SLEOLA ADDENDUM

MARYLAND
State of Maryland

Guide to your Health Benefits

Putting the pieces together to improve your health

JANUARY 2016 to DECEMBER 2016

WHAT'S NEW IN 2016

- Diabetic Supplies Available through your Medical AND now also under your Prescription Plan
- Increase in Health Care Flexible Spending Account Limit

Larry Hogan, Governor Boyd K. Rutherford, Lt. Governor David R. Brinkley, Secretary Marc L. Nicole, Deputy Secretary

State Law Enforcement Officers Labor Alliance (SLEOLA) employees have different medical plan options, prescription plan design and rates than other Non-SLEOLA employees and retirees under the State Employee and Retiree Health and Welfare Benefits Program (the Program). This addendum provides information on the medical and prescription coverage available and the rates. For all other health insurance options including dental, flexible spending, life insurance, accidental death & dismemberment insurance or long term care insurance, please refer to the 2016 Guide To Your Health Benefits available online at: **www.dbm.maryland.gov/benefits.**

SLEOLA employees are not eligible to participate in the Wellness Program.

If you are a SLEOLA participant and are promoted to Lieutenant or above, you must enroll in the non-SLEOLA medical and prescription coverage within 60 days of the promotion in order to have health coverage. Upon retirement, all SLEOLA employees who are eligible and choose to continue benefits will only be eligible to enroll in the Non-SLEOLA medical and prescription plans.

SLEOLA (January 1, 2016 to December 31, 2016) CareFirst					
Benefit	**PPO**		**POS**		**EPO**
TYPE OF SERVICE	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK
Annual Deductible					
Individual	None	$250	None	$250	None
Family	None	$500	None	$500	None
YEARLY MAXIMUM OUT-OF-POCKET COSTS					
Coinsurance Out-of-Pocket					
Individual	None	$3,000	None	$3,000	None
Family	None	$6,000	None	$6,000	None
Copayment Out-of-Pocket					
Individual	$1,000	None	$1,000	None	$1,000
Family	$2,000	None	$2,000	None	$2,000
Total Medical Out-of-Pocket					
Individual	$1,000	$3,000	$1,000	$3,000	$1,000
Family	$2,000	$6,000	$2,000	$6,000	$2,000
Lifetime Maximum	Unlimited				
Network	National		Regional		National
HOSPITAL - INPATIENT SERVICES (Preauthorization Required)*					
Inpatient Care	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Hospitalization	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Acute Inpatient Rehabilitation for Stroke and Traumatic Brain Injury Patients when Medically Necessary	100% of allowed benefit	Not Covered	100% of allowed benefit	Not Covered	100% of allowed benefit
Anesthesia	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Surgery	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Organ Transplant	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
HOSPITAL - OUTPATIENT SERVICES (Preauthorization Required)*					
Chemotherapy/ Radiation	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Diagnostic Lab & X-Ray	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Outpatient Surgery	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Anesthesia	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
THERAPIES (Preauthorization Required)					
Benefit Therapies	$25 copay	80% of allowed benefit after deductible	$25 copay	80% of allowed benefit after deductible	$25 copay
Physical Therapy (PT) and Occupational Therapy (OT)	PT/OT services must be preauthorized after the 6th visit, based on medical necessity; 50 days per plan year combine for PT/OT/Speech Therapy.				
Speech Therapy	Speech Therapy must be preauthorized from the first visit with exceptions and close monitoring for special situations (e.g., trauma, brain injury) for additional visits.				

SLEOLA (January 1, 2016 to December 31, 2016) CareFirst					
Benefit	**PPO**		**POS**		**EPO**
TYPE OF SERVICE	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK
COMMON AND PREVENTIVE SERVICES					
Physician Office Visit - Primary Care	$15 copay	80% of allowed benefit after deductible	$15 copay	80% of allowed benefit after deductible	$15 copay
Physician Office Visit - Specialist	$25 copay	80% of allowed benefit after deductible	$25 copay	80% of allowed benefit after deductible	$25 copay
Physical Exams and Associated Lab (Adult and Child)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	Not covered	100% of allowed benefit
	One exam per plan year for all members and their dependents age 3 and older.				
Well Baby Care	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	Not covered	100% of allowed benefit
	Birth - 36 months: 13 visits total				
Routine Annual GYN Exam (including PAP test)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	Not covered	100% of allowed benefit
Mammography (Preventive)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
	Screening: one mammogram per plan year (35+)				
Mammography (Diagnostic)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
	No age/frequency limitation on diagnostic mammogram				
Hearing Examinations (1 exam every 3 years)	$15 copay (PCP) or $25 copay (Specialists) for exam	80% of allowed benefit after deductible for exam	$15 copay (PCP) or $25 copay (Specialists) for exam	Not covered, except for hearing aids as mandated for minor children	$15 copay (PCP) or $25 copay (Specialists) for exam
Hearing Aids (1 hearing aid per ear every 3 years)	100% of allowed benefit for Basic Model Hearing Aid	100% of allowed benefit for Basic Model Hearing Aid	100% of allowed benefit for Basic Model Hearing Aid		100% of allowed benefit for Basic Model Hearing Aid
	Includes Maryland mandated benefit for hearing aids for minor children (0-18) effective 1/1/02, including hearing aids per each impaired ear for minor children.				
Immunizations	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
	Immunizations are only covered as recommended by the U.S. Preventive Services Task Force. The immunization benefit covers immunizations required for participation in school athletics and Lyme Disease immunizations when medically necessary.				
Flu Shots	100% of allowed benefit	Not Covered	100% of allowed benefit	Not Covered	100% of allowed benefit
STI Screening & Counseling (including HPV DNA and HIV)	100% of allowed benefit	Not covered	100% of allowed benefit	Not covered	100% of allowed benefit
	Counseling and screening for sexually active women as mandated by PPACA.				
Allergy Testing	$15 copay (PCP) or $25 copay (Specialists)	80% of allowed benefit after deductible	$15 copay (PCP) or $25 copay (Specialists)	80% of allowed benefit after deductible	$15 copay (PCP) or $25 copay (Specialists)
EMERGENCY TREATMENT					
Urgent Care Centers	$20 copay	80% of allowed benefit after deductible	$20 copay	80% of allowed benefit after deductible	$20 copay
Emergency Room (ER) Services - In and Out of Network	100% of allowed benefit after $50 facility copay and $50 physician copay	100% of allowed benefit after $50 facility copay and $50 physician copay	100% of allowed benefit after $50 facility copay and $50 physician copay	100% of allowed benefit after $50 facility copay and $50 physician copay	100% of allowed benefit after $50 facility copay and $50 physician copay
	Copays are waived if admitted				
	If criteria are not met for a medical emergency, plan coverage is 50% of allowed amount, after two $50 copays.				
Observation - up to 23 hours and 59 minutes - presented via Emergency Department	100% of allowed benefit after $50 facility copay and $50 physician copay	80% of allowed benefit after deductible	100% of allowed benefit after $50 facility copay and $50 physician copay	80% of allowed benefit after deductible	100% of allowed benefit after $50 facility copay and $50 physician copay
Observation - 24 hours or more - presented via Emergency Department	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Ambulance Services - Emergency Transport	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit
Ambulance Services - Non-Emergency Transport	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
MATERNITY BENEFITS					
Maternity Benefits*	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Prenatal Care (Mandated)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Breastfeeding Support & Counseling (per birth)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Breastfeeding Supplies (per birth)	100% of allowed benefit	Not Covered	100% of allowed benefit	Not Covered	100% of allowed benefit
	Covers the cost of rental/purchase of certain breastfeeding pumps and pump supplies through the insurance carrier's durable medical equipment partner(s).				

SLEOLA (January 1, 2016 to December 31, 2016)
CareFirst

Benefit	PPO		POS		EPO
TYPE OF SERVICE	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK
OTHER SERVICES & SUPPLIES (Preauthorization Required)					
Acupuncture Services for Chronic Pain Management	$20 copay	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Chiropractic Services	$20 copay	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Cardiac Rehabilitation**	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Dental Services	Not covered except as a result of accident or injury or as mandated by Maryland or federal law (if applicable).				
Nutritional Counseling	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Durable Medical Equipment	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
	Must be medically necessary as determined by the attending physician.				
Extended Care Facility	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
	Skilled nursing care and extended care facility benefits are limited to 180 days per benefit period as long as skilled nursing care is medically necessary. Inpatient care primarily for or solely for rehabilitation is not covered.				
Family Planning & Fertility Testing	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
	Family planning benefits include: sperm count hysterosalpingography, eudiometrical biopsy and vasectomy.				
Contraception	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
	Includes IUD insertion and tubal ligation. For information on coverage of prescription contraceptives, please refer to the Prescription Drug section of this addendum.				
Contraceptive Counseling	100% of allowed benefit	Not Covered	100% of allowed benefit	Not Covered	100% of allowed benefit
In Vitro Fertilization (IVF) & Artificial Insemination (AI)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
	Available to opposite and same sex married couples. See carrier's evidence of coverage documents for details. Not covered following reversal of elective sterilization.				
Hospice Care	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Home Health Care	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
	Home Health Care benefits are limited to 120 days per plan year.				
Medical Supplies	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
	Includes, but not limited to, surgical dressings; casts; splints; syringes; dressings for cancer, burns, or diabetic ulcers; catheters, colostomy bags; oxygen; supplies for renal dialysis equipment and machines; and all diabetic supplies as mandated by Maryland law.				
Outpatient Prescription Drugs	Covered separately from Plan. See Prescription Drug Benefits Section.				
Private Duty Nursing	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Whole Blood Charges	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES					
Inpatient Hospital Care	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Partial Hospitalization Services	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Outpatient Services (including Intensive Outpatient Services)	$15 Copay	80% of allowed benefit after deductible	$15 Copay	80% of allowed benefit after deductible	$15 Copay
Residential Crisis Services	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
	Habilitative Services, which include occupational therapy, physical therapy, speech therapy, and applied behavior analysis are covered for children under the age of 19 with congenital birth defects including but not limited to autism, autism spectrum disorder, and cerebral palsy.				

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Benefit	PPO		POS		EPO
TYPE OF SERVICE	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK
VISION SERVICES					
Vision – Non-Routine (Services related to medical health of the eye)	$15 copay (PCP) or $25 copay (Specialist)	80% of allowed benefit after deductible	$15 copay (PCP) or $25 copay (Specialist)	80% of allowed benefit after deductible	$15 copay (PCP) or $25 copay (Specialist)
Vision – Routine (One per plan year)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Frames (One per plan year)	Up to $45				
Prescription Lenses	Single vision: $52.00, Bifocal: $82.00, Trifocal: $101.00, Lenticular: $181.00				
Contact Lenses (in lieu of frames & lenses)	Medically necessary: $285.00, Cosmetic: $97.00				
VISION SERVICES (Dependent children age 18 and under)					
Vision – Non-Routine (Services related to medical health of the eye)	$15 copay (PCP) or $25 copay (Specialist)	80% of allowed benefit after deductible	$15 copay (PCP) or $25 copay (Specialist)	80% of allowed benefit after deductible	$15 copay (PCP) or $25 copay (Specialist)
Vision – Routine (One per plan year)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Vision hardware (frames, lenses, contacts) are only covered in-network for covered dependent children 18 and under.					
Frames	100% of allowed benefit				
	No limits on the number of medically necessary frames purchased in a plan year for children through age 18.				
Basic Prescription Lenses	100% of allowed benefit				
	No limit on the number of medically necessary lenses for children through age 18.				
Contact Lenses (in lieu of frames & lenses)	100% of allowed benefit				
	No limit on medically necessary contacts for children through age 18.				
* Newborns' and Mothers' Health Protection Act Notice. See Guide To Your Health Benefits.					
** Cardiac rehabilitation benefits: 36 sessions in a 12-week period (or on a case-by-case basis thereafter) with physician supervision and in a medical facility. Cardiac rehabilitation must be medically necessary with a physician referral and patient history of a heart attack in past 12 months, Coronary Artery Bypass Graft (CABG) surgery, angioplasty, heart valve surgery, stable angina pectoris, congestive heart failure or heart and lung transplants. Inpatient care primarily for rehabilitation is not covered.					
Medicare COB	If an employee or covered dependent's eligibility is due to ESRD, they must sign up for both Medicare parts A & B as soon as they are eligible. If the Medicare eligible SLEOLA employee and/or their dependent(s) fail to enroll in Medicare, the Medicare eligible SLEOLA employee and/or dependent(s) will be responsible for any claim expenses that would have been paid under Medicare Parts A & B, had they enrolled in Medicare.				
Non-Medicare COB	When the SLEOLA plan is the secondary payor, payments will be limited to only that balance of claim expenses that will reach the published limits of the SLEOLA plan.				

SLEOLA (January 1, 2016 to December 31, 2016)
PRESCRIPTION BENEFITS

Diabetic supplies now also available under prescription

Copayments at Retail Pharmacies

Type of Drug	Prescription for 1-45 Days (1 copay)	Prescription for 46-90 Days (2 copays)
Generic drug	$5	$10
Preferred brand name drug	$15	$30
Non-preferred brand name drug	$25	$50

Copayments through Voluntary Mail Order Program

Type of Drug	Prescription for 1-45 Days (1 copay)	Prescription for 46-90 Days (2 copays)
Generic	$5	$10
Preferred brand name	$15	$20
Non-preferred brand name	$25	$20

Out-of-Pocket Maximum:

Out-of-Pocket Maximum:	$700
	This means that when the total amount of copays you and your covered dependents pay during the plan year reaches $700, you and your covered dependents will not pay any more copays for eligible prescriptions for the remainder of the plan year.

Refer to the 2016 Guide to your Health Benefits for detailed information on the Program's zero dollar copy for the generic drug program, the specialty drug management program, and other details related to the prescription drug benefits.

MARYLAND
State of Maryland

DEPARTMENT OF BUDGET & MANAGEMENT
Employee Benefits Division
301 West Preston Street, Room 510
Baltimore, MD 21201

SLEOLA 2016 RATES

CAREFIRST BC/BS HEALTH PLANS

Plan Type	Bi-Weekly Rates			Monthly Rates		
	PPO	POS	EPO	PPO	POS	EPO
Individual	$65.99	$46.50	$44.91	$131.98	$93.01	$89.81
Individual + Child	$117.43	$82.68	$92.61	$234.85	$165.35	$185.22
Individual + Spouse	$117.43	$82.68	$92.61	$234.85	$165.35	$185.22
Individual + Family	$162.44	$114.33	$114.38	$324.88	$228.65	$228.75

PRESCRIPTION DRUG

Plan Type	Bi-Weekly Rates	Monthly Rates
Individual	$25.09	$50.18
Individual + Child	$33.34	$66.69
Individual + Spouse	$41.64	$83.28
Individual + Family	$50.18	$100.36

DENTAL PLANS

Plan Type	Delta Dental DHMO		United Concordia DPPO	
	Bi-Weekly Rates	Monthly Rates	Bi-Weekly Rates	Monthly Rates
Individual	$3.22	$6.44	$5.82	$11.64
Individual + Child	$5.61	$11.22	$11.12	$22.24
Individual + Spouse	$6.45	$12.89	$11.64	$23.27
Individual + Family	$9.05	$18.11	$21.80	$43.60

ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE PREMIUM RATES

Plan Coverage Level	Employee Only Bi-Weekly Rates	Employee + Family Bi-Weekly Rates	Employee Only Monthly Rates	Employee + Family Monthly Rates
$100,000	$0.75	$1.40	$1.50	$2.80
$200,000	$1.50	$2.80	$3.00	$5.60
$300,000	$2.25	$4.20	$4.50	$8.40

TERM LIFE INSURANCE PREMIUM RATES

Age of Employee/ Retiree	Bi-Weekly Employee Retiree Rates (per $1,000)	Monthly Employee Retiree Rates (per $1,000)	Age of Spouse	Bi-Weekly Spouse Rates (per $1,000)	Monthly Spouse Rates (per $1,000)
Under 30	$0.017	$0.034	Under 30	$0.051	$0.102
30 to 34	$0.021	$0.041	30 to 34	$0.055	$0.110
35 to 39	$0.027	$0.054	35 to 39	$0.069	$0.138
40 to 44	$0.043	$0.085	40 to 44	$0.101	$0.202
45 to 49	$0.069	$0.137	45 to 49	$0.156	$0.313
50 to 54	$0.108	$0.216	50 to 54	$0.232	$0.464
55 to 59	$0.196	$0.392	55 to 59	$0.361	$0.722
60 to 64	$0.277	$0.553	60 to 64	$0.553	$1.106
65 to 69	$0.413	$0.826	65 to 69	$0.804	$1.608
70 to 74	$0.740	$1.480	70 to 74	$1.264	$2.528
75 to 79	$1.030	$2.060	75 to 79	$1.264	$2.528
80 and older	$1.030	$2.060	80 and older	$1.264	$2.528
Dependent Child Coverage is $0.156 per $1,000 per month; $0.078 per $1,000 per bi-weekly pay period.					