

SLEOLA Medical Benefits
for
July 1, 2012 to June 30, 2013

Aetna			
Benefit	POS In-Network	POS Out-of-Network	EPO In-Network
Plan Year Deductible			
Individual	None	\$250	None
Family	None	\$500	None
Out-of-Pocket Coinsurance Maximum			
Individual	None	\$3,000	None
Family	None	\$6,000	None
Lifetime Maximum	Unlimited		
National Network	Yes	Yes	Yes
Primary Care Physician Required	No	No	Yes
COMMON AND PREVENTIVE SERVICES			
Primary Care Physician's (PCP) Office Visit	\$15 copay	80% of allowed benefit after deductible	\$15 copay
Specialist Office Visit	\$25 copay	80% of allowed benefit after deductible	\$25 copay
Adult Physical Exams & Associated Lab Work	100% of allowed benefit	Not covered	100% of allowed benefit
One exam per plan year for all members and their dependents age 22 and older.			
Well Baby/Child Visits	100% of allowed benefit	Not covered	100% of allowed benefit
Birth through 36 months - up to 12 visits total; 3 through 21 years - 1 annual visit per plan year			
Contact Aetna for further details on eligibility for visits.			
Immunizations* and Vaccines covered	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Contact Aetna for a detailed list.			
Routine Annual GYN Exam (including Pap test)	100% of allowed benefit after deductible	80% of allowed benefit after deductible	100% of allowed benefit
Mammography **	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Hearing Examinations & Hearing Aids (No exam copay for children when part of well-child visit.)	\$15 copay (PCP) or \$25 copay (Specialists) for exam for adults	Not covered, except for hearing aids as mandated for minor children	\$15 copay (PCP) or \$25 copay (Specialists) for exam for adults
	100% of allowed benefit for Basic Model Hearing Aid		100% of allowed benefit for Basic Model Hearing Aid
	1 exam and hearing aid per ear every 3 years for each employee/retiree and dependent		1 exam and hearing aid per ear every 3 years for each employee/retiree and dependent
	Includes benefit for hearing aids for minor children (ages 0-18) as mandated by Maryland law effective 1/1/02.		
Allergy Testing	\$15 copay (PCP) or \$25 copay (Specialists)	80% of allowed benefit after deductible	\$15 copay (PCP) or \$25 copay (Specialists)
Nutritional Counseling & Health Education	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Contact Aetna for details.			
HOSPITAL - INPATIENT SERVICES			
Inpatient Care/ Hospitalization (requires preauthorization)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Inpatient care primarily for or solely for rehabilitation is not covered.			
Anesthesia	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit

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Aetna			
Benefit	POS In-Network	POS Out-of-Network	EPO In-Network
Surgery (requires preauthorization)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Organ Transplant (requires preauthorization)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
	Benefit is per calendar year for cornea, kidney, bone marrow, heart, heart-lung, single or double lung, liver and pancreas.		
HOSPITAL - OUTPATIENT SERVICES			
Chemotherapy/ Radiation	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Diagnostic Lab & X-Ray	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Outpatient Surgery	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Anesthesia	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
THERAPIES			
Benefit Therapies	\$25 copay when precertified by the Plan	80% of allowed benefit after deductible	\$25 copay when precertified by the Plan
Habilitative Services ^{^^^}	Covers children under age 19 with congenital or genetic birth defects. Not subject to 50 visits per plan year limit.		
Physical Therapy (PT), Occupational Therapy (OT) & Speech Therapy	PT/OT services must be per certified after the 6th visit, based on medical necessity; 50 visits per plan year combines for PT/OT/Speech Therapy; Speech Therapy must be per certified from the first visit with exceptions and close monitoring for special situations (e.g., trauma, brain injury) for additional visits.		
EMERGENCY TREATMENT			
Urgent Care Centers	\$20 copay	\$20 copay	\$20 copay
Emergency Room (ER) Services - Inside and outside of service area ***	\$50 copy for ER Facility & \$50 for ER Physician Services	\$50 copy for ER Facility & \$50 for ER Physician Services	\$50 copy for ER Facility & \$50 for ER Physician Services
	Copays are waived if admitted; if criteria are not met for a medical emergency, plan coverage is 50% of allowed amount, after two \$50 copays.		
Ambulance Services	100% of allowed benefit for medical emergencies	100% of allowed benefit for medical emergencies	100% of allowed benefit for medical emergencies
MATERNITY			
Maternity Benefits	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Newborn Care****	Contact Aetna to confirm your hospital's Neonatal Unit participates in the plan. If the Neonatal Unit and its physicians do not participate with the plan, you will be responsible for any balances up to the charge of the Neonatal Unit's providers. The PPO and POS plan will only pay these providers under the out-of-network coverage benefits. There will be no coverage for these providers under the EPO plan.		
OTHER SERVICES & SUPPLIES			
Acupuncture Services for Chronic Pain Management	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Behavioral Health	Not covered by Plan See Behavioral Health Benefits Section.		Inpatient care: 100% of allowed benefit when preauthorized by the Plan. Outpatient care: \$15 copay
Cardiac Rehabilitation [^]	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit

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Aetna			
Benefit	POS In-Network	POS Out-of-Network	EPO In-Network
Chiropractic Services	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Dental Services	Covered separately from Plan. See Dental Benefits Section.		
Durable Medical Equipment	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Extended Care Facility (requires preauthorization)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
	Skilled nursing care and extended care facility benefits are limited to 180 days per benefit period as long as skilled nursing care is medically necessary. Inpatient care primarily for or solely for rehabilitation is not covered.		
Family Planning & Fertility Testing	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
	Family planning benefits include: sperm count hysterosalpingography, eudiometrical biopsy, IUD insertion, vasectomy, and tubal ligation		
Home Health Care (requires preauthorization)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
	Home Health Care benefits are limited to 120 days per plan year.		
Hospice Care (requires preauthorization)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
In Vitro Fertilization (IVF) & Artificial Insemination (AI)^ (requires preauthorization)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
	For up to 3 attempts of IVF and 3 attempts of AI per live birth, lifetime maximum of \$100,000. Contact Aetna for further details.		
Medical Supplies	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
	Includes, but not limited to, surgical dressings; casts; splints; syringes; dressings for cancer, burns, or diabetic ulcers; catheters, colostomy bags; oxygen; supplies for renal dialysis equipment and machines; and all diabetic supplies as mandated by Maryland law.		
Outpatient Prescription Drugs	Covered separately from Plan. See Prescription Drug Benefits Section.		
Private Duty Nursing (requires preauthorization)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Second Surgical Opinion	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit
Whole Blood Charges	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
VISION SERVICES & SUPPLIES			
Vision - Medical Any services that deal with the medical health of the eye.	\$15 copay (PCP) or \$25 copay (Specialists) (when rendered by Preferred Provider)	80% of allowed benefit after deductible	\$15 copay (PCP) or \$25 copay (Specialists)
Vision - Routine Any services that deal with correcting vision.	Exam: Plan pays up to \$45 (available once every plan year)		
	Prescription lenses, frames, contact lenses (per plan year): \$200 every 12 months per member (Member pays out-of-pocket and then submits a claim for reimbursement.) You may obtain vision services from any licensed vision provider, whether in the CareFirst network or not. However, you may have to pay the full cost up front and submit a claim form to CareFirst for partial reimbursement. Contact Aetna for more information.		
See Footnote Tab for Medical footnotes			

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CAREFIRST					
Benefit	PPO In-Network	PPO Out-of-Network	POS In-Network	POS Out-of-Network	EPO In-Network
Plan Year Deductible					
Individual	None	\$250	None	\$250	None
Family	None	\$500	None	\$500	None
Out-of-Pocket Coinsurance Maximum					
Individual	None	\$3,000	None	\$3,000	None
Family	None	\$6,000	None	\$6,000	None
Lifetime Maximum: Unlimited					
National Network	Yes	Yes	No, Regional	Yes	Yes
Primary Care Physician Required	No	No	Yes	No	No
COMMON AND PREVENTIVE SERVICES					
Primary Care Physician's (PCP) Office Visit	\$15 copay	80% of allowed benefit after deductible	\$15 copay	80% of allowed benefit after deductible	\$15 copay
Specialist Office Visit	\$25 copay	80% of allowed benefit after deductible	\$25 copay	80% of allowed benefit after deductible	\$25 copay
Adult Physical Exams & Associated Lab Work	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	Not covered	100% of allowed benefit
One exam per plan year for all members and their dependents age 22 and older.					
Well Baby/Child Visits	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	Not covered	100% of allowed benefit
Birth through 36 months - up to 12 visits total; 3 through 21 years - 1 annual visit per plan year					
Contact CareFirst for further details on eligibility for visits.					
Immunizations* and Vaccines covered	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Contact CareFirst for a detailed list.					
Routine Annual GYN Exam (including Pap test)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit after deductible	80% of allowed benefit after deductible	100% of allowed benefit
Mammography **	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Hearing Examinations & Hearing Aids (No exam copay for children when part of well-child visit.)	\$15 copay (PCP) or \$25 copay (Specialists) for exam for adults	80% of allowed benefit after deductible for exam	\$15 copay (PCP) or \$25 copay (Specialists) for exam for adults	Not covered, except for hearing aids as mandated for minor children	\$15 copay (PCP) or \$25 copay (Specialists) for exam for adults
	100% of allowed benefit for Basic Model Hearing Aid	100% of allowed benefit for Basic Model Hearing Aid	100% of allowed benefit for Basic Model Hearing Aid		100% of allowed benefit for Basic Model Hearing Aid
	1 exam and hearing aid per ear every 3 years for each employee/retiree and dependent	1 exam and hearing aid per ear every 3 years for each employee/retiree and dependent	1 exam and hearing aid per ear every 3 years for each employee/retiree and dependent		1 exam and hearing aid per ear every 3 years for each employee/retiree and dependent
Includes benefit for hearing aids for minor children (ages 0-18) as mandated by Maryland law effective 1/1/02.					
Allergy Testing	\$15 copay (PCP) or \$25 copay (Specialists)	80% of allowed benefit after deductible	\$15 copay (PCP) or \$25 copay (Specialists)	80% of allowed benefit after deductible	\$15 copay (PCP) or \$25 copay (Specialists)
Nutritional Counseling & Health Education	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Contact CareFirst for details					
HOSPITAL - INPATIENT SERVICES					
Inpatient Care/ Hospitalization (requires preauthorization)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Inpatient care primarily for or solely for rehabilitation is not covered.					
Anesthesia	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Surgery (requires preauthorization)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Organ Transplant (requires preauthorization)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Benefit is per calendar year for cornea, kidney, bone marrow, heart, heart-lung, single or double lung, liver and pancreas.					
HOSPITAL - OUTPATIENT SERVICES					
Chemotherapy/ Radiation	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit

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July 1, 2012 to June 30, 2013

CAREFIRST					
Benefit	PPO In-Network	PPO Out-of-Network	POS In-Network	POS Out-of-Network	EPO In-Network
Diagnostic Lab & X-Ray	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Outpatient Surgery	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Anesthesia	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
THERAPIES					
Benefit Therapies	\$25 copay when preauthorized by the Plan	80% of allowed benefit after deductible	\$25 copay	80% of allowed benefit after deductible	\$25 copay when preauthorized by the Plan
Habilitative Services ^{^^^}	Covers children under age 19 with congenital or genetic birth defects. Not subject to 50 visits per plan year limit.				
Physical Therapy (PT), Occupational Therapy (OT) & Speech Therapy	PT/OT services must be per certified after the 6th visit, based on medical necessity; 50 visits per plan year combines for PT/OT/Speech Therapy; Speech Therapy must be per certified from the first visit with exceptions and close monitoring for special situations (e.g., trauma, brain injury) for additional visits.				
EMERGENCY TREATMENT					
Urgent Care Centers	\$20 copay	\$20 copay	\$20 copay	\$20 copay	\$20 copay
Emergency Room (ER) Services - Inside and outside of service area ***	\$50 copay for ER Facility & \$50 for ER Physician Services	\$50 copay for ER Facility & \$50 for ER Physician Services	\$50 copay for ER Facility & \$50 for ER Physician Services	\$50 copay for ER Facility & \$50 for ER Physician Services	\$50 copay for ER Facility & \$50 for ER Physician Services
	Copays are waived if admitted; if criteria are not met for a medical emergency, plan coverage is 50% of allowed amount, after two \$50 copays.				
Ambulance Services	100% of allowed benefit for medical emergencies	100% of allowed benefit for medical emergencies	100% of allowed benefit for medical emergencies	100% of allowed benefit for medical emergencies	100% of allowed benefit for medical emergencies
MATERNITY					
Maternity Benefits	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Newborn Care ^{****}	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
	Contact CareFirst to confirm your hospital's Neonatal Unit participates in the plan. If the Neonatal Unit and its physicians do not participate with the plan, you will be responsible for any balances up to the charge of the Neonatal Unit's providers. The PPO and POS plan will only pay these providers under the out-of-network coverage benefits. There will be no coverage for these providers under the EPO plan.				
OTHER SERVICES & SUPPLIES					
Acupuncture Services for Chronic Pain Management	\$20 copay	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Behavioral Health	Not covered by Plan See Behavioral Health Benefits Section.				Inpatient care: 100% of allowed benefit when preauthorized by the Plan. Outpatient care: \$15 copay
Cardiac Rehabilitation [^]	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Chiropractic Services	\$20 copay	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Dental Services	Covered separately from Plan. See Dental Benefits Section.				
Durable Medical Equipment	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Extended Care Facility (requires preauthorization)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
	Skilled nursing care and extended care facility benefits are limited to 180 days per benefit period as long as skilled nursing care is medically necessary. Inpatient care primarily for or solely for rehabilitation is not covered.				
Family Planning & Fertility Testing	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
	Family planning benefits include: sperm count hysterosalpingography, eudiometrical biopsy, IUD insertion, vasectomy, and tubal ligation				
Home Health Care (requires preauthorization)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit

SLEOLA Medical Benefits
for
July 1, 2012 to June 30, 2013

CAREFIRST					
Benefit	PPO In-Network	PPO Out-of-Network	POS In-Network	POS Out-of-Network	EPO In-Network
	Home Health Care benefits are limited to 120 days per plan year.				
Hospice Care (requires preauthorization)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
In Vitro Fertilization (IVF) & Artificial Insemination (AI) ^{^^} (requires preauthorization)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
	For up to 3 attempts of IVF and 3 attempts of AI per live birth, lifetime maximum of \$100,000. Contact CareFirst for further details.				
Medical Supplies	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
	Includes, but not limited to, surgical dressings; casts; splints; syringes; dressings for cancer, burns, or diabetic ulcers; catheters, colostomy bags; oxygen; supplies for renal dialysis equipment and machines; and all diabetic supplies as mandated by Maryland law.				
Outpatient Prescription Drugs	Covered separately from Plan See Prescription Drug Benefits Section.				
Private Duty Nursing (requires preauthorization)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Second Surgical Opinion	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit
Whole Blood Charges	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
VISION SERVICES & SUPPLIES					
Vision - Medical Any services that deal with the medical health of the eye.	\$15 copay (PCP) or \$25 copay (Specialists)	80% of allowed benefit after deductible	\$15 copay (PCP) or \$25 copay (Specialists) (when rendered by Preferred Provider)	80% of allowed benefit after deductible	\$15 copay (PCP) or \$25 copay (Specialists)
Vision - Routine Any services that deal with correcting vision.	Exam: Plan pays up to \$45 (available once every plan year)				
				Single vision:	\$28.80
				Bifocal, single	\$48.60
				Bifocal, double	\$88.20
				Trifocal	\$70.20
				Aphakic - glass	\$54.00
				Aphakic - plastic	\$126.00
				Aphakic - aspheric	\$162.00
	Frames: Plan pays up to 45 (available once every plan year)				
				Medically Necessary	\$201.60
			Cosmetic	\$50.40	
You may obtain vision services from any licensed vision provider, whether in the CareFirst network or not. However, you may have to pay the full cost up front and submit a claim form to CareFirst for partial reimbursement. Contact CareFirst for more information.					
See Footnote Tab for Medical footnotes					

SLEOLA Medical Benefits
for
July 1, 2012 to June 30, 2013

UnitedHealthcare					
Benefit	PPO In-Network	PPO Out-of-Network	POS In-Network	POS Out-of-Network	EPO In-Network
<u>Plan Year Deductible</u>					
Individual	None	\$250	None	\$250	None
Family	None	\$500	None	\$500	None
<u>Out-of-Pocket Coinsurance Maximum</u>					
Individual	None	\$3,000	None	\$3,000	None
Family	None	\$6,000	None	\$6,000	None
Lifetime Maximum	Unlimited				
National Network	Yes	Yes	Yes	Yes	Yes
Primary Care Physician Required	No	No	No	No	Yes
COMMON AND PREVENTIVE SERVICES					
Primary Care Physician's (PCP) Office Visit	\$15 copay	80% of allowed benefit after deductible	\$15 copay	80% of allowed benefit after deductible	\$15 copay
Specialist Office Visit	\$25 copay	80% of allowed benefit after deductible	\$25 copay	80% of allowed benefit after deductible	\$25 copay
Adult Physical Exams & associated lab work	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	Not covered	100% of allowed benefit
One exam per plan year for all members and their dependents age 22 and older.					
Well Baby/Child Visits	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	Not covered	100% of allowed benefit
Birth through 36 months - up to 12 visits total; 3 through 21 years - 1 annual visit per plan year					
Contact UnitedHealthcare for further details on eligibility for visits.					
Immunizations* and Vaccines covered	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Contact UnitedHealthcare for a detailed list.					
Routine Annual GYN Exam (including Pap test)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit after deductible	80% of allowed benefit after deductible	100% of allowed benefit
Mammography **	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Hearing Examinations & Hearing Aids (No exam copay for children when part of well-child visit.)	\$15 copay (PCP) or \$25 copay (Specialists) for exam for adults	80% of allowed benefit after deductible for exam	\$15 copay (PCP) or \$25 copay (Specialists) for exam for adults	Not covered, except for hearing aids as mandated for minor children	\$15 copay (PCP) or \$25 copay (Specialists) for exam for adults
	100% of allowed benefit for Basic Model Hearing Aid	100% of allowed benefit for Basic Model Hearing Aid	100% of allowed benefit for Basic Model Hearing Aid		100% of allowed benefit for Basic Model Hearing Aid
	1 exam and hearing aid per ear every 3 years for each employee/retiree and dependent	1 exam and hearing aid per ear every 3 years for each employee/retiree and dependent	1 exam and hearing aid per ear every 3 years for each employee/retiree and dependent		1 exam and hearing aid per ear every 3 years for each employee/retiree and dependent
Includes benefit for hearing aids for minor children (ages 0-18) as mandated by Maryland law effective 1/1/02.					
Allergy Testing	\$15 copay (PCP) or \$25 copay (Specialists)	80% of allowed benefit after deductible	\$15 copay (PCP) or \$25 copay (Specialists)	80% of allowed benefit after deductible	\$15 copay (PCP) or \$25 copay (Specialists)
Nutritional Counseling & Health Education	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Contact UnitedHealthcare for details					
HOSPITAL - INPATIENT SERVICES					
Inpatient Care/ Hospitalization (requires preauthorization)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Inpatient care primarily for or solely for rehabilitation is not covered.					
Anesthesia	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Surgery (requires preauthorization)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit

SLEOLA Medical Benefits
for
July 1, 2012 to June 30, 2013

UnitedHealthcare					
Benefit	PPO In-Network	PPO Out-of-Network	POS In-Network	POS Out-of-Network	EPO In-Network
Organ Transplant (requires preauthorization)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Benefit is per calendar year for cornea, kidney, bone marrow, heart, heart-lung, single or double lung, liver and pancreas.					
HOSPITAL - OUTPATIENT SERVICES					
Chemotherapy/ Radiation	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Diagnostic Lab & X-Ray	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Outpatient Surgery	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Anesthesia	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
THERAPIES					
Benefit Therapies	\$25 copay when preauthorized by the Plan	80% of allowed benefit after deductible	\$25 copay	80% of allowed benefit after deductible	\$25 copay when preauthorized by the Plan
Habilitative Services ^{^^}	Covers children under age 19 with congenital or genetic birth defects. Not subject to 50 visits per plan year limit.				
Physical Therapy (PT), Occupational Therapy (OT) & Speech Therapy	PT/OT services must be per certified after the 6th visit, based on medical necessity; 50 visits per plan year combines for PT/OT/Speech Therapy; Speech Therapy must be per certified from the first visit with exceptions and close monitoring for special situations (e.g., trauma, brain injury) for additional visits.				
EMERGENCY TREATMENT					
Urgent Care Centers	\$20 copay	\$20 copay	\$20 copay	\$20 copay	\$20 copay
Emergency Room (ER) Services - Inside and outside of service area ***	\$50 copay for ER Facility & \$50 for ER Physician Services	\$50 copay for ER Facility & \$50 for ER Physician Services	\$50 copay for ER Facility & \$50 for ER Physician Services	\$50 copay for ER Facility & \$50 for ER Physician Services	\$50 copay for ER Facility & \$50 for ER Physician Services
Copays are waived if admitted; if criteria are not met for a medical emergency, plan coverage is 50% of allowed amount, after two \$50 copays.					
Ambulance Services	100% of allowed benefit for medical emergencies	100% of allowed benefit for medical emergencies	100% of allowed benefit for medical emergencies	100% of allowed benefit for medical emergencies	100% of allowed benefit for medical emergencies
MATERNITY					
Maternity Benefits	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Newborn Care****	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Contact UnitedHealthcare to confirm your hospital's Neonatal Unit participates in the plan. If the Neonatal Unit and its physicians do not participate with the plan, you will be responsible for any balances up to the charge of the Neonatal Unit's providers. The PPO and POS plan will only pay these providers under the out-of-network coverage benefits. There will be no coverage for these providers under the EPO plan.					
OTHER SERVICES & SUPPLIES					
Acupuncture Services for Chronic Pain Management	\$20 copay	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Behavioral Health	Not covered by Plan See Behavioral Health Benefits Section.				Inpatient care: 100% of allowed benefit when preauthorized by the Plan. Outpatient care: \$15 copay
Cardiac Rehabilitation [^]	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Chiropractic Services	\$20 copay	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Dental Services	Covered separately from Plan. See Dental Benefits Section.				
Durable Medical Equipment	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit

SLEOLA Medical Benefits
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UnitedHealthcare					
Benefit	PPO In-Network	PPO Out-of-Network	POS In-Network	POS Out-of-Network	EPO In-Network
Extended Care Facility (requires preauthorization)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
	Skilled nursing care and extended care facility benefits are limited to 180 days per benefit period as long as skilled nursing care is medically necessary. Inpatient care primarily for or solely for rehabilitation is not covered.				
Family Planning & Fertility Testing	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
	Family planning benefits include: sperm count hysterosalpingography, eudiometrical biopsy, IUD insertion, vasectomy, and tubal ligation				
Home Health Care (requires preauthorization)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
	Home Health Care benefits are limited to 120 days per plan year.				
Hospice Care (requires preauthorization)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
In Vitro Fertilization (IVF) & Artificial Insemination (AI)^^(requires preauthorization)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
	For up to 3 attempts of IVF and 3 attempts of AI per live birth, lifetime maximum of \$100,000. Contact UnitedHealthcare for further details.				
Medical Supplies	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
	Includes, but not limited to, surgical dressings; casts; splints; syringes; dressings for cancer, burns, or diabetic ulcers; catheters, colostomy bags; oxygen; supplies for renal dialysis equipment and machines; and all diabetic supplies as mandated by Maryland law.				
Outpatient Prescription Drugs	Covered separately from Plan See Prescription Drug Benefits Section.				
Private Duty Nursing (requires preauthorization)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Second Surgical Opinion	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit
Whole Blood Charges	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
VISION SERVICES & SUPPLIES					
Vision - Medical Any services that deal with the medical health of the eye.			\$15 copay (PCP) or \$25 copay (Specialists) (when rendered by Preferred Provider)		
	\$15 copay (PCP) or \$25 copay (Specialists)	80% of allowed benefit after deductible		80% of allowed benefit after deductible	\$15 copay (PCP) or \$25 copay (Specialists)
Vision - Routine Any services that deal with correcting vision.	Exam: Plan pays up to \$45 (available once every plan year)				
				Single vision:	\$28.80
				Bifocal, single	\$48.60
				Bifocal, double	\$88.20
				Trifocal	\$70.20
				Aphakic - glass	\$54.00
				Aphakic - plastic	\$126.00
				Aphakic - aspheric	\$162.00
	Frames: Plan pays up to 45 (available once every plan year)				
				Contacts (per pair, instead of frames and lenses - available once every plan year):	Medically Necessary \$201.60 Cosmetic \$50.40
You may obtain vision services from any licensed vision provider, whether in the UnitedHealthcare network or not. However, you may have to pay the full cost up front and submit a claim form to UnitedHealthcare for partial reimbursement. Contact UnitedHealthcare for more information.					
See Footnote Tab for Medical footnotes					

BENEFIT CHART FOOTNOTES

* Immunizations: Contact your plan for up-to-date information on covered immunizations. The immunization benefit Influenza (flu shots - one per plan year, regardless of age), Pneumococcal, HPV, Meningitis, and Shingles vaccines, immunizations required for participation in college admission, and Lyme Disease immunizations when medically necessary. Travel immunizations not covered.

** Coverage for screening mammograms is in accordance with the Maryland State mandate and healthcare reform varies by age: one baseline screening (age 35-39); one mammogram every plan year (ages 40 and above). Diagnostic mammograms have no age limitations.

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: 1) placing

**** Newborns' and Mothers' Health Protection Act Notice. See page 71 of the July 2012 to July 2013 Benefits Guide

^Cardiac rehabilitation benefits: 36 sessions in a 12-week period (or on a case-by-case basis thereafter) with physician supervision and in a medical facility. Cardiac rehabilitation must be medically necessary with a physician referral, and patient history of a heart attack in past 12 months; Coronary Artery Bypass Graft (CABG) surgery; angioplasty, heart valve surgery, stable angina pectoris, congestive heart failure; or heart and lung transplants. Inpatient care primarily for rehabilitation is not covered.

^^ In-Vitro Fertilization (IVF) and Artificial Insemination (AI) benefits are available for a married (as recognized by the laws of Maryland) woman if: 1) She was fertile throughout the most recent two years of marriage to the same man; 2) Her infertility is due to endometriosis, exposure in womb to diethylstilbestrol (DES), or blockage of or surgical removal of one or more fallopian tubes; or 3) Male infertility is the documented diagnostic cause. The patient's oocytes must be fertilized with her spouse's sperm. IVF and AI are covered for a maximum of three attempts per procedure. Coverage of the three IVF attempts per live birth will not exceed a maximum expense of \$100,000 per lifetime. The AI attempts must be taken, when medically appropriate, before IVF attempts will be covered.

^^^ Habilitative Services, which include occupational therapy, physical therapy, and speech therapy, 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.

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Behavioral Health Coverage for PPO and POS Plan Participants		
Type of Service	In-Network Care	Out-Of-Network Care
Inpatient Facility and Professional Services	100% of APS' negotiated fee maximums when preauthorized by the Plan	80% of APS' negotiated fee maximums
Partial Hospitalization Services and Residential Crisis Services	100% of APS' negotiated fee maximums	80% of APS' negotiated fee maximums
Outpatient Facility	100% of APS' negotiated fee maximums	80% of APS' negotiated fee maximums
Office and Professional Services (excluding Intensive Outpatient Services)	\$15 copay	80% of APS' negotiated fee maximums
Intensive Outpatient Services	\$15 copay	80% of APS' negotiated fee maximums
Outpatient Medication Management Services	\$15 copay	80% of APS' negotiated fee maximums
<u>Plan Year Deductible</u>		
Individual	None	None
Family		
<u>Out-of-Pocket Coinsurance Maximum</u>		
Individual	None	\$3,000
Family	None	\$6,000
Lifetime Maximum	Unlimited	
Behavioral Health Coverage for EPO Plan Participants		
Type of Service	In-Network Care	Out-Of-Network Care
Inpatient Facility and Professional Services	100% of the allowed benefit when preauthorized by the Plan	No Out-Of-Network Coverage
Residential Crisis Services	100% of the allowed benefit	No Out-Of-Network Coverage
Outpatient Facility	100% of the allowed benefit	No Out-Of-Network Coverage
Office and Professional Services (excluding Intensive Outpatient Services)	\$15 copay	No Out-Of-Network Coverage
Intensive Outpatient Services	\$15 copay	No Out-Of-Network Coverage
Services	\$15 copay	No Out-Of-Network Coverage
<u>Plan Year Deductible</u>		
Individual	None	No Out-Of-Network Coverage
Family		
<u>Out-of-Pocket Coinsurance Maximum</u>		
Individual	None	
Family	None	No Out-Of-Network Coverage
Lifetime Maximum	Unlimited	No Out-Of-Network Coverage

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PRESCRIPTION DRUG BENEFITS		
Copayments at Retail Pharmacies		
Type of Drug	Prescription for 1-45 Days (1 copay)	Prescription for 46-90 Days (2 copays)
Generic drug	\$5	\$10
Preferred brand name drug	\$15	\$30
Non-preferred brand name drug	\$25	\$50
Copayments through Voluntary Mail Order Program		
Type of Drug	Prescription for 1-45 Days (1 copay)	Prescription for 46-90 Days (2 copays)
Generic	\$5	\$10
Preferred brand name	\$15	\$20
Non-preferred brand name	\$25	\$20
Out-of-Pocket Maximum:		
Out-of-Pocket Maximum:	\$700	
	<p>This means that when the total amount of copays you and your covered dependents pay during the plan year reaches \$700, you and your covered dependents will not pay any more copays for eligible prescriptions for the remainder of the plan year.</p>	