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

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THIS GUIDE IS NOT A CONTRACT

This guide is a summary of general benefits available to State of Maryland eligible employees and retirees through the State Employee and Retiree Health and Welfare Benefits Program (the Program). Wherever conflicts occur between the contents of this guide and the contracts, rules, regulations, or laws governing the administration of the various programs, the terms set forth in the various program contracts, rules, regulations, or laws shall prevail. Space does not permit listing all limitations and exclusions that apply to each plan. Before using your benefits, call the plan for information. Benefits provided can be changed at any time without the consent of participants.

Revised 09/01/2023

For details about each specific plan, review the sections in this guide or see the inside of the front cover for contact information for each of the plans.

OR

Visit our Benefits Microsite mymdbenefits.com

The State of Maryland provides a generous benefit package to eligible employees and retirees with a wide range of benefit options from healthcare to income protection. The following chart outlines your benefit options for the plan year January 1, 2024 - December 31, 2024.

Benefit Options

Plan	Options	Coverage	Who Is Eligible*
Medical	**PPO Plans** • CareFirst BlueCross BlueShield • UnitedHealthcare **EPO Plans** • CareFirst BlueCross BlueShield • UnitedHealthcare **IHM** • Kaiser	Provide benefits for a variety of medical services and supplies. Benefit coverage levels vary by plan; review the information carefully. Medical plans include routine vision services and behavioral health coverage.	• Active Full-time State/ Satellite employees* • Part-time State employees • State retirees** • ORP retirees**
Prescription Drug	• CVS Caremark • SilverScript EGWP	Provide benefits for a variety of prescription drugs. Some limitations (quantity limits, prior authorization, and step therapy) apply for certain drugs. Plan wraps around Medicare Part D for Medicare eligible retirees and dependents.	• Active Full-time State/ Satellite employees* • Part-time State employees • State retirees • ORP retirees
Dental	**DPPO** • United Concordia **DHMO** • Delta Dental	Provide benefits for a variety of dental services and supplies.	• Active Full-time State/ Satellite employees* • Part-time State employees • State retirees • ORP retirees
Flexible Spending Accounts	P&A Group • Healthcare • Dependent Daycare	Allow you to set aside money on a pre-tax basis to reimburse yourself for eligible healthcare or dependent daycare expenses.	• Active Full-time State employees*
Term Life	MetLife Coverage for you in increments of $10,000 up to $300,000 Coverage for dependents in increments of $5,000 up to 50% of your coverage	Pays a benefit to your designated beneficiary in the event of your death. You are automatically the beneficiary for your dependent's coverage. May be subject to medical review.	• Active Full-time State/ Satellite employees* • Part-time State employees • State retirees*** • ORP retirees***
Accidental Death and Dismemberment	MetLife Coverage amounts for yourself and/ or your dependents: $100,000, $200,000, or $300,000.	Pays a benefit to you or your beneficiary in the event of accidental death or dismemberment.	• Active Full-time State/ Satellite employees* • Part-time State employees

* To be eligible you must meet the eligibility requirements as outlined in the Eligibility section of this guide. Amount of state subsidy, if any, varies by what category of employee (including contractuals) or retiree you are.

** 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 in retirement.

What's New for 2024?

- Online benefits enrollment is mandatory for active and contractual employees who wish to make or change benefits elections for plan year 2024.
- Wellness activities carryover in 2024. See pages 4-5 for details on how to reduce your costs this calendar year.
- There are no changes to the prescription coverage provided to Medicare eligible retirees in 2024.
- Healthcare FSA annual amount will increase to $3,050.
- FSA's require an annual election
  - Healthcare funds may be used for employees and their eligible family members
  - Dependent care funds may be used for daycare expenses for dependents under the age of 13
- Flu shots are available at most pharmacies nationwide at no cost!
- Domestic Partner Eligibility
  - lived together for at least 12 months
  - not married to anyone else nor have another domestic partner
  - at least 18 years of age and mentally competent to consent to contract
  - reside together in the same residence and intend to do so indefinitely
  - have an exclusive mutual commitment similar to that of marriage
  - are jointly responsible for each other's common welfare and share financial obligations
  - visit dbm.maryland.gov/benefits for full details

Wellness Plan

2023 wellness activities will carryover through Plan Year 2024.

Notice Regarding Wellness Plan

The wellness plan administered under the Program is voluntary. Employees, non-Medicare eligible retirees and spouses or domestic partners who are enrolled in a medical plan are eligible to participate. The wellness plan is administered in accordance with all federal laws and regulations to the extent they are applicable to the Program, including but not limited to the Americans with Disabilities Act, the Genetic Information Nondiscrimination Act, the Health Insurance Portability and Accountability Act, and the Affordable Care Act. If you choose to participate in the wellness plan, you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to select a primary care physician (PCP) and complete an age/gender appropriate preventive screenings for the plan year. You are not required to participate in any of the wellness activities in order to participate in the Health Benefit Program.

However, those employees who choose to participate in the wellness plan and complete all of the wellness plan activities will receive the following incentives during the 2024 plan year:

- $0 copays for PCP visits and
- a $5 reduction in Specialist copays for:
  - Complete one of the recommended screenings
  - Complete an annual eye exam

  Maximum reduction = $10

The data from your HRA and the results of an annual physical may be used to provide you with information to help you understand your current health and potential risks. Additionally, you may receive offers of other services such as free video visits with your PCP lab screens for certain chronic conditions, health coaching, and/or disease management assistance.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness plan under the Program may use aggregate information it collects to design a program based on identified health risks in the workplace, the Program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness plan, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness plan will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness plan, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness plan or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness plan will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are your PCP and associated personnel and health coach as appropriate and if elected in order to provide you with services under the wellness plan.

In addition, all medical information obtained through the wellness plan will be stored electronically and encrypted. Health information obtained through the wellness plan will be maintained separate and apart from any personnel records unrelated to the Program. Appropriate precautions will be taken to avoid any

data breach, and in the event a data breach occurs involving information you provide in connection with the wellness plan, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness plan, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact – Employee Benefits Division at compliance.ebd@maryland.gov or 410.767.4775.

For information concerning the 2024 Wellness Plan activities, go to the Employee Benefits Wellness website at **www.dbm.maryland.gov/benefits** and click on the Wellness tab at the top of the screen. There you will find the 2024 Wellness Plan Activities and additional wellness resources available to you.

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.

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. Although they each have different provider networks, all plans cover the same services (such as 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 out of pocket costs are 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 supplies, 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, your ID cards will be sent to the address on file in the SPS Benefits System. 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, as well as any additional cost 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 for 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/or 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, a summary of coverage from the plan will be available on the Health Benefits website. The Summary of Benefits & Coverage provides details on your plan. https://dbm.maryland.gov/benefits

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. Changes to your plan can be made during any 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 20th 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.
Preventive Cancer Screenings • US Preventive Services Task Force • Mammography • Colonoscopy • Well woman exam	100% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	Preventative mammogram coverage at age 35+		
Diagnostic Cancer Screenings	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	Mammogram/Breast and Lung Cancer Screenings paid at 100% of allowed amount		
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)	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.		
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; Lenticular $181	70% 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	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 $45 per frame	70% of allowed benefit after deductible up to $70 per frame	100% of allowed benefit up to $45 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)	100% of allowed amount (see benefit summary for details)	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 72 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 Stage 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 20th 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.
Preventive Cancer Screenings • US Preventive Services Task Force • Mammography • Colonoscopy • Well woman exam	100% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	Preventative mammogram covered at age 35+		
Diagnostic Cancer Screenings	90% of allowed benefit	70% of allowed benefit after deductible	100% of allowed benefit
	Mammogram/Breast and Lung Cancer Screenings paid at 100% of allowed amount.		
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) (Preauthorization Required)	90% of allowed benefit (outpatient hospital) 100% after $30 copay (physician office)	70% 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 (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.		
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; Lenticular $181	70% 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	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 $45 per frame	70% of allowed benefit after deductible up to $70 per frame	100% of allowed benefit up to $45 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)	100% of allowed amount (see benefit summary for details)	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 72 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 Stage 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 is part of the Kaiser Permanente network in the **Baltimore/ DC/ NVA (Northern Virginia)** 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 20th 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
Well Baby Care	100% of allowed benefit
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 (Coverage for children until the end of the month in which the child turns 19) 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
	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.
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
Vision – Routine (One per plan year)	100% of allowed benefit
Frames	100% of allowed benefit Up to $70 per frame
Basic Prescription Lenses	100% of allowed benefit Single vision: $40, Bifocal: $60, Trifocal: $80, Lenticular: $100
Contact Lenses (in lieu of frames & lenses)	100% of allowed benefit Medically necessary: $225 Cosmetic: $105
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 72 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.

Prescription Drug Benefits

Prescription coverage is not included in any of our medical plans. It is offered separately and you have to enroll in order to participate.

The State offers prescription drug coverage through a separate plan; it is not included in your medical plan. To have prescription drug coverage you **must** enroll in it.

The prescription drug plan is administered by CVS Caremark. After you elect coverage, you will receive an ID card to present when you have your prescriptions filled at the participating pharmacy of your choice.

Here are some important features of the program:

- You may use any pharmacy in the CVS Caremark network which includes not only CVS, but also chain retail pharmacies such as Giant, Walgreens and Walmart in addition to the many independent pharmacies;
- Your prescription drug coverage has a "mandatory generics" feature. 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 between the brand name and the generic, **plus** the applicable copayment;
- CVS Caremark Mail Service Pharmacy is available for prescribed maintenance medications (medications you take regularly for an ongoing health condition) with no cost for standard shipping;
- There is no copayment for a limited list of generic medications filled at a retail pharmacy and through the CVS Caremark Mail Service;
- If you are eligible for Medicare, your prescription drug coverage is through the CVS Medicare Part D EGWP program. When you become eligible for Medicare, you will be enrolled in SilverScript® Employer PDP sponsored by State of Maryland (SilverScript);
- Active employees represented by Bargaining Unit I (SLEOLA) have a different premium schedule and plan design for prescription drug benefits. Please refer to the SLEOLA Addendum or visit the Employee Benefits Division's website for more information: **www.dbm.maryland.gov/benefits**;
- As part of the ACA, your health plan offers certain preventive service benefits at no cost to you. CVS Caremark works with your health plan to provide these benefits.

CVS Caremark can provide you with additional plan information, including participating pharmacy locations, the preferred drug list and prescription costs. Please see the inside front cover of this guide for CVS Caremark's contact information.

Coverage for Generic Drugs

Generic drugs are those drugs approved by the FDA as being as safe and effective as their brand name counterparts; they are just less expensive.

An Innovative Approach to Diabetes Management

Transform Diabetes Care is a health benefit that combines advanced blood glucose testing technology with coaching to support chronic health conditions like diabetes. It is available at no cost to you as part of your CVS Caremark prescription benefit plan.

What's included at $0 cost to you:

- ✓ A connected glucose meter
- ✓ As many strips as you need
- ✓ Lancing device, lancets, and carrying case
- ✓ Personalized insights with each reading
- ✓ Anytime access to Certified Diabetes Educators
- ✓ And more

Look for more information about this program at **https://info.caremark.com/stateofmaryland**.

Preferred Brand Name Medications

Preferred brand name medications are those medications that CVS Caremark has on its formulary (preferred drug list). CVS Caremark uses an independent panel of doctors and pharmacists to evaluate the medications approved by the U.S. Food & Drug Administration (FDA) for inclusion on the preferred drug list.

Each prescription medication is reviewed for safety, side effects, efficacy (how well it works), ease of dosage and cost. Preferred medications are reviewed throughout the year and are subject to change.

You can review and/or print the list at **https://info.caremark.com/stateofmaryland**. You may also call CVS Caremark for a copy of the list.

Zero Dollar Copay for Generics Program

To support your efforts to improve your health and help stick with your doctor's recommended treatment, you do not pay a copayment for specific generic medications at a retail pharmacy and through the CVS Caremark Mail Service. The five drug classes, including some examples of generic medications covered under this program, are listed in the chart below. Not all generic drugs in these drug classes are covered under the Zero Dollar Copay for Generics Program.

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.

Zero-Dollar Copayment for Generics Program		
DRUG CLASS	USED TO TREAT	GENERIC MEDICATION
HHG CoA Reductase Inhibitors (Statins)	High Cholesterol	simvastatin (generic Zocor) pravastatin (generic Pravachol)
Angiotensin Converting Enzyme Inhibitors (ACEIs)	High Blood Pressure	lisinopril (generic Zestril) lisinopril/HCTZ (generic Zestoretic) enalapril (generic Vasotec) enalapril/HCTZ (generic Vaseretic)
Proton Pump Inhibitors (PPIs)	Ulcer/GERD	omeprazole (generic Prilosec)
Inhaled Corticosteroids	Asthma	budesonide (generic Pulmicort Respules)
Selective Serotonin Reuptake Inhibitors (SSRIs)	Depression	fluoxetine (generic Prozac) paroxetine (generic Paxil) sertraline (generic Zoloft) citalopram (generic Celexa)
Contraception Methods	Prevention of Pregnancy	Oral Contraceptives, Diaphragm, Levonorgestrel (Generic Plan B)
Tobacco Cessation	Smoking	Bupropion (generic Zyban)

Your Cost for Prescription Drugs

Whether you have a prescription filled at a retail pharmacy or CVS Caremark Mail Service Pharmacy, your copayment depends 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

CVS Caremark Mail Service

Mail Service from CVS Caremark delivers your maintenance medications (the prescription medication you take regularly to treat an ongoing condition) to your home with no cost for standard shipping.

You may refill your mail ordered medications online or by phone.

Visit **https://info.caremark.com/oe/stateofmaryland**, download the CVS Caremark App, or call **(844) 460-8767** to get started with home delivery service from CVS Caremark Mail Order Pharmacy.

The standards of quality are the same for generics as brand name medications. 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.

Annual Out-of-Pocket Copayment Maximum for Prescription Drugs

The annual out-of-pocket copayment maximum for prescription drugs is separate from your medical plan's annual out-of-pocket maximum and is as follows:

- 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 for prescription drugs during the plan year reaches the annual out-of-pocket copayment maximum, the plan will pay 100% of your prescription drug costs for the remainder of the plan year (through December 31).

If you purchase a brand name medication when a generic medication is available, your copayment will count toward your annual out-of-pocket copayment maximum, but the difference in cost you pay between the generic and brand name medication ***will not*** count toward the maximum.

Specialty Guideline Management

CVS Caremark ensures the appropriate use of specialty medications. Many specialty medications are biotech medications that may require special handling and may be difficult to tolerate.

Examples of specialty medications included in this program are for the treatment of rheumatoid arthritis, multiple sclerosis, blood disorders, cancer, hepatitis C and osteoporosis. Specialty medications will be reviewed automatically for safety, and clinical appropriateness. Specialty medications will continue to be limited to a maximum 30-day supply per prescription per fill. Some of these specialty drugs are listed in the chart below.

For drugs limited to a 30 day supply, you will pay one-third (1/3) of the 90 day copay for up to 30 days' worth of medication.

Examples of Medications in Specialty Drug Management	
Auto-Immune Diseases (such as Rheumatoid Arthritis, Psoriasis and Inflammatory Bowel Disease)	Cosentyx, Enbrel, Humira, Kevzara, Otezla, Stelara, and Xeljanz
Multiple Sclerosis	Glatiramer, Betaseron, Copaxone, Rebif, Acthar HP, Tysabri, Gilenya, Aubagio, Tecfidera
Blood Disorder	Nplate, Procrit Leukine, Neulasta, Zarxio, Neumega, Proleukin, Hemophilia agents
Cancer	Afinitor, Gleevec, Iressa, Nexavar, Revlimid, Sprycel, Sutent, Tarcva, Tasigna, Temodar, Thalomid, Treanda, Tykerb, Xeloda, Zolinza, Eligard, Plenaxis, Trelstar, Vantas, Viadur, Zoladex, Thyrogen, Bosulif, Stivarga, Pomalyst, Cometriq, Iclusig, Afinitor, Ibrance, and Imbruvica
Hepatitis C	Epclusa, Harvoni, Vosevi , Alferon N, Ribavirin
Osteoporosis	Forteo, Prolia
Growth Hormones	Genotropin, Norditropin
**This list not comprehensive and is subject to change without notice to accommodate new prescription medications and to reflect the most current medical literature.*	

CVS Specialty emphasizes the importance of patient care and quality customer service. As a CVS Specialty patient, you will have access to a team of specialists including pharmacists, nurse clinicians, social workers, patient care coordinators and reimbursement specialists who will work closely with you and your doctor throughout your course of therapy. CVS Specialty also provides an on-call pharmacist 24 hours a day, 7 days a week. However, you may fill your specialty medications at any pharmacy in the CVS Caremark network that carries the medication.

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 CVS Caremark can verify their medical necessity. Prior authorization medications include, but are not limited to, the following:

- Acne Medications (such as oral isotretinoins, topical tretinoins, Tazorac and Fabior)
- Attention Deficit Hyperactivity Disorder Medications in Adults (such as Adderall products, Dexedrine, Desoxyn, and Ritalin products)
- Anabolic Steroids
- Topical Diclofenac Products (such as Voltaren Gel, Pennsaid, Solaraze)
- Oral and Intranasal Fentanyl Products (such as Actiq, Fentora, Subsys)
- Select Medical Devices and Artificial Saliva Products
- Disposable Insulin Pumps
- Atopic Dermatitis (such as Opzelura)
- Vision Enhancement Agents (such as Vuity,Upneeq)

The list of prior authorization medications is subject to change and is available by visiting **https://info.caremark.com/oe/stateofmaryland**

Medications with Quantity Limits

Some medications have limits on the quantities that will be covered under the prescription drug plan. Quantity limits are placed on prescriptions to make sure you receive the safe daily dose as recommended by the FDA and medical studies. Some medications with quantity limits include, but are not limited to, the following:

- Erectile dysfunction medications
- Proton pump inhibitors
- Sedative/Hypnotics (e.g., sleeping pills)
- Nasal inhalers
- Migraine Medications
- Opioid and Opioid Combination Products

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 additional 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 and is available by visiting **https://info.caremark.com/stateofmaryland**.

Step Therapy

Step therapy is a process for finding the best treatment while ensuring you are receiving the most appropriate medication therapy and reducing prescription drug costs.

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 may pay more for brand name medications.

These steps follow the most current and appropriate medication therapy recommendations. CVS Caremark 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 pharmacy 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 need 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 of the second-line medication.

The list of step therapy medications is subject to change and is available by visiting **https://info.caremark.com/oe/stateofmaryland**

Drug Exclusions

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

- Over-the-counter vitamins, except those covered under the Affordable Care Act
- Anorectics (any drug used for the purpose of weight loss)
- Bulk compounding ingredients, kits, high cost bases
- Experimental/investigative drugs
- Unapproved Products

Refer to the CVS Caremark's State of Maryland website for a full list of excluded medications: **https://info.caremark.com/stateofmaryland**.

Medicare-Eligible Prescription Drug

A note about the communications you will receive from Medicare.

Plan coverage documents and Explanations of Benefits will only show the Medicare Part D benefits. Remember that our plan wraps around those benefits so you don't have to pay the Part D cost share that appears in the communications you receive from Medicare.

If you are a retiree enrolled in Medicare, your prescription drug coverage is provided by SilverScript Employer PDP sponsored by the State of Maryland. The common name for this type of plan is an Employer Group Waiver Plan (EGWP). You may see both names in the communications you receive. As a Medicare-eligible retiree, you qualify for the EGWP as long as:

- You live in the United States;
- You are entitled to Medicare Part A, or you are enrolled in Medicare Part B (or you have both Part A and Part B); and
- You qualify for retiree health benefits from the State of Maryland.

Highlights of this plan include:

- You pay the same copays as noted in this guide for non-Medicare-eligible retirees.
- You have one ID card.
- You don't deal with Medicare Part D – it's all handled behind the scenes.
- Many of the prescription drug step therapies, quantity limits and prior authorization requirements noted in this Section do not apply to you. Refer to your annual Notice of Coverage for information about what is and what is not allowed.

Those with limited incomes may qualify for Extra Help to pay for their Medicare prescription drug costs. If you are eligible to receive Extra Help, Medicare could pay up to 75% or more of your drug costs, including monthly prescription drug premiums, annual deductibles and copayments. For more information about Extra Help, contact your local Social Security office or call Social Security at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call 1-800-325-0778.

Most people will pay the standard monthly Part D premium. However, some people pay an extra amount because of their yearly income. If your income exceeds current limits for individuals, married individuals

filing separately, or married couples, you must pay an extra amount for your Medicare Part D coverage. If you have to pay an extra amount, the Social Security Administration, not your Medicare plan, will send you a letter telling you what that extra amount will be. For more information about Part D premiums based on income, you can visit http://www.medicare.gov on the Web or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you may also call the Social Security Administration at 1-800-772-1213. TTY users should call 1-800-325-0778.

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 may be entitled to reimbursement, subject to plan terms and conditions. Please do the following for your out-of-pocket expenses to be considered for reimbursement:

- Complete the Prescription Drug Claim Form. Forms are available by calling CVS Caremark (844) 460-8767 or by going to **www.dbm.maryland.gov/benefits** and clicking on the Prescription Drug coverage and then the CVS Caremark symbol.
- Attach a detailed pharmacy receipt. This includes medication dispensed, quantity and cost.
- Send the information to CVS Caremark 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 your responsibility and will not be reimbursed. However, if you have reached the annual out-of-pocket maximum, the copayment (or a smaller payment amount, if applicable) will be reimbursable.

Claims reimbursements are subject to plan terms and conditions and therefore 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.

Out of Country Claims

(Please note: SilverScript members are not eligible for out-of-country claims reimbursement.)

Out-of-country claims are covered if the drug is FDA approved. Prescriptions filled in the United States must be filled by a network pharmacy for claims to be covered. The claim request must be submitted within the prescription fill date for reimbursement to be issued.

Dental Benefits

Dental coverage is available to all individuals who are eligible for State health benefits. You have two dental plans from which to choose:

- A Dental Preferred Provider Organization (DPPO) plan through United Concordia; or
- A Dental Health Maintenance Organization (DHMO) plan through Delta Dental.

Predetermination of Benefits

You or your dentist should seek predetermination of benefits before a major dental procedure so you and your dentist will know exactly what will be covered and what you will need to pay out-of-pocket.

How the Plans Work

The DPPO Plan

United Concordia is committed to providing you quality DPPO benefits. Under this plan, you do not have to select a Primary Dental Office (PDO) and can receive coverage from any licensed dentist. If you use one of its Advantage Plus network dentists, you can maximize your benefit dollars with their negotiated discount rates. Some United Concordia dentists have agreed to offer discounts for non-covered services and services received over your annual max.

No referrals are needed for specialty care. Orthodontia services are only covered for eligible dependent children (not employees) age 26 or younger.

Orthodontic Treatments in Progress

Switching dentists isn't always easy—especially when you have a treatment in progress, such as orthodontia. If you have to switch dentists and need to continue with your treatments in progress, we'll switch your services and coverage, while also determining your payable benefits.

Out-of-Area Coverage

You never need to worry about where you are if you need dental care as you may receive services from any dentist, in-network or out. However, if you use an out-of-network dentist, you must submit a claim form for reimbursement and may be billed for the amount charged that exceeds the allowed benefit.

Member Services

When you use an in-network DPPO dentist, the in-network dentist will bill the plan directly for the amount the plan will pay. You will be billed your share of the cost under the plan. You can access all of your dental information online any time on My Dental Benefits:

- Visit www.UnitedConcordia.com/statemd
- Select My Dental Benefits and sign in or create an account, then
- View all your Explanations of Benefits (EOBs) under Claims & Deductibles
- You can also view your benefits from your mobile device by using the State of Maryland Members App
- Questions regarding the DPPO plan? Call United Concordia at 1-888-638-3384.

DPPO Plan Design

Feature	Benefit Coverage (In-Network and Out-of-Network Services)
Plan Year deductible	$50 per individual; $150 per family Only applies to Class II and Class III services
Plan Year Maximum	$2,500 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 benefit
Class II: Basic Restorative services, including composite/resin fillings, inlays, endodontic services, periodontal services, oral surgery services, general anesthesia, prosthodontic maintenance, relines and repairs to bridges, and dentures, space maintainers	Plan pays 70% of allowed benefit after deductible
Class III: Major services, including crowns and bridges, dentures (complete and partial), fixed prosthetics, implants	Plan pays 50% of allowed benefit after deductible
Class IV: Orthodontia (for eligible child(ren) only, age 26 or younger), diagnostic, active, retention treatment	Plan pays 50% of allowed benefit, up to $2,000 lifetime maximum

The DHMO Plan

Important note: Before enrolling, we strongly recommend that you contact your primary care dental facility to be sure that the facility participates in Delta Dental's **DeltaCare® USA** network. The plan cannot guarantee the continued participation of a particular facility or dentist.

Delta Dental is the Program's DHMO carrier. Delta Dental offers quality, convenience, and predictable costs through their DeltaCare® USA network.

When you enroll, you'll select a DeltaCare USA primary care general dentist to provide services. Family members may select different dentists, as many as three per family, for treatment within the covered service area. You'll receive most of your dental care from your primary care dentist. If you need treatment from a specialist, your DeltaCare USA primary care dentist will coordinate a referral for you.

With the DHMO there are no claim forms to complete, no deductibles or annual and lifetime dollar maximums. Preventive and diagnostic services are covered at low or no costs.

You must visit your selected primary care dentist to receive benefits under your plan. If you don't select a dentist, Delta Dental will choose one for you near your home address.

To select a primary care dentist:

- Visit deltadentalins.com/statemd and click on "Find a Dentist."
- Select "DeltaCare USA" as your plan network.
- Once you have selected a dentist, call Delta Dental's Customer Service at 844-697-0578 with the dentist's name and practice number.

Selections of or changes to primary dentists received between the first and 15th of the month are effective immediately. Changes received on the 16th through the end of the month will be effective on the first of the next month. You can also call Customer Service at 844-697-0578 for help with finding or changing a dentist.

Continuous orthodontic coverage:

If you or an eligible family member has started orthodontic treatment (banding has taken place) under a previous plan, you may be able to continue that coverage when you switch to Delta Dental DHMO dentist through a provision called orthodontic treatment in progress. Please contact Delta Dental at 844-697-0578 for details.

Out-of-area emergencies:

If you experience an emergency while traveling outside the service area of your network office, you may use your out-of-area emergency benefit. This benefit provides for emergency treatment up to a maximum allowance of $100. You may initially be required to pay for services upon treatment. To receive reimbursement, simply submit a copy of the itemized treatment from the attending dentist to Delta Dental within 90 days of treatment. Depending on the plan benefits, copayments may apply.

Online Services Available:

You can access your eligibility and benefits information online with a secure, simple Online Services account:

- Visit deltadentalins.com/statemd
- Select "Register Today" in the "Online Services" box and create your profile. You can choose to go paperless and receive email alerts when new documents are ready to view.
- Read your information anytime from your desktop or mobile device.

If your dentist discontinues participation in the plan, is terminated from the network or closes his/her practice to new patients, you will need to select another primary care dentist. You will not be able to change your plan or withdraw from the plan until the next Open Enrollment period.

Predetermination of Benefits

You or your dentist should seek predetermination of benefits before a major dental procedure so you and your dentist will know exactly what will be covered and what you will need to pay out-of-pocket.

DHMO Fee Schedule		
ADA Code	**ADA Description**	**Member Pays $**
0120	Periodic oral evaluation - established patient	0
0140	Limited oral evaluation - problem focused	0
0150	Comprehensive oral evaluation - new or established patient	0
0210	Intraoral - complete series of radiographic images	0
0220	Intraoral - periapical first radiographic image	0
0230	Intraoral - periapical each additional radiographic image	0
0272	Bitewings - two radiographic images	0
0274	Bitewings - four radiographic images	0
0330	Panoramic radiographic image	0
1110	Prophylaxis - adult	0
1120	Prophylaxis - child	0
1206	Topical application of fluoride varnish - through age 18	0
1208	Topical application of fluoride (excluding varnish)	0
1351	Sealant - per tooth	0
2140	Amalgam - one surface, primary or permanent	0
2150	Amalgam - two surfaces, primary or permanent	0
2160	Amalgam - three surfaces, primary or permanent	0
2161	Amalgam - four or more surfaces, primary or permanent	0
2330	Resin-based composite - one surface, anterior	0
2331	Resin-based composite - two surfaces, anterior	0
2332	Resin-based composite - three surfaces, anterior	0
2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	70
2391	Resin-based composite - one surface, posterior	40
2392	Resin-based composite - two surfaces, posterior	60
2750	Crown - porcelain fused to high noble metal	276
2752	Crown - porcelain fused to noble metal	270
2790	Crown - full cast high noble metal	228
2792	Crown - full cast noble metal	264
2920	Recement or rebond crown	15
2950	Core buildup, including any pins	100
2954	Prefabricated post and core in addition to crown	108
3310	Root canal - Endodontic therapy, anterior tooth (excluding final restoration)	108
3320	Root canal - Endodontic therapy, bicuspid tooth (excluding final restoration)	144
3330	Root canal - Endodontic therapy, molar (excluding final restoration)	198
4341	Periodontal scaling and root planing - four or more teeth per quadrant	60
4910	Periodontal maintenance	30
7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	20
7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	27
7230	Removal of impacted tooth - partially bony	55
7240	Removal of impacted tooth - completely bony	65
9110	Palliative (emergency) treatment of dental pain - minor procedure	15
D9222	Deep sedation/general anesthesia – first 15 minutes	103
D9223	Deep sedation/general anesthesia – each subsequent 15 minute increment	103
Please refer to the DBM website at www.dbm.maryland.gov/benefits, select dental coverage and then Delta Dental for a complete DHMO Copay Schedule.		

Flexible Spending Accounts

A Flexible Spending Account (FSA) is an account that allows you to set aside pre-tax dollars from your pay to be reimbursed for qualified healthcare or dependent daycare expenses. You choose how much money you want to contribute to an FSA at the beginning of each plan year. You can be reimbursed from your account throughout the plan year.

There are two types of FSAs: a healthcare FSA and a dependent daycare FSA. The FSAs are administered by the P&A Group.

There are hundreds of eligible expenses for your FSA funds, including prescriptions, doctor visit copays, health insurance deductibles and coinsurance for you, your spouse or eligible dependents, and daycare for your eligible dependents while you work.

Tax Savings with an FSA

All FSA contributions are pre-tax, which means they come out of your pay before taxes. You save money by not paying taxes on the amount you contribute to your account for eligible healthcare and dependent daycare expenses.

Actual savings will vary based on your individual tax situation; please consult a tax professional for more information.

Healthcare Flexible Spending Account

Through a Healthcare Flexible Spending Account, you can be reimbursed tax-free for eligible out-of-pocket healthcare expenses not paid by insurance, including deductibles, copays or coinsurance for eligible medical, prescription, dental and vision. Also, certain eligible over-the-counter (OTC) items are eligible for reimbursement. For a complete list of what's covered and what's not, visit **www.irs.gov/publications/p502**.

You can use the Healthcare Flexible Spending Account to pay eligible healthcare expenses for yourself, your spouse, and your qualifying dependent children who have not reached age 27 by the end of the taxable year. You and your dependent(s) do not have to be covered under a State medical plan to participate in an FSA. To change the contributions you make to this account, the same qualifying status change rules apply as for the medical plans.

For 2024, you may contribute between $120 and $3,050 on a pre-tax basis to your healthcare FSA. Our plan does not allow Healthcare FSA funds to roll over from one year to the next, so be sure to plan carefully when deciding how much to contribute. **Any amount remaining in your account at year-end for which you did not file a claim will be forfeited.**

Healthcare FSA	Minimum	Maximum
Annually	$120.00	$3,050.00
12 pay period deductions	$10.00	$254.16
24 pay period deductions	$5.00	$127.08
20 Pay Faculty Scheduled deduction	$6.00	$152.50

This plan may not discriminate in favor of highly compensated employees with respect to eligibility, 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 if, in the Plan Administrator's judgment, such actions serve to assure that the plan does not violate applicable nondiscrimination rules.

Use It or Lose It!

Estimate carefully so that you can be sure you will use all of your FSA funds by the end of the year!

You may still have to submit receipts for some of your purchases (per IRS regulations), so don't throw your itemized receipts away – you may be asked to show them even after reimbursement has been made.

Reimbursement

For the Healthcare FSA, the easiest way to pay for eligible expenses is by using the debit card. But, when you cannot use your card for Healthcare FSA purchases, you may pay the amount due out of your pocket and then submit a reimbursement request by following the steps below:

- Keep your itemized receipts as documentation for all your healthcare FSA purchases.
- Submit a claim online at **MD.padmin.com** from your computer or mobile device. (If you do not have web or mobile access, you may contact Customer Service to request a paper claim form at the number on the inside front cover of this guide.)
- For easy reimbursement, sign up to receive all reimbursements through direct deposit to your checking or savings accounts.

How does the debit card work?

The debit card 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 verified automatically as an eligible expense, reducing the need for you to submit receipts.

You may still be asked to provide verifying documentation. Failure to provide that documentation within 31 days of the request may result in reversal of the payment, card suspension and/or additional taxes due. Documentation can be submitted directly online when logging into your P&A Group Account at **MD.padmin.com** (under Member Tools choose Upload a Claim, then under Claim Type select Request for Debit Card Documentation). You can also fax the verifying documentation to (844) 633-5399.

When will my debit card expire?

Be sure to keep your card (even after your funds have been used for the plan year) for future plan years. Your card will remain active for three years from the date of issue; it is good through the last day of the month shown on your card. When your card is nearing its expiration date, a new card will be mailed to the address on file automatically, approximately one month before your current card expires as long as you continue to enroll in a Healthcare FSA.

What items may I purchase using my debit card?

You can pay for most eligible expenses by using the debit card, including the cost of prescription drugs, certain over- the-counter items at most retailers, and doctors' charges at offices that accept debit cards. Your card will not work at retail locations that do not offer healthcare items or medical services. ***Dependent Daycare FSA funds cannot be paid by using the card.***

Using the debit card for Over-The-Counter (OTC) Medicines

Under the CARES Act of 2020, OTC medications and feminine care products, like tampons and pads, are reimbursable without a prescription. You can use your debit card at the point-of-service to purchase these expenses, or pay out-of-pocket and submit a claim for. Please see **MD.padmin.com** for details.

USING YOUR ONLINE Healthcare ACCOUNT

The Healthcare FSA comes with an online account feature. Use your online account to do the following:

- Get your account balance
- View debit card charges
- Enter a new claim
- View claim status
- Find answers to frequently asked questions

P&A Group Mobile Website

Visit P&A Group's secure mobile website, **MD.padmin.com**, to access all of your healthcare account information from your mobile device. You may also obtain your account balance using the automated telephone service. Simply call P&A Group's Customer Service Team at 844-638-1900.

You can also download P&A's mobile app from the App Store or Google Play. Search "P&A Group" at the store to download the app, where you can register for important account alerts!

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 healthcare FSA, submit your request in writing along with a copy of your orders to the Employee Benefits Division before December 31of the plan year.

Dependent Daycare Flexible Spending Account

The Dependent Daycare FSA covers dependent daycare expenses while you (or you and your spouse, if married) work or look for work, or while you work and your spouse attends school full-time. The care may be provided inside or outside of your home and may include things like before-and after-school care, nursery school and summer day camp.

You can use the Dependent Daycare FSA to pay eligible expenses for the care of:

- Your dependent children 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; or for 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.

For 2024, you may contribute between $120 and $5,000 on a pre-tax basis (or up to $2,500 a year pre-tax if married and filing separately), to your Dependent Daycare FSA to pay for eligible dependent daycare expenses. If your spouse is a full-time student or incapacitated, the maximum annual election is $3,000 for one child or $5,000 for two or more children. Our plan does not allow dependent daycare FSA funds to roll over from one year to the next, so be sure to plan carefully when deciding how much to contribute. ***Any amount remaining in your account at year-end for which you did not file a claim by the deadline will be forfeited.***

Dependent Daycare FSA	Minimum	Maximum
Annually	$120.00	$5,000.00
12 pay period deductions	$10.00	$416.66
24 pay period deductions	$5.00	$208.33
20 Pay Faculty Scheduled deduction	$6.00	$250.00

IMPORTANT NOTE:

If you retire or terminate employment during the plan year, you may only seek reimbursement for claims incurred through your last day of employment. You have 90 days from the date of your termination to submit claims for reimbursement. Remaining unused funds will be forfeited.

What's Not Covered

Eligible dependent daycare 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. Sample ineligible expenses include the following:

- Education and tuition fees;
- Late payment fees;
- Overnight camps (in general);
- Sports lessons, field trips, clothing; and
- Transportation to and from a dependent daycare provider.

Reimbursement

All Dependent Daycare Expenses must be submitted for reimbursement either online or using a paper claim form. Requests for reimbursements for Dependent Daycare Expenses cannot be made until the service is provided and an itemized statement from your dependent daycare provider is received by P&A Group.

Timeline for Using Account Funds

You must use all of your FSA funds by the date below or the remaining funds will be forfeited, in accordance with IRS regulations. Be sure to plan carefully so you contribute the right amount.

Availability of FSA funds

You may be reimbursed from your Healthcare FSA at any time throughout the plan year for expenses up to the full 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 can only be reimbursed from the Dependent Daycare FSA up to the amount contributed at the time care is received. 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.

Deadline for Eligible Expenses

You have until **March 15, 2025** to incur eligible expenses for your Healthcare FSA. You have until **December 31, 2024** to incur eligible expenses for your Dependent Daycare FSA.

Deadline for Submitting Reimbursement Requests

For both the Healthcare FSA and the Dependent Daycare FSA, you have until **April 15, 2025** to submit claims for eligible expenses. Remember, even though you have until **April 15, 2025** to submit the claim, the service dates must be on or before the dates listed above to be eligible for reimbursement.

P&A Group Contact Information

For more information or questions regarding your FSA, contact the P&A Group Monday – Friday, 8:00 AM – 10:00 PM ET, or visit our website.

Website: **MD.padmin.com**

Phone: (844) 638-1900

Fax: (844) 638-1901

Mailing Address: 6400 Main Street, Suite 210, Williamsville, NY 14221

Term Life Insurance

Group Term Life insurance provides a base level of protection that will help protect your family against the unexpected loss of your life during your working years. Term Life insurance builds no cash value; it simply pays a benefit at your death.

Life Insurance Choices for Active Employees

Coverage for Yourself

If you are an eligible employee, you may elect coverage in $10,000 increments up to $300,000. If you are a public safety employee who scuba dives, or you fly in or pilot a helicopter as part of your job, you may elect coverage in $10,000 increments up to a maximum of $500,000. For employees who are eligible for the $500,000 maximum, if you cease to be a scuba diver, fly in or pilot a helicopter as part of your job, you will no longer be eligible for the $500,000 maximum and your coverage will be reduced to $300,000.

You may choose up to $50,000 of guaranteed coverage without completing an Evidence of Insurability (EOI) form. To receive guaranteed coverage, you must elect coverage within 60 days after your start date. If you select coverage greater than $50,000 for yourself, or if you elect coverage after your initial eligibility, you must complete and submit an EOI form to MetLife. Benefit amounts over $50,000 will not be in effect, nor will the increased premiums be deducted from your pay, until MetLife approves the additional coverage.

Coverage for Your Dependents

You may elect coverage for your dependents in $5,000 increments up to a maximum of $150,000 or half of your life insurance amount, whichever is less.

You may elect coverage up to the guaranteed coverage amount of $25,000 for your spouse or domestic partner and each of your eligible child(ren). If total coverage for your spouse or domestic partner is greater than $25,000, an EOI form is required. EOI forms are not required for eligible children.

Elected coverage above the guaranteed coverage amount is dependent upon the approval of the active employee's coverage as your dependents can never be more than half of your election as an active employee.

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 life insurance policy within 31 days after becoming ineligible. Please contact MetLife at 1-866-574-2863 for more information.
- Premium changes due to age start at the beginning of each plan year (January 1) based on your age on January 1.
- The life insurance offered to you and your dependents is term life coverage. This type of life insurance has no cash value.

How the Plan Works During Active Employment

New Enrollment

For new enrollment in the Group Term Life Insurance plan offered through the State to begin, you must be employed by the State of Maryland and performing services for compensation on your regularly scheduled working days. "Actively at work" means the individual is performing the material duties of his/her own occupation at the employer's usual place of business. You are considered **Actively at Work** if an absence is due to a regularly scheduled day off, holiday or vacation day.

If you do not enroll when first eligible, you will have to wait until a qualifying life change or the next Open Enrollment period.

No Duplication of Benefits or Enrollment

If you and your spouse or domestic partner are both State employees and/or retirees, and you cover yourself for life insurance, you cannot be covered as a dependent of your spouse or domestic partner. Also, children of State employees and retirees cannot have duplicate coverage under both parents. If a child has coverage as a State employee, he or she cannot also be covered as a dependent. MetLife will only pay benefits under one policy.

You are always the beneficiary for your dependent's life insurance coverage.

Changing Coverage and When Coverage is Effective

If you are currently enrolled in the plan, you may continue at your current coverage level each plan year without medical review. If your election requires proof of good health, you must submit the Evidence of Insurability (EOI) form directly to MetLife. Your increased coverage amount will become effective when you pay increased premiums on:

- The first of the month following the date MetLife approves your Evidence of Insurability.

If your request for increased coverage is denied, your coverage will remain at your previous amount.

Plan Features

Accelerated Benefit

An Accelerated Benefit is available in the event of a terminal illness. An insured employee, spouse, domestic partner or child has the option to receive an accelerated benefit of up to 100% of the life insurance coverage amount, if the insured person is medically certified by MetLife to be terminally ill with less than 12 months to live and has at least $10,000 in coverage.

Waiver of Premium During Total Disability

If you become totally disabled before you reach age 60 and are enrolled in the term life insurance plan as an active State employee on your date of disability, you may be entitled to a waiver of premium after nine months of total disability. Call MetLife at 1-866-574-2863 for information to apply.

Conversion and Portability of Coverage

If you are no longer eligible for coverage as an active employee and are not retiring, you may transfer your Group Term Life insurance as well as your in-force dependent life insurance (portable coverage ends at age 70) or you may convert your and your dependent's life coverage to an individual life insurance policy. Premiums may be higher than those paid by active employees. **NOTE:** You have 31 days after your termination date to select one of the above options.

Additional Benefits

If you are covered under the Term Life Insurance Plan, you and your dependents have access to travel assistance services, will preparation, grief counseling, funeral discounts and planning services and Digital Legacy; your beneficiaries have access to beneficiary claim assistance, grief counseling, funeral assistance, and estate resolution services.

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 paid according to the plan provisions listed in MetLife's certificate of group coverage.

Beneficiaries can be changed at any time throughout the year. Beneficiary designation forms are available from MetLife's web site: **https://www.metlife.com/stateofmd**.

Life Insurance Choices When You Retire

Coverage for Yourself

State 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;
- Cancel life insurance coverage; or
- Convert to an individual policy.

You cannot increase your life insurance coverage or add new dependents to your life insurance coverage when you retire or at any time after retirement. If you reduce or cancel life insurance coverage, you will not be permitted to increase coverage or re-enroll in the State Life Insurance plan. There cannot be a break in life insurance coverage between active employment and retirement.

Coverage for Your Dependents

As a retiree, you may choose to continue, reduce, or cancel your dependent life insurance coverage for any dependents that 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, domestic partner or children who had life insurance as the dependent of a deceased retiree can only continue life insurance coverage through a conversion policy.

Automatic Reduction of Benefits for You and Your Dependents

As a retiree, life insurance benefits for you and your spouse or domestic partner will reduce automatically based on your age, according to the reduction schedule below. Premium changes due to an automatic reduction of benefits for you and your dependents will begin the first of your birthday month.

At Age...	Spouse Benefits Reduce To...
65	65% of your and your dependent's original amount
70	45% of your and your dependent's original amount
75	30% of your and your dependent's original amount
80	20% of your and your dependent's original amount

For more information or questions about additional services, conversion policies, limitations, definitions, restrictions, terminating events, or exclusions, please call MetLife at 1-866-574-2863 or visit their dedicated website for the State of Maryland's Group Term Life Insurance Plan: **https://www.metlife.com/stateofmd**.

Accidental Death and Dismemberment

Accidental Death and Dismemberment (AD&D) is available to all active employees and their dependents eligible for health benefits with the State. AD&D is offered through MetLife. AD&D insurance provides beneficiaries with additional financial protection if an insured's death or dismemberment is due to a covered accident, whether it occurs at work or elsewhere. Evidence of insurability is not required.

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

- $100,000,
- $200,000, or
- $300,000.

If you choose family coverage, the amount of a dependent's AD&D insurance is based on the composition of the employee's family as follows:

Employee's Family Consists of	Amount of AD&D Insurance
Spouse , Domestic Partner and Eligible Children	Spouse/Domestic Partner: 55% of employee's amount of insurance Each Child: 15% of employee's amount of insurance*
Spouse , Domestic Partner and No Eligible Children	65% of employee's amount of insurance
No Spouse/Domestic Partner but Eligible Children	25% of employee's amount of insurance*

*The maximum benefit for child coverage is $50,000

How the Plan Works

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

As with Term Life Insurance, coverage under the AD&D Plan entitles you to additional benefits through MetLife. For more information or questions about additional services, conversion policies, limitations, definitions, restrictions, terminating events, or exclusions, please call MetLife at 1-866-574-2863 or visit their dedicated website for the State of Maryland's Group Term Life Insurance Plan: **https://www.metlife.com/stateofmd**.

Eligibility

The charts on the following pages explain if you are eligible for benefits under the State of Maryland Employee and Retiree Health and Welfare Benefits Program. If you are eligible, you may also cover your eligible dependents for certain benefits.

For plans in which you are enrolled, your dependents must be in one of the categories listed in the table beginning on page 40. Beneficiaries of deceased State retirees can only cover dependents who would be eligible dependents of the State retiree if they 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 covered dependent child, domestic partner or spouse immediately when they no longer meet dependent eligibility criteria provided on page 51 under "Removing Dependents Who Lose Eligibility." Children (biological, adopted and stepchildren) reaching age 26 and/or other child relatives (grandchildren, legal wards, step-grandchildren or other child relatives) reaching age 25 with no disability certification are removed from coverage automatically at the end of the month in which they turn age 26 or 25 respectively. A notice will be sent to your address in the SPS Benefits system in advance of the termination of coverage.

Two State employees and/or retirees may not be covered as both the employee/retiree and a dependent in the same plan. It is your responsibility to make sure that you and your dependents do not have duplicate State coverage. This includes your children who may also be State employees. Duplicate benefits will not be paid.

When Coverage Begins

Generally speaking if enrolling during the annual Open Enrollment period, the coverage you elect will begin January 1 and remain in effect through December 31 of the same calendar year 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 when not enrolling during the annual Open Enrollment period.

If you are...	Coverage becomes effective...
A new employee enrolling for the first time	1st of the month after date of hire. If hired on the first of the month, date of hire. Coverage for Flexible Spending Accounts (FSAs) is effective the 1st of the month following the date the enrollment event is approved.
An active employee making an authorized mid-year change in coverage	1st of the month following the qualifying status change. Exceptions are births and adoptions which are effective on the date of the event. Term Life Insurance & Accidental Death and Dismemberment coverage are effective the 1st of the month following the date of birth. FSA coverage see "new active employee" above.
Newly retired or retiree beneficiary	1st of the month of retirement.
A retiree making an authorized mid-year change in coverage	1st of the month following the date of the qualifying status change. Exceptions are births and adoptions which are effective on date of event.

For our New Hires, Newly Retired or those experiencing a qualified status change - you have 60-days from the initial date to enroll or make changes. **Coverage will be retroactive based on this chart and missed premium deductions will be billed to you for payment.**

Special Note for Employees

Any missed premium deductions (e.g., due to a short-term disability absence, a transfer between two State agencies or because of a payroll errors, mid-month termination, etc.), must be paid by the due date in the invoice. Three invoices will be mailed to the employee, failure to pay the invoice(s) will result in the debt to be referred to the State Central Collections Unit (CCU) for collection. The payment due date is strictly enforced. In some cases, your coverage may be canceled and you will not be permitted to re-enroll until the next Open Enrollment period.

Active Employees who transferred or missed deductions due to a payroll error cannot have an interruption of coverage for the plan year. Missing one to two pay periods is considered a short-term leave of absence. Please review the policy section in the guide on Leave of Absence/COBRA Coverage.

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);
- Your Medicare eligibility;
- Your status (full-time permanent, part-time permanent, contractual/variable hour employee, retiree, ORP retiree, etc.); and
- Your length of service with the State (retirees).

If you are eligible for the maximum State subsidy, you pay the amount shown on the Retiree Rate Sheet. However, some individuals are eligible for only a percentage of the State subsidy or are not eligible to receive the State subsidy. The Employee Benefits Division will provide a confirmation statement reflecting actual monthly contributions.

Part-time regular (working less than a 50% work week), COBRA members, and employees on an approved Armed Services leave 31 or more days do not receive any State subsidy for their coverage and should refer to the Direct Pay Rate Sheet. Contractual/Variable hour employees who work less than 30 hours/week or 130 hours/month do not receive any State subsidy for their coverage. Contractual/Variable hour employees working more than 30 hours/week or an average of 130 hours/month receive an alternative State subsidy for medical and prescription coverage only. All Contractual/Variable hour employees regardless of the number of hours worked should refer to the Contractual/Variable Hour Rate Sheet. All rate sheets can be found at **www.dbm.maryland.gov/benefits**.

It is your responsibility to verify your benefit deductions on your check or retirement stub and your Benefits Summary Statement to ensure they match the coverage you elected. If there is an error, contact the following immediately:

- Your Agency Benefits Coordinator, if you are an Active, Satellite or Direct Pay employee; or
- The Employee Benefits Division, if you are a retiree or a COBRA enrollee.
- **You may not retroactively elect to participate in a Flexible Spending Account.**

Enrolling Eligible Dependents

You must submit documentation for each dependent you wish to enroll for coverage verifying they meet the eligibility requirements of the Program. If you do not provide all required documentation at the time of enrollment the dependent(s) will not have coverage. The following chart lists eligible dependents and the documents you must submit to cover an eligible dependent. Photocopies are acceptable provided any seal or official certification can be seen clearly.

Employees/retirees adding dependents during Open Enrollment or following a qualifying status change (including new hires) must attach the dependent documentation to the SPS Benefits System Benefit Event.

Satellite employees and COBRA enrollees must attach the dependent documentation to the enrollment form.

Dependent Relationship	Eligibility Criteria	Required Documentation
Spouse	• Lawfully married to an employee or retired employee as recognized by the laws of the State of Maryland or in a jurisdiction where such marriage is legal	• Official State marriage certificate (must be a certified copy recorded, signed by the appropriate State or County official, such as the Clerk of Court): - From the court in the County or City in which the marriage took place; or - From the Maryland Division of Vital Records for marriages that occurred at least six months prior to enrollment; or - From the Department of Health and Mental Hygiene (DHMH) website: **www.dhmh.maryland.gov** (click Online Services) – also **www.vitalchek.com**
Children • Biological Child • Adopted Child • Step-child	• Under age 26 • 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 26 and incapable of self-support due to mental or physical incapacity occurring prior to age 26 with proof of continuous employer sponsored coverage	**Biological Child** • Copy of child's official state birth certificate showing lineage • NEWBORNS: Official birth certificate is required within 60 days of birth. **https://www.vitalchek.com** (recommended) OR **https://health.maryland.gov** **Adopted Child** • Pending Adoption: Notice of placement for adoption on adoption agency letterhead or copy of court order placing child pending final adoption • Final Adoption: Copy of final adoption decree signed by a judge or a State-issued birth certificate showing employee/retiree as 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
Other Child Relatives • Grandchild • Legal ward • Step-grandchild or other dependent child relatives	• **Under age 25** • Must reside in your home • Must be unmarried • May not be eligible for coverage under own employer • For whom you provide sole support	**Other Child Relatives (for all types)** • Copy of child's official state birth certificate showing lineage • Proof of permanent residence with enrolled employee/retiree (one of the following): - Valid driver's license, - State-issued identification card, - School records certifying child's address, - Daycare records certifying child's address, or - Tax documents with child's name listed certifying address. Must also submit following specific documentation for specified dependent: **Legal Wards (temporary guardianship not covered):** • Copy of Legal Ward/Testamentary court document, signed by a judge. **Grandchild, Step-grandchild, or other child relative:** • Proof of relation by blood or marriage
Medical Child Support Order		• Copy of court order requiring Employee/Retiree to provide support and health coverage, signed by the child support officer or judge

Information on how to upload documents into the SPS Benefits System is included on the DBM Health Benefits website: **https://dbm.maryland.gov/sps/pages/benefits_helpcenter.aspx**.

If you add a qualifying dependent during open enrollment, you must provide all required documentation when completing the "Open Enrollment Benefit Event" in the SPS Benefits System. If documentation is not appropriately provided by the end of open enrollment, your dependent(s) will be removed from the plan

If you are enrolling using a paper enrollment form, you must attach all required supporting dependent documentation, or your dependent(s) will not be covered.

Dependent Relationship	Eligibility Criteria	Required Documentation
Domestic Partner	• Lived together for at least twelve months. • Not married to anyone else nor have another Domestic Partner. • At least 18 years of age and mentally competent to consent to contract. • Reside together in the same residence and intend to do so indefinitely. • Have an exclusive mutual commitment similar to that of marriage. • Are jointly responsible for each other's common welfare and share financial obligations.	• Affidavit of Domestic Partnership • Two of the following: - Joint lease or mortgage - Designation of Domestic Partner as beneficiary for life insurance AND retirement contract - Designation of Domestic Partner as primary beneficiary in employee's or insured's will - Durable property AND health care powers of attorney - Joint ownership of a motor vehicle, joint checking account or joint credit account
Domestic Partner Children • Biological Child • Adopted Child	• Under age 26 • 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 26 and incapable of self-support due to mental or physical incapacity occurring prior to age 26 with proof of continuous employer sponsored coverage	**Biological Child** • Copy of child's official state birth certificate showing lineage • NEWBORNS: Official birth certificate is required within 60 days of birth. **https://www.vitalchek.com** (recommended) OR **https://health.maryland.gov** **Adopted Child** • Pending Adoption: Notice of placement for adoption on adoption agency letterhead or copy of court order placing child pending final adoption • Final Adoption: Copy of final adoption decree signed by a judge or a State-issued birth certificate showing employee/retiree as the parent If domestic partner is NOT a covered dependent, documentation of domestic partnership (see Required Documentation for Domestic Partners)
Domestic Partner Other Child Relatives • Grandchild • Legal ward • Other dependent child relatives	• **Under age 25** • Must reside in your home • Must be unmarried • May not be eligible for coverage under own employer For whom you provide sole support	**Other Child Relatives (for all types)** • Copy of child's official state birth certificate showing lineage • Proof of permanent residence with enrolled employee/retiree (one of the following): - Valid driver's license, - State-issued identification card, - School records certifying child's address, - Daycare records certifying child's address, or - Tax documents with child's name listed certifying address. Must also submit following specific documentation for specified dependent: **Legal Wards (temporary guardianship not covered):** Copy of Legal Ward/Testamentary court document, signed by a judge. **Grandchild or other child relative:** Proof of relation by blood or marriage If domestic partner is NOT a covered dependent, documentation of domestic partnership (see Required Documentation for Domestic Partners)

Important Information About Covering Your Domestic Partner and Your Domestic Partner's Child(ren)

- **How your taxes may be affected**- Internal Revenue Service (IRS) regulations treat insurance costs associated with health benefits related to domestic partners and their children differently. In most cases, domestic partners and their eligible children are considered non-qualified dependents. Thus, health benefits will be taxed as outlined below:
- **Payroll Deduction**- For each health insurance plan where there is an Employee contribution and a State subsidy in which you enroll your domestic partner and your partner's eligible dependents, you will pay:
  - Post-tax deduction for the coverage attributable to the domestic partner (and/or domestic partner's child(ren); and
  - Pre-tax deduction applicable to the Employee only coverage.
  - Retiree deductions are always post-tax
- **Imputed Income**- Each health benefit plan that includes a State subsidy for your domestic partner and your domestic partner's children is subject to tax withholding. In other words, the State's contribution toward health benefits is considered earnings and will be included in your taxable gross income. This is known as imputed income.
  - **Retirees**-domestic partners and domestic partner's dependents do not receive State subsidy towards the cost of their enrolled health benefits. Therefore, retirees are not subject to imputed income.

Important information About Covering Grandchildren, Legal Wards and Other Child Relatives

- **How your taxes may be affected**- Internal Revenue Service (IRS) regulations treat insurance costs associated with Health benefits related to grandchildren, legal wards and other child relatives differently. In many cases, grandchildren, legal wards and other child relatives are considered non-qualified dependents. Thus, health benefits will be taxed as outlined below:
- **Payroll Deduction**- For each health insurance plan where there is an Employee contribution and a State subsidy in which you enroll your grandchild, legal ward or other child relative, you will pay:
  - Post-tax deduction for the coverage level attributable to the grandchild, legal ward or other child relative; and
  - Pre-tax deduction applicable to the Employee only coverage.
  - Retiree deductions are always post-tax.
- **Imputed Income**- Each health benefit plan that includes a State subsidy for grandchildren, legal wards and/or other child relatives is subject to tax withholding. In other words, the State's contribution toward health benefits is considered earnings and will be included in your taxable gross income. This is known as imputed income.
  - Retirees-grandchildren, legal wards and other child relatives do not receive State subsidy towards the cost of their enrolled health benefits. Therefore, retirees will pay the full premium associated with each of the listed other child relatives.

For information on Domestic Partner's or Grandchild, Legal Ward or Other Child Relative Federal Tax Dependent Status visit dbm.maryland.gov/benefits

Dependent Child to Age 26

- Dependent child is defined as a biological, adopted or stepchild.
- You can cover your eligible dependent child through the end of the month in which they turn age 26. Disability certification is required to cover children beyond age 26.
- Disabled Eligible Dependent Child: You are not required to provide disability certification until a disabled, eligible dependent child reaches age 26. You will then be required to provide certification of their permanent disability status to keep them on your coverage. The application must be received in the Employee Benefits Division no later than 60-days following the date coverage is terminated. Note: The onset of disability must have occurred before the child reached age 26. Contact the Employee Benefits Division for details and requirements.

Other Dependent Child Relative to Age 25

- Other Dependent Child Relative is defined as grandchild, legal ward, great grandchild or other child relative.
- You can cover your eligible other dependent child relative through the end of the month in which they turn age 25. Disability certification is required to cover other dependent child relative beyond age 25.
- Disabled Eligible Other Dependent Child: You are not required to provide disability certification until a disabled, eligible other dependent child reaches age 25. You will then be required to provide certification of their permanent disability status to keep them on your coverage. The application must be received in the Employee Benefits Division no later than 60-days following the date coverage is terminated. Note: The onset of disability must have occurred before the child reached age 25.

Translation of Non-English Documentation

If you submit dependent documentation that is written in a language other than English, it must be translated by an official translator—someone other than you or your dependent(s). Generally, an official translator can be found at any college or university. The translation of each document must be signed by the translator and notarized.

Important Note About Documentation

- Marriage certificates must be recorded, signed, dated, and certified by the clerk of the court or other appropriate state or county official. Certificates signed by a clergy member (e.g., a minister or rabbi) are not acceptable.
- Birth certificates must show direct lineage to you, your spouse or your domestic partner.

For information on Domestic Partners OR grandchildren, legal wards or other child relatives Federal Tax Dependent Status visit dbm.maryland.gov/benefits

Eligibility by Employee/Retiree Type

Eligibility	Subsidy Amount	How You Will Pay for Benefits
STATE REGULAR EMPLOYEES		
You are eligible for benefits if you are: • A permanent full-time or part-time permanent (working 50% or more of the workweek) State employee who is regularly paid salary or wages through an official State payroll center, including but not limited to: – Central Payroll Bureau; – Maryland Transit Administration; and – University of Maryland, including graduate assistants and the University's Far East and European Divisions; • An elected State official; • Register of Wills or an employee of the Register of Wills; • Clerk of the Court or an employee of the offices of Clerks of the Court; or • A State Board or Commission member who is regularly paid salary or wages and works at least 50% of the work week.	Maximum State Subsidy	Through payroll deductions, using pre-tax deductions, where pre-tax deductions are permitted. If for any reason you do not have a deduction for a pay period, or if your wages are not enough to cover your deductions, you will be required to pay the State directly for that unpaid amount. An invoice will be mailed to the home address on file for any missed payroll premium deductions. Unpaid invoices will be referred to the State's Central Collections Unit (CCU) where an additional 17% administrative fee will be added to the debt.
STATE REGULAR EMPLOYEES (WORKING LESS THAN 50%)		
You are eligible to enroll in the same benefits as full-time State employees, with the exception of the Flexible Spending Accounts. Part-time employees must follow the same participation rules as full-time employees.	No State Subsidy – you pay the full amount	Premiums are paid on a post-tax basis. Monthly payment coupons will be mailed to the address provided in the SPS Benefits System for the first month of coverage through the end of the plan year or the end of your current contract period, whichever comes first. Payments must begin with the first coupon received and are due the first of every month, with a 30-day grace period. Unpaid invoices will be referred to the State's Central Collections Unit (CCU) where an additional 17% administrative fee will be added to the debt.
SATELLITE EMPLOYEES		
• You are eligible for benefits if you are: – An employee of a political subdivision which participates in the State's health benefits program with the approval of the governing body; or – An employee of an agency, commission, or organization permitted to participate in the State's health benefits program by law. • Satellite Employees may not participate in the Program's FSA plans.	As determined by the Satellite Employer	As determined by the Satellite Employer

Eligibility by Employee/Retiree Type

Eligibility	Subsidy Amount	How You Will Pay for Benefits
CONTRACTUAL/VARIABLE HOUR EMPLOYEES (WORKING LESS THAN 30 HOURS/WK OR 130 HOURS/MO)		Premiums are paid on a post-tax basis. Monthly payment coupons will be mailed to the address provided in the SPS Benefits System for the first month of coverage through the end of the plan year or the end of your current contract period, whichever comes first. Payments must begin with the first coupon received and are due the first of every month, with a 30-day grace period. Unpaid invoices will be referred to the State's Central Collections Unit (CCU) where an additional 17% administrative fee will be added to the debt. If you do not receive payment coupons within one month of submitting your "Benefit Event" through the SPS Benefits System, please contact your Agency Benefits Coordinator.
You are eligible to enroll in the same benefits as full-time State employees, with the exception of the Flexible Spending Accounts. Contractual employees must follow the same participation rules as full-time employees: • Changes to coverage normally cannot be made at the time of an employment contract renewal. • Contractual employees must have a current active contract to enroll.	No State Subsidy – you pay the full amount	
CONTRACTUAL/VARIABLE HOUR EMPLOYEES (WORKING MORE THAN 30 HOURS/WK OR 130 HOURS/MO)		
You are eligible to enroll in the same benefits as full-time State employees, with the exception of the Flexible Spending Accounts. Contractual employees must follow the same participation rules as full-time employees: • Changes to coverage cannot be made at the time of an employment contract renewal. • Contractual employees must have a current active contract to enroll.	75% State Subsidy for Medical and Prescription; no State Subsidy for other benefit options.	

Eligibility by Employee/Retiree Type

Eligibility	Subsidy Amount	How You Will Pay for Benefits
MARYLAND STATE RETIREMENT SYSTEM RETIREES (HIRED PRIOR TO 7/1/11)		
You are eligible for benefits if you are a State retiree who is currently receiving a monthly State retirement allowance and meet one of the following criteria: • You left State service with at least 16 years of service; • You retired directly from State service with at least five years of service; • You left State service (deferring your retirement allowance) with at least 10 years of service and within five years of normal retirement age; • You retired from State service with a disability retirement; or • Your State employment ended before July 1, 1984. Note: Retirees of a County that participates with the State Retirement System are generally not eligible for health benefits coverage through the State Employee and Retiree Health and Welfare Benefits Program. Certain other retirees, including but not limited to retirees of the Maryland Environmental Service or the University of Maryland Medical System that receive a State retirement allowance, may be eligible. Contact your Agency Benefits Coordinator or the Employee Benefits Division if you think you may be eligible.	Maximum State Subsidy if: • You retire with 16 or more years of service; • You receive a disability retirement; or • You retired from State service before July 1, 1984. Partial State Subsidy if you have at least five years of State service, but less than 16. For example, if you have 10 years of State service, you would receive 10/16 of the maximum State subsidy.	Premiums will be deducted from your monthly retirement check once the State Retirement Agency (SRA) has created a pension record. When deductions begin to be taken from your pension check, our office will then send a mandatory retroactive adjustment bill for missed pension deductions from the date of retirement to the date of the first successful pension deduction. You must pay this mandatory bill by the due date or risk having the debt referred to the State's Central Collections Unit (CCU) where an additional 17% administrative fee may be added. Deductions taken from your retirement check are always taken after any taxes have been deducted. If your retirement check is not enough to cover all of your monthly plan premiums, you will be billed for the plan premiums that could not be deducted. You will receive invoices mailed to the home address on file. Premium payments are due on the first of every month, with a 30-day grace period (Exception: January premiums are due upon receipt of the coupons, with a 30-day grace period). Unpaid invoices will be referred to the State's Central Collections Unit (CCU) where an additional 17% administrative fee will be added to the debt.
MARYLAND STATE RETIREMENT SYSTEM RETIREES (HIRED ON OR AFTER 7/1/11)		
You are eligible for benefits if you are a State retiree who is currently receiving a monthly State retirement allowance and meet one of the following criteria: • You left State service with at least 25 years of creditable service; • You retired directly from State service with at least 10 years of creditable service; • You left State service (deferring your retirement allowance) with at least 10 years of creditable service and within five years of normal retirement age; or • You retired from State service with a disability retirement. Note: Retirees of a County that participates with the State Retirement System are generally not eligible for health benefits coverage through the State Employee and Retiree Health and Welfare Benefits Program. Certain other retirees, including but not limited to retires of the Maryland Environmental Services or the University of Maryland Medical System that receive a State retirement allowance, may be eligible. Contact your Agency Benefits Coordinator or the Employee Benefits Division if you think you may be eligible.	Maximum State Subsidy if: • You retire with 25 or more years of creditable service; or • You receive a disability retirement. Partial State Subsidy if you have least 10 years of State creditable service, but less than 25. For example, if you have 15 years of State creditable service, you would receive 15/25 of the maximum State subsidy.	Premiums will be deducted from your monthly retirement check once the State Retirement Agency (SRA) has created a pension record. When deductions begin to be taken from your pension check our office will then send a mandatory retroactive adjustment bill for missed pension deductions from the date of retirement to the date of the first successful pension deduction. You must pay this mandatory bill by the due date or risk having the debt referred to the State's Central Collections Unit (CCU) where an additional 17% administrative fee may be added. Deductions taken from your retirement check are always taken after any taxes have been deducted. If your retirement check is not enough to cover all of your monthly plan premiums, you will be billed for the plan portion that could not be deducted. You will receive invoices mailed to the home address on file. Premium payments are due on the first of every month, with a 30-day grace period. (Exception: January premiums are due upon receipt of the coupons, with a 30-day grace period). Unpaid invoices will be referrred to the State's Central Collections Unit (CCU) where an additional 17% administrative fee will be added to the debt.

Eligibility by Employee/Retiree Type

Eligibility	Subsidy Amount	How You Will Pay for Benefits
BENEFICIARIES OF DECEASED MARYLAND STATE RETIREMENT SYSTEM RETIREES		
You are eligible for benefits if you are a surviving spouse, domestic partner or child of a deceased State retiree and: • Are receiving a monthly State retirement allowance as the surviving beneficiary of a deceased retiree; and • Meet the dependent eligibility criteria for health benefits. If the surviving spouse or domestic partner is the beneficiary, the spouse or domestic partner may cover themselves and any eligible dependent children of the deceased retiree. However, they may only cover dependents that would be eligible dependents of the deceased retiree if they were still living. If the beneficiary is a child, the child will only be eligible for subsidized health benefits as long as they meet the dependent eligibility requirements for children. When the child no longer meets the dependent eligibility criteria for children, the subsidized health benefits end. Non-subsidized benefits under COBRA may then be available for up to 36 months. If you were enrolled in dependent Term Life Insurance at the time of the retiree's death, that policy must be converted to an individual policy directly through MetLife within 30 days in order to continue Term Life Insurance coverage. Plan phone numbers are located on the inside front cover of this guide.	If you are eligible for coverage as a beneficiary, you will receive the same State subsidy that the retiree was entitled to receive at the time of his or her death. If you are the deceased retiree's domestic partner beneficiary, you will not receive a State subsidy towards benefits premiums.	Premiums will be deducted from your monthly retirement check once the State Retirement Agency (SRA) has created a pension record. When deductions begin to be taken from your pension check our office will then send a mandatory retroactive adjustment bill for missed pension deductions from the date of retirement beneficiary status to the date of the first successful pension deduction. You must pay this mandatory bill by the due date or risk having the debt referred to the State's Central Collections Unit (CCU) where an additional 17% administrative fee may be added. Deductions taken from your retirement check are always taken after any taxes have been deducted. If your retirement check is not enough to cover all of your monthly plan premiums, you will be billed for the plan premiums that could not be deducted. You will receive invoices mailed to the home address on file. Premium payments are due on the first of every month, with a 30-day grace period (Exception: January premiums are due upon receipt of the coupons, with a 30-day grace period). Unpaid invoices will be referrred to the State's Central Collections Unit (CCU) where an additional 17% administrative fee will be added to the debt. A deceased retiree's domestic partner beneficiary will have premiums direct billed: Premiums are paid on a post-tax 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. Payments must begin with the first coupon received and are due the first of every month, with a 30-day grace period. Unpaid invoices will be referrred to the State's Central Collections Unit (CCU) where an additional 17% administrative fee will be added to the debt. 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.

Eligibility by Employee/Retiree Type

Eligibility	Subsidy Amount	How You Will Pay for Benefits
OPTIONAL RETIREMENT PROGRAM (ORP) RETIREES (HIRED PRIOR TO 7/1/11)		
There are special rules governing your eligibility and costs for health benefits if you are a retiree of an Optional Retirement Program (ORP). Current and former ORP vendors include: Teachers Insurance and Annuity Association College Retirement Equities Fund (TIAA-Cref), AIG-Valic, Fidelity, American Century, and ING. You are eligible for benefits with the first of the month of retirement, which must coincide with the initial periodic distribution from a Maryland ORP account if you meet one of the following criteria: • You retire directly from and have at least 5 years of service with a Maryland State institution of higher education with a periodic distribution of benefits; • You ended service with a Maryland State institution of higher education when you were at least 57 and had at least 10 years of service; or • You ended service with a Maryland State institution of higher education with at least 16 years of service.	**Maximum Individual/No Dependent State subsidy if you:** • retire directly from a Maryland State institution of higher education and have at least 16 years of service but less than 25 years of service. **Partial Individual/No Dependent State subsidy if you:** • retire directly from a Maryland State institution of higher education and have at least 5 years of service but less than 16 years of service. **No Individual or Dependent State subsidy if you:** • do not retire directly upon ending ORP service with a Maryland State institution of higher education, with the exception noted below.	Premiums are paid on a post-tax 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. Payments must begin with the first coupon received and are due the first of every month, with a 30-day grace period. Unpaid invoices will be referrred to the State's Central Collections Unit (CCU) where an additional 17% administrative fee will be added to the debt. 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.

Eligibility by Employee/Retiree Type

Eligibility	Subsidy Amount	How You Will Pay for Benefits
OPTIONAL RETIREMENT PROGRAM (ORP) RETIREES (HIRED ON OR AFTER 7/1/11)		
You are eligible for benefits with maximum, partial or no State subsidy beginning the first of the month of retirement, which must coincide with the initial periodic distribution from a Maryland ORP account if you meet one of the following criteria: •You retire directly from a Maryland State institution of higher education with 10 years of service; •You ended service with a Maryland State institution of higher education when you were at least age 57 and had at least 10 years of service; or •You ended service with a Maryland State institution of higher education with at least 25 years of service.	**Maximum Individual/ Dependent State Subsidy if you:** • retire directly from a Maryland State institution of higher education and have at least 25 years of service. **Partial Individual/No Dependent State subsidy if you:** • retire directly from a Maryland State institution of higher education and have at least 10 years but less than 25 years of service. **No Individual or Dependent State Subsidy if you:** • do not retire directly upon ending ORP service with a Maryland State Institution of higher education, with the exception noted below.	Premiums are paid on a post-tax 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. Payments must begin with the first coupon received and are due the first of every month, with a 30-day grace period. Unpaid invoices will be referrred to the State's Central Collections Unit (CCU) where an additional 17% administrative fee will be added to the debt. 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.
OPTIONAL RETIREMENT PROGRAM (ORP) RETIREES (REGARDLESS OF DATE OF HIRE)		
If you are an ORP retiree with service equal to 25 or more full years of regular employment with the State, in any branch of government, you may be eligible for the maximum State subsidy of the coverage for you and your dependent(s), even if you did not retire directly from a Maryland State institution of higher education. One year of employment at 50% of standard work hours, with contributions to a Maryland ORP, provides six months of applicable ORP service. If you stop receiving a periodic distribution from your Maryland ORP account, you will no longer be eligible for health benefits. Lump sum payments, supplemental retirement accounts, or non-Maryland State institution service do not count for enrollment in, or State subsidy for, retiree health benefits. If coverage in the Program is terminated for an ORP Retiree or Beneficiary for any reason, either voluntarily or involuntarily, documentation confirming the current continuing receipt of a periodic distribution from the Maryland ORP must be provided to qualify for re-enrollment. **Required Documentation:** Completion of a Retiree Health Enrollment and Change form and a State of Maryland Optional Retirement Program (ORP) Packet. The form and packet are available from your Agency Benefits Coordinator, by mail from the Employee Benefits Division, or from our website at **www.dbm.maryland.gov/benefits**.		

Eligibility by Employee/Retiree Type

Eligibility	Subsidy Amount	How You Will Pay for Benefits
BENEFICIARIES OF DECEASED ORP RETIREES		
You are eligible for health benefits coverage if you are the surviving spouse, domestic partner or child of a deceased ORP retiree and: • You are receiving a periodic distribution of benefits from the retiree's Maryland ORP; and • You meet the spouse, domestic partner or child dependent eligibility criteria for health benefits. If the surviving spouse or domestic partner is the beneficiary, the spouse or domestic partner may cover themself and any eligible dependent of the deceased ORP retiree. However, only dependents that would be eligible dependents of the deceased ORP retiree if they were still living may be covered. If a child is the beneficiary, only the child will be eligible for health benefits as long as they meet dependent eligibility requirements for children (see page 39). **Required Documentation:** Completion of a Retiree Health Benefits Enrollment and Change form and a State of Maryland Optional Retirement Program (ORP) packet. The form and packet are available from an Agency Benefits Coordinator, at a Maryland State institution of higher education, from our website, **www.dbm.maryland.gov/benefits**, or by calling the Employee Benefits Division. If you were enrolled in dependent Term Life Insurance at the time of the retiree's death, that policy must be converted to an individual policy directly through MetLife within 30 days in order to continue Term Life Insurance coverage. Plan phone numbers are located on the inside front cover of this guide.	• Maximum State subsidy if the retiree had service equal to 25 or more full years of regular employment with the State in any branch of government; you may be eligible for the maximum State subsidy even if the retiree did not retire directly from a Maryland State institution of higher education. • **No State Subsidy if the retiree had less than 25 years of Maryland State service.** • **No State Subsidy If you are the deceased retiree's domestic partner beneficiary regardless of the number of years of service.**	Same as ORP retirees
If coverage in the Program is terminated for an ORP Retiree or Beneficiary for any reason, either voluntarily or involuntarily, documentation confirming the current continuing receipt of a periodic distribution from the Maryland ORP must be provided to qualify for re-enrollment.		

Qualifying Status Changes

IRS regulations strictly govern when and how benefits election changes can be made. The same rules apply to all program participants including employees and retirees.

Generally, you can only change your health coverage during the Open Enrollment period each year. The coverage you elect during Open Enrollment will be effective January 1 through December 31. However, you may make certain changes to your coverage outside of the annual Open Enrollment period if you have a qualifying change in status. Examples include the following:

- 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 State Children's Health Insurance Program (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 or domestic partner's employment ends;
- Gaining Medicare eligibility allows a reduction in coverage.
- Losing Medicare eligibility allows an increase in coverage.
- Changes in your other coverage (such as through a spouse's employer), which has a different plan year.

You have 60 days from the date of the qualifying change in status to submit the Benefit Event through the SPS Benefits System, upload the supporting documentation to change your coverage, and make your elections. Any changes submitted later than 60 days after the qualifying change in status will not be accepted, and you will have to wait until the next Open Enrollment period to make a change,with the exception of a divorce and death of a dependent. Divorce or Death events may be older than 60 days only when removing ineligible dependents.

NOTE: Documentation supporting a qualifying status change must be submitted with your Benefit Event through the SPS Benefits System. For example, if you are ending your State coverage because you have coverage under another employer's health plan, you must provide a letter from the other employer (on company letterhead) or the insurance provider with the effective date of coverage.

If you decline enrollment under a State plan for yourself or a dependent during Open Enrollment because you have other coverage, you may be able to enroll outside of the Open Enrollment period if you or your dependent(s) lose that other coverage.

Aging Out Dependent Child

If you are covering a child (biological, adopted or stepchild) reaching age 26 and/or an other child relative (grandchild, legal ward, step-grandchild, or other child relative) reaching age 25 with no disability certification, he/she will be removed as a dependent from health coverage automatically. A COBRA notice will be sent directly to the dependent child at your home address.

You can initiate your life event changes online using the SPS Benefits System. See the job aids provided on **https://dbm.maryland.gov/sps/Pages/BenefitsHelpCenter.aspx** for instructions.

IRS regulations strictly govern when and how benefit election changes can be made.

Removing Dependents Who Lose Eligibility

You must provide supporting documentation with the Benefit Event through the SPS Benefits System to remove any dependent as soon as they lose eligibility for coverage under a State benefit plan. If you do not remove the ineligible dependent within 60 days following the date of ineligibility, you will be billed the full insurance premium (including the State subsidy) from the date they became ineligible until the date removed. You may also 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 (see page 39). In most cases, dependents that lose eligibility are entitled to COBRA/Continuation Coverage for a limited time. This coverage is not subsidized by the State. Please see the COBRA/Continuation of Coverage section for more information.

Coverage for Your Former Spouse

If you are obligated to continue coverage for a former spouse according to the terms of your divorce agreement your former spouse cannot remain covered as a dependent under your State health benefits. The former spouse may elect COBRA which will be his/her own account and he/she will be responsible for paying premiums directly. COBRA coverage is not subsidized by the State.

Instructions on how to make mid-year changes	
IF YOU...	THEN...
Are rehired 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 rehire or transfer. This is not applicable to contractual employees.
Are an active State employee (New Hire) enrolling for the first time	A "New Hire Benefit Event" will be sent to the employee's SPS Benefits System inbox. You have 60 days from the date of hire to submit the "New Hire Benefit Event" including benefits elections, dependent documentation, etc. If you need assistance with dependent documentation accuracy, please contact your Agency Benefits Coordinator before submitting the "New Hire Benefit Event" to the Employee Benefits Division. The Benefit Event will not be accepted after 60 days. Your coverage will begin the first of the month following your date of hire or on the date of hire if you are hired on the first of the month. You will be required to pay a post-tax retroactive adjustment for missed premiums back to your enrollment effective date.
Are enrolling as a new retiree	You must submit an enrollment form within 60 days of your retirement date. Submit the enrollment form and any 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 retiree premium deduction.
Active Employees mid-year qualifying status change	A qualifying status change will be effective the first of the month following the event date or the date of the event, if the event date is the first of the month. The only exception is for birth/adoption which will be effective on the event date. You have 60 days from the event date to initiate your qualifying event in the SPS Benefits System and provide applicable documentation verifying the qualifying event. Mandatory post-tax retroactive adjustments will be required as necessary. Flexible Spending Accounts cannot be made effective retroactively.
Retiree mid-year qualifying status change	A qualifying status change will be effective the first of the month following the event date or the date of the event, if the event date is the first of the month. The only exception is for birth/adoption which will be effective on the event date. You have 60 days from the event date to initiate or submit an enrollment form and provide applicable documentation verifying the qualifying event to the Employee Benefits Division. Mandatory post-tax retroactive adjustments will be required as necessary.
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. You must initiate "Birth/Adoption Event" and upload an official state birth certificate. Provide the child's social security number upon receipt by uploading the document into SPS Benefits System Worker Documents. A retroactive adjustment invoice will be mailed to the employee's address listed on file and payment must be submitted by the due date listed in the invoice, unless you already have family coverage. Active employees with questions should contact their Agency Benefits Coordinator. All other enrollees should contact the Employee Benefits Division for assistance. If a newborn is not added within 60 days of birth, you must wait until the next Open Enrollment period to enroll the child.
Need to remove an ineligible dependent (e.g., divorced spouse, etc.)	You must initiate the related Benefit Event in the SPS Benefits System and upload the applicable supporting documentation verifying the ineligible dependent within 60 days of becoming an ineligible dependent. Retirees can initiate the related Benefit Event or notify the Employee Benefits Division directly. If you do not remove an ineligible dependent within 60 days of the loss of eligibility, you will be responsible for the lesser of the premium or the claims incurred while the ineligible dependent was covered. In addition, keeping an ineligible dependent on your coverage may result in disciplinary action, termination of employment, and/or criminal prosecution.

Leave of Absence

While on Leave of Absence

If you take a Leave of Absence Without Pay (LWOP), you may continue the same health benefits coverage you had as an active employee by electing to enroll as a Direct Pay participant and submitting premiums payments directly to DBM via payment coupons.

Short-Term LWOP

If you are on short-term LWOP (two pay periods or less or up to 30 days), you will be billed for all missed payroll deductions. You will receive a "Zero Pay" invoice from the Employee Benefits Division for your missed premiums. Payroll deductions may resume if you return to work before the due date on the "Zero Pay" invoice. However, payment for the missed premiums is mandatory; you cannot have a break in your benefits coverage. The payment due date is strictly enforced failure to pay the "Zero Pay" invoices will result in the debt to be referred to the State Central Collections Unit (CCU). In some cases, your coverage may be canceled and you will not be permitted to re-enroll until the next Open Enrollment period.

Long-Term LWOP

If you are on a leave of absence without pay for more than two bi-weekly pay periods (more than 30 days), your leave is considered a long-term LWOP. If you are on an approved long-term LWOP, you may elect to continue or discontinue health insurance for the duration of the LWOP.

If you wish to continue or discontinue your coverage, you must complete the "Benefit Event" in the SPS Benefits System inbox as soon as you receive the event in your SPS Benefits System inbox. You may continue any or all of your current health benefit plans, or you may reduce your coverage level when enrolling for LWOP benefits. However, you may not change plans until the next Open Enrollment period or within 60 days of a qualifying status change—the same as an active employee.

Returning from Long Term LWOP

When you return from Long Term LWOP, please check your SPS Benefits System inbox for the "Return from Leave Benefit Event". This request for re-enrollment in employee pre-tax benefits must be completed within 60 days after your return to work along with any required supporting documentation such as military discharge orders.

Eligibility	Subsidy Amount	How You Will Pay for Benefits
LONG TERM LEAVE WITHOUT PAY		
Personal If on approved leave without pay for personal reasons, your current health benefit plans will continue for 30 calendar days. If leave exceeds 30 calendar days, you may continue coverage under COBRA.	Maximum State Subsidy for the first 30 days of the approved leave. No State Subsidy – you pay the full amount under COBRA	Premiums are paid on a post-tax basis. Monthly payment coupons will be mailed to the address provided in the SPS Benefits System for the first month of coverage through the end of the plan year or the end of your approved leave, whichever comes first. 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-enroll until the next Open Enrollment period. Payment may be made in advance to cover any or all coupons received, payment deadlines are strictly enforced. If you do not receive payment coupons within one month of submitting your Benefit Event, please contact your Agency Benefits Coordinator.
Temporary Total Disability If on approved leave without pay due to an on-the-job injury, you will receive a Benefit Change Leave event to continue current coverage or waive coverage, while on leave for up to two (2) years.	Maximum State Subsidy	

Eligibility by Employee/Retiree Type

Eligibility	Subsidy Amount	How You Will Pay for Benefits
LEAVE OF ABSENCE- MILITARY ADMINISTRATIVE (ACTIVE DUTY)		
If on approved leave of absence for active military duty, you may continue any or all of your current health benefit plans, or you may reduce your coverage level while on leave for up to five (5) years. Your agency HRC must enter the leave type in the SPS Benefits System along with uploading the employee's Active Military Orders under Worker's Documents.	• Employee and State Subsidy paid by State for medical, prescription and dental • Employee responsible for payment of premiums if he/she elects to continue AD&D and Life insurance.	Premiums are paid on a post-tax basis. Monthly payment coupons will be mailed to the address provided in the SPS Benefits System for the first month of coverage through the end of the plan year or the end of your approved leave, whichever comes first. Payments must begin with the first coupon received and are due the first of every month, with a 30-day grace period. 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.dbm.maryland.gov/benefits; click on "Pay Your Direct Pay Coupons Now." 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-enroll until the next Open Enrollment period. Payment may be made in advance to cover any or all coupons received. Payment deadlines are strictly enforced. If you do not receive payment coupons within one month of submitting your Benefit Event, please contact your Agency Benefits Coordinator.
LEAVE OF ABSENCE-ARMED SERVICES 30 DAYS OR LESS (MILITARY TRAINING)		
If on an approved leave of absence for military training, you may continue any or all of your current health benefit plans (except the healthcare or dependent day care flexible spending accounts), or you may reduce your coverage while on leave for the first 30 days of approved unpaid military training duty. Your agency HRC must enter the leave type in the SPS Benefits System along with uploading the employees Training Military Orders under Worker's Document.	Maximum State Subsidy	
ARMED SERVICES MORE THAN 30 DAYS		
If on approved unpaid leave of absence for military training for more than 30 days, you may continue any or all of your current health benefit plans, or you may reduce your coverage level while on leave. Your agency HRC must enter the leave type in the SPS Benefits System along with uploading the employee's Training Military Orders under Worker Documents.	No State Subsidy	
FAMILY MEDICAL LEAVE ACT – FMLA		
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 while on FMLA and receiving a paycheck, we will continue deducting your premiums through pre-tax payroll 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 post-tax basis. Biweekly coupons will be mailed to the address on 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, this debt may be forwarded to the State of Maryland's Central Collections Unit. If referred to the Central Collections Unit, a collection fee of 17% will be added to the amount owed. In addition, the Central Collections Unit is authorized to report this debt to consumer reporting agencies. Debts referred to these agencies may affect your credit rating.
MEDICAL LEAVE WITHOUT PAY		
If on approved medical leave without pay, you will receive a Benefit Change Leave event to continue current coverage or waive coverage, while on leave for up to six (6) months.	Maximum State Subsidy	Premiums are paid on a post-tax basis. Monthly payment coupons will be mailed to the address provided in the SPS Benefits System for the first month of coverage through the end of the plan year or the end of your approved leave, whichever comes first. 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-enroll until the next Open Enrollment period. Payment may be made in advance to cover any or all coupons received. Payment deadlines are strictly enforced. If you do not receive payment coupons within one month of submitting your Benefit Event, please contact your Agency Benefits Coordinator

When Coverage Ends

If you are...	Coverage ends...
Leaving State employment	Last day of the month in which you worked.
On an unpaid leave of absence	See page 53-54 for details
Age 25/26	Last day of the month in which age 25/26 is reached
Divorce	Last day of the month in which divorce event with decree is approved
Gaining coverage elsewhere	If new coverage is effective the 1st day of a month, coverage will terminate on the last day of the preceding month. If new coverage is effective the 2nd through last day of a month, coverage will terminate on the last day of the month in which coverage was gained.

When Coverage Ends

You may choose to cancel your coverage during the annual Open Enrollment period or if you have a qualifying status change that allows you to end your coverage mid-year.

- If you cancel your coverage during the Open Enrollment period, your coverage will end on December 31 of the current plan year.
- If you end your coverage because of a qualifying status change, the date your coverage ends will be the end of the month in which the qualifying event occurred unless it is for a divorce.
- For a divorce, coverage ends on the last day of the month in which the divorce qualifying event is approved in the SPS Benefits System.
- FSA claims cannot be incurred past the last day of employment. You have 90 days from your last day of employment to submit claims for reimbursement.

FOR MORE INFORMATION about enrollment and changes outside of the Open Enrollment period, please contact the following:

- Your Agency Benefits Coordinator, if you are an Active or Satellite employee; or
- The Employee Benefits Division, if you are a retiree or COBRA participant.

For additional information about qualifying status changes, visit **www.irs.gov**.

Coverage is through the end of the month. Missed payroll deductions for premium will be billed to you for payment.

COBRA Continuation of Coverage

You and/or your dependents may elect to continue your health, prescription drug, dental, and/or healthcare flexible spending account participation by paying for coverage with after-tax dollars, for a timeframe determined based on Federal regulations.

If you or one of your dependents experiences a COBRA Coverage qualifying status change, you or your dependent may be eligible to continue the same health benefits that you or your dependent(s) had at the time of the qualifying status change.

NOTE: Loss of coverage through an Open Enrollment transaction is not a qualifying status change. You must have one of the qualifying status changes listed below to enroll in continuation coverage.

Summary of COBRA Coverage Conditions		
QUALIFYING EVENT	PERSON AFFECTED	LENGTH OF COBRA COVERAGE
Termination of employment (other than for gross misconduct), including layoff or resignation of employee or reduction in hours resulting in loss of coverage	• 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	• Spouse • Dependent Child(ren)	36 months or until eligible for coverage elsewhere, including Medicare*, whichever occurs first
Divorce, limited divorce/legal separation **NOTE: A separated spouse who is still legally married to the employee remains eligible for coverage.**	• Former Spouse • Dependent Child(ren)	Indefinitely 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.
	• Step-child(ren) of employee or retiree	If enrolled separately, 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 COBRA COVERAGE
Divorce or legal separation from COBRA participant	• 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	• 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 premium. If you become entitled to Medicare while on COBRA, you will not be able to continue your medical coverage after you become eligible for Medicare. You may, however, continue your prescription drug and dental coverage. If you have dependents on your COBRA coverage when you become entitled to Medicare, your dependents may elect to continue their coverage under COBRA.

Other Health Coverage Options

There may be other coverage options for you and your family on a Health Insurance Marketplace (exchange) provided by the state in which you live or the federal government. If you choose coverage from a Marketplace, you may receive a federal tax credit that lowers your monthly premiums. Being eligible for COBRA does not limit your eligibility for a tax credit through a Marketplace. For information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov outside of Maryland or www.marylandhbe.com in Maryland.

Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as your spouse's plan), even if that plan generally does not accept late enrollees, if you request enrollment within 30 days of losing your State coverage.

Coupons and Payments

If you receive COBRA Coverage, premium payment coupons will be mailed to your address on file. If you pay with a personal 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 may pay for coverage online by going to **www.dbm.maryland.gov/benefits**; click on "Pay Your Direct Pay Coupons Here." Your benefits will be effective as of the date noted on your payment coupon cover letter. Payments are due the first of every month; there is a 30-day grace period each month.

Payment may be made in advance to cover any or all coupon(s) received, but must be made in full monthly increments. If payment is not post-marked by the end of the 30-day grace period, your COBRA coverage will be canceled and you will not be permitted to re-enroll.

Payment deadlines are strictly enforced. If you do not receive these coupons within one month of signing your enrollment form, or you change your mailing address, please contact the Employee Benefits Division immediately.

The section entitled General Notice of COBRA and Continuation of Coverage Rights reviews your rights and responsibilities beginning on page 65. It is important for you to review it carefully with all covered dependents. If you have questions about a qualifying status change or continuation of coverage, please contact the Employee Benefits Division.

Domestic partners, domestic partner's children, grandchildren, legal wards, and other child relatives do not have individual COBRA election rights, unless they are considered a qualified tax dependent.

Domestic partners, domestic partner's children, grandchildren, legal wards, and other child relatives may be enrolled under the former employee/ retiree's COBRA elections.

Domestic partners and domestic partner's dependents covered under an active employee's policy should contact 1-800-Medicare or CMS.gov to discuss Medicare enrollment in Parts A, B, & D upon becoming Medicare eligible due to age or disability.

Medicare and Your State Benefits

Medicare Parts A, B and D

Medicare Parts A and B (Hospital and Physician Expenses)

Active employees and or their dependents enrolled in the State Health Benefits Program do not have to sign up for Medicare Parts A and B when you or the enrolled dependents become eligible because of age or disability. The State benefits coverage will continue as primary insurance as long as you are an active employee.

Retirees and/or their dependents enrolled in the State Health Benefits Program must enroll in Medicare Parts A and B to have full medical claims coverage as soon as you and/or your enrolled dependents become eligible for Medicare because of reaching age 65 or due to disability, regardless of your Social Security full retirement age (which may be greater than 65, depending on your birth date). Even if you do not wish to start receiving your Social Security retirement benefit, you must still enroll in Medicare Parts A and B to have full medical claims coverage. Medicare Part A and B becomes your primary insurance and the State health plan automatically becomes secondary-meaning the State medical plans will pay eligible hospital and physician expenses after Medicare pays its portion. Medicare Part A helps pay for hospital care, some skilled nursing facility care, and hospice; Medicare Part B helps pay for physician charges and other medical services. **If you and/or your covered dependents are eligible for, but not enrolled in, Medicare Parts A and B, you will be responsible for the claims that Medicare would have paid**. For information on Medicare enrollment, call the Social Security Administration at 1-800-772-1213.

Employees, retirees, or enrolled dependents eligible for Medicare because of End Stage Renal Disease (ESRD), see the ESRD rules on the next page.

Medicare Part D – Medicare Drug Benefit

How Does This Apply to You?

If you are a retiree and have prescription drug coverage through the State Employee and Retiree Health and Welfare Benefits Program, and are eligible for Medicare due to age or disability you are automatically enrolled in Medicare Part D through the Program's CVS Caremark plan (SilverScript). For the 2024 plan year, the State of Maryland Prescription Drug Plan remains as good as, or better than, the standard Medicare Part D plan. See the Notice of Creditable Coverage in this guide.

Initial, Special, and General Enrollment Periods for Medicare Parts A, B and D

As a retiree enrolled in the State Employee and Retiree Health and Welfare Benefits Program, you must enroll in Medicare Parts A&B when first eligible in order to have full claims coverage. In addition, you may pay a late enrollment penalty for Part B coverage (which will be applied to your monthly premium for as long as you have Part B coverage). A similar penalty may apply under Medicare Part D (prescription coverage) if you do not enroll in either the State's retiree prescription drug coverage or an individual Medicare Part D plan when first eligible.

If your health benefits coverage is under an active employee's policy when you reach age 64, you do not have to enroll in Medicare until you retire, unless your employment or coverage under an active employee's policy will end during your initial enrollment period. See the Special Enrollment Period information table.

Your Initial Enrollment Period for Medicare

You are eligible for Medicare coverage when you reach age 65. Your Initial Enrollment Period is a 7 month period which begins three months before the month you are eligible for Medicare and ends three months after the month you are eligible for Medicare. The timing of when your Medicare eligibility begins depends on the day of the month you become age 65, as follows:

- If you reach age 65 on the 1st day of the month – Medicare eligibility begins the 1st day of the previous month; Example: If your birthday is January 1, you are eligible for Medicare on December 1 of the previous year.
- If you reach age 65 on the 2nd day through the last day of the month – Medicare eligibility begins the 1st day of the month you turn 65; Example: If your birthday is January 2 – 31, you are eligible for Medicare on January 1.

The chart on page 64 shows the schedule for an Initial enrollment Period and a sample schedule for a birth date of April 2nd – 30th.

Medicare Special Enrollment Period

The Medicare Special Enrollment Period is an eight-month period beginning the month your group coverage ends or the month your employment ends, whichever comes first. If you were eligible for Medicare, but didn't enroll because you had health benefits under an active employee's policy, you can enroll during your Special Enrollment Period without paying a monthly penalty for Part B coverage. Special enrollment period rules don't apply if employment or active employee group coverage ends during your initial enrollment period.

Medicare General Enrollment Period

The Medicare General Enrollment Period is a three-month enrollment period for Medicare each year from January 1 through March 31 for Part B coverage to start the first of the month following the month of Medicare Part B enrollment or sign-up. If you were eligible for but did not enroll in Medicare and you did not have health benefits coverage under an active employee's policy, your Part B premium will be penalized 10% for every 12 months you were entitled to Part B coverage but you were not enrolled.

If your Initial Enrollment Period or Special Enrollment Period enrollment falls between January 1 and March 31, you must tell the Social Security Administration representative that you have an initial or special enrollment period. Otherwise, you may be enrolled as a general enrollee, which means your Part B coverage will not start until the first of the month following the month of Medicare Part B enrollment and you may pay a Part B premium penalty.

The Open Enrollment Period for Medicare Part D is October 15th through December 7th.

Disability

If you are certified as being disabled by the Social Security Administration, you will become eligible for Medicare two years (24 months) after your disability determination date. If you are a retiree, you and your covered dependents enrolled in the State's benefits program and eligible for Medicare MUST enroll in Medicare Parts A & B if you are eligible due to disability in order to receive the maximum coverage available. This is the case regardless of your age. **It is your responsibility to notify the Employee Benefits Division of Medicare entitlement due to disability.**

If the Social Security Administration denies your Medicare coverage, you must provide a copy of the Social Security Administration's denial to the Employee Benefits Division. If your Medicare entitlement is due to disability and the Social Security Administration determines that your disability status ends, you must provide the Employee Benefits Division documentation from the Social Security Administration stating when Medicare entitlement ended.

Medicare Due to Disability

If you are entitled to Medicare due to a disability, the same enrollment period rules apply as described above. If you have health benefits coverage under an active employee's policy, you do not have to enroll in Medicare. **However, when your employment or active employee coverage ends, you must apply for Medicare Parts A & B to have the full level of benefits coverage you would otherwise have. Otherwise, you must pay the portion of covered expenses that Medicare would have paid if you were enrolled for Medicare coverage.**

Domestic partners and domestic partner's dependents covered under an active employee's policy should contact 1-800-Medicare or CMS.gov to discuss Medicare enrollment in Parts A, B, & D upon becoming Medicare eligible due to age or disability.

Initial Enrollment Period Schedule		Sample Initial Enrollment Period for Individuals with birth dates between April 2nd and 30th	
MONTH ENROLLED	PART B COVERAGE STARTS	MONTH ENROLLED	PART B COVERAGE STARTS
1st month	1st day of the month you reach age 65*	January	April 1st
2nd month	1st day of the month you reach age 65*	February	April 1st
3rd month	1st day of the month you reach age 65*	March	April 1st
4th month	First day of the month following enrollment	April	May 1st
5th month	First day of the month following enrollment	May	June 1st
6th month	First day of the month following enrollment	June	July 1st
7th month	First day of the month following enrollment	July	August 1st

To find your Initial Enrollment Period, circle the month you turn 65 and the three months before and after.

*If you were born on the first day of the month, move your schedule back one month.

January	February	March	April	May	June	July	August	September	October	November	December

If your employment or your health benefits coverage under an active employee's policy ends during your initial enrollment period, special enrollment period rules do not apply.

Special Enrollment Period Schedule		Sample Initial Enrollment Period for someone retiring on April 1st	
MONTH ENROLLED	PART B COVERAGE STARTS	MONTH ENROLLED	PART B COVERAGE STARTS
1st month	You choose: 1st day of month enrolled or 1st day of following three months	March	March 1st, April 1st, May 1st or June 1st
2nd month	You choose: 1st day of month enrolled or 1st day of following three months	April	April 1st, May 1st, June 1st or July 1st
3rd month	1st day of the month after enrollment	May	June 1st
4th month	1st day of the month after enrollment	June	July 1st
5th month	1st day of the month after enrollment	July	August 1st
6th month	1st day of the month after enrollment	August	September 1st
7th month	1st day of the month after enrollment	September	October 1st
8th month	1st day of the month after enrollment	October	November 1st

General Enrollment Period Schedule	
ENROLLMENT DATE	PART B COVERAGE STARTS
January 1st – March 31st	The first of the month following Medicare enrollment.

About End Stage Renal Disease (ESRD) and Medicare Coverage

If you have ESRD, you may be eligible for coverage under Medicare Parts A and B. If you have ESRD, it is strongly recommended that you read the Centers for Medicare and Medicaid Services publication "Medicare Coverage for Kidney Dialysis and Kidney Transplant Services" before making a decision about whether to enroll in Medicare Part A and/or Part B. This publication is available at your local Social Security office, by calling the Social Security Administration at 1-800-772-1213, or going to **www.medicare.gov/Pubs/pdf/10128-Medicare-Coverage-ESRD.pdf**. The information below about the Coordination of Benefits (COB) for Medicare due to End Stage Renal Disease (ESRD) applies to individuals enrolled in an active employee group only.

According to the Centers for Medicare and Medicaid Services, the information in this section only applies to you if you are eligible for Medicare because of ESRD, not based on your age or disability.

During the 30-Month Coordination of Benefits (COB) Period

If you become eligible for Medicare because of ESRD, there is a 30-month COB period (determined by Social Security) during which your active State health coverage is primary (which means it pays benefits first, before Medicare), regardless of whether or not you are enrolled in Medicare Part A and/or Part B. Do not change your coverage level in the State health plan to a Medicare coverage level during your 30-month COB period.

After the 30-Month Coordination of Benefits (COB) Period

NOTE: If you are enrolled in a medical plan under the State's Program and you are covered as a participant in an active employee group, you are not required to enroll in Medicare. However, if you choose to enroll in Medicare Part A only, or in Parts A and Part B because you are eligible for Medicare coverage due to ESRD (determined by Social Security), your claims will be processed according to the Coordination of Benefits (COB) regulations described below.

Medicare Coverage After a Successful Kidney Transplant

If you were eligible for Medicare because of ESRD and have a successful kidney transplant, Medicare will no longer be your primary insurer starting three years after the transplant. If Medicare eligibility ends, you should contact the Social Security Administration to confirm that Medicare Part A and Part B have been canceled. If you are enrolled in a State medical plan with a Medicare coverage level and you receive a Medicare cancellation letter from the Social Security Administration, please contact the Employees Benefits Division (EBD) immediately or EBD will automatically change you to a non-Medicare coverage level based on the information provided by the medical plans, whichever comes first.

The following link is for the Social Security publication "Medicare Coverage of Kidney Dialysis and Kidney Transplant Services": **www.medicare.gov/Pubs/pdf/10128-Medicare-Coverage-ESRD.pdf**.

Important Notice From the State of Maryland About Prescription Drug Coverage and Medicare

PART D NOTICE OF CREDITABLE COVERAGE

Please read this notice carefully and keep it where you can find it. This notice applies to all State of Maryland employees, retirees, and dependents that are entitled to Medicare and are enrolled in the current prescription drug plan through the State Employee and Retiree Health Benefits Program ("The Program") and has information about our Program's prescription drug coverage. It also explains the options you have under Medicare Part D prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

IMPORTANT POINTS TO REMEMBER

Medicare prescription drug coverage ("Medicare Part D") is available to everyone with Medicare if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

- The prescription drug plan is not available to retirees and/or dependents who reside or have an address listed outside of the United States.
- The State of Maryland has determined that the prescription drug coverage offered through our Program is creditable coverage. Creditable coverage means that, on average for all plan participants, our Program is expected to pay out as much or more than the standard Medicare Part D prescription drug coverage will pay. It also means that if you keep our Program's coverage and do not enroll in a Medicare prescription drug plan now, you will not pay extra if you later decide to enroll in a Medicare prescription drug plan, so long as you do not have a break in coverage of 63 or more continuous days.
- If you go 63 or more continuous days without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.
- Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from October 15th through December 7th. In addition, if you cancel or lose coverage with our Program, you may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the Medicare prescription drug plans in your area. Remember, our Program will only cover eligible dependents in a plan in which you are enrolled as well.

- If you decide to enroll in a Medicare prescription drug plan and drop your prescription drug coverage through our Program, you may not be able to get our Program coverage back until our next Open Enrollment period or when you cancel or lose your Medicare prescription drug coverage. If you lose or cancel Medicare Part D prescription drug coverage, you may be able to re-enroll in our Program before the next annual Open Enrollment period if you request re-enrollment with the Employee Benefits Division within 60 days and you have had a change in circumstances that permits a mid-year change in enrollment. See the annual Benefits Guide section entitled "Qualifying Status Changes" on page 50

for more information. **If you drop our Program coverage for prescription drug benefits, your dependent(s) will also lose coverage under our Program's prescription drug plan**.

If you cancel your coverage under our Program's prescription drug plan, you are still eligible for enrollment in our Program's other types of coverage, such as health and dental plans. Prescription coverage is elected separately from these other coverages.

- Keep this notice with your important papers. If you enroll in one of the Part D plans approved by Medicare that offer prescription drug coverage, you may need to give a copy of this notice when you join to show that you are not required to pay a higher premium amount.

For more information about this notice or your current prescription drug coverage, contact the Employee Benefits Division at 410-767-4775 or 1-800-307-8283. More information can also be found by visiting **www.dbm.maryland.gov/benefits**. NOTE: A copy of this Notice will appear in our Program's annual Open Enrollment guide each year. You also may request a paper copy at any time.

For more information about your options under Medicare prescription drug coverage:

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. If you are enrolled in Medicare, you will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug plans:

- Visit **www.medicare.gov**;
- Call your State Health Insurance Assistance Program (see your copy of the "Medicare & You" handbook or visit www.mdoa.state.md.us for the telephone number of the local office in your area); or
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit the SSA online at **www.socialsecurity.gov**, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in one of the prescription drug plans approved by Medicare, you may be required to provide a copy of this notice when you join, to determine whether or not you are required to pay a higher premium amount.

If you are eligible for Medicare prescription drug coverage, you have the right to:

- Keep our Program's coverage and not enroll in a Medicare prescription drug plan; or
- Enroll in a Medicare prescription drug plan and drop our Program's coverage.

Important Notices & Information

This guide contains several very important Notices for you and your dependents 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.

Employee Fraud and Abuse

Fraud, abuse and unethical conduct in connection with the benefits provided through the State Employee and Retiree Health and Welfare Benefits Program is a serious issue. Fraud and abuse can take many forms, including the following:

- Adding a dependent to your coverage who you know is not eligible for coverage;
- Submitting false or altered affidavits or documentation as part of adding or removing a dependent;
- Letting someone else who is not covered under your enrollment use your insurance card to get health benefits or services;
- Lying to get coverage or access to health benefits (such as prescription drugs or treatments) that are not medically necessary;
- Giving or selling your prescriptions to another person; or
- Submitting reimbursement requests for health benefits or services that were not provided.

The Department of Budget and Management Employee Benefits Division must investigate allegations of fraud and abuse; each plan and benefit option has programs to look for and eliminate fraud and abuse. If fraud or abuse is determined to have taken place, there can be serious consequences, including:

- Lock-down of your prescription benefits to only one doctor or pharmacy;
- Termination of coverage; and/or
- Seeking repayment or reimbursement of any claims or premiums for benefits that were inappropriately paid.

There may also be serious criminal or civil consequences.

Notice About Disclosure and Use of Your Social Security Number

A federal mandatory reporting law (Section 111 of Public Law 110-173) requires group health plans to report, as directed by the Secretary of the Department of Health and Human Services, information that the Secretary requires for purposes of coordination of benefits. Two key elements that will be required to be reported are Social Security numbers (SSNs) of covered individuals or Health Insurance Claim Number (HICNs) and the plan sponsor's employer identification number (EIN). For Medicare to coordinate Medicare payments properly with other insurance and/or workers' compensation benefits, Medicare relies on the collection of both the SSN or HICN and the EIN, as applicable. As an employee/retiree (or family member of an employee/retiree) covered by a group health plan arrangement, your SSN and/or HICN will likely be requested to meet the requirements of this law. For more information about the mandatory reporting requirements under this law, visit the CMS website at **https://www.cms.gov/Medicare/Medicare.html**. 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.

How We Calculate Hours

Under the Affordable Care Act (ACA), the Program is required to offer affordable health insurance coverage meeting minimum value to all full-time employees and dependents to avoid being penalized by the Internal Revenue Service (IRS). Each employer is required to establish a measurement period used to identify full-time employees for purposes of offering health insurance coverage. The Program's measurement period is from October 15 to October 14 of each year. The Program uses the "look-back" measurement method to determine employee's hours of service during the measurement period to determine his or her full-time status for a future period (the stability period). The stability period begins with the start of the next plan year which is January 1 of each year. The Program will offer a special limited enrollment period during the annual open enrollment, which is known as the administrative period. This allows each employee who is newly qualified as a full-time employee during the measurement period to elect or decline health insurance coverage for the stability period.

General Notice of Continuation of Coverage (COBRA) Rights

The Employee Benefits Division may process an enrollment for you as the employee/retiree, spouse, or covered dependent in the State Employee and Retiree Health and Welfare Benefits Program (the Program). If so, this notice on possible future group health insurance continuation coverage rights applies individually to you, your spouse and all covered dependent children enrolled under the Program. It is important that you and all enrolled individuals take the time to read this notice carefully and become familiar with its contents. If you are the employee, and if there is a covered dependent whose legal residence is not yours, please provide written notification of that covered dependent's address to the Employee Benefits Division so a notice can be sent to that covered dependent as well.

The Department of Budget and Management Employee Benefits Division administers the Program. The Program sponsored by the State of Maryland is a governmental group health plan covered by the Public Health Service Act, which includes the COBRA continuation of coverage provisions described in this Notice. This Notice explains continuation coverage rights only for these health benefits offered through the Program: the medical PPO, the medical IHM, the medical EPO, the prescription drug plan, the dental PPO, the dental HMO and the Healthcare Flexible Spending Account. You may be enrolled in one or more of these benefits. This Notice does not apply to any other benefits offered by the State of Maryland or through the Program, such as the Dependent Daycare Flexible Spending Account, life insurance benefit, or accidental death and dismemberment insurance benefit. For SLEOLA participants your medical plans are separate and are limited to PPO, POS and EPO.

Under federal law, group health plans like the Program must offer covered employees and covered family members the opportunity for a temporary extension of health coverage (called COBRA) at group premiums when coverage under the health plan would otherwise end due to certain qualifying status changes. In this Notice, the term "covered employee" also means "covered retiree." This Notice is intended to inform all plan participants of potential future options and obligations related to COBRA. Should an actual qualifying status change occur in the future, the State of Maryland would send you additional information and the appropriate election notice at that time. Please take special note, however, of your notification obligations, highlighted in this Notice.

Other Coverage Options

There may be other coverage options for you and your family through the Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower your out-of-pocket costs. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. For information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov. For information on the Marketplace for Maryland residents visit **www.marylandhbe.com**.

Who is Entitled to Elect COBRA Continuation Coverage?

Qualifying Status Changes For Covered Employee

If you are the covered employee, you may have the right to elect COBRA coverage if you lose group health coverage because of the following qualifying status changes:

- Termination of your employment (for reasons other than gross misconduct);
- Resignation;
- Layoff; or
- A reduction in your hours of employment.

Qualifying Status changes For Covered Spouse

If you are the covered spouse of an employee, you may have the right to elect COBRA coverage for yourself if you lose group health coverage under the Program because of any of the following qualifying status changes:

- A termination of your spouse's employment, including resignation and layoff, (for reasons other than gross misconduct);
- A reduction in your spouse's hours of employment;
- The death of your spouse; and
- Divorce from your spouse.

If your spouse (the employee or retiree) reduces or eliminates your group health coverage in anticipation of your divorce and your divorce happens soon after that, then the divorce may be considered a qualifying status change for you even though you lost coverage earlier than the date of the divorce. The rules of the Program do not require you to lose coverage if you and your spouse are legally separated but are still legally married to the employee or retiree.

Qualifying Status Changes for Covered Dependent Children

If you are the covered dependent child of an employee, you may have the right to elect COBRA coverage for yourself if you lose group health coverage under the Program because of any of the following qualifying status changes:

- A termination of the employee's employment (for reasons other than gross misconduct);
- A reduction in the employee's hours of employment;
- The death of the employee;
- Parent's divorce or, if applicable, legal separation;
- You cease to be a "dependent child" under the terms of the Program.

Please contact the Employee Benefits Division regarding the special rule for newly born or adopted children.

When is COBRA or Continuation of Coverage available?

Coverage starts from the day you lose coverage due to a qualifying status change – usually the end of the month in which the qualifying status change occurred. When the qualifying status change is the end of employment, reduction of employment hours or death of the employee, the Program will offer this coverage to qualified beneficiaries. Qualified beneficiaries are the employee, the spouse and the dependent children who lost group health coverage as a result of the qualifying status change. You will not need to notify the Employee Benefits Division of any of these three qualifying status changes because your employing agency should notify the Employee Benefits Division of these events. You will need to notify the Employee Benefits Division of any other qualifying status change.

Important: Notifications Required By the Employee, Spouse and Dependent

For the other qualifying status changes (divorce, and a covered dependent ceasing to meet the definition of a "dependent" under the Program's rules), you must notify the Employee Benefits Division within 60 days after the later of: (1) the date of the event or (2) the date on which health plan coverage would be lost under the terms of the Program because of the qualifying status change. If you do not notify the Employee Benefits Division of the qualifying status change within 60 days after the change, you will lose the right to elect COBRA or Continuation of Coverage. Under federal law, this is the responsibility of all employees, spouses and covered dependent children (or the parent of covered dependent children).

To provide the required notification, you must contact the Employee Benefits Division and request that a Direct Pay Enrollment form be mailed to you. Complete the form, attach documentation of the qualifying status change (e.g., copy of divorce decree), and mail the form and documentation to Employee Benefits Division, 301 West Preston Street, Room 510, Baltimore, Maryland 21201.

If this notification is not completed according to these procedures and within the required 63-day notification period, rights to continuation coverage will be forfeited. Read the dependent eligibility rules contained in this benefit guide carefully so you and all covered enrollees are familiar with when a dependent is no longer a dependent under the terms of the plan. The Direct Pay Enrollment form is also available at **www.dbm.maryland.gov/benefits**.

How much does COBRA coverage cost?

You or a qualified beneficiary covered under COBRA must pay the entire applicable premium plus a 2% administration charge for continuation coverage. The State of Maryland does not subsidize COBRA coverage. These premiums will be adjusted during the continuation period if the applicable premium amount changes. In addition, if continuation coverage is extended from 18 months to 29 months due to Social Security disability, the State of Maryland can charge up to 150% of the applicable premium during the extended coverage period for the disabled beneficiary. Qualified beneficiaries are required to pay on a monthly basis. Premiums are due on the first day of every month. There will be a maximum grace period of thirty days for regularly scheduled monthly premiums.

How Do I Elect COBRA or Continuation of Coverage?

Each qualified beneficiary will have an independent right to elect COBRA or Continuation of Coverage; parents may elect COBRA coverage on behalf of minor children who were covered dependents.
The Employee Benefits Division will send you an Election Notice outlining your rights to COBRA or Continuation of Coverage after it receives notification of a qualifying status change from you or your agency. Each qualified beneficiary has the right to elect COBRA or Continuation of Coverage in the group health benefits the qualified beneficiary had on the last day of coverage in the Program, but must do so within 63 days of receiving the notice.

How long does COBRA or Continuation of Coverage last?

COBRA coverage is a temporary continuation of coverage. Depending on the nature of the qualifying status change that caused the loss of coverage, COBRA coverage may last a maximum of 18 months or 36 months, except in the case of COBRA continuation coverage in a healthcare flexible spending account. If you are participating in a healthcare flexible spending account at the time of the qualifying status change, you will only be allowed to continue the healthcare flexible spending account on a post-tax basis until the end of the current plan year in which the qualifying status change occurs. See below for a description of how COBRA continuation coverage may end earlier than these maximum periods if your account has a positive balance at the time of termination.

Length of Continuation Coverage – 18 Months

If the event causing the loss of coverage is a termination of employment (other than for reasons of gross misconduct), resignation, layoff or a reduction in work hours, each qualified beneficiary will have the opportunity to continue coverage for 18 months from the date of the qualifying status change. This 18-month coverage period may be extended only in limited situations: (1) when the qualified beneficiary receives a Social Security disability determination, (2) when a second qualifying status change occurs during COBRA continuation coverage, and (3) when the employee became eligible for Medicare within 18 months before the termination of employment or reduction in hours (see below for explanation). You must notify the Employee Benefits Division in writing within 60 days after these events to be eligible for an extension of the maximum coverage period. If you do not do so, you cannot extend your coverage period.

Social Security Disability

The 18 months of continuation coverage can be extended an additional 11 months, to a maximum of 29 months, for all qualified beneficiaries if the Social Security Administration determines a qualified beneficiary was disabled according to Title II or XVI of the Social Security Act on the date of the qualifying status change or at any time during the first 60 days of coverage. The disability must last during the entire 18 months of continuation coverage. It is the qualified beneficiary's responsibility to obtain this disability determination from the Social Security Administration and provide a copy of the determination to the Employee Benefits Division within 60 days of the later of: (1) the date of the determination, (2) the date of the termination of employment or reduction in hours, or (3) the date the original 18-month coverage period expires. This notice must be provided no later than the date the original 18-month coverage period expires. If you do not notify the Employee Benefits Division in writing within this timeframe, you may lose the ability to extend this coverage.

This extension applies separately to each qualified beneficiary. If the disabled qualified beneficiary chooses not to continue coverage, all other qualified beneficiaries are still eligible for the extension. If coverage is extended, and the disabled qualified beneficiary has elected the extension, the applicable premium is 150% of the premium. If only the non-disabled qualified beneficiaries extend coverage, the premium will remain at 102%. It is also the qualified beneficiary's responsibility to notify the Employee Benefits Division within 30 days if a final determination has been made that they are no longer disabled.

Secondary Qualifying Status Changes

Extension of the 18- or 29-month continuation period could occur, if during the 18 or 29 months of continuation coverage, a second event takes place (divorce, legal separation, death, or a dependent child ceasing to be a dependent) that would have caused the qualifying beneficiary to lose coverage under the Program if the first qualifying status change (termination of employment or reduction of hours) had not occurred. If a second event occurs, the original 18 or 29 months of continuation coverage can be extended to 36 months from the date of the original qualifying status change date for eligible dependent qualified beneficiaries. If a second event occurs, it is the qualified beneficiary's responsibility to notify the Employee Benefits Division in writing within 60 days after the second event and within the original 18- or 29-month continuation period. In no event, however, will continuation coverage last beyond 36 months from the date of the first qualifying status change that originally made the qualified beneficiary eligible for continuation coverage. A reduction in hours followed by a termination of employment is not a second qualifying status change.

Length of Continuation Coverage - 36 Months

If the original event causing the loss of coverage was the death of the employee (or a dependent child ceasing to be a dependent child), each qualified beneficiary of the employee will have the opportunity to continue coverage for 36 months from the date of the qualifying status change. When the employee had become entitled to Medicare benefits less than 18 months before the termination of employment or reduction in work hours, the covered spouse and covered dependent qualifying beneficiaries may be entitled to continued coverage for up to 36 months. This extension does not apply to the employee, who will only have a maximum of 18 months of COBRA coverage unless a secondary qualifying status change occurs. The 36-month coverage period cannot be extended.

Length of Continuation Coverage – Indefinitely

If the original event causing the loss of group health coverage was your divorce, the qualified beneficiary will have the opportunity to continue coverage indefinitely under Maryland law. This indefinite period of coverage will end when any of the following non-exhaustive list of events happens: (1) Program coverage for the employee terminates, (2) the qualified beneficiary obtains coverage elsewhere (including Medicare), or (3) the qualified beneficiary spouse remarries.

This indefinite period of continuation coverage is a result of a Maryland state law that is similar to COBRA and does not apply to healthcare flexible spending arrangements. However, the dependent child qualified beneficiary will also lose coverage when the child does not meet Program eligibility requirements under standard COBRA rules.

Former stepchildren of the covered employee do not gain access to indefinite continuation coverage under these provisions of Maryland law.

Notification of Address Change

To ensure you and your eligible dependents receive information properly and on time, you must notify the State of Maryland Employee Benefits Division of any address change as soon as possible. The Employee Benefits Division must have your current address at all times. A Personal Information Change form is available at **www.dbm.maryland.gov/benefits**; click on Forms. Instructions for completing and filing the form are at the bottom of the form. If you don't follow the instructions on the form, your notifications may be delayed and you may lose your opportunity for benefit coverage continuation.

If You Have Questions

This Notice is simply to inform you of your responsibility to notify the Employee Benefits Division if you have a qualifying status change that allows you to continue your coverage beyond the date it would otherwise end. If you have a qualifying status change and you are eligible for coverage continuation, you will be notified of your rights at that time as part of the COBRA Election Notice. If you or any covered individual does not understand any part of this summary notice or has questions about this information or your obligations, please contact the State of Maryland Employee Benefits Division at 410-767-4775. More information about COBRA continuation coverage is available at **www.dbm.maryland.gov/benefits**. The Program name and address is:

The State of Maryland Employee and Retiree Health and Welfare Benefits Program
c/o Employee Benefits Division
301 West Preston Street, Room 510
Baltimore, Maryland 21201.

Health Insurance Portability and Accountability Act (HIPAA)

Certificates of Coverage and the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

If you or your dependents obtain new employment, you may request a certificate of coverage from the State, which describes the length and types of benefits coverage (e.g., medical, dental, etc.) you and your dependents had under the State Program. You may request a HIPAA Certificate of Coverage by writing to the Department of Budget and Management (DBM), Employee Benefits Division, at the address on the inside front cover of this guide.

Notice of Privacy Practices and HIPAA Authorization Form

The State conforms to Federal HIPAA and State regulations regarding the privacy of your health information. The Notice of Privacy Practices describes the privacy practices of the State Employee and Retiree Health and Welfare Benefits Program.

HIPAA and State regulations require your written authorization to disclose certain health information to other people. If your written authorization is needed, you may use the HIPAA authorization form to provide the needed authorization. This form is located on our website, www.dbm.maryland.gov/benefits; click on Forms. Assigned HIPAA authorizations remain in effect unless you change or revoke the authorization.

Notice of Privacy Practices – The State Employee and Retiree Health And Welfare Benefits Program

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. PLEASE ALSO CAREFULLY REVIEW ANY SEPARATE NOTICE OF PRIVACY PRACTICES MAINTAINED BY DEPARTMENT OF BUDGET & MANAGEMENT.

Under Federal and State law, DBM administers the State Employee and Retiree Health and Welfare Benefits Program (the Program) and protects the privacy of your protected health information. DBM takes steps to ensure that your protected health information is kept secure and confidential and is used only when necessary to administer the Program. DBM is required to give you this notice to tell you how DBM and your Healthcare Flexible Spending Account (HCFSA) Administrator may use and give out ("disclose") your protected health information held by DBM and your HCFSA. This information generally comes to DBM when you enroll in the Program, from your plan administrator as part of administration of the health plan, and to your HCFSA when you submit requests for reimbursement. DBM and the HCFSA abide by the terms of this Notice. Your health plan in the Program (for example, the CareFirst BlueCross BlueShield PPO) will also protect, use, and disclose your personal health information. For questions about your health information held by your health plan, please contact your health plan directly. The plans in the Program all follow the same general rules that DBM and the HCFSA follow to protect, use, and disclose your protected health information. Each plan will use and disclose your protected health information for payment purposes, for treatment purposes, and for administration purposes. DBM has the right to use and disclose your protected health information to administer the Program. For example, DBM will use and disclose your protected health information:

- To communicate with your Program health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue. DBM may need written authorization from you for your health plan to discuss your case.

- To determine your eligibility for benefits and to administer your enrollment in your chosen health plan.
- For payment related purposes, such as to pay claims for services provided to you by doctors, hospitals, pharmacies, and others for services delivered to you that are covered by your health plan, to coordinate your benefits with other benefit plans (including Workers' Compensation plans or Medicare) to reimburse you from your HCFSA, or to make premium payments.
- To collect payment from you when necessary, such as copayments, premiums or other contributions.
- For treatment related purposes, such as to review, make a decision about, or litigate any disputed or denied claims.
- For healthcare operations, such as to conduct audits of your health plan's quality and claims payments, to procure health benefits offered through this Program, to set premiums, and to investigate potential fraudulent claims. However, note that federal law prohibits the use and disclosure of genetic information about an individual, including for underwriting purposes. The group health plan benefits options and the HCFSA offered through the Program do not use genetic information for underwriting (or for any other) purposes.

DBM and/or your HCFSA will also use and disclose your protected health information:

- To you or someone who has the legal right to act for you (your personal representative). To authorize someone other than you to discuss your protected health information, please contact DBM to complete an authorization form.
- To law enforcement officials when investigating and/or processing alleged or ongoing civil or criminal actions.
- Where required by law, such as to the Secretary of the U.S. Department of Health and Human Services, to the Office of Legislative Audits, or in response to a subpoena.
- For healthcare oversight activities (such as mandatory reporting, and fraud and abuse investigations).
- To avoid a serious and imminent threat to health or safety.

DBM must have written permission (an "authorization") from you, or your dependents over the age of 18 years, to use or give out your protected health information to other persons or organizations. You may revoke an authorization at any time by written notice.

DBM and your HCFSA do not use your protected health information for fundraising or marketing purposes. DBM and your HCFSA are prohibited from selling your protected health information. However, we can request payment for treatment or coverage provided to you, for services provided in connection with the health plan (such as processing claims), and for copying costs when you ask for copies of records we have containing your information.

By law, you have rights related to protected health information about you. These include your rights to:

- Make a written request and see or get a copy of your protected health information held by DBM, the HCFSA, or a plan in the Program. If DBM or your HCFSA use Electronic Health Records ("EHR"), you can ask for a copy of that EHR. We do not use EHRs currently.
- Amend any of your protected health information created by DBM or the HCFSA if you believe it is wrong or if information is missing, and DBM agrees. If DBM or the HCFSA disagrees, you may have a statement of your disagreement added to your protected health information.
- Ask in writing for a listing of those receiving your protected health information from DBM or your HCFSA for up to six years prior to your request. The listing will not cover your protected health information that was used or disclosed for treatment, healthcare operations or payment purposes, given to you or your personal representative, disclosed pursuant to an authorization. If DBM or your

HCFSA begins to use EHRs, you could ask for a copy of EHR disclosures over the most recent three years for healthcare operations, treatment, and payment purposes as well.

- Ask DBM or your HCFSA in writing to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address) if using your address on file creates a danger to you.
- Ask DBM or your HCFSA in writing to limit how your protected health information is used or given out. However, DBM or your HCFSA may not be able to agree to your request if the information is used for treatment, payment, or to conduct operations in the manner described above, or if a disclosure is required by law. If you wish to exercise these rights in connection with the Program or a health plan, you may contact DBM at the address below.
- Get a separate paper copy of this notice. If you wish to exercise any of these rights in connection with your HCFSA, you can contact the FSA Administrator at the address listed on the inside front cover or you can contact DBM for assistance. You may also contact your dental plan, prescription plan, medical PPO, medical POS, or medical EPO directly.

DBM cannot disclose protected health information to an employer for employment-related actions or personnel transactions without authorization.

For more information on exercising your rights in this notice, visit the DBM website: **www.dbm.maryland.gov/benefits**. You may also call 410-767-4775 or 1-800-30-STATE (1-800-307-8283) and ask for DBM's HIPAA Privacy Official. If you believe DBM has violated your privacy rights, you may submit a written complaint with DBM at the following address:

Department of Budget and Management
Employee Benefits Division
301 West Preston Street
Room 510
Baltimore, MD 21201
ATTN: HIPAA Privacy Officer

Filing a complaint will not affect your benefits under the HIPAA. You also may submit a complaint with the Secretary of the U.S. Department of Health and Human Services at:

Department of Health and Human Services
Office of Civil Rights
150 South Independence Mall West, Suite 372
Public Ledger Building
Philadelphia, PA 19106-9111

Newborns' and Mothers' Health Protection Act Of 1996

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse, midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other healthcare provider obtain authorization for prescribing a length of stay up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information, contact your plan administrator.

Notice of Women's Health & Cancer Rights Act Of 1998

As required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, the group health plan benefits options offered here provide coverage for:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter. Contact your plan administrator, the State of Maryland Employee Benefits Division, for more information.

Genetic Information Nondiscrimination Act Of 2008

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to any request for medical information.

"Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party- liability/childrens-health-insurance-program-reauthorization- act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid- a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com

MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and- families/health-care/health-care-programs/programs-and- services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs- services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP- Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium- assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium- assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

Benefits Appeal Process

Important Information about Your Health Benefits Claims Review and Appeal Rights

Internal Appeals: If a healthcare claim you will be incurring or have incurred is 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, experimental or investigational, you 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 of the type of claim denial noted above, 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 the Maryland Insurance Administration (MIA):

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:

Employee Benefits Division Attn: Adverse Determinations 301 West Preston Street, Room 510 Baltimore, MD 21201	Telephone: (410) 767-4775 Toll-free: 1-800-307-8283 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 insurance carrier at the phone number listed on the back of your insurance identification card.

Assistance resources: For questions about your rights or for assistance in filing an appeal, you can contact the 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/HEAU.htm
heau@oag.state.md.us

OR

Employee Benefits Security Administration 1-866-444-3272

Nondiscrimination and Accessibility Requirements Notice

The State Employee and Retiree Health and Welfare Benefits Program (the Program) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex in its activities or the health plans that are offered.[1] The Program does not exclude or treat people differently because of race, color, national origin, age, disability or sex.

The Program provides free aids and services to people with disabilities to enable them to communicate effectively with us, such as qualified sign language interpreters and written information in other format and provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Employee Benefit Division's Compliance Officer (see below).

If you believe that the Program has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex in its activities or the health plans that are offered, you can file a complaint with the Compliance Officer . You can file a complaint in person or by mail, fax, or email. If you need help filing a complaint, the Compliance Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, room 509F, HHH Building, Washington, D.C. 20201. 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at **https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html**.

Compliance Officer:

Compliance Officer
Employee Benefits Division
301 West Preston Street – Room 510
Baltimore, MD 21201
Phone: 410.767.4775
Fax: 410.333.7104
compliance.ebd@maryland.gov

Interpreter Services Are Available for Free

Help is available in your language: 1-800-307-8283 (TTY: 711). These services are available for free.

Definitions

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

Balance Billing: When an out-of-network provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. This amount is not counted toward your out-of-pocket maximum. An in-network provider is not permitted to balance bill you for covered services.

Cafeteria Plans: Plans under Section 125 of the Internal Revenue Code that allow employees to choose from a menu of one or more qualified benefits and to pay for those qualified benefits on a pre-tax basis.

CHIP: Children's Health Insurance Program. Your state may have a premium assistance program to help pay for coverage, if you are eligible for assistance.

CMS: Centers for Medicare and Medicaid Services. The agency of the U.S. Department of Health and Human Services that is responsible for administering the Medicare and Medicaid programs.

COB (Coordination of Benefits): If an employee, retiree, or eligible dependents are covered under more than one insurance plan, the insurance plan of the person with the earlier birthday in the calendar year is primary and the other plan is secondary. The employee's or retiree's primary coverage will pay its benefits first, without regard to other coverage.

COBRA (The Consolidated Omnibus Budget Reconciliation Act of 1985): This law amended by ERISA, the PHSA, and the tax code requires employers to offer the option of purchasing continuation coverage to qualified beneficiaries who would otherwise lose group health insurance coverage as the result of a qualifying status change. The federal statute that applies to the State of Maryland Health plans is the Public Health Service Act (PHSA).

Coinsurance: The percentage of the cost you and the plan pay for a covered expense. Coinsurance is different for services received from in-network providers and out-of-network providers.

Copayment: The fixed dollar amount an employee, retiree, or covered dependent pays at the time service is rendered. This money goes directly to the healthcare provider. Copayments differ for each type of service.

Creditable Service: Service credit used for calculating the amount of a benefit, and credit used to determine when a member qualifies to receive a benefit. Consists of earned, purchased, or claimed credit.

Deductible: The amount an employee or retiree is required to pay before your medical plan pays benefits for out-of-network care.

Deferred Retirement: Retirement option when employee elects to receive benefit after the last day on payroll 60 day window.

DHMO (Dental Health Maintenance Organization): A dental plan that operates in a way similar to a medical HMO but provides dental services. Participants can use only those designated dental providers approved by and registered with the DHMO.

Direct Retirement: Retirement option when within 60 days of the last day on payroll an employee/retiree claims/receives retirement benefits.

DPPO (Dental Preferred Provider Organization): A dental plan that operates in a way similar to a medical PPO. You have the option to go in or out-of the network. You do not need to designate a primary dentist or get referrals to see a specialist. Your costs are lower if you remain in-network.

Emergency Services or Medical Emergency: Healthcare services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in the following:

- placing the patient's health in jeopardy;
- serious impairment of bodily functions; or
- serious dysfunction of any bodily organ or part.

EPO (Exclusive Provider Organization): An EPO is a type of managed care medical plan. The EPO contracts with providers from a specific network from which members must choose. Benefits for EPO members are provided only if a member sees a network EPO provider (except for emergency care).

ESRD (End Stage Renal Disease): A medical condition of the kidneys and renal system when the kidneys do not work well enough to function without dialysis or a transplant. This kind of kidney failure is permanent; it cannot be fixed.

Flexible Spending Account (FSA): A benefit option that allows employees to contribute tax-free money from their pay to an account that can be used for reimbursement of eligible healthcare and/or dependent daycare expenses. These arrangements are regulated by federal tax law.

FMLA (Family and Medical Leave Act of 1993): A type of Leave of Absence governed by Federal and State statutes under which an employee may take a leave of absence due to his/her medical condition, a family member's medical condition, or his/her active military duty.

HIPAA (Health Insurance Portability and Accountability Act of 1996): A federal law that calls for among other aspects certain confidentiality standards and requires employers to provide certificates of coverage for former employees and their eligible dependents to minimize preexisting condition exclusions by the former employee's next employer.

IHM: An Integrated Health Management plan is one in which all of your care is managed by your primary care physician generally in a regional network of providers.

In-Network Service: Service provided by a participating provider, Primary Care Physician or other provider approved by the plan.

LWOP (Leave of Absence Without Pay): An employer-approved period of leave during which the employee is not paid but continues to be a State employee. Any approved leave of absence of two pay periods or less is considered a short-term LAW. Any approved leave of absence more than two pay periods is considered a long-term LAW.

Medicare: A federal health insurance program administered by the Social Security Administration for disabled individuals and those age 65 or older. Eligible Medicare participants must enroll in Parts A & B; the State healthcare plan is often the secondary payer and will not cover healthcare expenses covered by Medicare. The optional Medicare Part D program covers prescription drugs.

Network: A group of providers that contract with an insurance carrier to provide healthcare services and treatment to individuals at reduced, fixed fees.

Open Enrollment Period: An annual period during which employees and retirees may enroll for benefits coverage or change their benefits coverage.

ORP (Optional Retirement Program): The ORP is a defined contribution plan open only to eligible faculty and administrators of Maryland public institutions of higher education.

Out-of-Network Service: Service received from providers outside of the plan's network. Such services are subject to deductibles and coinsurance.

Out-of-Pocket Maximum: The most a covered individual or family will pay out of his or her pocket in deductible and coinsurance charges in a plan year. Copayments have a separate out-of-pocket maximum.

Preauthorization: A decision by your health insurer or plan that a healthcare service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

PPO (Preferred Provider Organization): A health plan that offers the flexibility to choose a doctor or hospital with no referrals in or out-of-network. Members will pay a lower cost by remaining in-network.

Premium: The amount of money an employee or retiree pays for insurance coverage. Premium does not include additional copayments or deductibles incurred for treatment.

Primary Care Provider (PCP): A General Practitioner, Nurse Practitioner, Family Practice, Internal Medicine, Pediatrician, OB-GYN, or Physician Assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of healthcare services.

Provider: Any approved healthcare professional who provides treatment or services.

Qualified Medical Child Support Order (QMCSO): A court order that requires a parent to provide healthcare coverage for dependent children.

Qualifying Status Change: An event such as marriage, divorce, or the birth of a child, that allows a change in healthcare coverage outside of the Open Enrollment period. Refer to page 50 for a complete list.

Retroactive Adjustment: The process of paying back premiums owed back to the effective date of the qualifying status change. (Applicable to active employees and retirees only).

State Subsidy: The portion of the insurance premium(s) paid by the State for eligible employees and retirees enrolled in Health Benefits.

Urgent Care: Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.