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

Benefit chart footnotes are on page 36

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.		

Benefit chart footnotes are on page 36

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

Benefit chart footnotes are on page 36

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.				

Benefit chart footnotes are on page 36

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.				

Benefit chart footnotes are on page 36

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

Benefit chart footnotes are on page 36

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.				

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.				

Benefit chart footnotes are on page 36

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.