



State of Maryland

July 2011 - June 2012

GUIDE TO YOUR HEALTH BENEFITS

Did You Know?

◆ **NEW! PRESCRIPTION BENEFITS COPAYS AND MAXIMUMS CHANGES** (See page 40)

◆ **EXTENSION OF ADULT CHILD COVERAGE TO AGE 26** (See page 2)

◆ **ELIMINATION OF LIFETIME MAXIMUM ON PPO AND POS PLANS** (See page 2)

◆ **ZERO COPAYS ON PREVENTIVE CARE SERVICES** (See page 3)



Martin O'Malley, Governor

Anthony Brown, Lt. Governor

T. Eloise Foster, Secretary

David C. Romans, Deputy Secretary

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	State Operations Center: 410-581-3601 (Baltimore); 1-800-225-0131 (outside Baltimore) TTY: 711 (Maryland only); 1-800-735-2258 (outside Maryland)	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		
Contact information to follow	Contact information to follow	Contact information to follow
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		
MetLife	1-866-492-6983	1-877-610-2954 www.metlife.com/mybenefits (group name: State of Maryland)
ACCIDENTAL DEATH AND DISMEMBERMENT PLAN		
MetLife	1-866-492-6983	1-877-610-2954 www.metlife.com/mybenefits (group name: State of Maryland)
LONG TERM CARE INSURANCE		
The Prudential Insurance Company of America (Prudential)	1-800-732-0416	www.prudential.com/gltc (group name: maryland; password: marylandltc)

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

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)	www.dbm.maryland.gov (click on Health Benefits)
--	--	--

Table of Contents

Introduction	ii
Healthcare Reform	2
Important Healthcare Reform Notices	2
Extension of Young Adult Coverage to Age 26	2
Special Enrollment Notice for Young Adult Coverage	2
Elimination of Lifetime Maximum on PPO and POS plans	2
Special Enrollment Notice for Individuals Who Have Reached Lifetime Limit	2
Primary Care Provider Designation – Patient Protection Disclosures	3
Elimination of Cost-Sharing for Preventive Care Services	3
Elimination of Rescission Provisions	3
Appeals Standards	3
Early Retiree Reinsurance Program	3
A Word About Program Requirements	4
Enrollment Instructions	5
Before You Call the IVR System	5
How to Enroll	6
If You Do Not Call the IVR	7
Special Instructions	7
Benefits Overview	8
Who is Eligible	8
Duplicate Coverage	9
Your Cost	9
Tax and Non Tax Favored Dependents	10
Eligibility and Subsidy	11
Required Documentation for Dependents	15
When Coverage Begins	17
Enrollment and Changes Outside of Open Enrollment	18
Making Mid-Year Changes	19
When Coverage Ends	20
Medical Benefits	21
Your Choices	21
How the Plans Work	21
Plan Comparison Charts	22
Aetna	22
CareFirst	26
UnitedHealthcare	31
For More Information	36
Behavioral Health Benefits	37
Your Choices	37
How the Plans Work	37
For More Information	39

Special Notice

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

Effective July 1, 2011, under the new IRS codes, there are now tax implications for your dependents not previously considered. For purposes of providing health coverage under the State's cafeteria plan, an employee will now have to pay for coverage using after-tax dollars for grandchildren and legal wards age 25. Please refer to page 10 for more in details on this change.

To enroll, call the Interactive Voice Response (IVR) system at: 410-669-3893 or 1-888-578-6434 during Open Enrollment.

Phone lines are open 24 hours a day, seven days a week from April 26 through May 26.

People who are deaf, hard of hearing or have a speech disability, please use Relay or 711. To enroll in Long Term Care Insurance, see page 64.

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 consent of the participants.

Table of Contents

Prescription Drug Benefits	40
How the Plan Works.....	40
For More Information	45
Dental Benefits	46
Your Choices	46
How the Plans Work.....	46
For More Information	47
DHMO Schedule of Benefits	48
Flexible Spending Accounts	52
Your Choices	53
How the Plans Work.....	53
Getting Reimbursed	55
For More Information	58
Term Life Insurance	59
Life Insurance for Active Employees	59
Life Insurance Upon Retirement.....	62
For More Information	62
Accidental Death and Dismemberment	63
Your Choices	63
How the Plan Works.....	63
For More Information	63
Long Term Care Insurance	64
Your Choices	65
How the Plan Works.....	65
For More Information	65
Important Notices and Information	67
Employee Fraud and Abuse	67
Notice About Disclosure and Use of Your Social Security Number	67
Leave/Continuation of Coverage/COBRA.....	67
General COBRA Notice	70
Health Insurance Portability and Accountability Act (HIPAA)	74
Notice of Privacy Practices.....	75
Newborns' and Mothers' Health Protection Act.....	76
Notice of Women's Health & Cancer Rights Act.....	77
Genetic Information Nondiscrimination Act of 2008.....	77
Children's Health Insurance Program Reauthorization Act (CHIPRA)	77
Medicare and Your State Benefits	79
Benefits Appeal Process	83
Notice of Creditable Prescription Drug Coverage	84
Definitions	86

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 plan year July 1, 2011-June 30, 2012. 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. 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	<p>PPO Plans</p> <ul style="list-style-type: none"> ◆ CareFirst BlueCross BlueShield ◆ UnitedHealthcare <p>POS Plans</p> <ul style="list-style-type: none"> ◆ Aetna ◆ CareFirst BlueCross BlueShield ◆ UnitedHealthcare <p>EPO Plans</p> <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 allowable expenses 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"> ◆ Regular State/Satellite employees ◆ Contractual State employees ◆ Less than 50% part-time State employees ◆ State retirees** ◆ ORP retirees**
Prescription Drug		<p>Provides benefits for a variety of prescription drugs. Some limitations (quantity limits, prior authorization, and step therapy) may apply for some drugs.</p>	<ul style="list-style-type: none"> ◆ Regular 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 	<p>Provides benefits for a variety of dental services and supplies.</p>	<ul style="list-style-type: none"> ◆ Regular 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 	<p>Allows you to set aside money on a pre-tax basis to reimburse yourself for eligible health care or dependent day care expenses.</p>	<ul style="list-style-type: none"> ◆ Regular State/Satellite employees
Term Life (MetLife)	<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>	<p>Pays a benefit to your designated beneficiary in the event of your death. You are automatically the beneficiary for your dependent's coverage.</p>	<ul style="list-style-type: none"> ◆ Regular State/Satellite employees ◆ Contractual State employees ◆ Less than 50% part-time State employees ◆ State retirees*** ◆ ORP retirees***
Accidental Death and Dismemberment (MetLife)	<p>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.</p>	<p>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.</p>	<ul style="list-style-type: none"> ◆ Regular State/Satellite employees ◆ Contractual State employees ◆ Less than 50% part-time State employees
Long Term Care (The Prudential)	<p>Choose from four different plans, then select:</p> <ul style="list-style-type: none"> ◆ three- or six-year facility benefit duration; and ◆ \$2,500, \$3,000, \$4,500, or \$6,000 facility monthly benefit amount. 	<p>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.</p>	<ul style="list-style-type: none"> ◆ Regular State/Satellite employees ◆ Contractual State employees ◆ Less than 50% part-time State employees ◆ State retirees ◆ ORP retirees ◆ Other relatives

* To be eligible, you must meet the eligibility requirements as outlined on pages 11-14 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. The federal regulations identified by the enactment of the PPACA are expected to have various impacts on employee benefit plan designs, costs, and eligibility over the course of the next four years, with the initial impacts occurring for the State Employee and Retiree Health and Welfare Benefits Program participants on July 1, 2011.

❁ NEW! Extension of Young Adult Coverage to Age 26

The PPACA has extended the eligible age limit of children from 25 to 26. A child is defined as an eligible biological, adopted, or step-child for the purposes of PPACA. As a result of health plan changes mandated by PPACA, employees will be allowed to re-enroll dependents who have lost health coverage due to turning age 25. Employees may enroll their adult children during the 2011-2012 Open Enrollment period. Enrollment elections made during the 2011-2012 Open Enrollment period will be effective on July 1, 2011.

The PPACA has 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 will continue to cover grandchildren.

❁ NEW! Open Enrollment will run for 30 Consecutive Days with No Correction Period

Special Enrollment Notice for Coverage of Children Up to Age 26

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before or upon attainment of age 25 are eligible to enroll in the State Employee and Retiree Health and Welfare Benefits Program. Individuals may request enrollment for such children during the 30 day Open Enrollment period. Enrollment will be effective July 1, 2011. The child may remain covered until the last day of the month in which he or she reaches age 26, provided all other eligibility criteria are met. For more information contact the Employee Benefits Division at 410-767-4775 or 1-800-30-STATE (1-800-307-8283).

❁ NEW! Elimination of Lifetime Maximum on PPO and POS Plans

Special Enrollment Notice for Individuals Who Have Reached Lifetime Limit

The lifetime limit on the dollar value of benefits paid under the PPO and POS plans no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan(s) are eligible to enroll in the plan. Individuals have the 30 day Open Enrollment period to request enrollment. For more information contact the Employee Benefits Division at 410-767-4775 or 1-800-30-STATE (1-800-307-8283) or at www.dbm.maryland.gov/benefits.

NEW! Primary Care Provider Designation Patient Protection Disclosures

CareFirst Point of Service (POS) generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact CareFirst at 410-581-3601 or 1-800-225-0131 or www.carefirst.com/statemd.

You do not need prior authorization from CareFirst or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional in the network who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating healthcare professionals who specialize in obstetrics or gynecology, contact CareFirst at 410-581-3601 or 1-800-225-0131 or www.carefirst.com/statemd.

NEW! Elimination of Cost-sharing for Preventive Care Services

Below are several examples of the types of preventive services requiring no copayment. 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 30 months - 12 visits; 3 years through 21 years - one per plan year) covered at 100% of Plan's allowed benefit with no copayment
- In-network **adult physical examination** (22 years and older) covered one per plan year at 100% of Plan's allowed benefit with no copayment

- In-network **annual GYN examination** at 100% of Plan's allowed benefit with no copayment
- In-network **nutritional counseling and health education** for chronic conditions covered at 100% of Plan's allowed benefit with no copayment
- **Annual screening mammograms** – Age 35-39 one baseline screening, Age 40+ one per plan year
- **Annual influenza vaccine** rendered by in-network provider covered at 100% of allowed benefit

NEW! Elimination of Rescission Provisions

The PPACA provides that effective July 1, 2011, your coverage can not be rescinded except –

- 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 of your coverage.

NEW! Appeals Standards

Internal claims and appeals process: Please contact your medical provider for more information. Plan contact information is located in the front of this guide or at www.dbm.maryland.gov/benefits.

External claims and appeals process: More information regarding the external review process will be forthcoming in a supplemental document which will be available in late April 2011.

NEW! Early Retiree Reinsurance Program

You are a plan participant, or are being offered the opportunity to enroll as a plan participant, in an employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a Federal program that was established under the Affordable Care Act. Under the Early Retiree Reinsurance Program, the Federal government reimburses a plan sponsor of an employment-based

health plan for some of the costs of healthcare benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

Under the Early Retiree Reinsurance Program, your plan sponsor may choose to use any reimbursements it receives from this program to reduce or offset increases in plan participants' premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs. If the plan sponsor chooses to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a plan participant, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and this plan sponsor chooses to use the reimbursements for this purpose. A plan sponsor may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in its own costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families.

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. Under the regulations, we cannot accept changes received more than 60 days after the event. Please refer to our website for a detailed list of qualified status changes.

We must abide by the regulations and cannot allow changes to elections after Open Enrollment closes. **Please be sure to make your changes early in the Open Enrollment period to leave time for review and correction of those elections if necessary.**

Enrollment Instructions

During Open Enrollment, you must use the Interactive Voice Response (IVR) system if you want to:

- ✿ Enroll in a new plan or make changes to your current benefit selections;
- ✿ Enroll in a Flexible Spending Account (FSA) (for Active/Satellite employees only) – for the first time or to re-enroll. **NOTE:** You **MUST** re-enroll each year to continue to participate; or
- ✿ Add or delete dependents.

To help you prepare for Open Enrollment, you will receive a personalized benefit statement with information about you and your benefit options for the 2011-2012 plan year.

- ✿ If you have never enrolled in any State health benefit plans, contact your Agency Benefits Coordinator for an enrollment packet. Retirees, please call the Employee Benefits Division to obtain an enrollment packet.
- ✿ If you did not receive a personalized benefits statement, please contact your Agency Benefits Coordinator. Retirees, please call the Employee Benefits Division.
- ✿ If you are retiring on or before July 1, 2011, see your Agency Benefits Coordinator for a Retiree Enrollment Worksheet.

Before You Call the IVR System...

- ✿ Review this benefits guide and have your personalized benefit statement handy when calling.
- ✿ Decide what changes and/or selections you want to make and note them on your personalized benefit statement.
- ✿ If you are an Active employee, decide if you want to contribute to an FSA and if so, **how much from each pay period deduction**. If you want to participate after July 1, you must enroll even if you already participate in the current plan year.
 - Decide on the total amount you want deducted for the 2011-2012 plan year: _____
 - Calculate your per pay deduction by dividing the total amount by your number of pay periods during the year: _____

PLEASE NOTE: Central Payroll employees will have 24 deductions. University employees who are 21-pay employees and Satellite employees should contact their Agency Benefits Coordinator to determine their number of deductions.
- ✿ Have the following information ready if you are adding a dependent or making changes to your dependent's information:
 - Dependent's full legal name
 - Dependent's Social Security Number
 - Dependent's gender
 - Dependent's relationship to you
 - Dependent's date of birth
- ✿ For a complete IVR script, detailing enrollment instructions, go to www.dbm.maryland.gov.

How to Enroll

Now you are ready to enroll – follow the steps below:

STEP 1: MAKE THE CALL

Call the IVR system 24 hours a day, 7 days a week at the number below:

- ✿ Baltimore area: 410-669-3893
- ✿ Outside Baltimore area: 1-888-578-6434
- ✿ People who are deaf, hard of hearing or have a speech disability, please use Relay or 711
- ✿ When prompted, enter your ID and Personal Identification Number.

Your ID is _____ (Social Security Number),
Your PIN is _____ (4 digit number - month
and day of your birthdate: mmdd)

Enroll early! There is a large volume of calls made during the last few days of the Open Enrollment period. The best time to call is during the non-peak hours of late evening and early morning.

If you are enrolling in benefits for the first time or have cancelled benefits and are now re-enrolling, you must call one of the numbers shown above during office hours to have a benefit packet created. To do this, press Option 8 when prompted and you will be connected to a Benefits staff member. Hours of operation are 8:30 am to 4:30 pm, Monday through Friday except for State holidays and emergency closures. Once a benefit packet has been created, you will be able to use the IVR system.

STEP 2: MAKE YOUR SELECTIONS

The IVR system will guide you through the steps for making selections and changes for:

- ✿ Medical;
- ✿ Prescription Drug;
- ✿ Dental;
- ✿ Flexible Spending Accounts;
- ✿ Term Life Insurance;
- ✿ Accidental Death and Dismemberment; and
- ✿ Adding/deleting dependents.

After you make each selection, the IVR system will confirm your selection. Note that after each dependent is added, you must indicate in which plan(s) you are enrolling the dependent(s).

If you are an Active employee and need assistance using the IVR system, contact the Agency Benefits Coordinator in your Personnel Office. If you are a retiree and need assistance, contact the Employee Benefits Division during business hours.

NOTE: The Prudential Insurance Company administers the Long Term Care (LTC) plan. If you want to enroll in this plan, follow the instructions in the LTC section of this guide.

STEP 3: MAKE SURE IT'S RIGHT

To review your enrollment, call the IVR system again and select the appropriate option to listen to the changes you just made. This option will not repeat information about plans in which you did not make a change. Information for dependents added through “speak and spell” is not available through this option. You will receive an updated summary statement of benefits within 10 days after your call.

- ✿ If you are an Active employee, you will receive your statement from your Agency Benefits Coordinator.
- ✿ If you are a retiree, your statement will be mailed to the home address we have in our system for you.

NOTE: You may make changes and corrections at any time during Open Enrollment. There will not be a special correction period at the end of Open Enrollment for any last minute changes, corrections or enrollment selections. Please enroll early and review your summary statement carefully.

If your selections are not correct, call the IVR system again to make the correct selections, or contact:

- ✿ Your Agency Benefits Coordinator, if you are an Active employee; or
- ✿ The Employee Benefits Division, if you are a retiree.

You cannot change your elections after Open Enrollment, except in limited circumstances. See page 18 for details.

If You Do Not Call the IVR

Your current benefit elections will roll over for the new plan year, except Flexible Spending Accounts (FSA).

If you currently participate in an FSA, you must re-enroll each year to continue participation. All other elections will automatically roll over to the new plan year.

**SPECIAL
INSTRUCTIONS:
IF YOU ARE ADDING OR
DELETING DEPENDENTS**

- You will need to “speak and spell” each dependent’s information clearly so that it can be accurately entered into the system.
- You may need to change the coverage level (i.e., Employee & Spouse or Employee & Family, etc.) of your plans if you add or delete a dependent. The system will not automatically change your coverage level.
- Following the close of Open Enrollment, you will be advised of the documentation required to cover your newly enrolled dependents. Failure to provide this documentation by the deadline indicated will result in the removal of the dependent. Any claims submitted for such dependents on or after the termination date will be your responsibility to pay. See pages 15-16 for dependent documentation requirements.
- If you add an ineligible dependent or fail to remove an ineligible dependent from your coverage, you will be required to pay the employee or retiree premium and full State subsidy for the ineligible dependent for each month that he or she remains enrolled.

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.

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

 **How Your Taxes May Be Affected** – Internal Revenue Service (IRS) regulations require different tax treatment for group insurance costs associated with health benefits for qualified same sex spouses and domestic partners and eligible same sex spouse and domestic partner's dependents for pre-tax coverage or FSA coverage. In most cases, the IRS does not qualify same sex spouse and domestic partners and same sex spouse or domestic partner's dependents for tax-free treatment under the tax code. Therefore, health benefits for same sex spouse/domestic partners and their eligible dependents who are not qualified as a dependent under the IRS tax code will be taxed as outlined below:

 **Payroll Deduction** – For each group health insurance plan where there is an employee contribution and a State subsidy in which you enroll your same sex spouse/domestic partner and your spouse/partner's eligible dependents, you will pay a:

- Post-tax deduction for the coverage level attributable to the same sex spouse/domestic partner (and/or spouse/domestic partner's child(ren)); and
- Pre-tax deduction for the coverage level applicable to the employee coverage level minus the amount of the post-tax deduction.

 **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/domestic partner and/or your same sex spouse/domestic partner's eligible dependents, you are subject to tax withholding on the State's

contribution towards the coverage for those dependents not qualified as tax dependents under the IRS code. In other words, the State's contribution towards coverage for your same sex spouse/domestic partner and your same sex spouse/domestic partner's dependents is considered wages and is included in your taxable gross income subject to tax withholdings. This is known as imputed income. Refer to the Same Sex Spouse/Domestic Partner rate pages available on the "July 2011-June 2012 Premium Rates" document at www.dbm.maryland.gov for details on how imputed income is calculated.

Retirees covering a same sex spouse/domestic partner will be billed quarterly for the Medicare taxes applicable to the imputed income and will receive a W-2 each January for the imputed income amount.

Dependent Child to Age 26

 You can cover your eligible dependent child through the end of the month in which they turn age 26. The child must be younger than the individual claiming him/her as a tax dependent. 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 apply to any grandchildren, legal wards, etc., that you cover under your benefit deductions. Please refer to the "July 2011-June 2012 Premium Rates" document for additional details.
- You must complete the dependent child affidavit for all newly enrolled dependent children.

 **Required Dependent Documentation:** You do not need to provide any documentation during Open Enrollment. After Open Enrollment ends, you will be contacted to provide the required documentation. See pages 15-16 for the required dependent documentation.

- After Open Enrollment ends, Active employees will receive written correspondence from their Agency Benefits Coordinator indicating the

required dependent documentation needed and the deadline for submitting it.

- After Open Enrollment ends, retirees will receive a letter mailed to their home address from the Employee Benefits Division indicating the required dependent documentation needed and the deadline by which it must be received.
- If you do not provide the required documentation by the deadline, any dependent(s) added during Open Enrollment will be removed from your coverage.

 **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.

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 10.

- 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.

PLEASE NOTE: It is your responsibility to remove a dependent child, spouse, domestic partner or domestic partner's child immediately when he/she no longer meets dependent eligibility criteria provided on page 10. Children reaching age 26 with no disability certification are removed from the coverage automatically at the end of the month in which they reach age 26. A notice is sent to your home address in advance of the termination of coverage.

Important – Duplicate Coverage Prohibited

A husband and wife or same sex spouse/domestic partner 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. This is

duplicate coverage and is not permitted under the benefit program. This also applies to Satellite agency dependents [including domestic partners and their child(ren)]. 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.**

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 (for retiree medical benefits only);
- 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 to receive, if any.

The premiums do not apply to Contractual, Part-time Active (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 Satellite Organization employer.

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 - Opposite Sex ◆ Not applicable
Spouse - Same Sex ◆ 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 ◆ Must permanently reside with you for entire taxable year, but; ◆ For whom you do not provide more than 50% support for the taxable year
Same Sex Domestic Partner ◆ Meets all Domestic Partner eligibility criteria, and; ◆ For whom you provide more than 50% support for the taxable year	Same Sex Domestic Partner ◆ Meets all Domestic Partner eligibility criteria, but; ◆ Does not depend on you for more than 50% of his/her support for the taxable year
Child ◆ Meets all dependent child eligibility criteria, and; ◆ Your or your spouse's biological child, step-child or adopted child ◆ Your domestic partner's biological child, step-child or adopted child that fully satisfies one of the three tax criteria tests (See Child Tax Affidavit.)	Child ◆ 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 Domestic Partner who does not fully satisfy one of the three tax tests. (See Child Tax Affidavit.)

All forms referenced in this guide can be located at www.dbm.maryland.gov/benefits.

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 regular (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; ◆ A State Board or Commission member who is regularly paid salary or wages and works at least 50% of the work week; 	<p>Maximum State Subsidy</p>	<p>Through payroll deductions, using pre-tax deductions through the State’s cafeteria plan, where pre-tax deductions are permitted.</p>
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); and ◆ Changes to coverage cannot be made at the time of an employment contract renewal. ◆ Contractual employees must have a current active contract to enroll. 	<p>No State Subsidy – you pay the full amount</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 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. Payments must begin with the first coupon received and are due the first of every month, with a 30-day grace period. Payments cannot be skipped.</p> <p>Untimely payments may cause a delay in your ability to use services and/or claims processing. Payments not postmarked within the 30-day grace period will result in the termination of your coverage and 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 signing your enrollment form, please contact the Employee Benefits Division.</p>
SATELLITE EMPLOYEES		
<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. ◆ 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). 	<p>As determined by the Satellite Employer</p>	<p>As determined by the Satellite Employer</p>

Eligibility	Subsidy Amount	How You Will Pay for Benefits
MARYLAND STATE RETIREMENT SYSTEM RETIREES		
<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>Please 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. If your retirement allowance is not enough to cover any or 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 12-month period of July-June in August for the premiums that could not be deducted from your monthly retirement allowance. 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). 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>
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 10). 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 MetLife 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>	<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.</p>	<p>Same as Maryland State Retirement System Retirees (see above).</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. Address Change forms may be downloaded at www.dbm.maryland.gov (click on Health Benefits, then Forms).

Eligibility	Subsidy Amount	How You Will Pay for Benefits
OPTIONAL RETIREMENT PROGRAM (ORP) RETIREES		
<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 first month in which you receive 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 service equal to at least five 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 service equaling at least 16 years of full-time employment with continuous contributions to a Maryland ORP account. <p>NOTE: 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>Required Documentation: Completion of a Retiree Health and Welfare Benefits enrollment 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 mail from the Employee Benefits Division.</p> <p>NOTE: Lump sum payments, supplemental retirement accounts, or non-Maryland State institution service do not count towards eligibility for enrollment in, or State subsidy for, retiree health benefits.</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 service equal to at least 16 years but less than 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 service equal to at least five years but less than 16 years of full-time service with contributions 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 following exception: <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>Contact your Agency Benefit Coordinator or the Employee Benefits Division if you have questions about your eligibility.</p>	<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 (July 2011 through June 2012 for forms processed during this Open Enrollment period).</p> <p>Payments must begin with the first coupon received and are due the first of every month, with a 30-day grace period. Payments cannot be skipped.</p> <p>All benefits are inactive and claims will not be processed until the Employee Benefits Division receives payment. Untimely payments may cause a delay in your ability to use services and/or claims processing. Payments not postmarked within the 30-day grace period will result in the termination of your coverage and 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 signing your enrollment form, please contact the Employee Benefits Division.</p>
<p>NOTE: 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>NOTE: If all coverage in the Health Benefits Program is terminated for an ORP Retiree or Beneficiary for any reason, either voluntarily or involuntarily, documentation confirming the current continuous receipt of a periodic distribution from the Maryland ORP must be provided to qualify for re-enrollment.</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 10).</p> <p>Required Documentation: Completion of a Retiree Health and Welfare Benefits enrollment 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 mail from the Employee Benefits Division.</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. <p>ORP Beneficiaries may cover dependents that would be eligible dependents of the deceased retiree.</p>	<p>Same as ORP retirees (see page 13).</p>
<p>NOTE: If all coverage in the Health Benefits Program is terminated for an ORP Retiree or Beneficiary for any reason, either voluntarily or involuntarily, documentation confirming the current continuous receipt of a periodic distribution from the Maryland ORP must be provided to qualify for re-enrollment.</p>		

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 under Health Benefits.

Required Documentation for Dependents

You are required to submit verifying documentation for each dependent you wish to enroll for coverage. 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. 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.

To Add an Eligible Dependent		
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 Spousal Eligibility and Tax Status ◆ 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
Same Sex Domestic Partner	<ul style="list-style-type: none"> ◆ Be of the same gender ◆ Be at least 18 yrs old ◆ Not related to each other by blood or marriage within four degrees of consanguinity under civil law rule ◆ Not married, in a civil union or in a domestic partnership with another individual ◆ In a committed relationship for at least 12 consecutive months ◆ Financial interdependency ◆ Share a common primary residence 	<ul style="list-style-type: none"> ◆ Affidavit of domestic partnership ◆ Documentation to verify a common primary residence (one of the following): <ul style="list-style-type: none"> - Common ownership of the primary residence via joint deed or mortgage agreement ; - Common leasehold interest in the primary residence; - Copies of both individual's driver's licenses or State-issued identification listing a common address; or - Utility or other household bill with both the name of the insured and the name of the domestic partner appearing ◆ Documentation to verify financial interdependence between domestic partners (one of the following): <ul style="list-style-type: none"> - Joint bank account or credit account; - Designation as the primary beneficiary for life insurance or retirement benefits of the domestic partner; - Designation as primary beneficiary under the domestic partner's will; - Mutual assignments of valid durable powers of attorney; - Mutual valid written advanced directives approving the other domestic partner as health care agent; - Joint ownership or holding of investments; or - Joint ownership or lease of a motor vehicle

Chart continued on next page.

To Add an Eligible Dependent (Continued)

Dependent Relationship	Eligibility Criteria	Required Documentation
<p>Children</p> <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 of 26 ◆ Not required to reside in your home (except for grandchildren and legal wards) ◆ Not required to be a student ◆ Not required to be a tax-dependent ◆ 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"> ◆ Child Tax Affidavit, and; Biological Child <ul style="list-style-type: none"> ◆ Copy of child's official state birth certificate Adopted Child <ul style="list-style-type: none"> ◆ Copy of adoption papers; must indicate child's date of birth ◆ Copy of child's official state birth certificate 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 Grandchild <ul style="list-style-type: none"> ◆ Copy of child's official state birth certificate ◆ Copy of child's parent's birth certificate (to document grandchild's relationship to employee/retiree) ◆ Proof of permanent residency (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; - Tax documents certifying address with child's name on document 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 ◆ Proof of permanent residency (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; - Tax documents certifying address with child's name on document ◆ Copy of Legal Ward/Testamentary court document, signed by a judge Step-grandchild or other dependent child relatives <ul style="list-style-type: none"> ◆ Copy of child's official state birth certificate ◆ Proof of permanent residency (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; - 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
<p>Same Sex Domestic Partner's Children</p> <ul style="list-style-type: none"> ◆ Biological Child ◆ Adopted Child or child placed with domestic partner for adoption by the domestic partner ◆ Step-Child of domestic partner ◆ Grandchild of domestic partner ◆ Legal ward, Testamentary, or Court appointed guardian (not-temporary for less than 12 months) ◆ Step-grandchild or other dependent child relatives 	<ul style="list-style-type: none"> ◆ Under age of 26 ◆ Not required to reside in your home (except for grandchildren and legal wards) ◆ Not required to be a student ◆ Not required to be a tax-dependent ◆ 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"> ◆ Documentation to establish existence of domestic partnership (see above) ◆ Affidavit signed by the domestic partner and the employee/retiree that the child is a dependent child of the domestic partner ◆ All the same documents (above) that are required for a dependent child of an employee/retiree establishing the relationship between the dependent child and the domestic partner

* Please refer to the "July 2011-June 2012 Premium Rates" document at www.dbm.maryland.gov/benefits for important tax information when covering these dependents who are age 25 and not disabled.

To Remove an Eligible Dependent outside of Open Enrollment*	
Dependent Relationship	Required Documentation
Spouse - Opposite Sex/Same Sex	<ul style="list-style-type: none"> ◆ Final limited divorce decree (must be signed by a judge); or ◆ Final divorce decree (must be signed by a judge)
Same Sex Domestic Partner	<ul style="list-style-type: none"> ◆ An affidavit signed by the employee/retiree attesting to the permanent dissolution of the domestic partner relationship ◆ Proof of the termination of common primary residence ◆ Proof of the termination of the financial interdependence
Children	<ul style="list-style-type: none"> ◆ Documents to establish the loss of eligibility of the dependent child
Same Sex Domestic Partner's Children	<ul style="list-style-type: none"> ◆ Documents listed above to remove a domestic partner if partnership is ending, and; ◆ Documents to establish the loss of eligibility of the dependent child of your domestic partner

*To remove a dependent from coverage during Open Enrollment, no documentation is required.

When Coverage Begins

If you enroll in benefits during the Open Enrollment period, the coverage you elect will begin July 1, 2011 and remain in effect through June 30, 2012, unless you have a qualifying status change that allows you to make a mid-year change in coverage as described under the Enrollment and Changes Outside of Open Enrollment section.

If you enroll in benefits at a time other than during the Open Enrollment period, 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.

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.

Enrollment and Changes Outside of Open Enrollment

Regardless of how you pay for your coverage (by automatic deduction from your paycheck or 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 Open Enrollment will be in place July 1 to June 30 of the plan year. However, there are some changes in status that permit you to make limited changes in the middle of the plan year. Examples of qualifying changes in status include:

- ✿ Birth or adoption/placement for adoption of a child;
- ✿ Death of a dependent;
- ✿ Dependent's loss of eligibility;
- ✿ Marriage or divorce;
- ✿ Dissolution of a domestic partnership;
- ✿ 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;
- ✿ Involuntary loss of other coverage, such as if coverage under your spouse's employment ends;
- ✿ Gaining eligibility for Medicare (for retirees); or
- ✿ Changes in your other coverage which has a different plan year.

* **NOTE:** If you are a new State employee, you have 60 days from your date of hire to submit an enrollment form indicating your benefit elections.

You have 60 days from the date of the qualifying change in status to submit an enrollment form 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 State 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

Ex-Spouse

You must submit an enrollment form to remove your ex-spouse as soon as you are divorced. The ex-spouse cannot be continued on your State benefits coverage. If you fail to remove your ex-spouse within 60 days of your divorce, you will be required to pay the full insurance premium, including the State subsidy for the period beginning with the date of divorce through the date your ex-spouse is removed from your coverage. You may also face disciplinary action, termination of employment, and/or criminal prosecution for continuing to cover a dependent who is no longer eligible.

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 or her own account and will be responsible for paying premiums directly. COBRA coverage is not subsidized by the State. Please see the Continuation of Coverage section for more information.

Ex-Domestic Partner

You must submit an enrollment form to remove your ex-domestic partner as soon as your partnership is dissolved. The ex-domestic partner cannot be continued on your State benefits coverage. If you fail to remove your ex-domestic partner within 60 days of the dissolution, you will be required to pay the full

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.**

insurance premium, including the State subsidy for the period beginning with the date of dissolution, through the date your ex-domestic partner is removed from your coverage. You may also 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 page 10.

Other Dependents

It is your responsibility to submit an enrollment form to remove any other dependents as soon as they lose eligibility.

If you fail to remove a dependent when he/she becomes ineligible, you will be required to pay the full premium including the State subsidy from the date he/she became ineligible until the date the dependent is removed. You may also face disciplinary action, termination of employment, and/or criminal prosecution. In most cases, dependents who lose eligibility are entitled to COBRA coverage for a limited time, which is not subsidized by the State. Please see the Continuation of Coverage section for more information.

INSTRUCTIONS ON HOW TO MAKE MID-YEAR CHANGES

If You...	Then...
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. The Agency Benefits Coordinator 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 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 to their Agency Benefits Coordinator. The Agency Benefits Coordinator must sign the enrollment form. Retirees must submit their form to the Employee Benefits Division, along with the required documentation.
Experience a qualifying event	In order for your change to be effective on the day of the qualifying event, you must request a retroactive adjustment. Even if the qualifying event does not change your coverage levels, a zero-balance retroactive adjustment is still required. Your request for a retroactive adjustment must be submitted within 30 days of the first premium deduction reflecting the change or, if there is no change in coverage level, within 30 days of the date on the Summary Statement of Benefits reflecting the change. Active employees must contact their Agency Benefits Coordinator. 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 and retroactive adjustment form even if you already have family coverage. You must submit temporary documentation of the child's birth (such as hospital discharge papers, copy of the child's hospital I.D. bracelet, or footprints) with the enrollment form. 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 meet with their Agency Benefits Coordinator. All other enrollees should call 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 delete 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 end 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.

It is your responsibility to verify your benefit deductions on your check or retirement stub and your Summary Statement of Benefits to make sure they match the coverage you requested. If there is an error or omission in your deductions, 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 because of an unpaid absence, 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 have a payroll error, please contact your Agency Benefits Coordinator immediately so that your Coordinator can calculate your share of the premiums and submit a retroactive adjustment form. This must be done so that your benefits continue without interruption for the remainder of the plan year.

If your benefits are cancelled, you will be permitted to re-enroll only during 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)*

Your Choices

You have eight medical plans from which to choose:

Preferred Provider Organization (PPO) Plans:

- CareFirst BlueCross BlueShield
- UnitedHealthcare

Point-of-Service (POS) Plans:

- Aetna
- CareFirst BlueCross BlueShield
- UnitedHealthcare

Exclusive Provider Organization (EPO) Plans:

- Aetna
- CareFirst BlueCross BlueShield
- UnitedHealthcare

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's 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 22-35 for more details on each medical plan option.

Allowed Amount

The plan's allowed amount refers to the reimbursement amount that 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 amount as payment in full and may charge more than the plan's allowed amount. In the charts that follow, if it indicates the service is covered at 80% out-of-network, it means the plan pays 80% of the allowed amount. You are responsible for any amount above the plan's allowed amount 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 any plan, contact that plan before obtaining any services or treatment. Call the plan for more information on coverage limitations, exclusions, determinations of medical necessity, and preauthorization requirements. In addition, you will receive a description of coverage book from the plan in which you enroll that will provide details on your plan coverage.

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, please note 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.

AETNA			
Benefit	POS In-Network	POS Out-of-Network	EPO In-Network Only
Plan Year Deductibles			
Individual	None	\$250	None
Family	None	\$500	None
Out-of-Pocket Coinsurance Maximums			
Individual	None	\$3,000	None
Family	None	\$6,000	None
	Any charges above the plan's Allowed Amount are not counted toward the out-of-pocket maximum.		
Lifetime Maximums	Unlimited		Unlimited
National Network	Yes	Yes	Yes
Primary Care Physician	No	No	Yes
Referrals Required	No	No	No

AETNA HOSPITAL – INPATIENT SERVICES

Inpatient Care (requires precertification)	100% of allowed benefit when precertified by Plan	80% of allowed benefit after deductible	100% of allowed benefit when precertified by Plan
	Inpatient care primarily for or solely for rehabilitation is not covered.		
Hospitalization	100% of allowed benefit when precertified by Plan	80% of allowed benefit after deductible	100% of allowed benefit when precertified by Plan
Anesthesia	100% of allowed benefit when precertified by Plan	80% of allowed benefit after deductible	100% of allowed benefit when precertified by Plan
Surgery (requires precertification)	100% of allowed benefit when precertified by Plan	80% of allowed benefit after deductible	100% of allowed benefit when precertified by Plan
Organ Transplants (requires precertification) Per calendar year for cornea, kidney, bone marrow, heart, heart-lung, single or double lung, liver, and pancreas	100% of allowed benefit when precertified by Plan	80% of allowed benefit after deductible	100% of allowed benefit when precertified by Plan

AETNA HOSPITAL – OUTPATIENT SERVICES

Chemotherapy/ Radiation	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Diagnostic Lab & X-Ray	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Outpatient Surgery (requires precertification)	100% of allowed benefit when precertified by Plan	80% of allowed benefit after deductible	100% of allowed benefit when precertified by Plan
Anesthesia	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit

AETNA			
Benefit	POS In-Network	POS Out-of-Network	EPO In-Network Only
AETNA THERAPIES			
Benefit Therapies (see below for further information on therapies)	100% of allowed benefit after \$25 copay when precertified by Plan	80% of allowed benefit after deductible	100% of allowed benefit after \$25 copay when precertified by Plan
Physical Therapy (PT) and Occupational Therapy (OT)	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		
AETNA COMMON AND PREVENTIVE SERVICES			
Primary Care Physician's Office Visit	\$15 copay	80% of allowed benefit after deductible	\$15 copay
Specialist Office Visit	\$25 copay	80% of allowed benefit after deductible	\$25 copay
Routine Annual GYN Exam (including Pap test)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Hearing Examinations and Hearing Aids (No exam copay for children when part of a well-child visit as recommended by PPACA)	100% of allowed benefit after \$15 copay for exam for adults 100% of allowed benefit for Basic Model Hearing Aid 1 exam and hearing aid per ear every 3 years for each employee and dependent	Not covered, except for hearing aids as mandated for minor children	100% of allowed benefit after \$15 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 and dependent
	Includes benefit for hearing aids for minor children (ages 0-18) as mandated by Maryland Law effective 01/01/02, including hearing aids per each impaired ear for minor children.		
Immunizations* and Vaccines covered; Contact Aetna for detailed list.	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Mammography**	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
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 Birth through 30 months; 12 visits total 3 through 21 years; 1 visit per plan year	100% of allowed benefit	Not covered	100% of allowed benefit
	Contact Aetna for further details on eligibility for visits.		
Allergy Testing	\$15 copay (primary care physician) or \$25 copay (specialist)	80% of allowed benefit after deductible	\$15 copay (primary care physician) or \$25 copay (specialist)
Nutritional Counseling and Health Education (Contact Aetna for details)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit

AETNA			
Benefit	POS In-Network	POS Out-of-Network	EPO In-Network Only
AETNA EMERGENCY TREATMENT			
Ambulance Services	100% of allowed benefit for medically necessary ambulance	100% of allowed benefit for medically necessary ambulance	100% of allowed benefit for medically necessary ambulance
Emergency Room (ER) Services – inside and outside of service area***	\$50 copay for ER Facility Care and \$50 copay for ER Physician Services	100% of allowed benefit of the allowed benefit after \$50 copay for ER Facility Care and \$50 copay for ER Physician Services	\$50 copay for ER Facility Care and \$50 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 amount after the two \$50 copays.			
AETNA MATERNITY			
Maternity Benefits	100% of allowed benefit after \$25 copay for initial office visit	80% of allowed benefit after deductible	100% of allowed benefit after \$25 copay for initial office visit
Newborn Care****	100% of allowed benefit when precertified by Plan	80% of allowed benefit after deductible	100% of allowed benefit when precertified by Plan
Contact Aetna to confirm if 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 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.			
AETNA OTHER SERVICES AND SUPPLIES			
Acupuncture Services for Chronic Pain Management	100% of allowed benefit when precertified by Plan	80% of allowed benefit after deductible	100% of allowed benefit when precertified by Plan
Cardiac Rehabilitation†	100% of allowed benefit when precertified by Plan	80% of allowed benefit after deductible	100% of allowed benefit when precertified by Plan
Chiropractic Services	100% of allowed benefit when precertified by Plan	80% of allowed benefit after deductible	100% of allowed benefit when precertified by Plan
Dental Services	Not covered	Not covered	Not covered
Durable Medical Equipment	100% of allowed benefit when precertified by Plan	80% of allowed benefit after deductible	100% of allowed benefit when precertified by Plan
Contact Aetna for details on covered items.			
Extended Care Facility (if medically necessary)	100% of allowed benefit when precertified by Plan	80% of allowed benefit after deductible	100% of allowed benefit when precertified by Plan
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.			
Family Planning And Fertility Testing	100% of allowed benefit when precertified by Plan based on place of service. Copay may apply.	80% of allowed benefit after deductible	100% of allowed benefit when precertified by Plan based on place of service. Copay may apply.
Family Planning benefits include: sperm count hysterosalpingography, eudiometrical biopsy, IUD insertion, vasectomy, and tubal ligation.			

AETNA			
Benefit	POS In-Network	POS Out-of-Network	EPO In-Network Only
AETNA OTHER SERVICES AND SUPPLIES (Continued)			
Home Health Care	100% of allowed benefit when precertified by Plan	80% of allowed benefit after deductible	100% of allowed benefit when precertified by Plan
Home Health Care benefits are limited to 120 days per plan year.			
Hospice Care	100% of allowed benefit when precertified by Plan	80% of allowed benefit after deductible	100% of allowed benefit when precertified by Plan
In Vitro Fertilization (IVF) and Artificial Insemination (AI) ^{††} Contact Aetna for further details	100% of allowed benefit when precertified by Plan for up to 3 attempts of AI and 3 attempts of IVF per live birth, lifetime maximum of \$100,000	80% of allowed benefit after deductible for up to 3 attempts of AI and 3 attempts of IVF per live birth, lifetime maximum of \$100,000	100% of allowed benefit when precertified by Plan for up to 3 attempts of AI and 3 attempts of IVF per live birth, lifetime maximum of \$100,000
Medical Supplies	100% of allowed benefit when precertified by Plan	80% of allowed benefit after deductible	100% of allowed benefit when precertified by Plan
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.			
Behavioral Health See the Behavioral Health Benefits section for more information (does not apply to EPOs)	Not covered by Plan Covered by State's Behavioral Health Plan	Not covered by Plan Covered by State's Behavioral Health Plan	Inpatient care: 100% of allowed benefit for up to 365 days when precertified by Plan Outpatient care: 100% of allowed benefit after \$15 copay
See pages 37-39 for behavioral health benefits.			
Outpatient Prescription Drugs	Not covered	Not covered	Not covered
Private Duty Nursing (must be precertified)	100% of allowed benefit when precertified by Plan	80% of allowed benefit after deductible	100% of allowed benefit when precertified by Plan
Surgical Second Opinion	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit
Urgent Care Centers	100% after \$20 copay	80% of allowed benefit after deductible	100% after copay
Whole Blood Charges	100% of allowed benefit when precertified by Plan	80% of allowed benefit after deductible	100% of allowed benefit when precertified by Plan
AETNA VISION SERVICES AND SUPPLIES			
Vision – Medical Any services that deal with the medical health of the eye	100% of allowed benefit after \$15 copay (primary care physician) or \$25 copay (specialist)	80% of allowed benefit after deductible	100% of allowed benefit after \$15 copay (primary care physician) or \$25 copay (specialist)
Vision – Routine Any services that deal with correcting vision (provided by Aetna health plan)	Exam: Plan pays up to \$45 (available once every plan year) Prescription lenses, frames, contact lenses (per plan year): \$200.00 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. To obtain vision benefits, you must contact Aetna for more information. Vision benefits are available once every plan year.			

CAREFIRST					
Benefit	PPO In-Network	PPO Out-of-Network	POS In-Network	POS Out-of-Network	EPO In-Network Only
Plan Year Deductibles					
Individual	None	\$250	None	\$250	None
Family	None	\$500	None	\$500	None
Out-of-Pocket Coinsurance Maximums					
Individual	None	\$3,000	None	\$3,000	None
Family	None	\$6,000	None	\$6,000	None
Any charges above the plan's Allowed Amount are not counted toward the out-of-pocket maximum.					
Lifetime Maximums	Unlimited		Unlimited		Unlimited
National Network	Yes	Yes	No, Regional Network	Yes	Yes
Primary Care Physician	No	No	Yes	No	No
Referrals Required	No	No	Yes	No	No

CAREFIRST HOSPITAL – INPATIENT SERVICES					
Inpatient Care/ Hospitalization 365 days (requires preauthorization)	100% of allowed benefit	80% of allowed benefit after deductible; 100% of the allowed benefit after emergency admission	100% of allowed benefit with PCP referral	80% of allowed benefit after deductible; 100% of the allowed benefit after emergency admission	100% of allowed benefit
Inpatient care primarily for or solely for rehabilitation is not covered.					
Anesthesia	100% of allowed benefit	100% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Surgery (requires preauthorization)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit with PCP referral	80% of allowed benefit after deductible	100% of allowed benefit
Organ Transplants (requires preauthorization) Per calendar year for cornea, kidney, bone marrow, heart, heart-lung, single or double lung, liver, and pancreas	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit with PCP referral	80% of allowed benefit after deductible	100% of allowed benefit

CAREFIRST					
Benefit	PPO In-network	PPO Out-of-Network	POS In-Network	POS Out-of-Network	EPO In-Network Only
CAREFIRST HOSPITAL – OUTPATIENT SERVICES					
Chemotherapy/Radiation	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible ^{†††}	100% of allowed benefit
Diagnostic Lab & X-Ray	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	100% of allowed benefit after deductible ^{†††}	100% of allowed benefit
Outpatient Surgery	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit with PCP referral	80% of allowed benefit after deductible	100% of allowed benefit
Anesthesia	100% of allowed benefit	100% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
CAREFIRST THERAPIES					
Benefit Therapies (see below for further information on therapies)	100% of allowed benefit after \$25 copay when preauthorized by Plan	80% of allowed benefit after deductible	100% of allowed benefit after \$25 copay	80% of allowed benefit of allowed benefit after deductible	100% of allowed benefit after \$25 copay when preauthorized by Plan
Physical Therapy (PT) and Occupational Therapy (OT)	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				
CAREFIRST COMMON AND PREVENTIVE SERVICES					
Primary Care Physician's Office Visit	100% of allowed benefit after \$15 copay	80% of allowed benefit after deductible	100% of allowed benefit after \$15 copay	80% of allowed benefit after deductible	100% of allowed benefit after \$15 copay
Specialist Office Visit	100% of allowed benefit after \$25 copay	80% of allowed benefit after deductible	100% of allowed benefit after \$25 copay	80% of allowed benefit after deductible	100% of allowed benefit after \$25 copay
Routine Annual GYN Exam (including Pap test)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit when rendered by Preferred Provider	80% of allowed benefit after deductible ^{†††}	100% of allowed benefit
Hearing Examinations and Hearing Aids (No exam copay for children when part of a well-child visit as recommended by PPACA)	100% of allowed benefit after \$15 copay for exam for adults 100% of allowed benefit for Basic Model Hearing Aid 1 exam and hearing aid per ear every 3 years for each employee and dependent	80% of allowed benefit after deductible for exam 100% of allowed benefit for Basic Model Hearing Aid 1 exam and hearing aid per ear every 3 years for each employee and dependent	100% of allowed benefit after \$15 copay for exam with PCP referral 100% of allowed benefit for Basic Model Hearing Aid 1 exam and hearing aid per ear every 3 years for each employee and dependent	Not covered, except for hearing aids as mandated for minor children	100% of allowed benefit after \$15 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 and dependent
Includes benefit for hearing aids for minor children (ages 0-18) as mandated by Maryland Law effective 01/01/02, including hearing aids per each impaired ear for minor children.					

CAREFIRST					
Benefit	PPO In-Network	PPO Out-of-Network	POS In-Network	POS Out-of-Network	EPO In-Network Only
CAREFIRST COMMON AND PREVENTIVE SERVICES (Continued)					
Immunizations* and Vaccines covered; Contact CareFirst for a detailed list.	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Mammography**	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	100% of allowed benefit ^{†††}	100% of allowed benefit
Adult Physical Exams & associated lab work	100% of allowed benefit	80% 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 Birth through 30 months; 12 visits total 3 through 21 years; 1 visit per plan year	100% of allowed benefit	80% of allowed benefit after deductible per visit	100% of allowed benefit	Not covered	100% of allowed benefit
Contact CareFirst for further details on eligibility for visits.					
Allergy Testing	100% of allowed benefit after \$15 copay (primary care physician) or \$25 copay (specialist)	80% of allowed benefit after deductible	100% of allowed benefit after \$15 copay (primary care physician) or \$25 copay (specialist) with PCP referral	80% of allowed benefit after deductible	100% of allowed benefit after \$15 copay (primary care physician) or \$25 copay (specialist)
Nutritional Counseling and Health Education (Contact CareFirst for details)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit with PCP referral	80% of allowed benefit after deductible	100% of allowed benefit
CAREFIRST EMERGENCY TREATMENT					
Ambulance Services	100% of allowed benefit for medical emergencies	100% of allowed benefit for medical emergencies	100% of allowed benefit for medical emergencies	100% of allowed benefit for medical emergencies	100% of allowed benefit for medical emergencies
Emergency Room (ER) Services – inside and outside of service area ^{***}	100% of allowed benefit after \$50 copay for ER Facility Care and \$50 copay for ER Physician Services	100% of the allowed benefit after \$50 copay for ER Facility Care and \$50 copay for ER Physician Services	100% of allowed benefit after \$50 copay for ER Facility Care and \$50 copay for ER Physician Services	100% of the allowed benefit after \$50 copay for ER Facility Care and \$50 copay for ER Physician Services	100% of allowed benefit after \$50 copay for ER Facility Care and \$50 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 amount, after the two \$50 copays.					
CAREFIRST MATERNITY					
Maternity Benefits	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit when rendered by Preferred Provider	80% of allowed benefit after deductible	100% of allowed benefit
Newborn Care ^{****}	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit when rendered by Preferred Provider	80% of allowed benefit after deductible	100% of allowed benefit
Contact CareFirst to confirm if 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.					

CAREFIRST					
Benefit	PPO In-Network	PPO Out-of-Network	POS In-Network	POS Out-of-Network	EPO In-Network Only
CAREFIRST OTHER SERVICES AND SUPPLIES					
Acupuncture Services for Chronic Pain Management	100% of allowed benefit after \$20 copay	80% of allowed benefit after deductible	100% of allowed benefit with PCP referral	80% of allowed benefit after deductible	100% of allowed benefit
Cardiac Rehabilitation†	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit with PCP referral	80% of allowed benefit after deductible	100% of allowed benefit
Chiropractic Services	100% of allowed benefit after \$20 copay	80% of allowed benefit after deductible	100% of allowed benefit with PCP referral	80% of allowed benefit after deductible	100% of allowed benefit
Dental Services	Not covered	Not covered	Not covered	Not covered	Not covered
Durable Medical Equipment	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Contact CareFirst for details on covered items.					
Extended Care Facility (requires preauthorization)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% 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.					
Family Planning And Fertility Testing	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit with PCP referral other than GYN	80% of allowed benefit after deductible	100% of allowed benefit
Family Planning benefits include: sperm count hysterosalpingography, eudiometrical biopsy, IUD insertion, vasectomy, and tubal ligation.					
Home Health Care (requires preauthorization)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible ^{†††}	100% of allowed benefit
Home Health Care benefits are limited to 120 days per plan year.					
Hospice Care (requires preauthorization)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	100% of allowed benefit after deductible ^{†††}	100% of allowed benefit
In Vitro Fertilization (IVF) and Artificial Insemination (AI) ^{††} (requires preauthorization) Contact CareFirst for further details	100% of allowed benefit for up to 3 attempts of AI and 3 attempts of IVF per live birth, lifetime maximum of \$100,000	80% of allowed benefit after deductible for up to 3 attempts of AI and 3 attempts of IVF per live birth, lifetime maximum of \$100,000	100% of allowed benefit with PCP referral for up to 3 attempts of AI and 3 attempts of IVF per live birth, lifetime maximum of \$100,000	80% of allowed benefit after deductible for up to 3 attempts of AI and 3 attempts of IVF per live birth, lifetime maximum of \$100,000	100% of allowed benefit for up to 3 attempts of AI and 3 attempts of IVF per live birth, lifetime maximum of \$100,000
Medical Supplies	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% 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.					

CAREFIRST					
Benefit	PPO In-Network	PPO Out-of-Network	POS In-Network	POS Out-of-Network	EPO In-Network Only
CAREFIRST OTHER SERVICES AND SUPPLIES (Continued)					
Behavioral Health See the Behavioral Health Benefits section for more information (does not apply to EPOs)	Not covered by Plan Covered by State's Behavioral Health Plan	Not covered by Plan Covered by State's Behavioral Health Plan	Not covered by Plan Covered by State's Behavioral Health Plan	Not covered by Plan Covered by State's Behavioral Health Plan	Inpatient care: 100% of allowed benefit when preauthorized by Plan Outpatient care: 100% of allowed benefit after \$15 copay
See pages 37-39 for behavioral health benefits.					
Outpatient Prescription Drugs	Not covered	Not covered	Not covered	Not covered	Not covered
Private Duty Nursing (must be preauthorized)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Surgical Second Opinion	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit
Urgent Care Centers	100% after \$20 copay	80% of allowed benefit after deductible	100% after \$20 copay	80% of allowed benefit after deductible	100% after \$20 copay
Whole Blood Charges	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
CAREFIRST VISION SERVICES AND SUPPLIES					
Vision – Medical Any services that deal with the medical health of the eye	100% of allowed benefit after \$15 copay (primary care physician) or \$25 copay (specialist)	80% of allowed benefit after deductible	100% of allowed benefit after \$15 copay (primary care physician) or \$25 copay (specialist) (when rendered by Preferred Provider)	80% of allowed benefit after deductible ^{†††}	100% of allowed benefit after \$15 copay (primary care physician) or \$25 copay (specialist)
Vision – Routine Any services that deal with correcting vision (provided by CareFirst)	Exam: Plan pays up to \$45 (available once every plan year) Prescription lenses (per pair – available once every plan year): ◆ 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): ◆ 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. To obtain vision benefits, you must contact CareFirst for more information. Vision benefits are available once every plan year.					

UNITEDHEALTHCARE					
Benefit	PPO In-Network	PPO Out-of-Network	POS In-Network	POS Out-of-Network	EPO In-Network Only
Plan Year Deductibles					
Individual	None	\$250	None	\$250	None
Family	None	\$500	None	\$500	None
Out-of-Pocket Coinsurance Maximums					
Individual	None	\$3,000	None	\$3,000	None
Family	None	\$6,000	None	\$6,000	None
Any charges above the plan's Allowed Amount are not counted toward the out-of-pocket maximum.					
Lifetime Maximums	Unlimited		Unlimited		Unlimited
National Network	Yes	Yes	Yes	Yes	Yes
Primary Care Physician	No	No	No	No	Yes
Referrals Required	No	No	No	No	No

UNITEDHEALTHCARE HOSPITAL – INPATIENT SERVICES					
Inpatient Care (requires prior notification)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Inpatient care primarily for or solely for rehabilitation/custodial care is not covered.					
Hospitalization	100% of allowed benefit for 365 days	80% of allowed benefit after deductible; 100% of the allowed benefit after emergency admission	100% of allowed benefit	80% of allowed benefit after deductible; 100% of allowed benefit after emergency admission	100% of allowed benefit
Anesthesia	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Surgery (Requires prior authorization)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Organ Transplants (requires prior notification) Per calendar year for cornea, kidney, bone marrow, heart, heart-lung, single or double lung, liver, and pancreas	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit

UNITEDHEALTHCARE					
Benefit	PPO In-network	PPO Out-of-Network	POS In-Network	POS Out-of-Network	EPO In-Network Only
UNITEDHEALTHCARE HOSPITAL – OUTPATIENT SERVICES – Some services require prior notification					
Chemotherapy/ Radiation	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Diagnostic Lab & X-Ray	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Outpatient Surgery	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Anesthesia	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
UNITEDHEALTHCARE THERAPIES					
Benefit Therapies (see below for further information on therapies)	100% of allowed benefit after \$25 copay	80% of allowed benefit after deductible	100% of allowed benefit after \$25 copay	80% of allowed benefit after deductible	100% of allowed benefit after \$25 copay
Physical Therapy (PT) and Occupational Therapy (OT)	PT/OT services must be pre-certified after the 6th visit, based on medical necessity; 50 visits per plan year combined for PT/OT/Speech Therapy				
Speech Therapy	Must be pre-certified from the first visit with exceptions and close monitoring for special situations (e.g., trauma, brain injury) for additional visits				
UNITEDHEALTHCARE COMMON AND PREVENTIVE SERVICES					
Primary Care Physician's Office Visit	100% of allowed benefit after \$15 copay	80% of allowed benefit after deductible	100% of allowed benefit after \$15 copay	80% of allowed benefit after deductible	100% of allowed benefit after \$15 copay
Specialist Office Visit	100% of allowed benefit after \$25 copay	80% of allowed benefit after deductible	100% of allowed benefit after \$25 copay	80% of allowed benefit after deductible	100% of allowed benefit after \$25 copay
Routine Annual GYN Exam (including Pap test)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Hearing Examinations and Hearing Aids (Requires prior notification if over \$1,000) (No exam copay for children when part of a well-child visit as recommended by PPACA)	100% of allowed benefit after \$15 (PCP), \$25 (Specialist) copay for exam for adults 100% of allowed benefit for Basic Model Hearing Aid 1 exam and hearing aid per ear every 3 years for each employee and dependent	80% of allowed benefit after deductible for exam 100% of allowed benefit for Basic Model Hearing Aid 1 exam and hearing aid per ear every 3 years for each employee and dependent	100% of allowed benefit after \$15 (PCP), \$25 (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 and dependent	Not covered, except 80% of allowed benefit after deductible for hearing aids as mandated for minor children	100% of allowed benefit after \$15 (PCP), \$25 (Specialist) copay for exam 100% for Basic Model Hearing Aid 1 exam and hearing aid per ear every 3 years for each employee and dependent
Immunizations* and Vaccines covered; Contact UnitedHealthcare for a detailed list.	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit

UNITEDHEALTHCARE					
Benefit	PPO In-Network	PPO Out-of-Network	POS In-Network	POS Out-of-Network	EPO In-Network Only
UNITEDHEALTHCARE COMMON AND PREVENTIVE SERVICES (Continued)					
Mammography**	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Adult Physical Exams & associated lab work	100% of allowed benefit	80% 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 Birth through 30 months; 12 visits total 3 through 21 years; 1 visit per plan year	100% of allowed benefit	80% of allowed benefit after deductible per visit	100% of allowed benefit	Not covered	100% of allowed benefit
Contact UHC for further details on eligibility for visits.					
Allergy Testing	100% of allowed benefit after \$15 copay (primary care physician) or \$25 copay (specialist)	80% of allowed benefit after deductible	100% of allowed benefit after \$15 copay (primary care physician) or \$25 copay (specialist)	80% of allowed benefit after deductible	100% of allowed benefit after \$15 copay (primary care physician) or \$25 copay (specialist)
Nutritional Counseling and Health Education (Contact UHC for details)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
UNITEDHEALTHCARE EMERGENCY TREATMENT					
Ambulance Services	100% of allowed benefit for medical emergencies	100% of allowed benefit for medical emergencies	100% of allowed benefit for medical emergencies	100% of allowed benefit for medical emergencies	100% of allowed benefit for medical emergencies
Emergency Room (ER) Services – inside and outside of service area***	100% of allowed benefit after \$50 copay for ER Facility Care and \$50 copay for ER Physician Services	100% of the allowed benefit after \$50 copay for ER Facility Care and \$50 copay for ER Physician Services	100% of allowed benefit after \$50 copay for ER Facility Care and \$50 copay for ER Physician Services	100% of the allowed benefit after \$50 copay for ER Facility Care and \$50 copay for ER Physician Services	100% of allowed benefit after \$50 copay for ER Facility Care and \$50 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 amount, after the two \$50 copays.					
UNITEDHEALTHCARE MATERNITY					
Maternity Benefits	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Newborn Care****	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Contact UHC to confirm if 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.					

UNITED HEALTHCARE

UNITEDHEALTHCARE					
Benefit	PPO In-Network	PPO Out-of-Network	POS In-Network	POS Out-of-Network	EPO In-Network Only
UNITEDHEALTHCARE OTHER SERVICES AND SUPPLIES					
Acupuncture Services for Chronic Pain Management	100% of allowed benefit after \$20 copay	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Cardiac Rehabilitation†	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Chiropractic Services	100% of allowed benefit after \$20 copay	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Dental Services	Not covered	Not covered	Not covered	Not covered	Not covered
Durable Medical Equipment (Preauthorization required if greater than \$1,000)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Contact UHC for details on covered items.					
Extended Care Facility (Prior notification required) (if medically necessary)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% 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.					
Family Planning And Fertility Testing	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Family Planning benefits include: sperm count hysterosalpingography, eudiometrical biopsy, IUD insertion, vasectomy, and tubal ligation.					
Home Health Care (Prior notification required)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Home Health Care benefits are limited to 120 days per plan year.					
Hospice Care (Prior notification required)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
In Vitro Fertilization (IVF) and Artificial Insemination (AI)†† (Contact UHC for further details. Requires prior notification for IVF)	100% of allowed benefit for up to 3 attempts of AI and 3 attempts of IVF per live birth, lifetime maximum of \$100,000	80% of allowed benefit after deductible for up to 3 attempts of AI and 3 attempts of IVF per live birth, lifetime maximum of \$100,000	100% of allowed benefit for up to 3 attempts of AI and 3 attempts of IVF per live birth, lifetime maximum of \$100,000	80% of allowed benefit after deductible for up to 3 attempts of AI and 3 attempts of IVF per live birth, lifetime maximum of \$100,000	100% of allowed benefit when preauthorized by Plan for up to 3 attempts of AI and 3 attempts of IVF per live birth, lifetime maximum of \$100,000
Medical Supplies	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% 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.					

UNITEDHEALTHCARE					
Benefit	PPO In-Network	PPO Out-of-Network	POS In-Network	POS Out-of-Network	EPO In-Network Only
UNITEDHEALTHCARE OTHER SERVICES AND SUPPLIES (Continued)					
Behavioral Health (does not apply to EPOs)	Not covered by Plan Covered by State's Behavioral Health Plan	Not covered by Plan Covered by State's Behavioral Health Plan	Not covered by Plan Covered by State's Behavioral Health Plan	Not covered by Plan Covered by State's Behavioral Health Plan	Inpatient care: 100% of allowed benefit for up to 365 days when preauthorized by Plan Outpatient care: 100% of allowed benefit after \$15 copay
	See pages 37-39 for behavioral health benefits.				
Outpatient Prescription Drugs	Not covered	Not covered	Not covered	Not covered	Not covered
Private Duty Nursing (Requires prior notification)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Surgical Second Opinion	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Urgent Care Centers	100% after \$20 copay	80% of allowed benefit after deductible	100% after \$20 copay	80% of allowed benefit after deductible	100% after \$20 copay
Whole Blood Charges	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
UNITEDHEALTHCARE VISION SERVICES AND SUPPLIES					
Vision – Medical Any services that deal with the medical health of the eye	100% of allowed benefit after \$15 copay (primary care physician) or \$25 copay (specialist)	80% of allowed benefit after deductible	100% of allowed benefit after \$15 copay (primary care physician) or \$25 copay (specialist) when preauthorized by Plan	80% of allowed benefit after deductible	100% of allowed benefit after \$15 copay (primary care physician) or \$25 copay (specialist) when preauthorized by Plan
Vision – Routine Any services that deal with correcting vision (provided by UHC)	Exam: Plan pays up to \$45 (available once every plan year) Prescription lenses (per pair – available once every plan year): ◆ 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): ◆ 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. To obtain vision benefits, you must contact UHC for more information. Vision benefits are available once every plan year.				

UNITED HEALTHCARE

NOTE: The benefits described in the Medical Benefits section are in compliance with the Patient Protection and Affordable Care Act (PPACA) signed March 23, 2010.

BENEFIT CHART FOOTNOTES

All medical plans comply with the Patient Protection and Affordable Care Act requirements for the coverage of preventive services. Please refer to www.uspreventiveservicestaskforce.org/recommendations.htm for a complete list of preventive services.

- * Immunizations: 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.
- ** Coverage for screening mammograms is in accordance with the Maryland State mandate and healthcare reform varies by age: one baseline screening (age 35-39); one mammogram every plan year (for ages 40 and above). Diagnostic mammograms have no age limitations.
- *** Emergency services or medical emergency is defined as: health care 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 76.
- † 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: heart attack in past 12 months; Coronary Artery Bypass Graft (CABG) surgery; angioplasty; heart valve surgery; stable angina pectoris; compensated 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.
- ††† Direct access service (written referral not required). Paid same as in-network.

This is only a summary. Contact your plan for further details on preauthorization requirements.

NOTE: 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.

For More Information

If you have questions about the plans, refer to the inside cover of this guide for phone numbers and websites for each of the benefit plans. You may also contact the Employee Benefits Division at 410-767-4775 or 1-800-30-STATE.

Behavioral Health Benefits

Your Choices

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. In addition, out-of-network services are not covered under any of the EPO plans. Please see chart on page 38 for details.

You must be enrolled in a State medical plan to have Behavioral Health benefits.

PPO AND POS PLANS

Your Behavioral Health benefits are provided 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.

To get the most from your benefits, you should contact APS before receiving any services. For a participating list of 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 and treatable 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 at the same level. Substance abuse detoxification and rehabilitation services are covered under inpatient, partial hospitalization, or outpatient services when medically necessary. See the benefit chart on page 38 for how the plan will pay benefits.

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.

Behavioral Health Coverage for PPO and POS Plan Participants

TYPE OF SERVICE	IN-NETWORK CARE	OUT-OF-NETWORK CARE
Inpatient Facility and Professional Services	100% of APS' negotiated fee maximums when preauthorized by Plan	80% of APS' negotiated fee maximums
Partial Hospitalization Services and Residential Crisis Services	100% of APS' negotiated fee maximums	80% of APS' negotiated fee maximums
Outpatient Facility	100% of APS' negotiated fee maximums	80% of APS' negotiated fee maximums
Office and Professional Services (excluding Intensive Outpatient Services)	\$15 copay for PCP/Specialist	80% of APS' negotiated fee maximums
Intensive Outpatient Services	\$15 copay for PCP/Specialist	80% of APS' negotiated fee maximums
Outpatient Medication Management Services	\$15 copay for PCP/Specialist	80% of APS' negotiated fee maximums
Annual Deductible Individual Family	Not Applicable	Not Applicable
Annual Out of Pocket Maximum Individual Family (Combined with Medical)	None None	\$3,000 \$6,000
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	Not Covered
Partial Hospitalization Services and Residential Crisis Services	100% of the allowed benefit	Not Covered
Outpatient Facility	100% of the allowed benefit	Not Covered
Office and Professional Services (excluding Intensive Outpatient Services)	Balance up to the allowed benefit after member co-pay. \$15 copay for PCP/Specialist	Not Covered
Intensive Outpatient Services	Balance up to the allowed benefit after member co-pay. \$15 copay for PCP/Specialist	Not Covered
Outpatient Medication Management Services	Balance up to the allowed benefit after member co-pay. \$15 copay for PCP/Specialist	Not Covered
Annual Deductible Individual Family	Not Applicable	Not Applicable
Annual Out of Pocket Maximum Individual Family	Not Applicable	Not Applicable
Lifetime Maximum	Unlimited	

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 and 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.

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).

Prescription Drug Benefits

THE STATE OF MARYLAND PRESCRIPTION DRUG PLAN ADMINISTRATOR IS SUBJECT TO CHANGE.

DETAILS TO FOLLOW IN SUPPLEMENTAL COMMUNICATION BULLETIN.

The State's Prescription Drug Plan is administered by a Pharmacy Benefit Manager called a "PBM." The PBM can provide you with additional plan information, the location of participating pharmacies, the identification of preferred drugs, the cost for your prescriptions, and other plan 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 the Medicare prescription drug plans (Part D) that became available January 1, 2006. Please see the Notice of Creditable Coverage in this guide for more information.

NEW! Copays and Out-of-Pocket Maximums for Active Employees

Effective July 1, 2011, the prescription plan copays and the annual out of pocket maximums have changed for active employees, other non-retirees and their dependents. Please see the chart on the following page.

How the Plan Works

BRAND NAME VERSUS GENERIC DRUGS

The State prescription plan only covers up to the cost of a generic drug when a generic is available. If you purchase a brand name drug when a generic drug is available, even if it is prescribed by your physician, you must pay the difference in price between the brand name and the generic, plus the applicable copay. 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 the mail order program.

PBM contact information to follow.

Preferred Brand Name Drugs

Preferred brand name drugs are those medications that the PBM has on its preferred drug list. **This list may change at any time.**

The PBM's physicians and pharmacists evaluate the medications approved by the Food and Drug Administration (FDA). Each drug is reviewed for safety, side effects, efficacy (how well the drug works), ease of dosage, and cost. The drugs that are judged the best overall are selected as preferred brand name drugs. You pay less if you choose preferred brand name drugs. Preferred drugs are reviewed quarterly and are subject to change.

ACTIVE EMPLOYEES ONLY —

NEW! SAME COPAYS FOR RETAIL PHARMACIES OR THROUGH THE VOLUNTARY MAIL ORDER PROGRAM

When you have a prescription filled, your copay is based on the type of drug you purchase and the quantity. As shown in the chart below, you will pay less if you fill your prescription with a generic or preferred brand name drug.

NOTE: If you choose a brand name drug when a generic is available, you will pay the generic copay plus the difference in cost between the generic and brand name drug.

The PBM also offers a voluntary mail order program that enables you to have long-term or maintenance medications (for conditions such as high blood pressure, high cholesterol, or diabetes) delivered to your home. You may refill your medications online or by phone.

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

The Prescription Drug plan has an annual out-of-pocket copay maximum of \$1,000 per individual and \$1,500 per family. This means that when the total amount of copays you pay during the plan year reaches \$1,000 or the total amount of copays combined for you and your covered dependents pay during the plan year reaches \$1,500, you and your covered dependents will not pay any more copays for eligible prescriptions for the remainder of the plan year (through June 30).

If you choose to purchase a brand name drug when a generic drug is available, the amount of the generic copay will be counted toward your \$1,000 or \$1,500 annual copay maximum, but the amount you pay that is the cost difference between the generic and brand name drugs will not.

Special Note for Retired Employees

Please note that a proposal has been made to change the retiree drug plan benefits as follows:

- Prescription coverage will closely mirror the basic Medicare Part D plan:
- Retiree pays first \$310 in Rx costs each year.
- After \$310 annual deductible is met, retiree pays 25% of prescription costs and Plan pays 75%, up to \$4,550 in retiree out of pocket costs.
- After maximum retiree out of pocket cost reached, Plan pays 100% for remainder of the plan year.

This proposal may be passed as is, amended and passed, or not passed at all.

If this proposal is passed, these benefits are effective July 1, 2011.

If the proposal is amended, the plan design in the chart to the left will change and you will be sent a supplemental communication detailing the changes. This information will also be posted on the Employee Benefits Division website.

If the proposal is not passed at all, Retirees will have the same new prescription copays and out of pocket limits as Active employees outlined in this section.

PRESCRIPTION DRUG MANAGEMENT PROGRAMS

Zero Copay for Generics Program

The copayment for specific classes of generic drugs is zero dollars (\$0) at both retail and mail order pharmacies. The five drug classes including some examples of generic drugs covered under this program are listed in the chart below.

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

Specialty Drug Management Program

The Specialty Drug Management Program is a program that is designed to ensure the appropriate use of specialty drugs. Many specialty drugs are biotech medications that may require special handling and may be difficult to tolerate.

The specialty drugs included in this program may be used for the treatment of Rheumatoid Arthritis, Multiple Sclerosis, Blood Disorders, Cancer, Hepatitis C, or Osteoporosis. Specialty drugs in this program will be automatically reviewed for step therapy, prior authorization, and quantity or dosage limits. These specialty drugs will be limited to a maximum 30-day supply per prescription fill. Some of these specialty drugs are listed in the chart on page 43.

Details on Specialty Drug Management Program to follow.

Voluntary Specialty Pharmacy

The PBM offers a voluntary specialty pharmacy that helps members who need specialty drugs. The specialty pharmacy has nurses, pharmacists and other health care professionals who can help you understand the special characteristics of these drugs. They can also help you with health educational materials, monitoring, and other health assistance.

Details on Specialty Pharmacy Benefits to follow.

ZERO COPAY FOR GENERICS PROGRAM

Drug Class	Used to Treat	Generic Drugs*
HMG 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)

*The standards of quality are the same for generics as brand-name. The Food and Drug Administration (FDA) requires that all drugs be safe and effective. When a generic drug product is approved and on the market, it has met the rigorous standards established by the FDA with respect to identity, strength, quality, purity and potency.

Disease	Specialty Drugs 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 drugs and to reflect the most current medical literature.	

Prior Authorization Drugs

Some drugs require prior authorization from the PBM before they can be covered under the Prescription Drug plan. These drugs are medications that have serious or toxic side effects, or are at a high risk for misuse or abuse. Prior authorization drugs include, but are not limited to:

- 🌸 Retin-A
- 🌸 Growth hormones
- 🌸 Lamisil
- 🌸 Desoxyn
- 🌸 Dexedrine
- 🌸 Adderall

Details on how to obtain Prior Authorization from the PBM to follow.

Drugs with Quantity Limits

Some drugs have limits on the quantities that will be covered under the State plan. Drugs with quantity limits include drugs the FDA only approved for short-term use. Other drugs with quantity limits may be less effective or harmful when overused. Quantity limits encourage the safe and appropriate use of prescription drugs. Some drugs 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 drug with a quantity limitation, your copay 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 \$1,000 individual/\$1,500 family annual copay maximum.

The list of quantity limitation drugs is subject to change at any time.

Details on Quantity Limits to follow.

Step Therapy

Step therapy is a process for finding the best treatment while ensuring you are receiving the most appropriate drug therapy and helping to reduce prescription costs.

The first step in the process is usually a treatment known to be safe and effective for most people, called first-line therapy. The next step is second-line therapy. First- and second-line drugs are selected by the PBM after careful review of medical literature, manufacturer product information, and consultation with medical professionals.

Example: The prescription drug Celebrex is a mandatory step therapy drug for those under age 60. Before first-time coverage for Celebrex is provided, you may need to try other first- and second-line medications. Your physician will need to submit medical documentation to the PBM's Prior Authorization Unit for Celebrex to be covered for first-time treatment.

Details on Step Therapy to follow.

Leukotriene Modifier Step Therapy Program

Leukotriene Modifiers (Singulair, Accolate and Zyflo) are medications used to treat asthma and generally should not be taken as first-line therapy for asthma or allergic rhinitis (allergy). Members and their dependents over the age of 12 who are not currently taking other asthma medications or first-line allergy medications (such as a non-sedating antihistamine and a nasal steroid), must request prior authorization for coverage.

Requirements for Approved Use of Singulair

1. Patient is 12 years old or younger or
2. Patient must have a history of asthma or
3. Patient must have tried other allergic rhinitis therapies without success

DRUG EXCLUSIONS

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

-  Weight-loss drugs;
-  Vitamins and minerals (except for prescription pre-natal vitamins); and
-  Drugs that are labeled by the FDA as "less than effective."

Information regarding Drug Exclusions to follow.

DIRECT MEMBER REIMBURSEMENT

If you or your covered dependent purchase a covered prescription drug without using your prescription drug card you must pay the full cost of the medication.

Details on how to file Direct Member Reimbursement claims to follow.

Allergy Serum Claims

When you receive an allergy medication, there may be two costs: one for the allergy serum and one for the physician's professional services.

Details on how to file Allergy Serum claims to follow.

Prescription Drug Benefits

**THE STATE OF MARYLAND
PRESCRIPTION DRUG PLAN
ADMINISTRATOR IS
SUBJECT TO CHANGE.**

**DETAILS TO FOLLOW IN
SUPPLEMENTAL
COMMUNICATION
BULLETIN.**

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**

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.

How the Plans Work

THE DHMO PLAN

When you enroll, 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.

What's Covered – DHMO Plan

Feature	Benefit Coverage (In-Network Services Only)
Annual deductible	None
Annual maximum	None
Preventive and diagnostic services , including exams, X-rays, cleanings, sealants, fluoride treatments, treatment of pain, other preventive care services	You pay \$0
Restorative services , including restoration of teeth, space maintainers, extraction of teeth, endodontic (root canal) services, periodontal services (including surgical and non-surgical services), oral surgery, general anesthesia	You pay according to the DHMO Benefit Schedule*
Major Restorative services , including crowns, inlays, onlays, bridges, dentures, denture repair, implants	You pay according to the DHMO Benefit Schedule*
Orthodontia (for adults and children through age 26), including evaluation and consultation, orthodontic treatment, orthodontic retention	You pay according to the DHMO Benefit Schedule*

You may change your primary provider site 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 (see page 47).

PLEASE NOTE: It is highly 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.

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 that you and your dentist will know exactly what will be covered and what you will need to pay out-of-pocket.

* Review the Schedule of Benefits carefully on pages 48-51 for the fee schedule amounts associated with each type of dental service. Services not listed on the Schedule of Benefits provided by the plan are not covered. The Schedule of Benefits for the DHMO plan is located on pages 48-51 as well as the State's website at www.dbm.maryland.gov, click on Health Benefits. They are also available on the United Concordia website.

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.

DHMO Network

If you live in an area or move to an area that is not in the DHMO network of dentists, please contact United Concordia to determine other options. To enroll in the DHMO plan, you must reside within the Maryland service area (MD, DC, VA, DE, WV, PA). 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 choose to participate in the plan network. In the DHMO plan, you can only receive coverage for services from a DHMO plan provider.

THE DPPO PLAN

The DPPO plan is also available through United Concordia. Under this Plan, you do not have to select a PDO. You may choose to receive services from any dentist of your choice whenever 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 by the dentist for the amount charged that exceeds the allowed amount. No referrals are needed for specialty care. Orthodontia services are only covered for eligible children 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.

What’s Covered – DPPO Plan

Feature	Benefit Coverage (In-Network and Out-of-Network Services)
Annual deductible	\$50 per individual; \$150 per family Only applies to Class II and Class III services
Annual maximum	\$1,500 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 amount
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 amount, after deductible
Class III: Major services , including crowns and bridges, dentures (complete and partial), fixed prosthetics, implants	Plan pays 50% of allowed amount, after deductible
Class IV: Orthodontia [for eligible child(ren) only, age 26 or younger], diagnostic, active, retention treatment	Plan pays 50% of allowed amount, up to \$2,000 lifetime maximum

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.

United Concordia– Concordia Plus Schedule of Benefits (Plan ST11)

- ✿ This schedule of benefits provides a list of 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 below 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 this 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 in addition to this Schedule of Benefits.
- ✿ If You have any questions about Your United Concordia Dental Plan, please call Our Customer Service Department toll free at 1-888-638-3384 or access Our Website at www.unitedconcordia.com/statemd.

ADA CODE	ADA DESCRIPTION	MEMBER PAYS \$
CLINICAL ORAL EVALUATIONS		
D0120	Periodic oral evaluation - established patient	0
D0140	Limited oral evaluation - problem focused	0
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	0
D0150	Comprehensive oral evaluation - new or established patient	0
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	0
D0180	Comprehensive periodontal evaluation - new or established patient	0
RADIOGRAPHS/DIAGNOSTIC IMAGING (including interpretation)		
D0210	Intraoral - complete series (including bitewings)	0
D0220	Intraoral - periapical first film	0
D0230	Intraoral - periapical each additional film	0
D0240	Intraoral - occlusal film	0
D0270	Bitewing - single film	0
D0272	Bitewings - two films	0
D0273	Bitewings - three films	0
D0274	Bitewings - four films	0
D0277	Vertical bitewings - 7 to 8 films	0
D0330	Panoramic film	0
D0340	Cephalometric film	0
TESTS AND EXAMINATIONS		
D0460	Pulp vitality tests	0
D0470	Diagnostic casts	0
DENTAL PROPHYLAXIS		
D1110	Prophylaxis - adult	0
D1120	Prophylaxis - child	0
TOPICAL FLUORIDE TREATMENT (office procedure)		
D1203	Topical application of fluoride - child	0
D1204	Topical application of fluoride - adult	0
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients	0
OTHER PREVENTIVE SERVICES		
D1330	Oral hygiene instructions	0
D1351	Sealant - per tooth	0

ADA CODE	ADA DESCRIPTION	MEMBER PAYS \$
SPACE MAINTENANCE (passive appliances)		
D1510	Space maintainer - fixed - unilateral	0
D1515	Space maintainer - fixed - bilateral	0
D1520	Space maintainer - removable - unilateral	0
D1555	Removal of fixed space maintainer	0
AMALGAM RESTORATIONS (including polishing)		
D2140	Amalgam - one surface, primary or permanent	0
D2150	Amalgam - two surfaces, primary or permanent	0
D2160	Amalgam - three surfaces, primary or permanent	0
D2161	Amalgam - four or more surfaces, primary or permanent	0
RESIN-BASED COMPOSITE RESTORATIONS - DIRECT		
D2330	Resin-based composite - one surface, anterior	0
D2331	Resin-based composite - two surfaces, anterior	0
D2332	Resin-based composite - three surfaces, anterior	0
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	70
D2391	Resin-based composite - one surface, posterior	40
D2392	Resin-based composite - two surfaces, posterior	60
D2393	Resin-based composite - three surfaces, posterior	72
D2394	Resin-based composite - four or more surfaces, posterior	84
INLAY/ONLAY RESTORATIONS		
D2510	Inlay - metallic - one surface	60
D2520	Inlay - metallic - two surfaces	100
D2530	Inlay - metallic - three or more surfaces	120
D2542	Onlay - metallic - two surfaces	20
D2543	Onlay - metallic - three surfaces	30
D2544	Onlay - metallic - four or more surfaces	50
CROWNS - SINGLE RESTORATIONS ONLY		
D2710	Crown - resin-based composite (indirect)	77
D2712	Crown - 3/4 resin-based composite (indirect)	86
D2740	Crown - porcelain/ceramic substrate	270
D2750	Crown - porcelain fused to high noble metal	276
D2751	Crown - porcelain fused to predominantly base metal	258

ADA CODE	ADA DESCRIPTION	MEMBER PAYS \$
CROWNS - SINGLE RESTORATIONS ONLY (Continued)		
D2752	Crown - porcelain fused to noble metal	270
D2780	Crown - 3/4 cast high noble metal	228
D2781	Crown - 3/4 cast predominantly base metal	228
D2782	Crown - 3/4 cast noble metal	228
D2783	Crown - 3/4 porcelain/ceramic	228
D2790	Crown - full cast high noble metal	228
D2791	Crown - full cast predominantly base metal	258
D2792	Crown - full cast noble metal	264
D2794	Crown - titanium	290
OTHER RESTORATIVE SERVICES		
D2910	Recement inlay, onlay, or partial coverage restoration	15
D2920	Recement crown	15
D2930	Prefabricated stainless steel crown - primary tooth	48
D2931	Prefabricated stainless steel crown - permanent tooth	56
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	48
D2940	Protective restoration	0
D2950	Core buildup, including any pins	100
D2951	Pin retention - per tooth, in addition to restoration	10
D2952	Post and core in addition to crown, indirectly fabricated	108
D2953	Each additional indirectly fabricated post - same tooth	45
D2954	Prefabricated post and core in addition to crown	108
D2957	Each additional prefabricated post - same tooth	45
D2970	Temporary crown (fractured tooth)	65
D2971	Additional procedures to construct new crown under existing partial denture framework	25
PULP CAPPING		
D3110	Pulp cap - direct (excluding final restoration)	0
D3120	Pulp cap - indirect (excluding final restoration)	0
PULPOTOMY		
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	25
D3221	Pulpal debridement, primary and permanent teeth	15
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	25
ENDODONTIC THERAPY ON PRIMARY TEETH		
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	40
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	55
ENDODONTIC THERAPY (including treatment plan, clinical procedures and follow-up care)		
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	108
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	144
D3330	Endodontic therapy, molar (excluding final restoration)	198
ENDODONTIC RETREATMENT		
D3346	Retreatment of previous root canal therapy - anterior	198
D3347	Retreatment of previous root canal therapy - bicuspid	234
D3348	Retreatment of previous root canal therapy - molar	288

ADA CODE	ADA DESCRIPTION	MEMBER PAYS \$
APICOECTOMY/PERIRADICULAR SERVICES		
D3410	Apicoectomy/periradicular surgery - anterior	107
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	107
D3425	Apicoectomy/periradicular surgery - molar (first root)	107
D3426	Apicoectomy/periradicular surgery (each additional root)	41
D3450	Root amputation - per root	50
OTHER ENDODONTIC PROCEDURES		
D3920	Hemisection (including any root removal), not including root canal therapy	41
SURGICAL SERVICES (including usual postoperative care)		
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces—per quadrant	125
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	50
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	135
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	54
D4245	Apically positioned flap	110
D4249	Clinical crown lengthening - hard tissue	105
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	210
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	110
D4263	Bone replacement graft - first site in quadrant	115
D4271	Free soft tissue graft procedure (including donor site surgery)	100
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	45
D4275	Soft tissue allograft	100
D4276	Combined connective tissue and double pedicle graft, per tooth	100
NON-SURGICAL PERIODONTAL SERVICES		
D4320	Provisional splinting - intracoronal	40
D4321	Provisional splinting - extracoronal	40
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	60
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	16
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	50
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, per report	100
OTHER PERIODONTAL SERVICES		
D4910	Periodontal maintenance	30
COMPLETE DENTURES (including routine post-delivery care)		
D5110	Complete denture - maxillary	264
D5120	Complete denture - mandibular	264
D5130	Immediate denture - maxillary	288
D5140	Immediate denture - mandibular	288

ADA CODE	ADA DESCRIPTION	MEMBER PAYS \$
PARTIAL DENTURES (including routine post-delivery care)		
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	174
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	174
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	270
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	270
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	350
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	350
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	78
ADJUSTMENTS TO DENTURES		
D5410	Adjust complete denture - maxillary	7
D5411	Adjust complete denture - mandibular	7
D5421	Adjust partial denture - maxillary	7
D5422	Adjust partial denture - mandibular	7
REPAIRS TO COMPLETE DENTURES		
D5510	Repair broken complete denture base	21
D5520	Replace missing or broken teeth - complete denture (each tooth)	28
REPAIRS TO PARTIAL DENTURES		
D5610	Repair resin denture base	23
D5620	Repair cast framework	33
D5630	Repair or replace broken clasp	23
D5640	Replace broken teeth - per tooth	18
D5650	Add tooth to existing partial denture	23
D5660	Add clasp to existing partial denture	33
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	147
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	147
DENTURE REBASE PROCEDURES		
D5710	Rebase complete maxillary denture	55
D5711	Rebase complete mandibular denture	55
D5720	Rebase maxillary partial denture	48
D5721	Rebase mandibular partial denture	48
DENTURE RELINE PROCEDURES		
D5730	Reline complete maxillary denture (chairside)	40
D5731	Reline complete mandibular denture (chairside)	40
D5740	Reline maxillary partial denture (chairside)	40
D5741	Reline mandibular partial denture (chairside)	40
D5750	Reline complete maxillary denture (laboratory)	55
D5751	Reline complete mandibular denture (laboratory)	55
D5760	Reline maxillary partial denture (laboratory)	55
D5761	Reline mandibular partial denture (laboratory)	55
INTERIM PROSTHESIS		
D5810	Interim complete denture (maxillary)	125
D5811	Interim complete denture (mandibular)	125
D5820	Interim partial denture (maxillary)	105
D5821	Interim partial denture (mandibular)	105

ADA CODE	ADA DESCRIPTION	MEMBER PAYS \$
OTHER REMOVABLE PROSTHETIC SERVICES		
D5850	Tissue conditioning, maxillary	25
D5851	Tissue conditioning, mandibular	25
SURGICAL SERVICES		
D6010	Surgical placement of implant body: endosteal implant	1,983
D6040	Surgical placement: eosteal implant	1,983
D6050	Surgical placement: transosteal implant	1,783
D6100	Implant removal, by report	172
IMPLANT SUPPORTED PROSTHETICS		
D6058	Abutment supported porcelain/ceramic crown	1,030
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	1,030
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	970
D6061	Abutment supported porcelain fused to metal crown (noble metal)	985
D6062	Abutment supported cast metal crown (high noble metal)	1,036
D6063	Abutment supported cast metal crown (predominantly base metal)	925
D6064	Abutment supported cast metal crown (noble metal)	985
D6065	Implant supported porcelain/ceramic crown	1,030
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	1,030
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	1,036
D6094	Abutment supported crown - (titanium)	987
OTHER IMPLANT SERVICES		
D6092	Recement implant/abutment supported crown	66
D6095	Repair implant abutment, by report	166
FIXED PARTIAL DENTURE PONTICS		
D6205	Pontic - indirect resin based composite	290
D6210	Pontic - cast high noble metal	276
D6211	Pontic - cast predominantly base metal	258
D6212	Pontic - cast noble metal	264
D6214	Pontic - titanium	297
D6240	Pontic - porcelain fused to high noble metal	276
D6241	Pontic - porcelain fused to predominantly base metal	258
D6242	Pontic - porcelain fused to noble metal	264
D6245	Pontic - porcelain/ceramic	258
FIXED PARTIAL DENTURE RETAINERS - INLAYS/ONLAYS		
D6610	Onlay - cast high noble metal, two surfaces	150
D6612	Onlay - cast predominantly base metal, two surfaces	100
D6614	Onlay - cast noble metal, two surfaces	125
FIXED PARTIAL DENTURE RETAINERS - CROWNS		
D6710	Crown - indirect resin based composite	290
D6740	Crown - porcelain/ceramic	258
D6750	Crown - porcelain fused to high noble metal	276
D6751	Crown - porcelain fused to predominantly base metal	258
D6752	Crown - porcelain fused to noble metal	264
D6790	Crown - full cast high noble metal	276
D6791	Crown - full cast predominantly base metal	258
D6792	Crown - full cast noble metal	264
D6794	Crown - titanium	290

ADA CODE	ADA DESCRIPTION	MEMBER PAYS \$
OTHER FIXED PARTIAL DENTURE SERVICES		
D6930	Recement fixed partial denture	17
EXTRACTIONS (includes local anesthesia, suturing, if needed, and routine postoperative care)		
D7111	Extraction, coronal remnants - deciduous tooth	8
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	20
SURGICAL EXTRACTIONS (includes local anesthesia, suturing, if needed, and routine postoperative care)		
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	27
D7220	Removal of impacted tooth - soft tissue	45
D7230	Removal of impacted tooth - partially bony	55
D7240	Removal of impacted tooth - completely bony	65
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	80
D7250	Surgical removal of residual tooth roots (cutting procedure)	35
D7251	Coronectomy - intentional partial tooth removal	65
OTHER SURGICAL PROCEDURES		
D7280	Surgical access of an unerupted tooth	52
D7283	Placement of device to facilitate eruption of impacted tooth	13
D7285	Biopsy of oral tissue - hard (bone, tooth)	35
D7286	Biopsy of oral tissue - soft	28
D7288	Brush biopsy - transepithelial sample collection	45
ALVEOLOPLASTY (surgical preparation of ridge for dentures)		
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	23
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	30
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	30
SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS		
D7450	Removal of benign odontogenic cyst or tumor -lesion diameter up to 1.25 cm	60
EXCISION OF BONE TISSUE		
D7471	Removal of lateral exostosis (maxilla or mandible)	60
D7472	Removal of torus palatinus	60
D7473	Removal of torus mandibularis	60
D7485	Surgical reduction of osseous tuberosity	60
SURGICAL INCISION		
D7510	Incision and drainage of abscess - intraoral soft tissue	35
OTHER REPAIR PROCEDURES		
D7960	Frenulectomy – also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	53
D7963	Frenuloplasty	27
D7972	Surgical reduction of fibrous tuberosity	60
LIMITED ORTHODONTIC TREATMENT		
D8010	Limited orthodontic treatment of the primary dentition	380
D8020	Limited orthodontic treatment of the transitional dentition	405
D8030	Limited orthodontic treatment of the adolescent dentition	430
D8040	Limited orthodontic treatment of the adult dentition	455

ADA CODE	ADA DESCRIPTION	MEMBER PAYS \$
INTERCEPTIVE ORTHODONTIC TREATMENT		
D8050	Interceptive orthodontic treatment of the primary dentition	650
D8060	Interceptive orthodontic treatment of the transitional dentition	750
COMPREHENSIVE ORTHODONTIC TREATMENT		
D8070	Comprehensive orthodontic treatment of the transitional dentition	1,800
D8080	Comprehensive orthodontic treatment of the adolescent dentition	1,950
D8090	Comprehensive orthodontic treatment of the adult dentition	2,200
MINOR TREATMENT TO CONTROL HARMFUL HABITS		
D8210	Removable appliance therapy	390
D8220	Fixed appliance therapy	370
OTHER ORTHODONTIC SERVICES		
D8680	Orthodontic retention [removal of appliances, construction and placement of retainer(s)]	150
*	Orthodontic records fee	150
UNCLASSIFIED TREATMENT		
D9110	Palliative (emergency) treatment of dental pain - minor procedure	15
ANESTHESIA		
D9210	Local anesthesia not in conjunction with operative or surgical procedures	20
D9211	Regional block anesthesia	26
D9212	Trigeminal division block anesthesia	15
D9215	Local anesthesia in conjunction with operative or surgical procedures	18
D9220	Deep sedation/general anesthesia - first 30 minutes	205
D9221	Deep sedation/general anesthesia - each additional 15 minutes	103
D9241	Intravenous conscious sedation/analgesia - first 30 minutes	205
D9242	Intravenous conscious sedation/analgesia -each additional 15 minutes	100
PROFESSIONAL CONSULTATION		
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	20
PROFESSIONAL VISITS		
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	0
D9440	Office visit, after regularly scheduled hours	30
DRUGS		
D9630	Other drugs and/or medicaments, by report	20
MISCELLANEOUS SERVICES		
D9951	Occlusal adjustment - limited	20
D9952	Occlusal adjustment - complete	45
FOOTNOTES		
* Please report under code D8999 "Unspecified orthodontic procedure, by report." Records include all diagnostic procedures, such as cephalometric films, full mouth x-rays, models, and treatment plans.		

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. 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 year. All FSA contributions are pre-tax, which means you save money by not paying taxes on the amounts you set aside to pay for eligible healthcare and dependent 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. Claims for Same Sex Spouses/Domestic partners and the dependent child(ren) of same sex spouses/domestic partners are not eligible for FSA (reimbursements of claims or services for them) unless they are your tax dependents as defined by the Internal Revenue Service (IRS).

NOTE: As of January 1, 2011, under healthcare reform, over the counter medications are no longer eligible for reimbursement under your healthcare FSA without a prescription. Insulin is still eligible for reimbursement.

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 plans does not violate applicable nondiscrimination rules.

Plan Features

Payment (Debit) Card

If you were enrolled in the healthcare FSA plan for the 2010-2011 plan year and received a payment card, and are re-enrolling for the 2011-2012 plan year PLEASE CONTINUE TO USE YOUR CURRENT CARD. If this is your first time enrolling in a healthcare FSA, you will receive a payment card, sometimes called an FSA debit card, to quickly and easily access healthcare FSA funds. Since there is no Personal Identification Number (PIN) associated with the card, you use it like you would a credit card, and funds are deducted directly from your account. In many cases, card transactions are automatically approved. However, you may be required to submit itemized receipts for some transactions. Be sure to always keep all documentation of your payments.

Online Claims Submission

If you do not use your payment card, you have the option to quickly and easily create a secure claim online. Once you submit your receipts, ConnectYourCare will send your reimbursement within a few days. There is no minimum amount for reimbursement.

24/7 Customer Service

If you have a question, the ConnectYourCare dedicated customer service center is available 24 hours a day, seven days a week. The customer service center number is toll-free 866-971-4646.

Your Choices

There are two types of FSAs available:

 **Healthcare Account:** You may contribute between \$120 and \$3,000 a year to reimburse yourself for eligible out-of-pocket healthcare expenses, including deductibles, copays or coinsurance not reimbursed by any medical, dental, vision or prescription plans for you, your spouse or your tax dependents.

Healthcare FSA	Minimum	Maximum
Annually	\$120.00	\$3,000.00
12 pay period deductions	\$10.00	\$250.00
24 pay period deductions	\$5.00	\$125.00
20 or 21 Pay Faculty (19*) Scheduled deduction	\$6.00	\$150.00
* 20 or 21 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.		

 **Dependent Care Account:** You may contribute between \$120 and \$5,000 a year, or up to \$2,500 a year if married and filing separately, to reimburse yourself for eligible dependent care expenses incurred so you and your spouse, if married, can work, look for work, or your spouse can attend school full-time. In addition to day care, the account may also cover some before- and after-school care expenses, summer day camp and pre-school tuition costs.

Dependent Care FSA	Minimum	Maximum
Annually	\$120.00	\$5,000.00
12 pay period deductions	\$10.00	\$416.66
24 pay period deductions	\$5.00	\$208.33
20 or 21 Pay Faculty (19*) Scheduled deduction	\$6.00	\$250.00
* 20 or 21 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.		

TAX SAVINGS WITH AN FSA

An FSA lets you set money aside for eligible 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 assume "Sue" earns \$35,000 a year and has \$1,500 in eligible expenses. The example below illustrates what she will pay with an FSA and without an FSA.*

	With FSA	Without FSA
Annual pay	\$35,000	\$35,000
Pre-tax contribution to FSA	– \$1,500	– \$0
Taxable income	= \$33,500	= \$35,000
Federal income and Social Security taxes	– \$7,362	– \$7,852
After-tax dollars spent on eligible expenses	– \$0	– \$1,500
Spendable income	= \$26,138	= \$25,648
Tax savings with your FSA	\$490	

* Sample tax savings for a single taxpayer with no dependents; actual savings will vary based on your individual tax situation; please consult a tax professional for more information.*

As you can see, Sue saved \$490 by enrolling in her FSA!

How FSAs Work

Opening and using an FSA is quick and easy.

Step 1. Determine how much money you need to set aside on an annual basis. Think about how much you spend each year on your medical plan copays, dental, vision, prescriptions and over-the-counter expenses like bandages, as well as money spent on dependent care and elder care. You may contribute up to the maximum amounts shown for each type of account. Since IRS regulations do not allow FSA funds to roll over from one year to the next, plan carefully when deciding how much to contribute. Use the FSA worksheet available at www.ConnectYourCare.com/statemd to estimate your expenses.

Step 2. That amount is automatically deducted from your paycheck before taxes are applied in equal amounts, based on your frequency of pay, throughout the year. For example, if you decide to contribute \$1,000 for the year, and you have 24 pay periods each year, you would have \$41.66 deducted from each paycheck and credited to your FSA.

Step 3. When you have eligible healthcare expenses, like copays for doctors' office visits or prescriptions, pay for them using your new healthcare payment card. For dependent day care expenses, pay using a personal form of payment and submit a claim for reimbursement. Be sure to keep your itemized receipts.

Step 4. If ConnectYourCare is not able to verify your healthcare payment card purchase, CYC will request a copy of your receipt. For all dependent care expenses and for healthcare expenses not paid for with the payment card, you can submit a claim for reimbursement either online or by filling out a claim form. You must submit appropriate documentation to support your claim, such as an itemized receipt.

Step 5. When you request reimbursement, ConnectYourCare will process your claim and reimburse you within a few working days. You can choose to set up direct deposit in your online account to have your reimbursements deposited directly into your personal banking account. Or, download a Direct Deposit form at www.ConnectYourCare.com/statemd.

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 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 periods.

Timeline for Using Account Funds

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

Deadline for Eligible Expenses

- ✿ For the Healthcare FSA, you have a 2 1/2 month grace period after the end of the plan year to use your account for eligible healthcare expenses. This means you have until September 15, 2012 to incur eligible expenses for your Healthcare FSA.
- ✿ For the Dependent Care FSA, all eligible services must be provided by the last day of the plan year. This means you have until June 30, 2012 to incur eligible expenses for your Dependent Care FSA.

Deadline for Submitting Reimbursement Requests

- ✿ For both the Healthcare FSA and the Dependent Care FSA, you have until October 15, 2012 to submit claims for eligible expenses. Remember, even though you have until October 15, 2012 to submit the claim, the service dates must be on or before the dates listed above.

HEALTHCARE FLEXIBLE SPENDING ACCOUNT

Who is Covered

You can use the Healthcare Flexible Spending Account to pay eligible healthcare expenses for yourself, your spouse, and anyone you claim as a dependent on your federal income tax return, even if you or your dependents are not covered under the State's medical plans. You may not submit expenses incurred by your same sex spouse, domestic partner or your domestic partner's children, unless they are your tax dependents as defined by IRS rules.

What Expenses are Covered

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 and vision and certain eligible over-the-counter (OTC) items. All eligible expenses are based on the State's benefit plan design and IRS regulations. There is a sample list of eligible expenses on page 57 of this guide. You cannot pay insurance premiums through your FSA.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

Who is Covered

You can use the Dependent Care Flexible Spending Account 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.

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 health 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 to 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 (June 30).

What is Covered

The Dependent Care Flexible Spending Account is used for 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 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 care services already provided.

Submitting a Claim for Reimbursement

If you pay for an expense out of pocket (without using your payment card), you may enter a secure claim for reimbursement online or using a paper claim form. There is no minimum reimbursement amount.

Online Submission

- Step 1.** Log into your online account at www.ConnectYourCare.com/statemd.
- Step 2.** Click Add New Claim from the left-hand menu. Follow the quick and easy steps on the screen to enter information about your claim. Continue through the screens and submit your claim.
- Step 3.** You are required to submit documentation for these claims. You may choose to upload scanned receipt images directly into the Claim Center, or, you may print the Claim Submission Form and submit your receipts via fax or postal mail. The Claim Submission Form has all of your personal and claim information in an encrypted bar code at the top and should be used as your fax cover sheet if faxing receipts or included in the envelope if mailing receipts.

A Healthcare Payment Card

A convenient new way to access funds and minimize the hassle of submitting claim forms. Sometimes called an FSA debit card, this payment card allows you to directly access funds in your account.

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, including many 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 do I get my payment card?

For new Healthcare FSA enrollee's, your payment card will be mailed to your house after the week of June 15, 2011. It will be automatically activated on July 1, 2011. The card will remain active for 3 years, so keep it even when your funds are depleted; the same card will be used for the next plan year's account.

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

Many 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 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 don't want to use the 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 care expenses and at times when using the payment card is not possible. However, it is always easier to use your card when you have the option.

Where can I use my payment card?

Your payment card can be used nationwide at qualified merchants. Examples of qualified merchants may include pharmacies, doctors' offices, vision centers, and hospitals. Your card should only be used to pay for medical expenses eligible under your plan, and you should always save your receipts.

Paper Form Submission

Step 1. Download a paper claim form from www.ConnectYourCare.com/statemd.

Step 2. Complete the form.

Step 3. Mail the form and your itemized receipts to the address on the form.

Once your claim is received, you can track the status of your claim at any time at www.ConnectYourCare.com/statemd. You'll receive your reimbursement within a few days. Set up direct deposit to receive reimbursements quickly.

Over-the-Counter (OTC) Items Requiring Prescriptions

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 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.

Direct Deposit

You are eligible to receive reimbursement funds by check or direct deposit. For quicker reimbursements, sign up for direct deposit into your checking or savings account. You can sign up for direct deposit on the ConnectYourCare web site.

Step 1. Log into your account and select Direct Deposit from the Home page under My Account.

Step 2. Complete the short, secure form. Be sure to have your bank account and routing numbers on hand.

Step 3. Choose Direct Deposit as your preferred method of Claim Reimbursement and click the Confirm button.

Auto Substantiation and the Debit Card

- ✿ Using Your Card at the Doctor’s Office – you may use your debit card; however, you may still have to submit documentation. Auto substantiation happens when there is a copay amount matching one found in any of our health plans. If your transaction auto substantiates, then you do not have to file a new claim.
- ✿ Paying at a Doctor Out-of-Pocket – if you pay out of pocket, you will have to submit a claim and you will have to submit documentation to support that transaction.

USING YOUR ONLINE 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 Health Education Tools

HEALTH CARE ACCOUNT – ELIGIBLE EXPENSES

Sample eligible expenses include:

- ◆ Copays, coinsurance, and deductibles (but not premiums);
- ◆ Acupuncture;
- ◆ Birth control pills;
- ◆ 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.

HEALTH CARE 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;
- ◆ Benefit 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 like corn pads;
- ◆ 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

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.

UPDATED IRS GUIDANCE ON THE USE OF DEBIT CARDS FOR OTC MEDICINES

Notice 2011-5 modifies the prior IRS guidance and permits participants to use their health FSA debit cards to pay for OTC medicines and drugs on and after January 16, 2011, but only in accordance with the following restrictions, which are based on the type of entity selling the medicine or drug.

When the OTC medicine or drug order is sold by a drug store, pharmacy, non-healthcare merchant with a pharmacy, mail-order vendor, or web-based vendor, all of the following conditions must be satisfied:

- ✿ The prescription must be presented to the pharmacist at or before the time of purchase,
- ✿ The OTC medicine or drug must be dispensed by a pharmacist under applicable law;
- ✿ A prescription number must be assigned;
- ✿ The pharmacy or other entity must retain records of the prescription number, purchaser, amount, and date of sale;
- ✿ The pharmacy or other entity must make these records available to the employer on request;
- ✿ The debit card system must be designed so that it will not accept a charge for OTC medicines or drugs unless a prescription number is assigned; and
- ✿ Other existing rules for the use of debit cards are satisfied.

When the OTC medicine or drug order is sold by a vendor that uses health-related Merchant Codes, all of the following conditions must be satisfied:

- ✿ The vendor must retain records of the purchaser, amount, and date of sale;
- ✿ The vendor must make these records available to the employer on request; and
- ✿ Other existing rules for the use of debit cards are satisfied.

When the OTC medicine or drug order is sold by a “90% pharmacy,” the following condition must be satisfied:

- ✿ Substantiation (including a copy of the prescription or other documentation that a prescription has been issued) must be properly submitted in accordance with the terms of the plan with other information from an independent third party that satisfies the requirements of the proposed cafeteria plan regulations.

Note: A pharmacy is a “90% pharmacy” if (i) it maintains no inventory information approval system, and (ii) 90% of the store’s gross receipts in its prior taxable year met the definition of medical care expenses under section 213(d) of the Internal Revenue Code.

When the OTC medicine or drug order is filled by a vendor that is not described above:

The vendor may not accept FSA debit cards to pay for OTC medicines and drugs after January 15, 2011.

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

Metropolitan Life (MetLife) Insurance Company is the provider of your life insurance program. Life Insurance coverage provides your beneficiary with a lump sum payment in the event of your death (or you, in the event of your dependent's death). The Policy number for term group life insurance through MetLife is #29992.

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. MetLife will only pay benefits for one policy.

Beneficiaries

MetLife 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 distributed according to the order detailed in MetLife's certificate of group coverage. Benefits will be paid in equal shares to the first surviving class of the following:

- Your spouse;
- Your children;
- Your parents;
- Your siblings; or
- Your estate.

Beneficiary designation forms are available from your Agency Benefits Coordinator or from MetLife's website: www.metlife.com/mybenefits (group name: State of Maryland).

Life Insurance for Active Employees

YOUR CHOICES

Coverage for Yourself

You may choose coverage in \$10,000 increments up to a maximum of \$300,000. You may choose up to \$50,000 guaranteed coverage without completing a Statement of Health form. If you select coverage greater than \$50,000 for yourself, you must complete and submit a Statement of Health form to be reviewed by MetLife.

Newly hired public safety employees who perform the duties listed below as part of their job

- Scuba Dive
- Fly in /or pilot helicopters

may purchase up to \$200,000 of life insurance without medical underwriting, within 60 days of their start date. Medical underwriting will be required for anyone eligible who does not enroll in additional life insurance coverage within 60 days of their start date.

Coverage for Your Dependents

You may choose to purchase coverage for your dependents who are eligible for health benefits with the State in \$5,000 increments up to half of your coverage amount (up to a maximum of \$150,000). You may choose up to \$25,000 guaranteed coverage for eligible dependents without completing a Statement of Health form. If you select coverage greater than \$25,000 for a dependent, a Statement of Health form for that dependent must be completed and reviewed by MetLife.

For More Information

If you have questions about how to report a death claim, portability requests or beneficiary information, please contact MetLife at 1-866-492-6983 for more details. For all other questions, call 1-877-610-2954.

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 whole life insurance policy within 31 days. Please contact MetLife at 1-866-492-6983.
- ✿ Statement of Health forms are available from your Agency Benefits Coordinator or from MetLife's website: www.metlife.com/mybenefits (group name: State of Maryland).
- ✿ Rates change at the start of the plan year (July 1) when you reach the next age level, shown on the premium chart in the back of this Guide.

HOW THE PLAN WORKS DURING ACTIVE EMPLOYMENT***New Enrollment***

For new enrollment in MetLife 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 you want to increase your coverage to more than \$50,000 during Open Enrollment, regardless of your current coverage amount, you must submit a Statement of Health to MetLife. Please note that 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 MetLife approves your Statement of Health; 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.

Additional Benefits***The MetLife Center for Special Needs Planning***

MetLife is committed to helping families through the maze of legal and financial complexities surrounding planning for the future of children and other dependents with special needs. Working with a qualified legal advisor, your MetLife Specialist can help you secure lifetime care and quality of life for your child or other dependent with special needs. Your Specialist will help you build financial freedom and protection for your loved one by addressing the following critical issues:

- ✿ Protecting future government benefit eligibility for Supplemental Security Income (SSI) and Medicaid:
- ✿ Ways that a special needs trust can provide lifetime care while still preserving government benefit eligibility:

- ✿ Choice of trustee, guardian, conservator or client self-determination and advocacy training, if appropriate; and
- ✿ Appropriate funding vehicles to fund a special needs trust, including life insurance, even for when you may no longer be there to serve as an advocate.

Working in cooperation with knowledgeable professionals who have expertise in special needs planning, we can help you implement a plan that meets the future care needs of your child or other dependent with special needs.

For more information about the MetLife Center for Special Needs Planning, please call 1-877-638-3375.

Accelerated Benefit

An Accelerated Benefit is available in the event of a terminal illness. An insured employee (or insured spouse) 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 MetLife to be terminally ill with less than 12 months to live, and has at least \$20,000 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 MetLife 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 MetLife. 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 whole life insurance policy by contacting MetLife.

Conversion and Portability of Coverage

If you leave employment with the State, you may continue your Term Life Insurance coverage on an individual basis. Two options are available:

- Portability – an individual term life insurance policy; or
 - Conversion – an individual whole life insurance policy.
- Please contact MetLife at 1-866-492-6983 for eligibility requirements and information about each option.

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

Will Preparation

Will preparation is available to all employees and their spouses who are enrolled in the Group Term Life Insurance Plan with MetLife. This is a value-added benefit by Hyatt Legal Plans, a MetLife company. You also have access to Hyatt’s nationwide network of participating plan attorneys to prepare or update your and your spouse’s wills. This is a complimentary service as long as you are enrolled in the Life Insurance Program.

Life Insurance Upon Retirement

YOUR CHOICES

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 be no 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 that were covered under the Life Insurance 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 beneficiaries who had spouse life insurance as the dependent of the deceased retiree can only continue life insurance coverage through a conversion policy.

HOW THE PLAN WORKS DURING RETIREMENT

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 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

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 MetLife at 1-877-610-2954.

For More Information

If you have questions about coverage, conversion policies, limitations, definitions, restrictions, terminating events, or exclusions, please call MetLife service at 1-877-610-2954. MetLife also has a dedicated website for the State of Maryland's Group Term Life Insurance Plan. The website address is www.metlife.com/mybenefits (group name: State of Maryland). On this website, you can find beneficiary designation and change forms, as well as Statement of Health forms.

Accidental Death and Dismemberment

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 Metropolitan Life Insurance Company (MetLife). The plan provides benefits in the event of an accidental death or dismemberment. No medical review is required for enrollment in the plan. This plan will cover you for accidents that occur at work as well as accidents off the job.

Your Choices

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:

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

NOTE: When you retire, please contact MetLife for information on a conversion policy within 30 days of retirement.

How the Plan Works

Benefits will be paid within 365 days of the date of an accident. The plan will pay, in one sum, a certain 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 amount.

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%

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

- Exposure and disappearance;
- Waiver of premium;
- Education;
- Day care;
- Common disaster;
- Identity Theft Solutions;
- Emergency evacuation;
- Repatriation of remains;
- Air Bag; Brain Damage; Coma;
- Common Carrier; and
- Travel Assistance.

ACCIDENTAL DEATH & DISMEMBERMENT

For More Information

Please contact MetLife at 1-877-610-2954 for an AD&D Beneficiary Designation Form, as well as for information about the plan.

Long Term Care Insurance

Long Term Care (LTC) is the 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.

Can I get coverage for other family members, too?

You can also extend coverage to qualifying family members (such as a spouse, parent, or grandparent). To be considered for enrollment, they will need to provide evidence of good health to Prudential.

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 due to retiree status, 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. Current State employees, State retirees and all family members covered by Active employees or retirees 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); and
- ✿ Children age 18 or older 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	\$85	\$43	\$93,075
Plan 2	\$85	\$43	\$186,250
Plan 3	\$100	\$50	\$109,500
Plan 4	\$100	\$50	\$219,000
Plan 5	\$150	\$75	\$164,250
Plan 6	\$150	\$75	\$328,500
Plan 7	\$200	\$100	\$219,000
Plan 8	\$200	\$100	\$438,000

* Benefits are paid up to the daily maximum.

** All benefits paid will be deducted from the lifetime maximum.

How the Plan Works

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

PERIODIC INFLATION PROTECTION

As part of the plan, you may increase your coverage on a periodic basis without submitting any additional health information (as long as you have not declined the previous two consecutive inflation offers). Inflation protection will be offered at least 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/gltc (group name: maryland; password: marylandltc); or
- 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 five 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;
- ✿ Independence support;
- ✿ Informal care;
- ✿ Caregiver training;
- ✿ Information and referral services;
- ✿ Private care management;
- ✿ Alternate plan of care;
- ✿ Death benefit;
- ✿ Cash alternative;
- ✿ International coverage benefit; and
- ✿ Marriage discount.

There is no waiting period for hospice care, independence support, caregiver training, information and referral services, or private care management.

EXCLUSIONS

Benefits will not be payable if any of the following situations apply:

- ✿ **Work-connected conditions charge:** A charge covered by a Workers' Compensation law, occupational disease law, or similar law
- ✿ **Government plan charge:** A charge for a service or supply:
 - Furnished by or for the United States government or any other government, unless payment of the charge is required by law; or
 - To the extent that the service or supply, or any benefit for the charge, is provided by any law or governmental plan under which the patient is or could be covered*
- ✿ **Self-inflicted injury or suicide:** Charges arising from intentionally self-inflicted injury or attempted suicide, while sane or suffering from inorganic-based insanity or mental illness
- ✿ **Services and supplies outside the United States:** Charges for services or supplies outside the United States and its possessions (does not apply to the International Coverage Benefit)
- ✿ **Treatment for chronic alcoholism or chemical dependency:** Charges in connection with the treatment of chronic alcoholism or chemical dependency
- ✿ **War, felony, riot, or insurrection:** Charges for a condition due to war or any act of war while you are insured or due to the insured's participation in an act of felony, riot, or insurrection**

* This does not apply to a State plan under Medicaid 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. When this is applied to Medicare, the benefits provided by Medicare will be deemed to include any amount that would have been payable by Medicare in the absence of a deductible or coinsurance requirement under that program.

** War means declared or undeclared war and includes resistance to armed aggression. Riot means a wild, violent, public disturbance of the peace.

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/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 that 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 about 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 in order to continue your benefits for the rest of the plan year. 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. If you do not pay by the due date on the "No Pay" bill, your enrollment and benefits coverage will 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 enrollment and benefits coverage will be cancelled. There will be a break in your coverage until you return to work and request re-enrollment in health benefits. 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, 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, which must be included with their premium payments at the address shown on the letter included with your premium coupons. Your benefits will be effective as of the date noted on your 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.

Military Leave Employees Important Information for Your Health While on Military Leave and When Returning to State Service**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 just 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, employees will be billed by the Direct-Pay unit through payment coupons.

To continue your benefits under an Active Military Leave of Absence, you will need to complete the "LAW - Military Notification Form." Please return this form to your Agency Benefits Coordinator along with a copy of your active military orders. 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 Regular 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 Health Care Spending Account participation, using post-tax premium payments, for a timeframe determined in accordance with the applicable 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 69), you or your dependent may be eligible to continue the same health benefits that you or

(continued on pg.70)

PLEASE 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	<ul style="list-style-type: none"> ◆ 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 	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.
	<ul style="list-style-type: none"> ◆ Step-child(ren) of employee or retiree 	If enrolled separately, 36 months or until eligible for coverage elsewhere, including Medicare*, whichever occurs first
Dissolution of Domestic Partnership	<ul style="list-style-type: none"> ◆ Former Domestic Partner ◆ Domestic Partner's Dependent Child(ren) 	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"> ◆ 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	<ul style="list-style-type: none"> ◆ 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 COBRA coverage after the entitlement date. If you have dependents on your COBRA coverage when you become entitled to Medicare, your dependents may elect to continue their coverage on COBRA.

Special Note: The continuation coverage made available to domestic partners and the dependent child(ren) of same-sex domestic partners will parallel the COBRA continuation coverage that is available to the covered spouse and dependent child(ren) of an employee or retiree in most respects. But domestic partners, and their children who are not the employees's/retiree's tax dependent, are not eligible for COBRA or COBRA subsidies under Federal law.

**** NOW AVAILABLE! ONLINE**
 Coupon Payment System Option. Go to www.dbm.maryland.gov/benefits for more information

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, which must be included with their premium payments at the address on the letter included with your premium coupons. These benefits will be effective as of the date noted on your 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.

** See page 69 for more information.

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/domestic partner 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 Accounts. 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 care flexible spending accounts, 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 and Continuation of Coverage for domestic partnerships. 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 that are highlighted in this Notice on page 69.

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.

Qualifying Events for Covered Same Sex Domestic Partner and Domestic Partner’s Dependent Children

As a domestic partner of an employee or retiree or the dependent child(ren) of a domestic partner, continuation coverage will be offered to you if you lose health benefits coverage as a result of any of the following events:

- ◆ The termination of the domestic partnership with the employee or retiree;
- ◆ The employee’s termination of employment, or reduction of hours of employment (for reasons other than gross misconduct);
- ◆ The death of the employee or retiree;
- ◆ A dependent child of a domestic partner ceasing to meet the coverage eligibility requirements for a dependent child of a domestic partner (such as turning age 27 or ceasing to be a tax dependent of the domestic partner).

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. In the case of a newborn or adopted child that is added to a covered employee qualified beneficiary’s COBRA coverage,

then the first 60 days of continuation coverage for the new born or adopted child is measured from the date of the birth or the date of the adoption. Procedures and timelines for adding these individuals can be found in your benefits guide.

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 actually covered by the Program health benefits 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/domestic partner and the dependent children of the employee and domestic partner 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/Domestic Partner and Dependent

For the other qualifying events (divorce, dissolution of domestic partnership 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 an enrollment form be mailed to you. You then fill out the form, attach documentation of the qualifying event (e.g. copy of divorce decree or dissolution of domestic partnership), and mail everything to: Employee Benefits Division, ATTN: Direct

Pay Unit, 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, then 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 COBRA form may also be obtained from the internet site.**

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 a 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 will be allowed 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, then the change and/or modification will be made to your COBRA coverage as well.

How long does COBRA continuation 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 health care flexible spending arrangement. **If you are participating in a health care flexible spending account at the time of the qualifying event, you will only be allowed to continue the health care flexible spending account 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, then 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 after the later of: the date of the determination, the date of the termination of employment or reduction in hours, or 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, then the applicable premium rate is 150% of the premium rate. If only the non-disabled qualified beneficiaries extend coverage, the premium rate will remain at the 102% level. 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

Another extension of the 18 or above mentioned 29-month continuation period could occur, if **during the 18 or 29 months** of continuation coverage, a second event takes place (divorce, legal separation, dissolution of domestic partnership, 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, then 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, dissolution of domestic partnership or a dependent child ceasing to be a dependent child, then 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 special extension such as the result of 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 who is the former 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 health care 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 the coverage of similarly situated on-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 to domestic partners and domestic partner'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 Change of Address Notification form is available on-line at www.dbm.maryland.gov, Employee Benefits link. 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 a required 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, dissolution of domestic partnership 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 that you are eligible for continuation; you will be notified of all 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, press Option 2. In addition, you can find more information about COBRA continuation coverage in the Open Enrollment health benefits guide and on the internet at www.dbm.maryland.gov.

The Program name and address is:

The State of Maryland Employee and Retiree Health and Welfare Benefits Program
c/o Employee Benefits Division
Direct Pay Unit
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 the Federal HIPAA regulations and State regulations on 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 that is located on our website, www.dbm.maryland.gov. Assigned HIPAA authorization remains 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 (HCFSA) may use and give out (“disclose”) your protected health information held by DBM and your HCFSA. This information generally comes to DBM when you enroll in the Program and from your plan administrator as part of administration of the health plan. This information comes to your HCFSA when you submit requests for reimbursement. This Notice also describes how your HCFSA uses and discloses your personal health information. DBM and the HCFSA 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 HCFSA follows 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 a 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 HCFSA, 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 health care 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 HCFSA offered through the Program do not use genetic information for underwriting (or for any other) purposes.

DBM and/or your HCFSA 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 health care 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 HCFSA do not use your protected health information for fundraising or marketing purposes. DBM and your HCFSA 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 ever start using Electronic Health Records, you can ask for an electronic copy of that EHR. We do not use EHRs now.
- ◆ Amend any of your protected health information created by DBM or the HCFSA if you believe that 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 getting 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, health care 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 ever begins to use EHRs, you could ask for a copy of EHR disclosures over the most recent 3 years for health care 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 an authorization.

For more information on exercising your rights set out in this notice, visit the DBM website: www.dbm.maryland.gov. You may also call 410-767-4775 or 1-800-30-STATE (1-800-307-8283) and ask for DBM’s Program privacy official for this purpose. If you believe DBM has violated your privacy rights set out in this notice, 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 Program. 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 health care 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.

MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed on page 78, 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, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

If you live in one of the States listed on page 78, you may be eligible for assistance paying your employer health plan premiums. The list of States is current as of November 3, 2010. You should contact your State for further information on eligibility.

To see if any more States have added a premium assistance program since November 3, 2010, 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
OMB Control Number 1210-0137 (expires 09/30/2013)

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The list of States is current as of November 3, 2010. You should contact your State for further information on eligibility.

ALABAMA – Medicaid

Website: <http://www.medicaid.alabama.gov>
Phone: 1-800-362-1504

ALASKA – Medicaid

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

ARIZONA – CHIP

Website: <http://www.azahcccs.gov/applicants/default.aspx>
Phone (In state): 1-877-764-5437

ARKANSAS – CHIP

Website: <http://www.arkidsfirst.com/>
Phone: 1-888-474-8275

GEORGIA – Medicaid

Website: <http://dch.georgia.gov/>
Click on Programs, then Medicaid
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/2408.htm>
Phone: 1-877-438-4479

IOWA – Medicaid

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

KANSAS – Medicaid

Website: <https://www.khpa.ks.gov>
Phone: 800-766-9012

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: 1-888-342-6207

MAINE – Medicaid

Website: <http://www.maine.gov/dhhs/oms/>
Phone: 1-800-321-5557

MASSACHUSETTS – Medicaid and CHIP

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

MINNESOTA – Medicaid

Website: <http://www.dhs.state.mn.us/>
Click on Health Care, then Medical Assistance
Phone (Outside of Twin City area): 800-657-3739
Phone (Twin City area): 651-431-2670

MISSOURI – Medicaid

Website: <http://www.dss.mo.gov/mhd/index.htm>
Phone: 573-751-6944

NORTH DAKOTA – Medicaid

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

OKLAHOMA – Medicaid

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

OREGON – Medicaid and CHIP

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

PENNSYLVANIA – Medicaid

Website: <http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm>
Phone: 1-800-644-7730

RHODE ISLAND – Medicaid

Website: www.dhs.ri.gov
Phone: 401-462-5300

SOUTH CAROLINA – Medicaid

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

TEXAS – Medicaid

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

CALIFORNIA – Medicaid

Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
Phone: 1-866-298-8443

COLORADO – Medicaid and CHIP

Medicaid Website: <http://www.colorado.gov/>
Medicaid Phone (In state): 1-800-866-3513
Medicaid Phone (Out of state): 1-800-221-3943
CHIP Website: <http://www.CHPplus.org>
CHIP Phone: 303-866-3243

FLORIDA – Medicaid

Website: <http://www.fdhc.state.fl.us/Medicaid/index.shtml>
Phone: 1-866-762-2237

MONTANA – Medicaid

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

NEBRASKA – Medicaid

Website: <http://www.dhhs.ne.gov/med/index.htm>
Phone: 1-877-255-3092

NEVADA – Medicaid and CHIP

Medicaid Website: <http://dwss.nv.gov/>
Medicaid Phone: 1-800-992-0900
CHIP Website: <http://www.nevadacheckup.nv.org/>
CHIP Phone: 1-877-543-7669

NEW HAMPSHIRE – Medicaid

Website: www.dhhs.nh.gov/ombp/index.htm
Phone: 603-271-4238

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 MEXICO – Medicaid and CHIP

Medicaid Website: <http://www.hsd.state.nm.us/mad/index.html>
Medicaid Phone: 1-888-997-2583
CHIP Website: <http://www.hsd.state.nm.us/mad/index.html>
Click on Insure New Mexico
CHIP Phone: 1-888-997-2583

NEW YORK – Medicaid

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

NORTH CAROLINA – Medicaid

Website: <http://www.nc.gov>
Phone: 919-855-4100

UTAH – Medicaid

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

VERMONT – Medicaid

Website: <http://ovha.vermont.gov/>
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.wvrecovery.com/hipp.htm>
Phone: 304-342-1604

WISCONSIN – Medicaid

Website: <http://dhs.wisconsin.gov/medicaid/publications/p-10095.htm>
Phone: 1-800-362-3002

WYOMING – Medicaid

Website: <http://www.health.wyo.gov/healthcare-fin/index.html>
Telephone: 307-777-7531

MEDICARE AND YOUR STATE BENEFITS

Medicare Parts A & B

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 must 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.

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 that 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.**

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.

Employees/dependents enrolled in both Parts A and B: Medicare becomes the primary insurer for both Part A (hospital) and Part B (medical) claims. The employee should complete an Active employee enrollment form to change their enrollment in the State medical plan to a Medicare coverage level.

Employees/dependents enrolled in Part A, but not enrolled in Part B: Medicare becomes the primary insurer for Part A (hospital) claims. In order for the State plan to remain the primary insurer for Part B (medical) claims, enrollment in the State medical plan should not be changed to a Medicare coverage level.

Employees/dependents not enrolled in Part A or Part B: There will be no COB with Medicare. The State plan will continue to be the primary insurer for both Part A (hospital) and Part B (medical) claims. Enrollment in the State medical plan should not be changed to a Medicare coverage level.

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 a 56-page Social Security publication, 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 (e.g., from "Individual & Spouse" to "Individual & One, One with Medicare").

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 and Welfare 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 and Welfare 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.

Medicare Part D – New Medicare Drug Benefit

How Does This Apply to You?

If you have prescription drug coverage through the State Employee and Retiree Health and Welfare Benefits Program, you are not required to enroll in Medicare Part D. For most people, keeping the State coverage and not enrolling in a Medicare Part D plan will be the most cost-effective prescription drug coverage. However, you should consider the premium, copay, coinsurance, deductible, and coverage gap costs under the plans you are considering to

make the best decision for your personal coverage. For the 2011-2012 plan year, the State of Maryland Prescription Drug Plan continues to be as good as, or better than, the standard Medicare Part D plan. See the Notice of Creditable Coverage in this guide.

If you have State prescription drug coverage, the Notice of Creditable coverage means that if you decide to keep the State prescription drug coverage and not enroll in Medicare Part D, you will be permitted to enroll in Medicare Part D at a later time without paying a higher premium, as long as you do not have a break in coverage of 63 or more days.

Retirees and Their Covered Dependents

As a retiree or a dependent of a retiree, if you decide to buy the Medicare Part D coverage and keep your State prescription coverage, Medicare Part D will become your primary source of prescription drug coverage, and the State coverage will be secondary. In other words, Medicare will pay benefits first, and then the State coverage will coordinate with the benefits that Medicare pays. Remember, you will have to pay both monthly premiums.

Here’s How the State Plan Will Work as Your Secondary Coverage When You Have Primary Coverage Through Medicare Part D

- ◆ You will give the pharmacist your Medicare Part D card first as your primary insurance and your State prescription card as your secondary insurance.
- ◆ You must meet an annual Medicare Part D deductible before Medicare will begin to pay benefits. During this time, your State coverage will pay benefits and you will only be required to pay the applicable copays for State coverage. Once your copays combined with the State payments reach the annual Medicare deductible, Medicare will begin paying benefits. Your true out-of-pocket (TROOP) cost for the Part D plan will only reflect what you paid, and not what the State paid.
- ◆ After you have met any Medicare annual deductible, Medicare Part D will pay their portion of eligible costs of the drugs on their preferred drug list, up to the determined coverage gap. The State will pay benefits and will make up the difference between what Medicare pays, if anything, and the applicable State copay you are required to pay.
- ◆ When the amount of State copays you have paid during the fiscal year reaches \$1,000 individual/\$1,500 family you will have met the out-of-pocket maximum for the State prescription drug coverage. This means the State plan pays for eligible expenses not covered by your Medicare Part D plan in full for the rest of the plan year. You should still give your pharmacist your Medicare Part D card.

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

*The federal government does not recognize Same-sex Domestic Partners for the Special Enrollment Period.

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

Active Employees and Covered Dependents

If you have prescription drug coverage because you are still working, or because your spouse or family member is still working, the employer coverage will remain your primary prescription drug coverage unless you drop it. If that coverage is creditable coverage, you can wait to enroll in Medicare Part D until a later time, and you will not pay more for your Part D premium when you enroll, as long as you do not have a break in coverage of 63 or more days.

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 left.

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 left 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.**

BENEFITS APPEAL PROCESS

Internal claims and appeals process: Please contact your Plan for more information. Plan contact information is located in the front of this guide or at www.dbm.maryland.gov/benefits.

External claims and appeals process: More information regarding the external review process will be forthcoming in a supplemental document which will be available in late April 2011.

For Dispute of Claims Payments

You should describe the nature of your claim and the reasons why you believe that the claim has been improperly denied, along with any supporting documentation, which may include a HIPAA Authorization Release Form. This form can be found on our website: www.dbm.maryland.gov by clicking on Health Benefits.

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’s 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’ll 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 November 15th through December 31st. 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 “Enrollment and Changes Outside of Open Enrollment” on page 18 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 separate 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 and clicking “Health 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); and
- ◆ 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: 07/01/11, **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.

NOTICE Creditable Prescription Drug Coverage

Definitions

Allowed Benefit: The maximum fee a health plan will pay for a covered service or treatment. The allowed amount 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: The portion of medical services that the employee must pay after the deductible.

Copayment: The amount an employee, retiree, or covered dependent pays at the time service is rendered. This money goes directly to the health care 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.

Domestic Partner: (See Same Sex Domestic Partner)

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. Some carriers require the member to select a primary care physician and may require referrals. Please see specific carrier's benefits on pages 22-35 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 health care expenses or dependent care 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.

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.

In-Network Service: Service provided by a participating provider, Primary Care Physician, or 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 health care 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.

Plan Year: The plan year for benefits begins July 1 and ends June 30 of the following year.

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 health care professional who provides treatment or services.

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

Qualifying Event: An event such as marriage, divorce, or the birth of a child, that allows a change in health care 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.

Same Sex Domestic Partner: An individual in a relationship with an employee or retiree who is the same sex as the employee or retiree, if both individuals: are at least 18 years old; are not related to each other by blood or marriage within four degrees of consanguinity under civil law rule; are not married, in a civil union, or in a domestic partnership with another individual; have been in a committed relationship of mutual interdependence for at least 12 consecutive months in which each individual contributes to some extent to the other individual's maintenance and support with the intention of remaining in the relationship indefinitely; and share a common primary residence.

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



**DEPARTMENT OF
BUDGET & MANAGEMENT**

301 West Preston Street
Baltimore, MD 21201



Printed on Recycled Paper