health insurance coverage for non-dependent same-sex spouses must be reported as taxable wages earned.

In-Network Service: Service provided by a participating provider, Primary Care Physician or other provider approved by the plan.

LAW (Leave of Absence Without Pay): An employer approved period of leave during which the employee is not paid, but does not terminate State service. Any approved leave of absence of two pay periods or less is considered a short term LAW. Any approved leave of absence more than two pay periods is considered a long term LAW.

Medicare: A federal health insurance program administered by the Social Security Administration for disabled individuals and those age 65 or older. Eligible Medicare participants must enroll in both Parts A & B, because the State plan is often the secondary payer, and will not cover expenses and claims covered by Medicare. The optional Part D program covers prescription drugs.

Network: A group of providers contracted by an insurance carrier to provide services and treatment to individuals.

Open Enrollment Period: An annual period during which employees and retirees are given the option of enrolling in or changing one or more healthcare plans.

ORP (Optional Retirement Program): Special Retirement Programs available to certain faculty and staff of institutions of higher education.

Out-of-Network Service: Service received from providers outside of the plan's network. Such services are subject to up-front deductibles and coinsurance.

Out-of-Pocket Maximum: The most a member will pay out of his or her pocket in coinsurance charges. Copays not included in out-of-pocket maximum.

PPACA: Patient Protection and Affordable Care Act.

Premium: The amount of money an employee or retiree pays for insurance coverage. A premium does not include additional copayments or deductibles incurred for treatment.

Provider: Any approved healthcare professional who provides treatment or services.

Qualified Medical Child Support Orders (QMCSO): A court order that requires a parent to provide healthcare coverage for dependent children.

Qualifying Event: An event such as marriage, divorce, or the birth of a child, that allows a change in healthcare coverage outside of the Open Enrollment period.

Retroactive Adjustment: The process of paying back premiums to back date coverage to the date of the qualifying event.

State Subsidy: The portion of the insurance premium(s) that the State pays as a benefit to employees and retirees.



DEPARTMENT OF BUDGET & MANAGEMENT

Employee Benefits Division

301 West Preston Street

Room 510

Baltimore, MD 21201



Printed on Recycled Paper