Medical Benefits

There are no preexisting 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.

Not Sure Which Plan to Choose?

Use this link to see how the different plans rank under the Maryland Healthcare Commission's Performance report: https://healthcarequality.mhcc.maryland.gov/public/healthplanssummary?subtopic=SatisfactionOverall

The State offers several comprehensive medical plan options—all designed to reduce your out-of-pocket cost for most medically necessary services and promote wellness. Please note that prescription coverage must be elected separately. Members of the State Law Enforcement Officers Labor Alliance (SLEOLA) please refer to the SLEOLA Addendum for medical coverage options and rates.

Choosing a Medical Plan

You have five medical plans from which to choose:

Two PPO options:
- Carefirst BlueCross BlueShield PPO
- United Healthcare PPO

Two EPO options:
- Carefirst BlueCross BlueShield EPO
- United Healthcare EPO

One IHM option:
- Kaiser Permanente IHM

You have the option to enroll in a PPO, EPO or IHM Plan for the 2018 plan year. Although they each have different provider networks, all plans cover the same services (like preventive care, specialty care, lab services and x-rays, hospitalization and surgery, routine vision care, and mental health/substance abuse treatment). Below is more information about each plan.

Preferred Provider Organization (PPO) Plan

With a PPO plan, you can see any doctor you want, whenever you want. However, the PPO plan has a national network of doctors, hospitals and other healthcare providers that you are encouraged to use. These "in-network" providers have contracts with the PPO plan and have agreed to accept certain fees for their services. Because their fees are lower, the plan saves money and so do you. You pay more for care if you use out-of-network providers.

PPO plans are available through Carefirst BlueCross BlueShield and United Healthcare. Both cover the same services, treatments and products. However, the cost of coverage and the provider networks are different. See the charts in this section to compare these two plans.

Exclusive Provider Organization (EPO) Plan

With an EPO plan, the Plan pays benefits only when you see an in-network provider (except in an emergency) within a national network. However, your monthly premium cost is lower. An EPO plan only covers eligible services from providers and facilities that are contracted in the EPO plan network.

EPO plans are available through Carefirst BlueCross BlueShield and United Healthcare. Both cover the same services, treatments and products, but the cost for coverage and the provider networks are different. See the chart in this section to compare these two plans.

Integrated Health Model (IHM) Plan

An IHM plan refers to care that allows doctors, hospitals and the plan to work together to coordinate a patient's care for a total health approach. It allows for a smooth transition from clinic to hospital or from primary care to specialty care. This plan option is available through Kaiser Permanente. If you elect this option, you need to reside in one of the following states; MD, DC, VA, DE, PA or WV and you must visit the providers and facilities that are part of the Kaiser Permanente network in the Baltimore/DC/VA area only for all of your care (except in an emergency). **This option is only available to our members who are not Medicare eligible.**

Medical Plan ID Cards

Once you enroll in a medical plan, you will receive ID cards in the mail. Take these cards with you every time you receive medical services. Depending on the type of medical plan you choose, the way you receive medical services and how much you pay at the time of service will vary.

Two terms you should know

Allowed Benefit

The plan's **allowed benefit** refers to the reimbursement amount the plan has contractually negotiated with network providers to accept as full payment. Nonparticipating (out-of-network) providers are not obligated to accept the allowed benefit as payment in full and may charge more than the plan's allowed benefit. In the charts that follow, if it indicates a service is covered at 90%, you only pay 10% of the allowed benefit up to your out-of-pocket maximum. If it indicates the service is covered at 70% out-of-network, it means the plan pays 70% of the allowed benefit. You are responsible for 30% of the cost of services or supplies, including any amount above the plan's allowed benefit, when you receive services from nonparticipating (out-of-network) providers.

Out-of-Pocket Maximum

When the total amount of copayments and/or coinsurance you and/or your covered dependents reaches the out-of-pocket limits noted in the charts, the plan will pay 100% of your copays and coinsurance for the remainder of the plan year (through December 31).

Comparing Medical Plan Benefits

The following charts are a summary of generally available benefits and do not guarantee coverage. **Check each carrier's website to find out if your providers and the facilities in which your providers work are included in the various plan networks.** To ensure coverage under your plan, contact the plan before receiving 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.

If Your Provider Terminates from Your Plan's Network

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

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.

CareFirst

Did You Know?

Not all outpatient surgery requires preauthorization. Your medical plan will advise your physician when he/she calls to verify benefits.

CareFirst			
	PPO		EPO
TYPE OF SERVICE	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK ONLY
Annual Deductible			
Individual	None	$250	None
Family	None	$500	None
Yearly Maximum Out-of-Pocket Costs			
Coinsurance OOP	90%	70%	N/A
Individual	$1,000	$3,000	None
Family	$2,000	$6,000	None
Copayment OOP			
Individual	$1,000	None	$1,500
Family	$2,000	None	$3,000
Total Medical OOP			
Individual	$2,000	$3,250	$1,500
Family	$4,000	$6,500	$3,000
Lifetime Benefit Maximum	Unlimited		
HOSPITAL INPATIENT SERVICES (Preauthorization Required)			
Inpatient Care	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Hospitalization	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Acute Inpatient Rehab when Medically Necessary	90% of allowed benefit	Not covered	100% of allowed benefit
Anesthesia	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Surgery	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Organ Transplant	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
HOSPITAL OUTPATIENT SERVICES			
Chemotherapy/Radiation	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Diagnostic Lab Work and X-rays*	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Outpatient Surgery (Preauthorization Required)	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Anesthesia	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Observation – up to 23 hours and 59 minutes - presented via Emergency Department	100% of allowed benefit after $150 copay	100% of allowed benefit after $150 copay	100% of allowed benefit after $150 copay
Observation – 24 hours or more - presented via Emergency Department	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit

CareFirst

	PPO		EPO
TYPE OF SERVICE	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK ONLY
THERAPIES (Preauthorization required)			
Benefit Therapies	$30 copay	70% of allowed benefit after deductible	$30 copay
Physical Therapy (PT) and Occupational Therapy (OT)	PT/OT services must be precertified after the 6th visit, based on medical necessity; 50 days per plan year combined for PT/OT/Speech Therapy.		
Speech Therapy	Must be precertified from first visit with exceptions and close monitoring for special situations (e.g. trauma, brain injury) for additional visits.		
COMMON AND PREVENTIVE SERVICES			
Physician Office Visits - Primary Care	100% after $15 copay	70% of allowed benefit after deductible	100% after $15 copay
Physician Office Visits – Specialist	100% after $30 copay	70% of allowed benefit after deductible	100% after $30 copay
Physical Exams and Associated Lab (Adult and Child)	100% of allowed benefit	70% of allowed benefit after deductible	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	70% of allowed benefit after deductible	100% of allowed benefit
	Birth – 36 months: 13 visits total		
Routine Annual GYN Exam (including PAP test)	100% of allowed benefit. Non-routine $15 copay.	70% of allowed benefit after deductible	100% of allowed benefit. Non-routine $15 copay.
Mammography Preventive	100% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	Screening: one mammogram per plan year (35+).		
Mammography Diagnostic	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	No age/frequency limitation on diagnostic mammogram.		
Hearing Examinations (1 exam every 3 years)	100% after $15 copay – PCP or $30 copay – Specialist	70% of allowed benefit after deductible	100% after $15 copay – PCP or $30 copay – Specialist
Hearing Aids (1 hearing aid per ear every 3 years)	100% of allowed benefit for Basic Model Hearing Aid	70% of allowed benefit after deductible for Basic Model Hearing Aid	100% of allowed benefit for Basic Model Hearing Aid
	Includes Maryland mandated benefit for hearing aids for minor children (ages 0-18) effective 01/01/02, including hearing aids per each impaired ear for minor children.		
Immunizations	100% of allowed benefit	70% 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
STI Screening and Counseling (Including HPV, DNA and HIV)	100% of allowed benefit	Not Covered	100% of allowed benefit
	Counseling and screening for sexually active women as mandated by PPACA.		
Allergy Testing	100% after $15 copay – PCP or $30 copay – Specialist	70% of allowed benefit after deductible	100% after $15 copay – PCP or $30 copay – Specialist

CareFirst

	PPO		EPO
TYPE OF SERVICE	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK ONLY
EMERGENCY TREATMENT			
Ambulance Services – Emergency Transport and Hospital Directed Transport Between Approved Facilities	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit
Ambulance Services – Non-Emergency Transport	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Emergency Room (ER) Services – In and Out of Network	100% of allowed benefit after $150 copay	100% of allowed benefit after $150 copay	100% of allowed benefit after $150 copay
	Copays are waived if admitted.		
	If criteria are not met for a medical emergency, plan coverage is 50% of allowed amount, plus the $150 copay.		
Urgent Care Office Visit	100% after $30 copay	70% of allowed benefit after deductible	100% of allowed benefit after $30 copay
MATERNITY BENEFITS			
Maternity Benefits**	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Prenatal Care	100% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Newborn Care	100% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Breastfeeding Support and Counseling (per birth)	100% of allowed benefit	Not Covered	100% of allowed benefit
Breastfeeding Supplies (per birth)	100% of allowed benefit	Not Covered	100% of allowed benefit
	Covers the cost of rental/purchase of certain breastfeeding pump and pump equipment through Plan's Durable Medical Equipment partner(s).		
OTHER SERVICES AND SUPPLIES			
Acupuncture Services for Chronic Pain Management	100% after $30 copay	70% of allowed benefit after deductible	100% after $30 copay
Chiropractic Services	100% after $30 copay	70% of allowed benefit after deductible	100% after $30 copay
Cardiac Rehabilitation	90% of allowed benefit	70% 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).		
Diabetic Nutritional Counseling, as mandated by Maryland Law	100% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Durable Medical Equipment	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	Must be medically necessary as determined by the attending physician		
Extended Care Facilities	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	Skilled nursing care and extended care facility benefits are limited to 180 days per calendar year as long as skilled nursing care is medically necessary. Inpatient care primarily for or solely for rehabilitation is not covered.		
Family Planning	100% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Contraception	100% of allowed Benefit	70% 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 guide.		
Contraceptive Counseling	100% of allowed Benefit	Not covered	100% of allowed Benefit
Fertility Testing (Preauthorization Required)	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
In-Vitro Fertilization (IVF) and Artificial Insemination (per MD mandate)	90% of allowed benefit (outpatient hospital) 100% after $30 copay (physician office)	70% of allowed benefit after deductible	100% of allowed benefit
(Preauthorization Required)	Available to opposite and same sex married couples. See carrier's evidence of coverage documents for details. Not covered following reversal of elective sterilization.		

CareFirst

	PPO		EPO
TYPE OF SERVICE	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK ONLY
OTHER SERVICES AND SUPPLIES (continued)			
Hospice Care (Preauthorization Required)	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Home Healthcare (Preauthorization Required)	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	Limited to 120 days per plan year		
Medical Supplies	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	Includes, but is 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.		
Private Duty Nursing	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Whole Blood Charges	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES			
Office Visit	$15 copay	70% of allowed benefit after deductible	$15 copay
Inpatient Hospital Care	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Partial Hospitalization Services	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Outpatient Services (including Intensive Outpatient Services)	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Residential Crisis Services	90% of allowed benefit	70% 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 or genetic birth defects including but not limited to autism, autism spectrum disorder, and cerebral palsy.		
VISION SERVICES (Adults 19 and older)			
Vision – Medical (Services related to medical health of the eye)	$15 copay (PCP) or $30 copay (Specialist)	70% of allowed benefit after deductible	$15 copay (PCP) or $30 copay (Specialist)
Vision – Routine (One per plan year)	100% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Frames (One per plan year)	100% of allowed benefit up to $45 per frame	70% 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; Lenitcular $181	70% of allowed benefit up to the following: Single Vision - $52; Bifocal - $82; Trifocal - $101; Lenitcular $181	100% of allowed benefit up to the following: Single Vision - $52; Bifocal - $82; Trifocal - $101; Lenitcular $181
Contact Lenses (in lieu of frames & lenses)	100% of allowed benefit up to the following: Medically Necessary - $285; Cosmetic - $97	70% 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 $30 copay (Specialist)	70% of allowed benefit after deductible	$15 copay (PCP) or $30 copay (Specialist)
Vision – Routine (One per plan year)	100% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Frames (One per plan year)	100% of allowed benefit up to $70 per frame	70% 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)	70% of annual supply (2 refills per plan year)	100% of annual supply (2 refills per plan year)
BENEFIT CHART FOOTNOTES * Laboratory testing services related to diabetes, hypertension, coronary artery disease, asthma and COPD are paid at 100%, including test strips for diabetics. ** Newborns' and Mothers' Health Protection Act Notice. See Page 70 of the booklet.			
Medicare COB	Retirees or their dependent(s) must enroll in Medicare Parts A & B upon becoming eligible for Medicare due to age or disability. If the Medicare eligible State retiree and their dependent(s) fail to enroll in Medicare, the Medicare eligible State retiree and their dependent(s) will be responsible for any claim expenses that would have been paid under Medicare Parts A or B, had they enrolled in Medicare. If a retiree or covered dependent's Medicare eligibility is due to End State Renal Disease (ESRD), they must sign up for both Medicare Parts A & B as soon as they are eligible.		
Non-Medicare COB	When the State's plan is the secondary payor, payments will be limited to only that balance of claim expenses that will reach the published limits of the State's plan.		

UnitedHealthcare®

Did You Know?

Not all outpatient surgery requires preauthorization. Your medical plan will advise your physician when he/she calls to verify benefits.

UnitedHealthcare			
	PPO		EPO
TYPE OF SERVICE	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK ONLY
Annual Deductible			
Individual	None	$250	None
Family	None	$500	None
Yearly Maximum Out-of-Pocket Costs			
Coinsurance OOP	90%	70%	N/A
Individual	$1,000	$3,000	None
Family	$2,000	$6,000	None
Copayment OOP			
Individual	$1,000	None	$1,500
Family	$2,000	None	$3,000
Total Medical OOP			
Individual	$2,000	$3,250	$1,500
Family	$4,000	$6,500	$3,000
Lifetime Benefit Maximum	Unlimited		
HOSPITAL INPATIENT SERVICES (Preauthorization Required)			
Inpatient Care	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Hospitalization	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Acute Inpatient Rehab when Medically Necessary	90% of allowed benefit	Not covered	100% of allowed benefit
Anesthesia	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Surgery	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Organ Transplant	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
HOSPITAL OUTPATIENT SERVICES			
Chemotherapy/Radiation	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Diagnostic Lab Work and X-rays*	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Outpatient Surgery (Preauthorization Required)	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Anesthesia	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Observation – up to 23 hours and 59 minutes - presented via Emergency Department	100% of allowed benefit after $150 copay	100% of allowed benefit after $150 copay	100% of allowed benefit after $150 copay
Observation – 24 hours or more - presented via Emergency Department	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit

UnitedHealthcare

	PPO		EPO
TYPE OF SERVICE	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK ONLY
THERAPIES (Preauthorization required)			
Benefit Therapies	$30 copay	70% of allowed benefit after deductible	$30 copay
Physical Therapy (PT) and Occupational Therapy (OT)	PT/OT services must be precertified after the 6th visit, based on medical necessity; 50 days per plan year combined for PT/OT/Speech Therapy.		
Speech Therapy	Must be precertified from first visit with exceptions and close monitoring for special situations (e.g. trauma, brain injury) for additional visits.		
COMMON AND PREVENTIVE SERVICES			
Physician Office Visits - Primary Care	100% after $15 copay	70% of allowed benefit after deductible	100% after $15 copay
Physician Office Visits – Specialist	100% after $30 copay	70% of allowed benefit after deductible	100% after $30 copay
Physical Exams and Associated Lab (Adult and Child)	100% of allowed benefit	70% of allowed benefit after deductible	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	70% of allowed benefit after deductible	100% of allowed benefit
	Birth – 36 months: 13 visits total		
Routine Annual GYN Exam (including PAP test)	100% of allowed benefit. Non-routine $15 copay.	70% of allowed benefit after deductible	100% of allowed benefit. Non-routine $15 copay.
Mammography Preventive	100% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	Screening: one mammogram per plan year (35+).		
Mammography Diagnostic	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	No age/frequency limitation on diagnostic mammogram.		
Hearing Examinations (1 exam every 3 years)	100% after $15 copay – PCP or $30 copay – Specialist	70% of allowed benefit after deductible	100% after $15 copay – PCP or $30 copay – Specialist
Hearing Aids (1 hearing aid per ear every 3 years)	100% of allowed benefit for Basic Model Hearing Aid	70% of allowed benefit after deductible for Basic Model Hearing Aid	100% of allowed benefit for Basic Model Hearing Aid
	Includes Maryland mandated benefit for hearing aids for minor children (ages 0-18) effective 01/01/02, including hearing aids per each impaired ear for minor children.		
Immunizations	100% of allowed benefit	70% 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
STI Screening and Counseling (Including HPV, DNA and HIV)	100% of allowed benefit	Not Covered	100% of allowed benefit
	Counseling and screening for sexually active women as mandated by PPACA.		
Allergy Testing	100% after $15 copay – PCP or $30 copay – Specialist	70% of allowed benefit after deductible	100% after $15 copay – PCP or $30 copay – Specialist

UnitedHealthcare

	PPO		EPO
TYPE OF SERVICE	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK ONLY
EMERGENCY TREATMENT			
Ambulance Services – Emergency Transport and Hospital Directed Transport Between Approved Facilities	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit
Ambulance Services – Non-Emergency Transport	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Emergency Room (ER) Services – In and Out of Network	100% of allowed benefit after $150 copay	100% of allowed benefit after $150 copay	100% of allowed benefit after $150 copay
	Copays are waived if admitted.		
	If criteria are not met for a medical emergency, plan coverage is 50% of allowed amount, plus the $150 copay.		
Urgent Care Office Visit	100% after $30 copay	70% of allowed benefit after deductible	100% of allowed benefit after $30 copay
MATERNITY BENEFITS			
Maternity Benefits**	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Prenatal Care	100% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Newborn Care	100% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Breastfeeding Support and Counseling (per birth)	100% of allowed benefit	Not Covered	100% of allowed benefit
Breastfeeding Supplies (per birth)	100% of allowed benefit	Not Covered	100% of allowed benefit
	Covers the cost of rental/purchase of certain breastfeeding pumps and pump equipment through Plan's Durable Medical Equipment partner(s).		
OTHER SERVICES AND SUPPLIES			
Acupuncture Services for Chronic Pain Management	100% after $30 copay	70% of allowed benefit after deductible	100% after $30 copay
Chiropractic Services	100% after $30 copay	70% of allowed benefit after deductible	100% after $30 copay
Cardiac Rehabilitation	90% of allowed benefit	70% 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).		
Diabetic Nutritional Counseling, as mandated by Maryland Law	100% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Durable Medical Equipment	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	Must be medically necessary as determined by the attending physician		
Extended Care Facilities	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	Skilled nursing care and extended care facility benefits are limited to 180 days per calendar year as long as skilled nursing care is medically necessary. Inpatient care primarily for or solely for rehabilitation is not covered.		
Family Planning	100% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Contraception	100% of allowed Benefit	70% 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 guide.		
Contraceptive Counseling	100% of allowed Benefit	Not covered	100% of allowed Benefit
Fertility Testing (Preauthorization Required)	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
In-Vitro Fertilization (IVF) and Artificial Insemination (per MD mandate)	90% of allowed benefit (outpatient hospital) 100% after $30 copay (physician office)	70% of allowed benefit after deductible	100% of allowed benefit
(Preauthorization Required)	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 (Preauthorization Required)	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit

UnitedHealthcare

	PPO		EPO
TYPE OF SERVICE	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK ONLY
OTHER SERVICES AND SUPPLIES (continued)			
Home Healthcare (Preauthorization Required)	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	Home Healthcare benefits are limited to 120 days per plan year		
Medical Supplies	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	Includes, but is 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.		
Private Duty Nursing	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Whole Blood Charges	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES			
Office Visit	$15 copay	70% of allowed benefit after deductible	$15 copay
Inpatient Hospital Care	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Partial Hospitalization Services	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Outpatient Services (including Intensive Outpatient Services)	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Residential Crisis Services	90% of allowed benefit	70% 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 or genetic birth defects including but not limited to autism, autism spectrum disorder, and cerebral palsy.		
VISION SERVICES (Adults 19 and older)			
Vision – Medical (Services related to medical health of the eye)	$15 copay (PCP) or $30 copay (Specialist)	70% of allowed benefit after deductible	$15 copay (PCP) or $30 copay (Specialist)
Vision – Routine (One per plan year)	100% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Frames (One per plan year)	100% of allowed benefit up to $45 per frame	70% 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; Lenitcular $181	70% of allowed benefit up to the following: Single Vision - $52; Bifocal - $82; Trifocal - $101; Lenitcular $181	100% of allowed benefit up to the following: Single Vision - $52; Bifocal - $82; Trifocal - $101; Lenitcular $181
Contact Lenses (in lieu of frames & lenses)	100% of allowed benefit up to the following: Medically Necessary - $285; Cosmetic - $97	70% 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 $30 copay (Specialist)	70% of allowed benefit after deductible	$15 copay (PCP) or $30 copay (Specialist)
Vision – Routine (One per plan year)	100% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
Frames (One per plan year)	100% of allowed benefit up to $70 per frame	70% 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)	70% of annual supply (2 refills per plan year)	100% of annual supply (2 refills per plan year)
BENEFIT CHART FOOTNOTES * Laboratory testing services related to diabetes, hypertension, coronary artery disease, asthma and COPD are paid at 100%, including test strips for diabetics. ** Newborns' and Mothers' Health Protection Act Notice. See Page 70 of the booklet.			
Medicare COB	Retirees or their dependent(s) must enroll in Medicare Parts A & B upon becoming eligible for Medicare due to age or disability. If the Medicare eligible State retiree and their dependent(s) fail to enroll in Medicare, the Medicare eligible State retiree and their dependent(s) will be responsible for any claim expenses that would have been paid under Medicare Parts A or B, had they enrolled in Medicare. If a retiree or covered dependent's Medicare eligibility is due to End State Renal Disease (ESRD), they must sign up for both Medicare Parts A & B as soon as they are eligible.		
Non-Medicare COB	When the State's plan is the secondary payor, payments will be limited to only that balance of claim expenses that will reach the published limits of the State's plan.		

KAISER PERMANENTE®

Kaiser Permanente has a regional network. You must visit a provider or facility that are part of the Kaiser Permanente network in the Baltimore/DC/VA area for all of your care (except in an emergency).

Did You Know?

Not all outpatient surgery requires preauthorization. Your medical plan will advise your physician when he/she calls to verify benefits.

Kaiser Permanente	
	IHM
TYPE OF SERVICE	IN-NETWORK ONLY
Annual Deductible	
Individual	None
Family	None
Yearly Maximum Out-of-Pocket Costs	
Copayment OOP	
Individual	$1,500
Family	$3,000
Total Medical OOP	
Individual	$1,500
Family	$3,000
Lifetime Benefit Maximum	Unlimited
HOSPITAL INPATIENT SERVICES (Preauthorization Required)	
Inpatient Care	100% of allowed benefit
Hospitalization	100% of allowed benefit
Acute Inpatient Rehab when Medically Necessary	100% of allowed benefit
Anesthesia	100% of allowed benefit
Surgery	100% of allowed benefit
Organ Transplant	100% of allowed benefit
HOSPITAL OUTPATIENT SERVICES (Preauthorization Required)	
Chemotherapy/Radiation	100% of allowed benefit
Diagnostic Lab Work and X-rays*	100% of allowed benefit
Outpatient Surgery	100% of allowed benefit
Anesthesia	100% of allowed benefit
Observation – up to 23 hours and 59 minutes - presented via Emergency Department	100% of allowed benefit after $150 copay
Observation – 24 hours or more - presented via Emergency Department	100% of allowed benefit
THERAPIES (Preauthorization required)	
Benefit Therapies	100% after $15 copay
Physical Therapy (PT) and Occupational Therapy (OT)	PT/OT services must be precertified after the 6th visit, based on medical necessity; 50 days per plan year combined for PT/OT/Speech Therapy.
Speech Therapy	Must be precertified from first visit with exceptions and close monitoring for special situations (e.g. trauma, brain injury) for additional visits.

NOTE: The Kaiser IHM medical plan does not coordinate benefits with Medicare Parts A & B for Active Employees, Retirees, and their dependents who are Medicare eligible.

Kaiser Permanente

	IHM
TYPE OF SERVICE	IN-NETWORK ONLY
COMMON AND PREVENTIVE SERVICES	
Physician Office Visits - Primary Care	100% after $15 copay
Physician Office Visits – Specialist	100% after $15 copay
Physical Exams and Associated Lab (Adult and Child)	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
	Birth – 36 months: 13 visits total
Routine Annual GYN Exam (including PAP test)	100% of allowed benefit. Non-routine $15 copay.
Mammography Preventive	100% of allowed benefit
	Screening: one mammogram per plan year (35+).
Mammography Diagnostic	100% of allowed benefit
	No age/frequency limitation on diagnostic mammogram.
Hearing Examinations (1 exam every 3 years)	100% after $15 copay – PCP/Specialist
Hearing Aids (1 hearing aid per ear every 3 years)	100% of allowed benefit for Basic Model Hearing Aid
	Includes Maryland mandated benefit for hearing aids for minor children (ages 0-18) effective 01/01/02, including hearing aids per each impaired ear for minor children.
Immunizations	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
STI Screening and Counseling (Including HPV DNA and HIV)	100% of allowed benefit
	Counseling and screening for sexually active women as mandated by PPACA.
Allergy Testing	100% after $15 copay – PCP or Specialist

Kaiser Permanente

	IHM
TYPE OF SERVICE	IN-NETWORK ONLY
EMERGENCY TREATMENT	
Ambulance Services – Emergency Transport and Hospital Directed Transport Between Approved Facilities	100% of allowed benefit
Ambulance Services – Non-Emergency Transport	100% of allowed benefit
Emergency Room (ER) Services –In and Out of Network	100% of allowed benefit after $150 copay
	Copays are waived if admitted.
	If criteria are not met for a medical emergency, plan coverage is 50% of allowed amount, plus the $150 copay.
Urgent Care Office Visit	100% after $15 copay
MATERNITY BENEFITS	
Maternity Benefits**	100% of allowed benefit
Prenatal Care	100% of allowed benefit
Newborn Care	100% of allowed benefit
Breastfeeding Support and Counseling (per birth)	100% of allowed benefit
Breastfeeding Supplies (per birth)	100% of allowed benefit
	Covers the cost of rental/purchase of certain breastfeeding pumps and pump equipment through Plan's Durable Medical Equipment partner(s).
OTHER SERVICES AND SUPPLIES	
Acupuncture Services for Chronic Pain Management	100% after $15 copay
Chiropractic Services	100% after $15 copay
Cardiac Rehabilitation	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).
Diabetic Nutritional Counseling, as mandated by Maryland Law	100% of allowed benefit
Durable Medical Equipment	100% of allowed benefit
	Must be medically necessary as determined by the attending physician
Extended Care Facilities	100% of allowed benefit
	Skilled nursing care and extended care facility benefits are limited to 180 days per calendar year as long as skilled nursing care is medically necessary. Inpatient care primarily for or solely for rehabilitation is not covered.
Family Planning and Fertility Testing	100% of allowed benefit
Contraception	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 guide.
Contraceptive Counseling	100% of allowed benefit
In-Vitro Fertilization (IVF) and Artificial Insemination (per MD mandate)	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
Home Healthcare	100% of allowed benefit
	Home Healthcare benefits are limited to 120 days per plan year

Kaiser Permanente

	IHM
TYPE OF SERVICE	IN-NETWORK ONLY
OTHER SERVICES AND SUPPLIES (continued)	
Medical Supplies	100% of allowed benefit
	Includes, but is 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.
Private Duty Nursing	100% of allowed benefit
Whole Blood Charges	100% of allowed benefit
MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES	
Office Visit	$15 copay
Inpatient Hospital Care	100% of allowed benefit
Partial Hospitalization Services	100% of allowed benefit
Outpatient Services (including Intensive Outpatient Services)	100% of allowed benefit
Residential Crisis Services	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 or genetic birth defects including but not limited to autism, autism spectrum disorder, and cerebral palsy.
VISION SERVICES (Adults 19 and older)	
Vision – Medical (Services related to medical health of the eye)	$15 copay (PCP) or $15 copay (Specialist)
Vision – Routine (One per plan year)	100% of allowed benefit
Frames (One per plan year)	Up to $45 per frame
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 – Medical (Services related to medical health of the eye)	$15 copay (PCP) or $30 copay (Specialist)
Vision – Routine (One per plan year)	100% of allowed benefit
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.
BENEFIT CHART FOOTNOTES * Laboratory testing services related to diabetes, hypertension, coronary artery disease, asthma and COPD are paid at 100%, including test strips for diabetics. ** Newborns' and Mothers' Health Protection Act Notice. See Page 70 of the booklet.	
Non-Medicare COB	When the State's plan is the secondary payor, payments will be limited to only that balance of claim expenses that will reach the published limits of the State's plan.