



PUTTING the PIECES TOGETHER

Open Enrollment 2012 – 2013 Member Information



GUIDE TO YOUR HEALTH BENEFITS

STATE OF MARYLAND



July 2012 – June 2013

Did You Know?

- Flu shots are covered when given by a provider in your medical plan network.
- You must re-enroll in FSA each year and save your receipts even when using your debit card.
- You must pay missed payroll deductions to ensure no gap in your coverage.
- Medicare eligibility affects your State benefits.

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



Martin O'Malley, Governor Anthony Brown, Lt. Governor T. Bole Foster, Secretary David C. Romas, Deputy Secretary



State of Maryland
Participating Active & Satellite Agency
Employees and State Retirees

Open Enrollment 2012– 2013
April 17, 2012 – May 1, 2012
Correction Period
May 9, 2012 – May 16, 2012

Open Enrollment is your opportunity to
make certain changes to your benefits
coverage elections

Refer to the Open Enrollment materials
mailed to your home or provided to you
by your Agency Benefits Coordinator

DETAILED OPEN ENROLLMENT INFORMATION IS AVAILABLE ON OUR WEBSITE AT:

www.dbm.maryland.gov/benefits
Department of Budget & Management
Employee Benefits Division
410.767.4775 or 1.800.307.8283 or EBDmail@dbm.state.md.us



(You can scan this QR code to go directly to our website)

- OE Packet
 - Will contain Guide, enrollment instructions, summary statement, What's New document, rate sheet, and wellness pamphlet
 - March 21 – Mailing to home address for Retirees and Direct Pay
 - March 27 – Active and Satellite packets sent to Agency Benefit Coordinator (ABC). ABCs will then distribute.

Changes to OE Enrollment Instructions

- Open Enrollment Instructions will not be included in the Benefit Guide. They will be in your OE packet as an individual document.

ENROLLMENT INSTRUCTIONS DURING OPEN ENROLLMENT

Open Enrollment Period: April 17, 2012 – May 1, 2012
Correction Period: May 9, 2012 – May 16, 2012
For Plan Year: July 1, 2012 – June 30, 2013

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 benefits selections;
- Enroll in a Flexible Spending Account (FSA) for Active/Satellite employees only – for the first time or to re-enroll; **NO!**
- Add or delete dependents.

To help you prepare for Open Enrollment, we have provided you with information about:

- If you have never enrolled in a plan, you must obtain an enrollment form from the Benefits Coordinator.
- If you are retiring or changing your status, you must complete an Enrollment Form.

Before You Call the IVR

- Review this benefits guide and have it handy when calling.
- Decide what changes you want to make to your current enrollment.
- If you are an Active employee, you must call in during the time you are on your pay stub from each pay period.
- Decide on the following:
 - Calculate the number of dependents you want to add.
 - Calculate the number of dependents you want to delete.

NOTE: Central Payroll will determine their number.

- Have the following information ready:
 - Dependent's name
 - Dependent's date of birth
 - Dependent's relationship to you
 - Dependent's Social Security Number

NOTE: The Prudential Insurance Company will determine their number.

After you make each selection, the system will ask you to confirm your selections. If you are an Active employee and Coordinator, if you are a retiree, or if you are a former employee, you must follow the instructions in the Enrollment Form.

USING THE IVR

For a complete IVR script detailing enrollment instructions, go to www.abcm.maryland.gov/benefits, click on "New to Enroll".

STEP 1: MAKE THE CALL
Call the IVR system 24 hours a day, 7 days a week at the number below between April 17 and May 1:

- Baltimore area: 410.643.3893
- Outside Baltimore or People who are deaf:
 - When prompted, enter your ID number.
 - Your ID number is the last four digits of your Social Security Number.
 - If you are enrolling in benefits for the first time, you must call in during the time you are on your pay stub from each pay period.

STEP 2: MAKE YOUR SELECTIONS
The IVR system will guide you through the enrollment process.

- Medical
- Prescription Drug
- Dental
- Flexible Spending Account
- Term Life Insurance
- Accidental Death and Dismemberment

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 system will read your information about plans in which you did not make a change. Information for dependents added through "speak and spell" is not available through this system. You will receive an updated benefits summary statement of benefits within 10 days after your call.

- If you are an Active employee, you will receive your benefits summary statement from your Agency Benefits Coordinator.
- If you are a retiree, your statement will be mailed to the address we have on file.

NOTE: This step may require changes and corrections at any time during Open Enrollment. However, there will be a special correction period at the end of Open Enrollment for any last minute changes, corrections or enrollment selections. You are encouraged to enroll early and review your benefits 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 selections after Open Enrollment, except in limited circumstances. See the Qualifying Event Change section of your benefits guide for details.

Call Your Benefits Coordinator if You Do Not Call the IVR
Your current benefits elections will roll over for the new plan year, except Flexible Spending Accounts (FSA).

SPECIAL INSTRUCTIONS IF YOU ARE ADDING OR DELETING DEPENDENTS

- You will need to "speak and spell" each dependent's information clearly so 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 plan if you add or delete dependents. 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 plans submitted for each dependent on or after the submission date will be your responsibility to pay. (See page 17.18 of your benefits guide for dependent documentation requirements.)
- If you add an eligible dependent or fail to remove an ineligible dependent from your coverage, you will be required to pay the employee or retiree premium cost (and costs add-on) for the eligible dependent for each month that he or she remains enrolled.

Employee Benefits Division
300 West Preston Street - Room 510
Baltimore, MD 21201
410.343.4775 or 800.343.6883
www.abcm.maryland.gov/benefits

Summary Statements

- A Summary Statement will be provided to you after you make changes during OE to allow you to review your changes for accuracy.
- If you call the IVR on Monday, entry to the Benefit Administration System will occur on Tuesday, and a new Summary Statement will be available on Wednesday.
- Active employees should receive a copy from their ABC. Retirees and Direct Pay will receive in mail from EBD.

Inside Front Cover of Benefit Guide

- Contact info for each of our carriers and for the main EBD customer service department.
- Please utilize these resources to contact the carrier directly for claims resolutions, ordering new ID cards, requesting copies of EOBs, etc.
- EMPOWER yourself! Be an active participant in your healthcare administration needs and be proactive in resolving any concerns you may have regarding providers, claims, etc.

Plan	Phone	Website
MEDICAL PLANS		
Aetna	1-800-501-9837	1-800-501-9837 (TTY/TDD) www.aetna.com
Select® EPO, Choice® POS II		
CareFirst BlueCross BlueShield EPO, POS, PPO	1-800-225-0131	1-800-735-2258 (TTY) www.carefirst.com/state/md
UnitedHealthcare	1-800-382-7513	1-800-553-7109 (TTY/TDD) www.uhcmaryland.com
Select EPO, ChoicePlus POS, Options EPO		
BEHAVIORAL HEALTH PLAN (FOR MEMBERS IN PPO AND POS HEALTH PLANS – EPO MEMBERS USE EPO)		
APS Healthcare	1-877-239-1458	www.apshealth.com PPO State Code: SCPT202
PRESCRIPTION DRUG PLAN		
Express Scripts, Inc.	1-877-213-3867	www.express-scripts.com
DENTAL PLANS		
United Concordia DHMO and DFFO	1-888-MD-TEETH (1-888-638-3384)	www.unitedconcordia.com/state/md
FLEXIBLE SPENDING ACCOUNTS		
ConnectYourCare	1-866-971-4646	www.connectyourcare.com/state/md
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	1-800-732-0416	www.prudential.com/ltcweb/maryland
HELPFUL CONTACTS		
State Retirement Pension System	410-425-5555 or 1-800-492-5909	www.srs.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) Email us at: ebdmail@ibm.state.md.us	 www.ibm.maryland.gov/benefits (or scan the QR code to the left to go directly to our website)

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Looking for Something?

- Searching for something that you just cannot seem to find in the Guide? – Did you know there’s a “Search and Find” tool available to you?
- Just like any basic web search function, you type the word or phrase you are searching for into the search bar and it will be found for you throughout the document!

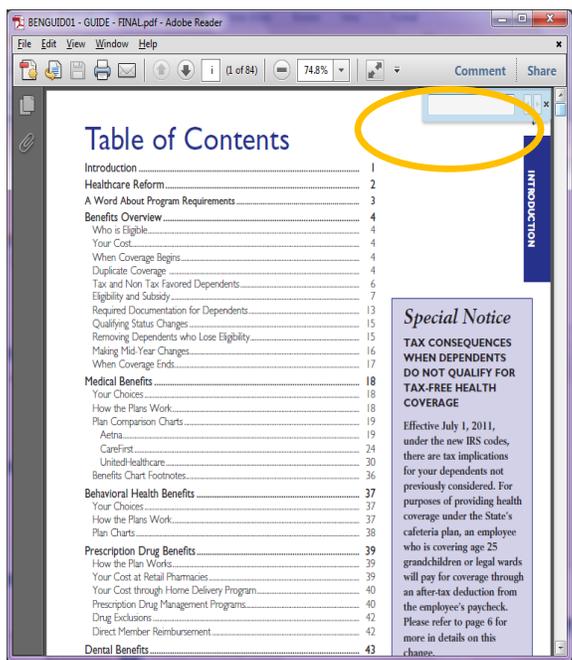


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Special Notice

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

Effective July 1, 2011, under the new IRS codes, there are tax implications for your dependents not previously considered. For purposes of providing health coverage under the State's cafeteria plan, an employee who is covering age 25 grandchildren or legal wards will pay for coverage through an after-tax deduction from the employee's paycheck. Please refer to page 6 for more in details on this change.

A Few Opening Notes

- Though we **STRONGLY ENCOURAGE** you to read this entire Guide, we realize sometimes that may not be feasible. Using the Table of Contents will allow you to skip to specific sections for immediate answer to most of your questions.
- We urge you, prior to contacting EBD Customer Service, to reference your Guide and attempt to find the answer to your question.

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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, 2012-June 30, 2013. For more details about each plan, review the sections in this guide or refer to the inside of the front cover for phone numbers and websites for each of the plans.

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

Plan Offerings

- In general, plan offerings for this year remain the same
- Details on changes to follow in this presentation.

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

* To be eligible, you must meet the eligibility requirements as outlined on page 7-14 in this guide.
 ** For retirees and their dependents who are Medicare eligible, all medical plans are secondary to Medicare Parts A & B regardless of whether the individual has enrolled in each.
 *** Only retirees who are enrolled in life insurance as an active employee at the time of retirement may continue life insurance coverage.

Benefits Overview

- No Duplicate Coverage!! Dependents may not be enrolled as both an employee/retiree in their own coverage and also as a dependent on another coverage.
- A child cannot be covered on two policies
- We do perform routine audits of this scenario, and will remove dependents who have duplicate coverage.

Benefits Overview

WHO IS ELIGIBLE

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

Who Can be Covered

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

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

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

NOTE: It is your responsibility to remove a dependent child, spouse, domestic partner or domestic partner's child immediately when he/she no longer meets dependent eligibility criteria provided on page 6.

Children reaching age 26 with no disability certification are removed from coverage automatically at the end of the month in which they reach age 26. A notice is sent to your address on file in advance of the termination of coverage.

WHEN COVERAGE BEGINS

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

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

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

You may purchase coverage retroactively to the date you or your dependent(s) became eligible for coverage or back to the date of the change in circumstances, permitting a mid-year change in coverage, whichever is earlier, on a post-tax basis but no more than 60 days in arrears. See your Agency Benefits Coordinator or call the Employee Benefits Division for more information. New retirees should receive a retroactive adjustment letter from the Employee Benefits Division regarding any missed premiums between their date of retirement and the period covered by their first retiree premium deduction. You may not retroactively cancel coverage, or retroactively elect to participate in an FSA.

YOUR COST

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

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

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

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

DUPLICATE COVERAGE PROHIBITED

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 nor may they both cover the same children. This is duplicate coverage and is not permitted under the Program. This

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Post Tax Benefits and Imputed Income

- IRS regulations dictate who is eligible for pre-tax coverage. Same Sex Domestic Partners, Same Sex Spouses and Children of the Same Sex Domestic Partner/Spouse (unless adopted by the employee) are NOT eligible for pre-tax benefits.
- Where these types of dependents are enrolled, there will be a pre-tax deduction for the employee and a post-tax deduction for the dependent(s).
- The amount of the State subsidy attributable to this type of dependent is considered income to the employee. The employee pays taxes on this value in each paycheck. This is known as imputed income.

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.

Dependent Child to Age 26

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

• If the child is 25 or older and not disabled, post-tax deductions and imputed income may apply to any grandchildren or legal wards that you cover under your benefit elections. Please refer to the "July 2012-June 2013 Premium Rates" document at www.dhm.maryland.gov/benefits for additional details.

• You must submit the required dependent documentation and Affidavit for Dependent Eligibility for all newly enrolled dependent children. See pages 13-14 for the required dependent documentation.

• Disabled Eligible Dependent Child: You are **not** required to provide Disability Certification until the child reaches age 26. You will then be required to provide continued certification of his/her disability status every two years in order to keep him/her on your coverage.

• Additional rules apply for covered children, see page 14.

Important Information About Covering Your Same Sex Spouse or Same Sex 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 premium payments or enrollment in 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 payroll deductions under the tax code. Therefore, health benefits premiums for same sex spouse/domestic partners and their eligible dependents who are not qualified as dependents 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 (after-tax) deduction for the coverage level attributable to the same sex spouse/domestic partner (and/or spouse/domestic partner's child); and

• Pre-tax (before-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 toward the coverage for those dependents not qualified as tax dependents under the IRS code. In other words, the State's contribution toward 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. For rate information refer to the Same Sex Spouse/Domestic Partner rate pages available on the "July 2012 - June 2013 Premium Rates" document at www.dhm.maryland.gov/benefits. 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 indicating the imputed income amount for the calendar year to be filed with their tax returns.

Tax Favored vs. Non Tax Favored

- Criteria used to determine if your dependent is eligible for tax favored treatment.
- If you have questions on your dependents, pre-tax vs. post-tax deductions and imputed income, just ask us!

6 SUMMARY OF GENERAL BENEFITS JULY 2012 – JUNE 2013

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

TAX FAVORED DEPENDENTS	NON TAX FAVORED DEPENDENTS (Subject to post-tax deductions/imputed income)
Spouse - Opposite Sex	
Spouse - Same Sex <ul style="list-style-type: none"> • Must permanently reside with you for entire taxable year; and, • For whom you provide more than 50% support for the taxable year 	Spouse - Same Sex <ul style="list-style-type: none"> • Permanently 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 <ul style="list-style-type: none"> • Meets all Domestic Partner eligibility criteria; and, • For whom you provide more than 50% support for the taxable year 	Same Sex Domestic Partner <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • Meets all dependent child eligibility criteria as described on page 14; and, • Is your or your spouse biological child, step-child or adopted child • Is your domestic partner's biological child, step-child or adopted child that fully satisfies one of the three tax criteria tests (See Affidavit for Dependent Eligibility) 	Child <ul style="list-style-type: none"> • Meets the eligibility criteria for grandchild or legal ward; and, • Age 15 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 Affidavit for Dependent Eligibility)

BENEFITS OVERVIEW

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

Leave of Absence

- If you have a need for a Leave of Absence due to Military Leave, Family Medical Leave, On the Job Injury or any other reason, please speak to your Agency Benefit Coordinator for details on how this may affect your benefits.

8 SUMMARY OF GENERAL BENEFITS JULY 2012 – JUNE 2013

Eligibility	Subsidy Amount	How You Will Pay for Benefits
LONG TERM LEAVE WITHOUT PAY – PERSONAL If an approved leave without pay for personal reasons, you may continue any or all of your current health benefit plans or you may receive your coverage level while on leave for up to two (2) years.	For leave without pay, you pay the full amount.	Premiums are paid on a pro-rata basis. Monthly payment coupons will be mailed to the address provided on your enrollment form for the first month of coverage through the end of the plan year or the end of your approved leave, whichever comes first. 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. Missed payments or payments not postmarked within the 30-day grace period will result in the termination of your coverage. You will not be permitted to re-apply until the

BENEFITS OVERVIEW

MARYLAND STATE EMPLOYEES AND RETIREES 9

Eligibility	Subsidy Amount	How You Will Pay for Benefits
LONG TERM LEAVE WITHOUT PAY If an approved leave without pay due to job injury, you may continue any or all of your current health benefit plans or you may receive your coverage level while on leave for up to two (2) years. • First request of leave must be used. • Agency Benefit Coordinator must complete and submit enrollment forms appropriate to your situation.	For leave without pay, you pay the full amount.	Premiums are paid on a pro-rata basis. Monthly payment coupons will be mailed to the address provided on your enrollment form for the first month of coverage through the end of the plan year or the end of your approved leave, whichever comes first. 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. Missed payments or payments not postmarked within the 30-day grace period will result in the termination of your coverage. You will not be permitted to re-apply until the next Open Enrollment period. 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. If you do not receive payment coupons within one month of submitting your enrollment form, please contact the Employee Benefits Division.

FAMILY MEDICAL LEAVE ACT – FMLA

Eligibility	Subsidy Amount	How You Will Pay for Benefits
If you are on approved FMLA, we will maintain your health coverage under our group health plan on the same terms as when you were actively working. If you are on paid leave under FMLA and receiving a paycheck, we will continue deducting your premiums through your pay period deductions. If you are on FMLA and do not have paid leave available, you will be responsible for the payment of your share of the premiums payments for your health insurance coverage for the period of time you are on approved FMLA leave. You may choose to submit payment due while on leave or within 30 days upon returning to work.	Maximum State Subsidy	If FMLA leave is unpaid, premiums are paid on a pro-rata basis. Monthly payment coupons will be mailed to the address file. You may pay each coupon as it is received, or you may pay all coupons within 30 days upon returning to work. Payments must begin with the first coupon received and are due by the due date indicated on the payment coupon. If payment is not made by the due date indicated, the date may be forwarded to the State of Maryland's Central Collection Unit. If returned to the Central Collection Unit, a collection fee of 1% will be added to the amount owed. In addition, the Central Collection Unit is authorized to report the date to consumer reporting agencies. Default returned to these agencies may affect your credit rating.

BENEFITS OVERVIEW

Required Documentation for Dependents

- You must supply documentation for all dependents you add to your coverage.
- If you add a dependent during OE, we will send you a letter requesting the documentation after OE has closed.

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

Dependent Relationship	Eligibility Criteria	Required Documentation
Spouse - Opposite Sex* Same Sex Domestic Partner	• Under age 35 • Except for grandchildren and legal wards, no requirement to reside in your home • May be eligible for coverage under own employer • May be married or unmarried, or • Over age 35 and incapable of self-support due to mental or physical incapacity incurred prior to age 35	• Affidavit for Dependent Eligibility* and Biological Child • Copy of most official state birth certificate • Adopted Child • Final Adoption Order of placement or adoption report, Affidavit or copy of court order placing child pending final adoption • Final Adoption: Copy of final adoption decree signed by a judge or a State Assisted Birth Certificate showing employment at the parent • Step-child • Copy of child's official state birth certificate with name of spouse of employee/retiree as child's parent • Copy of employee/retiree's official state marriage certificate • Legal Ward, Testamentary or Court appointed guardian (not temporary for less than 12 months) • Copy of dependent's official state birth certificate • Copy of legal Ward/Testamentary court document signed by a judge • Grandchild, Step-grandchild or other dependent child relative • Copy of child's official state birth certificate • Proof of relation by blood or by marriage • Proof of permanent residency (one of the following): - Valid driver license - State-issued identification card - School records certifying dependent's address - Tax documents certifying dependent's address or - Tax documents certifying address with child's name or document • Sole Support Affidavit • Child with mental or physical incapacity incurred prior to age 35 • Copy of child's disability certification form in addition to applicable documentation above
BENEFITS OVERVIEW Same Sex Domestic Partner's Children Same as Children section above	Same as Children section above	• Documentation to establish existence of domestic partnership (see page 13) • Affidavit for Dependent Eligibility* (one for Domestic Partner and one for Domestic Partner's Child) • All the same documents (above) that are required for a dependent child of an employee/retiree, including the relationship between the dependent child and the domestic partner
Medical Child Support Order	Same as Children section above	• Copy of court order requiring Employee/Retiree to provide support and health coverage, signed by the child support officer or judge

* Main refer to the "July 2012-June 2013 Pension Book" document at www.dsm.maryland.gov/benefits for important tax information when covering these dependents who are age 15 and not disabled.
 ** This form can be downloaded at www.dsm.maryland.gov/benefits

Dependent Eligibility and Tax Status Forms

- Page 1
- Gives you a basic overview of tax favored and non tax favored rules
- Obtains Member and Dependent Information
- Asks for the relationship of the dependent
- You affirm that the information provided is true and correct.

 **MARYLAND** Affidavit for Dependent Eligibility and Tax Status

Things to consider regarding dependent tax status:

- Employer-provided health care coverage for employees, spouses and certain other family members is exempt from federal income and employment taxes, and in most states, state taxes. However, family members must meet various criteria for these tax advantages to apply.
- Federal law determines the circumstances under which health benefits coverage for the dependent of an employee is eligible for tax favored treatment. If eligible for tax favored treatment, payroll deductions for benefits are taken on a pre-tax basis (deducted from pay before taxes are assessed and withheld).
- Retiree health benefit coverage is always paid on a post-tax basis, whether deducted from pension earnings or paid by the retiree via coupon.
- When coverage is provided for dependents that are not eligible for pre-tax coverage, the employee contribution for that dependent's coverage must be made on a post-tax basis. In addition, the employer subsidy for that coverage becomes taxable income (imputed income) for the employee. The Benefits Guide describes imputed income in more detail.

There are two tools presented to help you determine if your dependents qualify for tax-free coverage. Both tools contain the same information, but are provided in different formats so you can choose the format better suited for you. Please see below for a Checklist and a Flowchart.

Name of Employee/Retiree: _____
 Employee/Retiree SSN: _____
 Name of Dependent: _____
 Dependent Date of Birth: _____ Dependent SSN: _____

Dependent Relationship (please check the applicable box(es)):

CHILD	SPOUSE / DOMESTIC PARTNER
Child is Employee/Retiree's dependent <input type="checkbox"/>	Legally married spouse of the opposite sex <input type="checkbox"/>
Child is dependent of same sex domestic partner <input type="checkbox"/>	Legally married spouse of the same sex <input type="checkbox"/>
<input type="checkbox"/> Biological child	<input type="checkbox"/> Same sex domestic partner
<input type="checkbox"/> Adopted child or child placed with me for adoption	
<input type="checkbox"/> Stepchild	
<input type="checkbox"/> Grandchild*	
<input type="checkbox"/> Legal Ward, Testamentary, or Court Appointed Guardianship*	
<input type="checkbox"/> Other Dependent Child Relative*	

* I certify by my initials here and signature below that this child is supported solely by me, and is my tax-dependent _____

I solemnly affirm under the penalties of perjury under applicable state laws that the foregoing is true and accurate. I understand that willful falsification of information contained in this Affidavit can result in referral of the matter for investigation and prosecution, the termination of enrollment and coverage of the person identified as my dependent, and the termination of coverage for myself (the employee/retiree). I understand that a civil action may be brought against me for any losses, including reasonable attorney fees because of a false statement contained in this Affidavit. In addition, where permissible, employment related action may be taken against an active employee.

I further agree that if this dependent's status changes, I will notify my Agency Benefit Coordinator or the Employee Benefits Division immediately to remove this dependent from my coverage. I also agree to provide the required documentation as outlined on the Documentation Checklist which substantiates the information above.

Employee/Retiree Signature: _____ Date: _____

Dependent Eligibility and Tax Status Forms

• Page 2

- Provides a checklist tool for you to determine if the dependent you are adding is eligible for pre-tax benefits.
- You should check the boxes that apply (are true statements) to the dependent in question.
- Must meet ALL boxes of at least one Test in order to have pre-tax coverage.

CHECKLIST:
Which Family Members Can Get Tax-Free Coverage?

Opposite Sex Spouse
Coverage is tax-free and contributions can be pretax if the person you're covering is:
 your opposite-sex spouse.

Test 1 – Child
Coverage is tax-free and contributions can be pretax if the person you're covering is:
 Under age 26,
AND
 Your child by birth or adoption, or Your stepchild.

Test 2 – Same Sex Domestic Partner or Same Sex Spouse
Coverage is tax-free and contributions can be pretax if the person you're covering is:
 Someone for whom you claim an exemption on your federal taxes (If you're unsure, refer to IRS publications 501 and 27 to see if you can claim this person as an exemption). You will be required to submit a copy of both your and your partner/spouse's most recent federal tax return showing your partner/spouse as your dependent.

Test 3 – Child dependent who doesn't satisfy Test 1 or 2
Coverage is tax-free and contributions can be pretax if you check ALL SEVEN boxes below as true:
 This person is any one of the following:
a. Your child by birth or adoption or your stepchild.
b. A descendant of someone in A.
 This person lives with you for more than half the year.
 This person is one of the following:
a. A US Citizen, national or resident.
b. A Resident of Canada or Mexico.
c. A child being adopted by a US Citizen or national whose household the child shares.
 This person does not provide more than half of his/her support through the year.
 This person is one of the following:
a. Age 18 or younger for the entire calendar year.
b. Age 23 or younger and a full-time student for the entire calendar year.
c. Totally and permanently disabled at any time during the calendar year (regardless of age).
 This person is younger than you (unless totally and permanently disabled).
 This person is unmarried (or has not filed a joint return with a spouse for the year, except to claim a refund).

Test 4 – Child dependent or other person not satisfying Test 1, 2, or 3
Coverage is tax-free and contributions can be pretax if you check ALL FOUR boxes below as true:
 This person is under the age of 26 and is any one of the following:
a. your relative,
b. unmarried to you but lives with you for the entire calendar year as a member of your household and the relationship isn't in violation of local law.
 You provide more than half of this person's support during the calendar year.
 This person is one of the following:
a. A US Citizen, national or resident.
b. A Resident of Canada or Mexico.
c. A child being adopted by a US citizen or national whose household the child shares.
 This person is either one of the two below:
a. cannot be claimed as any other taxpayer's qualifying child dependent.
b. can be claimed as another taxpayer's qualifying child dependent, but that taxpayer isn't required to file a federal tax return and doesn't do so (or only files to get a refund of previously withheld income taxes).

If your dependent does not meet the standards of any of the tests above, your deductions will be withheld on a post-tax basis and you will be taxed on the value of the employer contribution toward your dependent's coverage (imputed income).

INSTRUCTIONS: Read each statement and place a check mark in the boxes that are true statements regarding this dependent. If you cannot check ALL of the boxes under a test, then move to the next test. Initial here to indicate the answers you have provided are true: _____

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New Dependent Eligibility and Tax Status Forms

- All documents needed for all eligible dependents under our plans are included on this one checklist.
- You should complete one packet for each dependent you are enrolling.
- If you are adding a new dependent during Open Enrollment, you do not have to submit this document with your enrollment – EBD will contact you following OE for you to complete this form and provide the required documentation.

DEPENDENT DOCUMENTATION CHECKLIST:

INSTRUCTIONS: In addition to completing the Checklist or Flowchart above, you must supply documentation supporting your relationship (or your spouse or domestic partner's relationship) to your dependent. Review the checklist below for the type (relationship) of dependent you are adding and supply ALL indicated documents with your enrollment. For details on the necessary documents, review the "Required Documentation for Dependents" section of your Benefit Guide.

Legally married, opposite sex spouse or same sex spouse	Copy of Official State marriage certificate (must be a certified copy and dated by the appropriate State or County official such as the Clerk of the Court).
Same sex Domestic Partner	Dually signed Affidavit of Domestic Partnership
	Notarized validation of signed Affidavit of Domestic Partnership
	Document to verify common primary residence
	Document to verify financial interdependence for previous 12 months
Biological child of employee/retiree or domestic partner	Copy of the child's official state birth certificate documenting lineage
	Newborns only: a copy of the crib card or hospital discharge papers if birth certificate is not yet available
Adopted child or child placed with you for adoption	Completed adoptions: Copy of adoption papers signed by a judge
	Pending adoptions: Notice of placement for adoption from adoption agency, or copy of court order placing child pending final adoption
	Copy of child's official state birth certificate (if available)
Stepchild	Copy of the child's official state birth certificate documenting lineage
	Copy of official state marriage certificate for employee/retiree and spouse
Grandchild	Copy of child's official state birth certificate documenting lineage
	Copy of child's parent's official state birth certificate documenting lineage
	Proof of permanent residency
Legal Ward, Testamentary, or Court appointed Guardianship (not temporary for less than 12 months)	Copy of child's official state birth certificate
	Copy of court documents signed by a judge
Step-Grandchild or other dependent child relative	Copy of child's official state birth certificate
	Proof of relation (marriage certificates, birth certificates of any/all related parties)
	Proof of permanent residency
Child with a physical or mental incapacity that occurred prior to reaching age 26	Disability certification form (in addition to documentation listed above depending on relationship)

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Official Dependent Eligibility Documentation

 EBD will only accept official documents.

-  Copies of official documents are accepted
-  Only exception: newborns

 Documents in a language other than English must be translated and notarized.



PUTTING the PIECES TOGETHER

Official Marriage Certificate

-  Shows the License Number.
-  Signed by the Deputy Clerk of the Circuit Court.



PUTTING the PIECES TOGETHER

Unacceptable Marriage Certificate



Signed only by the minister.

Not certified



Official Birth Certificate

CERTIFICATION OF VITAL RECORD

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
DIVISION OF VITAL RECORDS
CERTIFICATE OF LIVE BIRTH

STATE FILE NUMBER: 1995-32153

NAME: [REDACTED] SEX: MALE

DATE OF BIRTH: [REDACTED] WEIGHT: 0 LBS 8 OZ

PLACE OF BIRTH: BALTIMORE CITY TIME: 04:20 PM

MAIDEN NAME OF MOTHER: [REDACTED] AGE: 30

MOTHER'S PLACE OF BIRTH: MARYLAND AGE: 33

NAME OF FATHER: [REDACTED]

FATHER'S PLACE OF BIRTH: MARYLAND

DATE RECORD FILED: JULY 10, 1995 DATE ISSUED: 03-11-1999

I HEREBY CERTIFY THAT THIS DOCUMENT IS A TRUE COPY OF A RECORD ON FILE IN THE DIVISION OF VITAL RECORDS.

Senora B. Apud
STATISREGISTRAR

DO NOT ACCEPT UNLESS ON SECURITY PAPER WITH SEAL OF VITAL RECORDS CLEARLY EMBOSSED.

Employee/retiree must be linked to the dependent on the birth certificate(s).

If the employee adding the child to his/her coverage is not indicated by name on the birth certificate, we will be unable to accept it.

Must be signed by the Registrar of Vital Records.

Unacceptable Birth Certificates



Document issued by hospital.



Only acceptable to use as temporary documentation when dependent child is a newborn.

The first sentence on this document says "this document is not a birth certificate".

This document is the "Birth Registration Notice" and is not signed by the State Registrar.



PUTTING THE PIECES TOGETHER

Qualifying Life Status Changes

- The only way to make changes mid-year to elections made (or not made) during Open Enrollment, is to experience a Qualified Life Status Change.
- Changes to your benefits MUST coincide with the event necessitating the change.
 - As an example – if you get divorced mid year, you can remove your ex-spouse and that spouses' children, however you cannot remove children that are biologically yours.

QUALIFYING STATUS CHANGES

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. However, there are some changes in status that permit you to make limited changes during the plan year. Examples of qualifying changes in status include:

- Birth or adoption/placement for adoption of a child;
- Death of a dependent;
- Marriage or divorce;
- 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;
- Loss of other coverage, such as if coverage under your spouse's employment ends or your child ceases to be eligible;
- Gaining eligibility for Medicare (for retirees); or
- Changes in your other coverage which has a different plan year.

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

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

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

REMOVING DEPENDENTS WHO LOSE ELIGIBILITY

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

Ex-Spouse

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

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

- Your Agency Benefits Coordinator, if you are an active or Standstill 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.

Removing Dependents and Mid-Year Change Instructions

- It is your responsibility to remove dependents who lose eligibility within 60 days of the life status change that results in loss of eligibility.
- Divorced spouses are not eligible to remain on our plan. If you are divorced and responsible for your spouse's insurance coverage, you have to elect COBRA continuation coverage.

16 SUMMARY OF GENERAL BENEFITS JULY 2012 – JUNE 2013

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 dependent's partner relationship; Proof of the termination of shared common primary residence; and Proof of the termination of financial interdependence.
Children	<ul style="list-style-type: none"> Documents to establish the loss of eligibility of the dependent child such as marriage certificate, proof of other coverage, etc.
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 such as marriage certificate, proof of other coverage, etc.

* No documentation is required when removing a dependent from coverage during Open Enrollment.

INSTRUCTIONS ON HOW TO MAKE MID-YEAR CHANGES

IF YOU...	THEN...
Are retired or transferred to another state agency within 30 days following termination from previous agency	You will automatically be enrolled into the same elections you had previously upon retire or transfer.
Are an active State employee enrolling for the first time	You must submit an enrollment form and dependent verification documentation within 60 days of your hire date. Enrollment forms will not be accepted after 60 days. 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 how to pay any missed premiums between your retirement date and the period covered by your first retroactive 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 qualifying event to be effective on the earliest effective date following the date of qualifying event, you must request a retroactive adjustment. A newborn's effective date may go back to the date of birth. Even if the qualifying event does not change your coverage levels, a zero-balance retroactive adjustment is still required. For newborns, no retroactive adjustment is required if employee already has family coverage. Your request for a retroactive adjustment must be submitted within 30 days of the first premium deduction reflecting the change 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 along with temporary documentation of the child's birth (such as hospital discharge papers, copy of the child's hospital ID bracelet, or footprints). A retroactive adjustment form and payment must also be submitted unless you already have family coverage. An official State birth certificate and the child's social security number must be submitted within 60 days of the date of receipt of the temporary documentation. Active employees with questions should contact their Agency Benefits Coordinator. All other enrollees should contact the Employee Benefits Division for assistance.
Need to remove an ineligible dependent (e.g., divorced spouse, child no longer eligible, etc.)	You must notify the Employee Benefits Division in writing through an enrollment form signed by your Agency Benefits Coordinator. (Retirees must notify the Employee Benefits Division directly.) You must include all necessary documentation with your notification. If you do not remove an ineligible dependent within 60 days of the loss of eligibility, you will be responsible for the total premium cost for coverage of the ineligible dependent, regardless of whether claims were submitted or paid. In addition, keeping an ineligible dependent on your coverage may result in disciplinary action, termination of employment, and/or criminal prosecution. Sanction agency employees must notify their Agency Benefits Coordinator.

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Verifying Payroll Deductions and Refunds

- It is your responsibility to ensure your payroll deductions and/or payment coupons are correct. If any inaccuracies are noted, EBD should be contacted so we can research and correct if necessary.
- Refunds will only be considered when an error by a State agency has occurred, if the error is brought to our attention within one year of the occurrence, and no more than one year (12 calendar months) of a refund will be granted.

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WHEN COVERAGE ENDS

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

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

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

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

Special Note for Active Employees

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

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

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

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

MEMBER SUPPORT

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 charges 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.

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Medical Benefits Overview

- Choosing a medical plan can be a daunting task. All the options, the treatments, the payments out of your pocket at time of service, the associated payroll deductions.
- It is extremely important to be an informed consumer when selecting a plan that best suits the needs of yourself and your family.

Medical Benefits (includes routine vision and behavioral health coverage)

NOT SURE WHICH PLAN TO CHOOSE?

Use this link to see how the different plans rate under the Maryland Health Care Commission's Performance report: <http://mhcc.maryland.gov/hmcc/comreport2011.pdf>

YOUR CHOICES

You have eight medical plans from which to choose:

- Preferred Provider Organization (PPO) Plans:
 - CareFirst BlueCross BlueShield
 - UnitedHealthcare Options PPO
- Point-of-Service (POS) Plans:
 - Aetna Choice POS II
 - CareFirst BlueCross BlueShield
 - UnitedHealthcare ChoicePlus POS
- Exclusive Provider Organization (EPO) Plans:
 - Aetna Select EPO
 - CareFirst BlueCross BlueShield
 - UnitedHealthcare Select EPO

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

HOW THE PLANS WORK

Once you enroll in a medical plan, you will receive identification cards in the mail. Take these cards with you every time you receive medical services. Depending on what type of medical plan you choose, the way you receive medical services and how much you pay at the time of service will vary. Please review the plans carefully and select the plan that best suits your needs. PPO and POS plans offer out-of-network benefits. EPO plans do not provide out of network benefits except for true emergencies.

Please refer to the benefit charts on pages 20-35 for more details on each medical plan option.

Allowed Amount

The plan's allowed amount refers to the reimbursement amount the plan has contractually negotiated with network providers to accept as payment in full. Non-participating providers (out-of-network) are not obligated to accept the allowed 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 70% out-of-network, it means the plan pays 70% 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 your plan, contact the plan before obtaining services or treatment to obtain more information on coverage limitations, exclusions, determinations of medical necessity, and preauthorization requirements. In addition, you will receive a summary of coverage from the plan in which you enroll, providing details on your plan coverage.

Coordination of Benefits

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

If Your Provider Terminates from Your Plan Network

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

NOTE: Outpatient prescription drug benefits are not included under the medical benefits plan and require a separate enrollment election. Please refer to page 39 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.

What's New for 2013?

- Flu shots are covered by the medical plan at 100%
 - In network only, pharmacists are not generally considered in-network providers
- Rabies vaccinations and allergy serum are now covered under Medical.

Choosing a Medical Plan: What is the Same?

- The services that are covered
 - except vision care - this benefit varies by plan
- The copays and coinsurance levels at which services are covered

Choosing a Medical Plan: What are the Differences?

- The network of available physicians and hospitals
- The “allowed benefit” for Out-of-Network reimbursement levels
- Which services require pre-authorization
- Vision benefits
- Web & Mobile Technology

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Definitions You’ll Need to Know

• PPO (Preferred Provider Organization) – A PPO is a health insurance plan that utilizes a network of physicians and facilities contracted by the insurance carrier to provide services within negotiated price boundaries. PPO members have the option to use physicians and facilities that are not part of the network, but their out of pocket costs will be significantly higher.

Benefit	PPO		POS		EPO
	In-Network	Out-Network	In-Network	Out-Network	Network Only
Plan Year Deductible					
Individual	None	\$250	None	\$250	None
Family	None	\$500	None	\$500	None
Out-of-Pocket Coinsurance Maximum					
Individual	\$1,000	\$3,000	\$1,000	\$3,000	None
Family	\$2,000	\$6,000	\$2,000	\$6,000	None

Any charges above the plan's Allowed Amount are not counted toward the out-of-pocket maximum.

• POS (Point of Service)
– A POS plan is like a hybrid between a PPO and an HMO. Members use a network of physicians and facilities to seek care, but also have the ability to see providers outside of the network.

• EPO (Exclusive Provider Organization)
– An EPO is a type of managed care plan. The EPO uses a network made up of providers from which a member must choose. EPO members are restricted to using In-Network providers only.

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Definitions You'll Need to Know

• **In-Network** – Services provided by a Participating Provider or facility

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

Benefit	PPO In-Network	PPO Out-of-Network	POS In-Network	POS Out-of-Network	EPO In-Network Only
Plan Year Deductible					
Individual	None	\$250	None	\$250	None
Family	None	\$500	None	\$500	None
Out-of-Pocket Coinsurance Maximum					
Individual	\$1,000	\$3,000	\$1,000	\$3,000	None
Family	\$2,000	\$6,000	\$2,000	\$6,000	None

Any charges above the plan's Allowed Amount are not counted toward the out-of-pocket maximum.

• **Deductible** – The amount a member is required to pay before payment for services are paid for out-of-network treatment

• **Out-of-Pocket Maximum** – This is the most a member will pay out of his or her pocket in coinsurance charges. The deductible is included in the OOP max. Copays are excluded from the Out of Pocket maximum

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Definitions You'll Need to Know

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

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

Primary Care Physician's Office Visit	\$15 copay	70% of allowed benefit after deductible	\$15 copay	70% of allowed benefit after deductible	\$15 copay
Specialist Office Visit	\$30 copay	70% of allowed benefit after deductible	\$30 copay	70% of allowed benefit after deductible	\$30 copay
Adult Physical Exams & associated lab work	100% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit	Not covered	100% of allowed benefit
<small>One exam per plan year for all members and their dependents age 22 and older.</small>					
Well Baby/Child Visit	100% allowed benefit	70% of allowed benefit after deductible per visit	100% of allowed benefit	Not covered	100% of allowed benefit
Inpatient Care/ Hospitalization (requires preauthorization)	90% of allowed benefit	70% of allowed benefit after deductible; 90% of the allowed benefit after emergency admission	90% of allowed benefit	70% of allowed benefit after deductible; 90% of the allowed benefit after emergency admission	100% of allowed benefit

• **Copayment** – The flat dollar amount a member pays at the time service is rendered. Copays vary by type of service.

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Details - Medical Plan Changes

PPO and POS In-Network Changes

Beginning 7/1/12

- No deductibles (no change)
- Plans pay 90% for all in-patient and out-patient hospitalization
- \$1,000 out of pocket max per individual/ \$2,000 per family

PPO and POS Out-of-Network Changes

Beginning 7/1/12

- 70% of allowed benefit after deductible
- \$250 deductible per individual / \$500 per family
- \$3,000 out of pocket max per individual / \$6,000 per family

**These changes are not
applicable to the EPO plans**

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Details - Medical Plan Changes

PPO, POS and EPO Copay Changes

Beginning 7/1/12

- Specialist office visit: \$30 copay
- Urgent care: \$30 copay
- Emergency room: \$75 facility copay PLUS \$75 physician copay

No Changes to the Following Benefits

- In-network primary care provider office visit copay remains \$15
- In-network preventive care still covered at 100% with no copay
 - routine GYN exams/mammograms
 - adult/child physicals
 - immunizations and vaccines

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When Will I Pay Coinsurance?

In-Network Examples – This List is NOT All Inclusive

- Inpatient Hospitalization & Services
- Inpatient Surgery
- Outpatient Surgery
- Anesthesia
- Diagnostic Lab & X-Ray
- Ambulance Services
- Durable Medical Equipment
- Home Healthcare
- Maternity Hospitalization
- Hospice Care

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Doing the Math – Coinsurance

(example assumes individual coverage)

In-Network

\$10,000 surgery
-but-
\$8,000 is the allowed benefit
 \times 10% (patient coinsurance)
\$800 (patient responsibility)

\$1,000 is the Out-of-Pocket Max
 $-$ \$800 patient responsibility 1st surgery
\$200 maximum coinsurance charge for any other service to which coinsurance applies through the end of the plan year.

Your coinsurance responsibility (10%) will never exceed \$1,000.

Out-of-Network

\$10,000 surgery
-but-
\$8,000 is the allowed benefit
 $-$ \$250 deductible (patient responsibility)
\$7,750
 \times 30% patient coinsurance
\$2,325 patient responsibility (coinsurance)
 $+$ \$250 patient responsibility (deductible)
\$ 2,575 total patient responsibility

\$3,000 is the Out-of-Pocket Max
 $-$ \$2,575 paid toward coinsurance & deductible
\$425 maximum coinsurance charge for any other service to which coinsurance applies through the end of the plan year.

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A Note About Out-of-Network Providers

Example From Previous Page

\$10,000 surgery
-but-
\$8,000 is the allowed benefit
- \$250 deductible (patient responsibility)
\$7,750
x 30% patient coinsurance
\$2,325 patient responsibility (coinsurance)
+ \$250 patient responsibility (deductible)
\$ 2,575 total patient responsibility

\$3,000 is the Out-of-Pocket Max
-\$2,575 paid toward coinsurance & deductible
\$ 425 maximum coinsurance charge for any other service to which coinsurance applies through the end of the plan year.

Beware of Balance Billing

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

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

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A Final Word About Out-of-Pocket Expenses

- Every July 1st, your deductible and out-of-pocket maximum resets to \$0.
- You have to meet these costs every plan year.

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Welcome to UnitedHealthcare

Thank you for considering UnitedHealthcare. We are committed to making health care clear and simple – from benefits to health and wellness tools that can help support your health goals.

We offer three great plan options – POS, PPO or EPO – with features that give our plans a clear advantage:

- **No referrals** – you have the freedom to see any doctor or specialist without a referral.
- **\$15 Primary Care and \$30 Specialist copayment**
- **Preventive care covered at 100% (in-network)**
- **National network** – our nationwide coverage gives you access to more than 665,000 physicians and health care professionals and 1,100 hospitals, including every hospital in Maryland.

Plan option	National network	Regional network	No referrals required	Out-of-network coverage	No primary doctor required	Online services, tools and programs
UnitedHealthcare ChoicePlan POS	●	●	●	●	●	●
UnitedHealthcare Options PPO	●	●	●	●	●	●
UnitedHealthcare Select EPO	●	●	●	●	●	●

Our POS plan offers the same freedom as our PPO, but at a lower cost.

Resources

- **Customer Care 24/7** - 1-800-382-7513
- **myuhc.com** – our exclusive member website where you can manage benefits, track claims, use health improvement tools and do much more.
- **uhcmaryland.com** – comprehensive custom website filled with information you need before you enroll.
- **Health Care Lane** – learn about health care in a fun and engaging way by taking a tour down this virtual street at www.healthcarelane.com/state/md.

Administration services provided by UnitedHealthcare Insurance Company, UnitedHealthcare Services, Inc. or their affiliates. Health Plan coverage provided by or through UnitedHealthcare of the Maryland, Inc.



The UHC Website



There's An App For That!

Mobile Technology for People On the Go

As a UnitedHealthcare member, you can now conveniently manage your health care needs by getting mobile access to the health information you need. Our mobile apps are available for iPhone, iPad, Android, Kindle Fire, and Windows Phone. You can also use our mobile website.

Our mobile apps and website are available for iPhone, iPad, Android, Kindle Fire, and Windows Phone. You can also use our mobile website.

Our mobile apps and website are available for iPhone, iPad, Android, Kindle Fire, and Windows Phone. You can also use our mobile website.

UNITEDHEALTHCARE	POS	PPO	EPO	POS	PPO	EPO
Plan Option	ChoicePlan POS	Options PPO	Select EPO	ChoicePlan POS	Options PPO	Select EPO
Annual Deductible	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000
Out-of-Pocket Maximum	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000
Primary Care Copayment	\$15	\$15	\$15	\$15	\$15	\$15
Specialist Copayment	\$30	\$30	\$30	\$30	\$30	\$30
Prescription Copayment	\$10	\$10	\$10	\$10	\$10	\$10

UNITEDHEALTHCARE	POS	PPO	EPO	POS	PPO	EPO
Plan Option	ChoicePlan POS	Options PPO	Select EPO	ChoicePlan POS	Options PPO	Select EPO
Annual Deductible	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000
Out-of-Pocket Maximum	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000
Primary Care Copayment	\$15	\$15	\$15	\$15	\$15	\$15
Specialist Copayment	\$30	\$30	\$30	\$30	\$30	\$30
Prescription Copayment	\$10	\$10	\$10	\$10	\$10	\$10

United Healthcare Benefit Charts. Please see guide for more details.

UNITEDHEALTHCARE	POS	PPO	EPO	POS	PPO	EPO
Plan Option	ChoicePlan POS	Options PPO	Select EPO	ChoicePlan POS	Options PPO	Select EPO
Annual Deductible	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000
Out-of-Pocket Maximum	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000
Primary Care Copayment	\$15	\$15	\$15	\$15	\$15	\$15
Specialist Copayment	\$30	\$30	\$30	\$30	\$30	\$30
Prescription Copayment	\$10	\$10	\$10	\$10	\$10	\$10

UNITEDHEALTHCARE	POS	PPO	EPO	POS	PPO	EPO
Plan Option	ChoicePlan POS	Options PPO	Select EPO	ChoicePlan POS	Options PPO	Select EPO
Annual Deductible	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000
Out-of-Pocket Maximum	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000
Primary Care Copayment	\$15	\$15	\$15	\$15	\$15	\$15
Specialist Copayment	\$30	\$30	\$30	\$30	\$30	\$30
Prescription Copayment	\$10	\$10	\$10	\$10	\$10	\$10

UNITEDHEALTHCARE	POS	PPO	EPO	POS	PPO	EPO
Plan Option	ChoicePlan POS	Options PPO	Select EPO	ChoicePlan POS	Options PPO	Select EPO
Annual Deductible	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000
Out-of-Pocket Maximum	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000
Primary Care Copayment	\$15	\$15	\$15	\$15	\$15	\$15
Specialist Copayment	\$30	\$30	\$30	\$30	\$30	\$30
Prescription Copayment	\$10	\$10	\$10	\$10	\$10	\$10

The APS Website



877-258-1458

The APS website is filled with articles, assessments, audio casts, online seminars and “skill builders” on many of life’s milestones and challenges.

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Prescription Drugs through Express Scripts

- Express Scripts (ESI) is the new Pharmacy Benefits Manager for the State of Maryland effective May 16, 2012. We have worked with ESI to develop a comprehensive communications plan to ensure all members receive clear and concise information on how to utilize their new prescription drug benefits.

- The Plan – the coverage, copays, etc. –has not changed from the prior year.

Prescription Drug Benefits

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

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

HOW THE PLAN WORKS

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

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

Preferred Brand Name Medications

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

Express Scripts doctors and pharmacists evaluate the medications approved by the U.S. Food & Drug

Administration (FDA). Each prescription medication is reviewed for safety, side effects, efficacy (how well it works), ease of dosage and cost. The medications that are judged best overall are selected as preferred brand name medications. Preferred medications are reviewed throughout the year and are subject to change.

Out-of-Pocket Copay Maximum

The annual out-of-pocket copayment maximum is:
 ● Active Employees: \$1,000 per individual and \$1,500 per family
 ● Retirees: \$1,500 per individual and \$2,000 per family

This means that when the total amount of copayments you and/or your covered dependents pay during the plan year reaches the annual out-of-pocket copayment maximum, you and your covered dependents will not pay any more copayments for eligible prescriptions for the remainder of the plan year (through June 30).

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

YOUR COST AT RETAIL PHARMACIES

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

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

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

Active employees represented by Bargaining Unit 1 (SLEOLA) have a different rate schedule and plan design for medical and prescription drug benefits. Please visit the Employee Benefit Division's website for more information at www.dbm.maryland.gov/benefits.

SCHEDULE DRUGS FROM A PREFERRED LIST

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Home Delivery, Zero Copay Generics, and Specialty Drugs

- The Home Delivery and Specialty Drug programs are changing. Current medications under these programs will be transferred from old PBM to ESI.
- Targeted communications will be sent directly to the members affected by these changes, notifying them of the new provider, and making them aware of new claims procedures for future claims.
- The Zero Dollar Generic program will continue for generic drugs in the therapeutic classes of high cholesterol, high blood pressure, Ulcer/GERD, Asthma and Depression.

YOUR COST THROUGH HOME DELIVERY PROGRAM

Home delivery from the Express Scripts Pharmacy delivers your maintenance medications, the prescription medications you take regularly to treat ongoing conditions, to your home with no cost for standard shipping. You may refill your medications online or by phone. Visit www.StartHomeDelivery.com or call (877) 213-3867 to get started with the home delivery service from the Express Scripts Pharmacy. Your cost for home delivery medications is the same as you would pay at the retail pharmacies, but home delivery offers the convenience of delivery to your home.

PRESCRIPTION DRUG MANAGEMENT PROGRAMS

Zero Dollar Copay for Generic Programs
The copayment for specific classes of generic medications is zero dollars (\$0) at both retail and the Express Scripts Pharmacy home delivery program. The five drug classes, including some examples of generic medications covered under this program, are listed in the chart below. If you are currently taking a brand name medication in one of these drug classes, please consult with your doctor to determine if a generic alternative is appropriate.

Drug Class	Used For Treating	Generic Medications
HMG CoA Reductase Inhibitors (Statins)	High Cholesterol	Atorvastatin (generic: Zocor) rosuvastatin (generic: Crestor)
Angiotensin Converting Enzyme Inhibitors (ACEIs)	High Blood Pressure	lisinopril (generic: Zestril) lisinopril/HCTZ (generic: Zestril) enalapril (generic: Vasotec) enalapril/HCTZ (generic: Vasotec)
Proton Pump Inhibitors (PPIs)	Ulcer/GERD	esomeprazole (generic: Protonix)
Inhaled Corticosteroids	Asthma	budesonide (generic: Pulmicort, Serovent)
Serotonin Reuptake Inhibitors (SSRIs)	Depression	sertraline (generic: Zoloft) paroxetine (generic: Paxil) venlafaxine (generic: Wellbutrin) citalopram (generic: Celexa) escitalopram (generic: Lexapro)

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

Specialty Drug Management Program

CuraScript®, the Express Scripts specialty pharmacy, ensures the appropriate use of specialty medications. Many specialty medications are biotech medications that may require special handling and may be difficult to tolerate. The specialty medications included in this program may be used for the treatment of rheumatoid arthritis, multiple sclerosis, blood disorders, cancer, hepatitis C or osteoporosis. Specialty medications will be automatically reviewed for step therapy, prior authorization and quantity of dosage limits. These specialty medications will be limited to a maximum 30-day supply per prescription per fill. Some of these specialty drugs are listed in the chart below. NOTE: You will still be limited to paying just two copayments per 90 days of medication. On your first and second fill, you will pay the standard under 46 days fill copay. Your third fill will be at zero cost.

Disease	Specialty Medications in the Specialty Drug Management Program
Rheumatoid Arthritis	Canakinumab, Humira, Kinercy, Cimzia, Oritinivic, Remicade, Enbrel, Humira, Simponi, Xeljanz
Multiple Sclerosis	Apremilast, Bimatoprost, Copaxone, mitoxantrone, Novartis, Rebif, Acthar, HD Tysabri
Blood Disorder	Avanacep, Aranesp, Eprex, Fragon, Invochap, Lowmox, Nplate, Procrit, Lasix, Nektrel, Neupogen, Neumega, Prolestin, anti-hemophilic agents
Cancer	Afinitor, Gleavec, Iressa, Navelox, Ravlemd, Sprycel, Sunitinib, Tarceva, Targis, Temodar, Trastuzumab, Tykerb, Xeloda, Zolara, Eligard, Plavix, Trastuzumab, Vioxx, Zoladex, Thyrogen, Alodol IV, Aranesp IV, Acthar IV, Zolgens IV
Hepatitis C	Albion N, Copagan, Intron A, Pegagan, Peg-Intron, Ribesic, ribavirin, sofosbuvir, Sofosbuvir, Sofosbuvir, Sofosbuvir
Osteoporosis	Forteo, Reclast

**This list is subject to change without notice to accommodate new prescription medications and to reflect the most current medical literature. CuraScript emphasizes the importance of patient care and quality customer service. As a CuraScript patient, you will have access to a team of specialists including pharmacists, nurse clinicians, social workers, patient care coordinators and reimbursement specialists who will

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Prior Authorizations and Step Therapy

- Prior Authorization is used for medications that have a tendency for misuse, and requires that a physician provide diagnosis information to ESI prior to ESI approving the medication to be paid through the plan.
- Step Therapy is in place for medications that have equally therapeutic alternatives at a lower cost to the member and the plan. Before using a high cost medication, some members are required to try at least one lower cost, equally therapeutic medication.
- When a medication requires step therapy or prior authorization, the pharmacist will notify you when you fill the prescription.

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

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

- Retin-A
- Growth hormones
- Lamisil
- Doxycylin
- Dexamethasone
- Adderall

When you go to the pharmacy to obtain a medication that requires prior authorization, the pharmacist will receive an electronic message from Express Scripts, which states that your medication cannot be covered until more information is sent by your doctor to Express Scripts. An Express Scripts representative will let your doctor know if the medication can be covered by your plan. If the medication is approved, you and your doctor's office will be notified. Once you are notified of approval, you can return to your pharmacy to pick up your prescription. If you are not approved for coverage, you may still purchase the medication, but you will pay the entire cost. This amount will not count toward the annual out-of-pocket copayment maximum. Prescription medications requiring prior authorization are subject to change at any time. Please visit www.express-scripts.com for more information.

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

- not limited to:
- Erectile Dysfunction medications
- Proton pump inhibitors
- Sedatives
- Hypnotics (e.g., sleeping pills)
- Nasal inhalers

When you go to the pharmacy for a prescription medication with a quantity limitation, your copayment will only cover the quantity allowed by the plan. You may still purchase the additional quantities, but you will pay the full cost. The cost of the additional quantities will not count toward your annual out-of-pocket copayment maximum. The list of quantity limitation medications is subject to change at any time and is available by visiting www.express-scripts.com.

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

Medications are grouped into two categories:

- **First-Line Medications:** These are the medications recommended for you to take first — usually generics, which have been proven safe and effective. You pay the lowest copayment for these.
- **Second-Line Medications:** These are brand name medications. They are recommended for you only if a first-line medication does not work. You almost always pay more for brand name medications. These steps follow the most current and appropriate medication therapy recommendations. Express Scripts will review your records for step therapy medications when you go to the pharmacy to fill a prescription. If your prescription is for a step therapy medication, the computer will search your prescription records for use of a first-line alternative. If prior use of a first-line medication is not found, the second-line medication will not be covered. You will be

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

Drug Exclusions and Direct Member Reimbursements

- Some medications are not covered under our plan either because the State of Maryland has specifically excluded them, or because they are not on ESI's formulary.
- Review the formulary for your medications. If a medication you currently take is not on the ESI formulary, please ESI Customer Service for assistance.

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

DRUG EXCLUSIONS

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

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

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

DIRECT MEMBER REIMBURSEMENT

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

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

NOTE:

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

PRESCRIPTION DRUG BENEFITS

Active employees represented by Bargaining Unit 1 (SLEOLA) have a different rate schedule and plan design for medical and prescription drug benefits. Please visit the Employee Benefit Division's website for more information at www.dhm.maryland.gov/benefits.

The Express Scripts Website



There's an App For That!



Express Scripts – Communication Plan

Targeted Mailings

- Communications to members who may have to make some changes under the new ESI plan.
- Early April
 - Members who have to choose a new pharmacy
 - Members who currently have preferred brand drugs that will be moving to the non-preferred brand tier
 - Members who have refills remaining in Catalyst mail order drug to get them transferred to ESI mail order
 - Members taking specialty drugs

Welcome to ESI Packets

- Sent to all members enrolled in pharmacy benefits
- Late April
 - Welcome Booklet with info on ESIs programs
 - Formulary Listing
 - Benefits of Generic Drugs Booklet

ESI ID Card Packets

- Early May
 - Welcome Letter
 - Packet with ID Card

Dental Benefits - UCCI

- The DPPO plan allows you to see any dentist, whether in network or out – just remember that you will always pay more to an out of network dentist.
- Predetermination of Benefits (also known as Pre-treatment Estimates) are always a good idea to obtain. Your dentist submits to UCCI the plan of treatment, and UCCI returns an estimate to the dentist for what they will pay and what will be your out of pocket cost.

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.

PREDETERMINATION OF BENEFITS

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

What's Covered – DPPO Plan

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

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 compositional/resin fillings, inlays, endodontic services, periodontal services, oral surgery services, general anesthesia, prosthodontic maintenance, repairs to bridges, and dentures, space maintainers	Plan pays 75% of allowed amount, after deductible
Class III: Major services, including crowns and bridges, dentures (complete and partial), fixed prosthodontics, implants	Plan pays 50% of allowed amount, after deductible
Class IV: Orthodontia (for eligible child(ren) only, age 24 or younger), diagnostic, active, retention treatment	Plan pays 50% of allowed amount, up to \$1,000 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.

How the DHMO Plan Works

- DHMO is Regional!!! Do not pick the DHMO if you do not live within the region, or if your children attend college outside of the region.
- Your dentist leaving the UCCI network is not a qualifying reason to change plans if there is still another dentist in the network within 50 miles of your home or work address.

DENTAL BENEFITS

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

The DHMO Plan

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

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

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

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

Out-of-Area Emergencies

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

What's Covered – DHMO Plan

- The schedule of benefits on pages 45-46 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.
- No annual deductible or annual maximum.

UCCI DHMO Benefit Charts. Please see guide for more details.

The UCCI Website

UNITED CONCORDIA
Insuring America's Dental Health

CLIENTS' CORNER
Dental Benefits Information Designed Exclusively for You

State of Maryland
Employees and Retirees

Featured Services

- Online Services
- 24/7 Live Chat
- Customer Service Center
- Local Customer Support

2013 Dental Plans

- Dental
- DDP

Toll Free Customer Service Number:
1-888-638-3384

What dental plans are available from United Concordia? - United Concordia offers two types of dental plans to meet different needs and preferences. For more information, contact your broker or call 1-888-638-3384.

What if I have a question? - If you have a question about your dental benefits prior to being enrolled in the program, visit our 2013 Dental Plan Information page on the left under [Dental](#). [Click here](#) to call 1-888-638-3384.

After you are enrolled: Visit [2013 Dental Benefits](#) for online access to your benefits, dental claim history, claim status, applicable information and more.

ConnectYourCare Flexible Spending Accounts

- Flexible Spending Accounts are a great way to save money on taxes!
- This plan year, with the increase to the coinsurance and some copays, you may have more out of pocket expenses that are eligible for reimbursement through a Healthcare FSA.
- Beginning in 2013, the maximum you can contribute under a Healthcare FSA is \$2,500 per year.

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 those funds throughout the year. All FSA contributions are pre-tax, which means you save money by not paying taxes on the amount you set aside to pay for eligible healthcare and dependent 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 Spouse/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).

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.

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

TAX SAVINGS WITH AN FSA

An FSA lets you set money aside for eligible 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.* As you can see, Sue saved \$400 by enrolling in her 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	-\$7,367	-\$7,857
After-tax dollars spent on eligible expenses	-\$0	-\$1,500
Spendable income	-\$33,138	-\$35,640
Tax savings with your FSA	\$400	

* Simple 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.*

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 your dependent children (as defined by the IRC Section 152 to include biological child, step-child, adopted child) who have not obtained age 27 by the end of the taxable year. You and your dependent(s) do not have to be 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, vision and certain eligible over-the-counter (OTC) items. There is

Healthcare vs. Dependent Care

- Only Active State and Satellite employees are eligible to participate in the Flexible Spending Accounts.
- Retirees and Direct Pay members are not eligible to participate.
- **Remember** – The FSA is Use it or Lost it! Be conservative in your contribution to be sure you do not over-contribute.

a sample list of eligible expenses on page 52 of this guide. You cannot pay insurance premiums through your FSA.

You may contribute between \$120 and \$2,500 a year to reimburse yourself for eligible out-of-pocket healthcare expenses.

Healthcare FSA	Minimum	Maximum
Annually	\$120.00	\$2,500.00
12 pay period deductions	\$10.00	\$208.33
24 pay period deductions	\$5.00	\$104.14
20 or 21 Pay Faculty (19*)	20 = \$4.00 21 = \$5.71	20 = \$125.00 21 = \$179.04

* 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.

SPECIAL NOTICE: FSA Distributions for Reservists

The Heroes Earning Assistance and Relief Tax Act of 2008 (HEART Act) allows plans to offer "qualified reservist distributions" of unused amounts in healthcare flexible spending accounts (FSAs) to reservists ordered or called to active duty for at least 180 days or on an indefinite basis. An Employee must request a qualified reservist distribution on or after the date of the order or call to active duty, and before the last day of the plan year (or grace period, if applicable) during which the order or call to active duty occurred. The Employee Benefits Division must receive a copy of the order or call to active duty (or extension thereof) to confirm compliance with the 180-day/indefinite requirement. To request a distribution of unused amounts contributed to the Health FSA, submit your request in writing along with a copy of your orders to the Employee Benefits Division before the last day of the plan year (June 30).

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

Who is Covered?

You can use the Dependent Day 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.

What Expenses are Covered?

The Dependent Day 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 day care services already provided.

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.

Dependent Care FSA	Minimum	Maximum
Annually	\$120.00	\$5,000.00
12 pay period deductions	\$10.00	\$416.64
24 pay period deductions	\$5.00	\$208.33
20 or 21 Pay Faculty (19*)	20 = \$4.00 21 = \$5.71	20 = \$250.00 21 = \$338.09

* 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.

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,

Submitting Claims

- Getting reimbursed is easy, and there are many options for submitting claims:
 - Online through your CYC account
 - Using a paper claim form and faxing or mailing it to CYC
 - Using CYC's mobile app
- Or-
- Skip the need to file for reimbursement by using your FSA Debit card!
- Reimbursements can be directly deposited to your bank account – the form is available on the DBM website.

Important information to note regarding the availability of FSA funds for reimbursement

vision, prescriptions and over-the-counter expenses like bandages, as well as money spent on dependent day care and older day care. You may contribute up to the maximum amounts shown for each type of account. 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/statelmd 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 deductions 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 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 have your reimbursements deposited directly into your personal banking account. Download a Direct Deposit form at www.ConnectYourCare.com/statelmd.

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

Remember to plan carefully. Any amounts unused at the end of the plan year are forfeited as required by the IRS.

REIMBURSEMENT INFORMATION

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/statelmd.

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.

Paper Form Submission

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

Step 2. Complete the form.

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

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

REIMBURSEMENT ACCOUNTS

Eligible Expenses and the FSA Debit Card

- A full list of eligible Healthcare FSA expenses is available from the IRS website. Go to www.irs.gov, and in the search bar, type "Publication 502".
- For the same detailed information regarding the Dependent Care FSA, search for "Publication 503".
- The Debit card makes using the Healthcare FSA easy.
- **YOU STILL NEED TO SAVE ALL OF YOUR RECEIPTS!!**
- The same card is used year after year, so save your card.

HEALTHCARE ACCOUNT – ELIGIBLE EXPENSES

- Simple eligible expenses include:
- Copays, coinsurance, and deductibles (but not premiums)
 - Acupuncture
 - Birth control pills
 - Chiropractic 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
 - Walk-baby and walk-child care.

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

HEALTHCARE ACCOUNT – WHAT IS NOT COVERED

- Simple 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
 - Nevada 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:
- Footbaths, toothbrushes, dental floss
 - Make-up, lipsticks, eye cream
 - Face cream, moisturizers
 - Perfume, body spray, deodorants
 - Shampoo and soap
 - Acne treatments (nearly reimbursable)
 - Foot-care products
 - Hair loss treatments, and
 - Dietary supplements and replacements (vitamins)

DEPENDENT DAY CARE ACCOUNT – ELIGIBLE EXPENSES

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

HEALTHCARE PAYMENT CARD FREQUENTLY ASKED QUESTIONS

What is a Healthcare Payment Card?
A convenient 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, doctors' offices, vision centers, hospitals, pharmacies and grocery stores (for eligible over-the-counter items), your charges may be automatically verified as an eligible expense, reducing the need for you to submit receipts. You may still have to submit receipts for some of your purchases (per IRS regulations), so you will need to keep your itemized receipts.

When do I get my payment card?
For new Healthcare FSA enrollees, your payment card will be mailed to your house after the week of June 15, 2012. It will be automatically activated on July 1, 2012. 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.

REIMBURSEMENT ACCOUNTS

Deadlines for Claims Submission

- Eligible expenses for Healthcare must be incurred between the first day of the plan year and September 15th of the following year.
- Eligible expenses for Dependent Care must be incurred between the first day of the plan year and the last day of the plan year.
- Claims must be submitted for reimbursement by October 15th, 2013 for both FSA accounts.
- If you terminate your employment prior to the end of the plan year, you have 90 days following your date of termination to submit all claims.

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.

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 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, 2013 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, 2013 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, 2013 to submit claims for eligible expenses. Remember, even though you have until October 15, 2013 to submit the claim, the service dates must be on or before the dates listed above.

UPDATED IRS GUIDANCE ON THE USE OF HEALTHCARE PAYMENT CARDS FOR OTC MEDICINES

Due to healthcare reform, all OTC items containing a drug or medication, like cold medicine, allergy treatment, and pain relievers, now require prescriptions for reimbursement. Some retailers will accept your OTC prescriptions at the point of sale and will allow you to use your healthcare payment card for those 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/statement for more details.

Notice 2011-5 modifies the prior IRS guidance and permits participants to use their health FSA healthcare payment cards to pay for OTC medicines and drugs after January 15, 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.

FLEXIBLE SPENDING ACCOUNTS

The ConnectYourCare Website

There's an App For That!



MetLife – Term Life Insurance

- Please remember – no duplication of benefits.
- Employees exiting state service have the option of converting their life insurance benefit to an individual policy. This must be done within 31 days of termination.
- Will Preparation, Power of Attorney and Living Will preparation services are offered to all participants in the plan at no additional charge through MetLife's partner Hyatt Legal Plans.

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 2962.

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 under 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.

Beneficiaries can be changed at any time throughout the year. Beneficiary designation forms are available from the DBM Benefits website.

LIFE INSURANCE CHOICES FOR ACTIVE EMPLOYEES

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 scuba diving or flying in or piloting helicopters as part of their job 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 life insurance coverage within 60 days of their start date.

Coverage for Your Dependents

You may choose to purchase coverage for your eligible dependents 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.

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 1-866-492-6963.
- Statement of Health forms are available from the DBM Benefits website.
- Rates change at the start of the plan year (July 1) when you reach the next age level.
- The life insurance offered to you and your dependents is term life coverage. This type of life insurance has no cash value.

FOR MORE INFORMATION

If you have questions about how to report a death claim, portability requests or beneficiary information, please contact MetLife at 1-866-492-6963 for more details. For all other questions, call 1-877-610-2954.

MetLife – Term Life Insurance

- Any increase to coverage amount or new election of coverage usually requires medical Evidence of Insurability (also called a Statement of Health). Your newly elected amount will not be in place until you submit the Evidence of Insurability form to MetLife, and they approve the increase or new election.
- Coverage is now available for your child(ren) through age 26!

56 SUMMARY OF GENERAL BENEFITS JULY 2012 – JUNE 2013

How the Plan Works During Active Employment

New Enrollment
For new enrollment, you must complete a Statement of Health form at work, online, or by mail. This form allows you to schedule your work days do not be at other school you have work consecutive or employment at are not current leave. If you do have to wait to

Changing Coverage
If you are currently covered at you without medical coverage to no regardless of if you submit a Statement of Health form you may increase:
• The first day of the date you paid or stop.

If your request coverage will if

ADDITION
The MetLife MetLife is some manner of legal planning for life with special re-endorsement, your

Life Insurance Coverage for You and Your Dependents
Insurance coverage for you and your covered dependents will be provided through MetLife. The coverage will end when you reach age 65 or when you are no longer disabled, whichever comes first. When your source 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 1-866-492-6963 for eligibility requirements and information about each option.
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. This is a complimentary service as long as you are enrolled in the Life Insurance Program.

LIFE INSURANCE CHOICES UPON RETIREMENT

Coverage for Yourself
As of January 1, 2010, life 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 schedule;
• Cancel life insurance coverage; or
• Convert to an individual policy.

Coverage for Your Dependents
As a retiree, you may also choose to continue, reduce, or cancel your dependent life insurance coverage for your dependents who 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 or children who had life insurance as the dependent of a 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 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. The reduction schedule is as follows:

Age	Benefit Reduce To...
65	65% of your or your dependent's original amount
70	60% of your or your dependent's original amount
75	50% of your or your dependent's original amount
80	35% of your or your dependent's original amount

FOR MORE INFORMATION
For more information about coverage, conversion options, restrictions, definitions, restrictions, terminating benefits, or beneficiary designations, call MetLife 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/maryland. On this website, you can find beneficiary designation and change forms, as well as Statements of Health forms.

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Accidental Death and Dismemberment

- AD&D has several value-added services, including Travel Assistance and Identity Theft Solutions.

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.

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

• \$100,000 • \$200,000 • \$300,000

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

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

Dependent	Benefit
Spouse (if you have children)	55% of your principal benefit amount
Spouse (if no eligible dependent children)	45% of your principal benefit amount
Eligible dependent children (if you have a spouse)	25% of your principal benefit amount
Eligible dependent children (if no spouse)	20% of your principal benefit amount

How the Plan Works

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

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	75%
Paraplegia	75%
One Arm	75%
One Leg	75%
One hand or one foot	50%
Entire sight of one eye	50%
Speech or hearing	50%
Ischemic stroke	50%
Thumb and index finger of same hand	35%

Travel Assistance*

Travel Assistance benefit is available when you enroll in MetLife's AD&D coverage.

With Travel Assistance service, offered with your (AD&D)/Business Travel Accident (BTA) coverage, you'll have extra peace of mind whenever you travel. This service provides you and your dependents with medical, legal and financial assistance 24 hours a day, 365 days a year, when you are more than 100 miles away from home.

Identity Theft Solutions*

While you are home or away, you can take advantage of this valuable benefit now packaged with Travel Assistance. You will be provided with educational tools and resources to help prevent an identity theft occurrence. If you become a victim, you will receive personal assistance 24 hours a day, 365 days a year, to help alleviate your stress and time burden.

*Travel Assistance services are administered by AXA Assistance USA, Inc. Certain benefits provided under the Travel Assistance program are underwritten by AIG American Insurance Company, AXA Assistance and AIG American are not affiliated with MetLife, and the Travel Assistance & Identity Theft Solutions services they provide are separate and apart from the insurance provided by MetLife.

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;
- Emergency evacuation;
- Repatriation of remains;
- Air Bag/Brain Damage; Coma;
- Common Carrier.

FOR MORE INFORMATION

Please contact MetLife at 1-877-410-2954 for an AD&D Beneficiary Designation Form, as well as for information about the plan.

Long Term Care The Prudential

- For this year's Open Enrollment, the plan is open for ALL eligible employees to enroll, without the requirement of medical evidence of insurability!!
- Plan improvements:
 - Expanded eligibility – now your siblings and their spouses can enroll in coverage. (ANY family members that enroll MUST submit evidence of insurability).
 - Increased daily and lifetime maximum payouts.

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.

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. Employees enrolling with guaranteed issue must be actively at work on coverage effective date. Current State employees, State retirees and all family members covered by active employees or retirees who do not enroll when first hired must provide medical history to be approved for coverage.

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

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

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

Optional Features & Additional Benefits

- This plan is still a separate enrollment – not done through the IVR during Open Enrollment, nor on a form for new hires.
- Information on how to enroll included in benefit guide.

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YOUR CHOICES

LTC Insurance is available to all activity at work full-time and part-time State of Maryland/Reserve Account members.

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.

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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-forensic shortened benefit period – allows you to retain access to a portion of the benefits if you stop paying premiums (after at least three years)

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

Additional Benefits

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

- Bed reservation
- Hospice care
- Dementia care
- Home Support Services
- Informal care
- Information and referral services
- Private care management
- Alternate place of care
- Death benefits
- Cash alternative
- International coverage benefit and
- Marriage discount

Coverage Exclusions

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

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

FOR MORE INFORMATION

For more information
• Visit www.mde.state.md.us
• Call 1-800-486-3888

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Important Notices

- Employee Fraud will not be tolerated! We routinely audit our plans – looking for duplicate coverage and recertifying certain dependent relationships as needed.
- Social Security numbers are required for all enrolled dependents in order for our plan to comply with Federal regulations regarding coordination of Medicare benefits. We will be performing an audit and requesting SSNs for those we are missing.

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Important Notices and Information

Employee Fraud and Abuse

Need, abuse and overbill conduct in connection with the benefits provided through the State Employee and Reserve 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 making or receiving a dependent health benefit.
- Listing someone else who is not covered under your enrollment as your dependent and/or health benefit.
- Listing to coverage or access to health benefits (such as prescription drugs or treatments) necessary.
- Giving or selling your prescription.
- Submitting reimbursement requests that were not provided.

The Department of Budget and Finance (DBF) and the Maryland State Employee and Reserve Health and Welfare Benefits Program will investigate all abuse of each plan and benefit option, and determine fraud and abuse if the determination to have taken place, then consequences including:

- Lock-down of your prescription by doctor or pharmacy.
- Termination of coverage or
- Seeking repayment or reimbursement for benefits that were not provided.

There may also be serious criminal consequences.

Notice About Disclosure and Use

Security Number

A federal mandatory reporting law, Law 131-173 requires group health benefit data by the Secretary of the State Human Services, information that if purposes of coordination of benefits will be required to be reported are a (DUNS) of covered individuals (or the sponsor's employer identification number for Medicare), Social Security numbers, and other insurance and/or worker benefits. Medicare rules on the collection of SSN and the SSN, or applicable spouse or family number of a recent health plan enrollment, your SSN is required in order to meet the requirements under this law, visit www.mde.state.md.us/medicare

Long-Term Law

If you are on a leave of absence without pay for more than two to 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 30 days of beginning your long-term LAW. You cannot retroactively terminate benefits and you may be required to pay the full premium for any period of coverage during your long-term LAW that has elapsed prior to your notification to terminate benefits during your long-term LAW.

If you wish to continue your coverage, you must complete a Direct Pay enrollment form and submit it to your Agency Benefits Coordinator. This enrollment form should be completed as soon as you know you will start your 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 benefits 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 the start of your coverage under the LAW.

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 Health Officer complete the applicable section of the Direct Pay enrollment form. The Employee Benefits Division will bill you for the appropriate amount.

All State employees who are on a Leave of Absence without pay will be mailed payment coupons to the address on file. If paying via check or money order, the payment coupon must be included with your payment and mailed to the address indicated on the payment coupon cover letter. You also have the option to pay online by going to www.mde.state.md.us/medicare, click on "Pay Direct Pay Coverage Now." Your benefits will be effective as of the date noted on your payment coupon cover letter, but no claims will be paid until the Employee Benefits Division receives your payment. Payments 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 coverage 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 your coverage is reactivated. This request

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

LEAVE/CONTINUATION OF COVERAGE/COBRA

While on Leave of Absence

If you take a Leave of Absence Without Pay (LAW) you may continue the same health benefit coverage by choosing to enroll and paying the full cost of your premium. If you take a leave of absence pursuant to the Family and Medical Leave Act (FMLA), you may be eligible for continuation of your health benefits coverage.

For re-enrollment must be made through your Agency Benefits Coordinator within 60 days of your return to work. Payment deadlines are strictly enforced. If you do not receive these coupons within one month of signing your enrollment form or if you change your mailing address, please contact your Agency Benefits Coordinator or the Employee Benefits Division immediately.

Leave of Absence - Military

Employees on Active Duty

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

To continue your health under due to being on active military duty, please see your Agency Benefits Coordinator to complete the LAW Military Notification Form. Please provide a copy of your active military orders to your Agency Benefits Coordinator to be submitted with the LAW Military Notification Form. If those 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 duty, please contact your Agency Benefits Coordinator.

Employees Returning from Active Duty

When an employee is returning from active duty, benefits should be restored by the Agency Benefits Coordinator to complete an Active Military Form. The completed enrollment form should be sent to the Employee Benefits Division along with the employee's discharge paperwork.

COBRA and Continuation of Coverage

You and/or your dependents may elect to continue your Health, Prescription Drug, Dental, and Health Care Spending Account participation, including the premium payments, for a maximum determined in accordance with Federal regulations.

If you or one of your dependents experiences a COBRA or Continuation of Coverage qualifying event (as described on the chart on page 64), you or your dependents may be eligible to continue the same health benefits that you or

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COBRA Qualifying Events

- Explains the various COBRA qualifying events, the people affected, and the length of continuation coverage offered.
- Removing a dependent during Open Enrollment is not a COBRA qualifying event. If you remove a dependent during OE, that dependent will not be offered continuation coverage.

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IMPORTANT NOTICE INFORMATION

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

Summary of Continuation of Coverage Conditions		
QUALIFYING EVENT	PERSON AFFECTED	LENGTH OF CONTINUATION COVERAGE
Termination of employment (other than for gross misconduct), including layoff or resignation of employee	<ul style="list-style-type: none"> Employee Spouse Dependent Child(ren) 	18 months or until eligible for coverage elsewhere, including Medicare*, whichever occurs first.
Dependent child(ren) of an employee or retiree no longer meets the dependent eligibility requirements	Dependent Child(ren)	36 months or until eligible for coverage elsewhere, including Medicare*, whichever occurs first.
Death of employee or retiree	<ul style="list-style-type: none"> Spouse Dependent Child(ren) 	36 months or until eligible for coverage elsewhere, including Medicare*, whichever occurs first.
Divorce, limited divorce/legal separation NOTE: A legally separated spouse who is still legally married to the employee remains eligible for coverage.	<ul style="list-style-type: none"> Former Spouse Step-child(ren) of employee or retiree 	Indefinitely or until remarriage or until eligible for coverage elsewhere, including Medicare, whichever occurs first. COBRA coverage includes the ability to enroll with dependents that meet the eligibility criteria.
Dissolution of Domestic Partnership	<ul style="list-style-type: none"> Former Domestic Partner Domestic Partner's Dependent Child(ren) 	If enrolled separately, 36 months or until eligible for coverage elsewhere, including Medicare*, whichever occurs first. 36 months or until eligible for coverage elsewhere, including Medicare*, whichever occurs first.

Qualifying Events After the Start of COBRA (Second Qualifying Events)		
QUALIFYING EVENT	PERSON AFFECTED	LENGTH OF CONTINUATION COVERAGE
Divorce or legal separation from COBRA participant	<ul style="list-style-type: none"> Spouse Step-child(ren) of participant 	36 months from the original qualifying event or until eligible for coverage elsewhere, including Medicare*, whichever occurs first.
Dependent child(ren) of a COBRA participant who no longer meets the dependent eligibility requirements	Child(ren)	36 months from the original qualifying event or until eligible for coverage elsewhere, including Medicare*, whichever occurs first.
Total and Permanent Disability of the employee or retiree (as defined by the Social Security Act) within the first 60 days of COBRA coverage	<ul style="list-style-type: none"> Employee Spouse Dependent Child(ren) 	The 18 months can be extended to 29 months at increased premiums equal to 150% of usual premiums for the additional 11 months.

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

Special Note: The continuation coverage made available to same sex 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. However, domestic partners and their children who are not the employee's/retiree's tax dependent, are not eligible for COBRA or COBRA subsidies under Federal law.

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Medicare – A Few Notes

- Coordination of Benefits
 - For Active employees with Medicare, the State plan is primary.
 - For Retiree participants with Medicare, the State plan is secondary.
- When Medicare is primary and the State plan is secondary, Medicare pays roughly 80% of claims, then the State pays per our plan document the remaining 20% that is usually the Member's full responsibility had the State plan not paid secondary.
- For the PPO and POS plans, when the new coinsurance begins on 07/01, that 20% will continue to be paid per our plan document, but at the new coinsurance rates. So, if a member goes to an In-Network hospital for a surgery, we will pay 90% of the 20% leftover by Medicare – the member will be responsible for the 10% coinsurance. This does not apply to the EPOs.

Benefits Appeal Process

BENEFITS APPEAL PROCESS

Important Information about Your Health Benefits Claims Review and Appeal Rights

Under the Patient Protection and Affordable Care Act (PPACA) of 2010, the claims appeals process has changed. Effective July 1, 2011, the following process is in place. Please read this notice carefully.

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

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

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

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

Employee Benefits Division
Attn: Adverse Determinations
301 West Preston Street, Room 510
Baltimore, MD 21201
Telephone: (410) 767-4775
Toll-free: 1-800-267-6283
Facsimile: (410) 333-7104

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

Assistance resource: For questions about your rights or for assistance in filing an appeal, you can contact:
Office of Health Insurance Consumer Assistance
Maryland Office of Attorney General
Health Education and Advocacy Unit
200 St Paul Place, 16th Floor
Baltimore, MD 21202
Telephone: (877) 261-8807
<http://www.oag.state.md.us/Consumer/IEAU1.htm>
heau@oag.state.md.us
Employee Benefits Security Administration
1-866-444-3272
OR

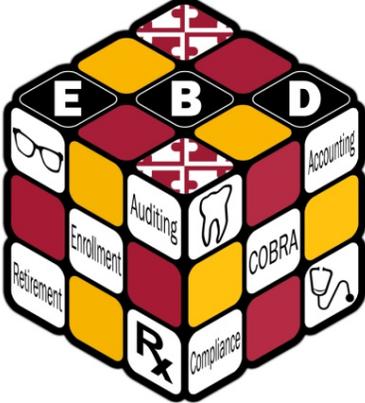
BENEFITS APPEAL PROCESS

The DBM – EBD Website

Improvements to site organization and quality of information provided are coming! Check back often for updates and improvements.



Thank You For Reading!



Local: 410-767-4775
Toll-Free: 1-800-30-STATE

PUTTING the PIECES TOGETHER