SLEOLA ADDENDUM

Maryland
DEPARTMENT OF BUDGET AND MANAGEMENT

Wes Moore, Governor
Aruna Miller, Lieutenant Governor
Helene Grady, Secretary
Marc L. Nicole, Deputy Secretary

Guide to your Health Benefits

Together, we are working toward a **healthier community**.

January 2024 - December 2024

What's New in 2024

- 2024 Premium Rates
- Domestic Partner Eligibility (see page 40)
- Healthcare FSA increase to $3,050
- Visit mymdbenefits.com for additional information on all our plans!

Awareness • Ownership • Accountability • Improvement

State Law Enforcement Officers Labor Alliance (SLEOLA) employees have different medical plan options, prescription plan design and rates than other 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, or accidental death & dismemberment insurance, refer to the 2024 Guide To Your Health Benefits available online at: **https://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 no lapse in your health coverage. Upon retirement, all SLEOLA employees who are eligible and choose to continue benefits are only eligible to enroll in the non-SLEOLA medical and prescription plans.

SLEOLA (January 1, 2024 to December 31, 2024) 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 20th 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, 2024 to December 31, 2024)
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
Preventive Cancer Screenings • US Preventive Services Task Force (Grade A) • Mammography • Colonoscopy • Well woman exam	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+)				
Diagnostic Cancer Screenings	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 $100 copay	100% of allowed benefit after $100 copay	100% of allowed benefit after $100 copay	100% of allowed benefit after $100 copay	100% of allowed benefit after $100 copay
	Copays are waived if admitted				
	If criteria are not met for a medical emergency, plan coverage is 50% of allowed amount, after $100 copay.				
Observation - up to 23 hours and 59 minutes - presented via Emergency Department	100% of allowed benefit after $100 copay	80% of allowed benefit after deductible	100% of allowed benefit after $100 copay	80% of allowed benefit after deductible	100% of allowed benefit after $100 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 and Hospital Directed Transport between Approved Facilities	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	Not Covered	100% of allowed benefit	Not Covered	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, 2024 to December 31, 2024) 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
	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.				
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					
Office Visit	$15 copay	80% of allowed benefit after deductible	$15 copay	80% of allowed benefit after deductible	$15 copay
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)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
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.				

SLEOLA (January 1, 2024 to December 31, 2024) CareFirst					
Benefit	**PPO**		**POS**		**EPO**
TYPE OF SERVICE	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK
VISION SERVICES (Adults 19 and older)					
Vision – Medical (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)	100% of allowed benefit up to $45 per frame	80% of allowed benefit after deductible up to $45 per frame	100% of allowed benefit up to $45 per frame	80% of allowed benefit after deductible up to $45 per frame	100% of allowed benefit up to $45 per frame
Prescription Lenses	100% of allowed benefit up to the following: Single Vision - $52; Bifocal - $82; Trifocal - $101; Lenticular $181	80% of allowed benefit up to the following: Single Vision - $52; Bifocal - $82; Trifocal - $101; Lenticular $181	100% of allowed benefit up to the following: Single Vision - $52; Bifocal - $82; Trifocal - $101; Lenticular $181	80% of allowed benefit up to the following: Single Vision - $52; Bifocal - $82; Trifocal - $101; Lenticular $181	100% of allowed benefit up to the following: Single Vision - $52; Bifocal - $82; Trifocal - $101; Lenticular $181
Contact Lenses (in lieu of frames & lenses)	100% of allowed benefit up to the following: Medically Necessary - $285; Cosmetic - $97	80% of allowed benefit up to the following: Medically Necessary - $285; Cosmetic - $97	100% of allowed benefit up to the following: Medically Necessary - $285; Cosmetic - $97	80% of allowed benefit up to the following: Medically Necessary - $285; Cosmetic - $97	100% of allowed benefit up to the following: Medically Necessary - $285; Cosmetic - $97
VISION SERVICES (Dependent children age 18 and under)					
Vision – Medical (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)	100% of allowed benefit up to $70 per frame	80% of allowed benefit after deductible up to $70 per frame	100% of allowed benefit up to $70 per frame	80% of allowed benefit after deductible up to $70 per frame	100% of allowed benefit up to $70 per frame
Basic Prescription Lenses	100% priced at charges				
Contact Lenses (in lieu of frames & lenses)	100% of annual supply (2 refills per plan year)	80% of annual supply (2 refills per plan year)	100% of annual supply (2 refills per plan year)	80% of annual supply (2 refills per plan year)	100% of annual supply (2 refills per plan year)

* 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, 2024 to December 31, 2024) 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 2024 Guide to your Health Benefits for detailed information on the Program's zero dollar copay generic drug program, the specialty drug management program, and other details related to the prescription drug benefits.

Maryland
DEPARTMENT OF BUDGET AND MANAGEMENT

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

SLEOLA 2024 RATES

CAREFIRST BC/BS HEALTH PLANS						
Plan Type	Bi-Weekly Rates			Monthly Rates		
	PPO	POS	EPO	PPO	POS	EPO
Individual	$83.82	$59.06	$57.04	$167.64	$118.12	$114.08
Individual + Child	$149.15	$105.01	$117.63	$298.30	$210.02	$235.26
Individual + Spouse	$149.15	$105.01	$117.63	$298.30	$210.02	$235.26
Individual + Family	$206.32	$145.22	$145.28	$412.64	$290.44	$290.56

PRESCRIPTION DRUG		
Plan Type	Bi-Weekly Rates	Monthly Rates
Individual	$32.76	$65.52
Individual + Child	$43.53	$87.06
Individual + Spouse	$54.36	$108.72
Individual + Family	$65.51	$131.02

DENTAL PLANS				
Plan Type	Delta Dental DHMO		United Concordia DPPO	
	Bi-Weekly Rates	Monthly Rates	Bi-Weekly Rates	Monthly Rates
Individual	$4.56	$9.12	$7.12	$14.24
Individual + Child	$9.14	$18.27	$13.63	$27.26
Individual + Spouse	$7.95	$15.90	$14.26	$28.52
Individual + Family	$12.83	$25.66	$26.72	$53.44

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	$0.60	$1.15	$1.20	$2.30
$200,000	$1.20	$2.30	$2.40	$4.60
$300,000	$1.80	$3.45	$3.60	$6.90

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	$0.02	$0.03	Under 30	$0.05	$0.09
30 to 34	$0.02	$0.04	30 to 34	$0.05	$0.10
35 to 39	$0.03	$0.05	35 to 39	$0.06	$0.12
40 to 44	$0.04	$0.08	40 to 44	$0.09	$0.18
45 to 49	$0.07	$0.13	45 to 49	$0.14	$0.28
50 to 54	$0.10	$0.20	50 to 54	$0.21	$0.42
55 to 59	$0.19	$0.37	55 to 59	$0.33	$0.65
60 to 64	$0.26	$0.52	60 to 64	$0.50	$1.00
65 to 69	$0.39	$0.77	65 to 69	$0.73	$1.45
70 to 74	$0.69	$1.38	70 to 74	$1.14	$2.28
75 to 79	$1.03	$2.06	75 to 79	$1.14	$2.28
80 and older	$1.03	$2.06	80 and older	$1.14	$2.28
Dependent Child Coverage is $0.07 per $1,000 per bi-weekly pay period; $0.14 per $1,000 per month.					

Rates may vary from what appears on your paystub due to rounding.

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