

**SLEOLA (JANUARY 1, 2014 TO DECEMBER 31, 2014)**

Aetna

Benefit	POS In-Network		POS Out-of-Network		EPO In-Network	
Plan Year Deductible						
	Individual	None	\$125		None	
	Family	None	\$250		None	
Plan Year Out-of-Pocket Coinsurance & Deductible Combined Maximum	Any charges above the plan's Allowed Benefit are not counted towards the out-of-pocket maximum.					
	Individual	None	\$3,000		None	
	Family	None	\$6,000		None	
Plan Year Copayment Out-of-Pocket Maximum						
	Individual	\$1,000	None		\$1,000	
	Family	\$2,000	None		\$2,000	
Lifetime Maximum	Unlimited					
National Network	Yes		Yes		Yes	
Primary Care Physician Required	No		No		Yes	
<b>COMMON AND PREVENTIVE SERVICES</b>						
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	100% of allowed benefit		80% of allowed benefit after deductible		100% of allowed benefit	
	Contact Aetna for a detailed list.					
Hearing Examinations & Hearing Aids (No exam copay for children when part of well-child visit.)	\$15 copay (PCP) or \$25 copay (Specialists) for exam		Not covered, except for hearing aids as mandated for minor children		\$15 copay (PCP) or \$25 copay (Specialists) for exam	
	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.					
<b>WOMAN'S SERVICES</b>						
Well Woman Visits	100% of allowed benefit		80% of allowed benefit after deductible		100% of allowed benefit	
	One per plan year or as necessary based on a women's health status, needs, and risk factors. Allows women to obtain recommended preventive services that are age and developmentally appropriate including preconception counseling, tobacco cessation counseling and interpersonal & domestic violence screening & counseling.					
Mammography (Preventive)	100% of allowed benefit		80% of allowed benefit after deductible		100% of allowed benefit	
Mammography (Diagnostic)	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	
	Up to 3 attempts of IVF and/or AI per live birth. Contact Aetna for further details and limitations.					
STI Screening & Counseling	100% of allowed benefit		Not Covered		100% of allowed benefit	
	Counseling and screening for sexually active women as mandated by PPACA.					

**SLEOLA (JANUARY 1, 2014 TO DECEMBER 31, 2014)**

Aetna

Benefit	POS	POS	EPO
	In-Network	Out-of-Network	In-Network
Contraceptive Counseling	100% of allowed benefit	Not Covered	100% of allowed benefit
	Includes pre-conception counseling, IUD insertion and tubal ligation. For information on coverage of prescription contraceptives, refer to the Prescription Drug section of the online benefits guide.		
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, endometrial biopsy and vasectomy.		
Prenatal Care (Mandated)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
	Routine prenatal obstetrical office visits, all lab services explicitly identified in the health reform law including gestational diabetes screening, tobacco cessation counseling specific to pregnant women, and certain immunizations.		
	8		
Maternity Benefits	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
	Includes delivery services, hospital stay, and other postnatal care and services.		
Breastfeeding Support, Supplies & Counseling (in conjunction with each birth)	100% of allowed benefit	Not Covered	100% of allowed benefit
	Covers the cost of rental/purchase of certain breastfeeding equipment through the insurance carrier's durable medical equipment partner(s). Contact Aetna for additional details.		
<b>THERAPIES (Preauthorization Required)</b>			
Benefit Therapies	\$25 copay	80% of allowed benefit after deductible	\$25 copay
Habilitative Services <sup>^^^</sup>	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 preauthorized after the 6th visit, based on medical necessity; 50 visits per plan year combine for PT/OT/Speech Therapy; Speech Therapy must be preauthorized from the first visit with exceptions and close monitoring for special situations (e.g., trauma, brain injury) for additional visits.		
<b>HOSPITAL - INPATIENT SERVICES (Preauthorization Required)</b>			
Inpatient Care	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.		
Hospitalization	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
Surgery	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Newborn Care <sup>****</sup>	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
	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.		
Organ Transplant	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.		
<b>HOSPITAL - OUTPATIENT SERVICES</b>			
Chemotherapy/ Radiation	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Outpatient Surgery (Preauthorization Required)	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

**SLEOLA (JANUARY 1, 2014 TO DECEMBER 31, 2014)**

Aetna

Benefit	POS		EPO
	In-Network	Out-of-Network	In-Network
<b>EMERGENCY TREATMENT</b>			
Urgent Care Centers	\$20 copay	80% of allowed benefit after deductible	\$20 copay
Emergency Room (ER) Services - Inside and outside of service area ***	\$50 copay for ER Facility plus \$50 for ER Physician Services	\$50 copay for ER Facility plus \$50 for ER Physician Services	\$50 copay for ER Facility plus \$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 - Emergency Transport	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit
Ambulance Services - Non-Emergency Transport	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
<b>OTHER SERVICES &amp; SUPPLIES (Preauthorization Required)</b>			
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 Aetna See Behavioral Health Benefits Section.		Inpatient care: 100% of allowed benefit Outpatient care: \$15 copay
Cardiac Rehabilitation^	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Chiropractic Services	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
Durable Medical Equipment	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
	Contact Aetna for details on covered items.		
Extended Care Facility	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.		
Home Health Care	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	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
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	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Second Surgical Opinion (No Preauthorization Required)	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit
Whole Blood Charges (No Preauthorization Required)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
<b>VISION SERVICES &amp; SUPPLIES</b>			
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 plan year 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 Aetna network or not. However, you may have to pay the full cost up front and submit a claim form to Aetna for partial reimbursement. Contact Aetna for more information.		
<b>See Footnote Tab for Medical Footnotes</b>			

## SLEOLA (JANUARY 1, 2014 TO DECEMBER 31, 2014)

## CAREFIRST

Benefit	PPO	PPO	POS	POS	EPO
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
<b>Plan Year Deductible</b>					
Individual	None	\$125	None	\$125	None
Family	None	\$250	None	\$250	None
<b>Plan Year Out-of-Pocket Coinsurance &amp; Deductible Combined Maximum</b>	Any charges above the plan's Allowed Benefit are not counted towards the out-of-pocket maximum.				
Individual	None	\$1,500	None	\$1,500	None
Family	None	\$3,000	None	\$3,000	None
<b>Plan Year Copayment Out-of-Pocket Maximum</b>					
Individual	\$1,000	None	\$1,000	None	\$1,000
Family	\$2,000	None	\$2,000	None	\$2,000
<b>Lifetime Maximum</b>	Unlimited				
<b>National Network</b>	Yes	Yes	No, Regional	Yes	Yes
<b>Primary Care Physician Required</b>	No	No	Yes	No	No
<b>COMMON AND PREVENTIVE SERVICES</b>					
<b>Primary Care Physician's (PCP) Office Visit</b>	\$15 copay	80% of allowed benefit after deductible	\$15 copay	80% of allowed benefit after deductible	\$15 copay
<b>Specialist Office Visit</b>	\$25 copay	80% of allowed benefit after deductible	\$25 copay	80% of allowed benefit after deductible	\$25 copay
<b>Adult Physical Exams &amp; Associated Lab Work</b>	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.					
<b>Well Baby/Child Visits</b>	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.					
<b>Immunizations* and Vaccines</b>	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.					
<b>Hearing Examinations &amp; Hearing Aids (No exam copay for children when part of well-child visit.)</b>	\$15 copay (PCP) or \$25 copay (Specialists) for exam	80% of allowed benefit after deductible for exam	\$15 copay (PCP) or \$25 copay (Specialists) for exam	Not covered, except for hearing aids as mandated for minor children	\$15 copay (PCP) or \$25 copay (Specialists) for exam
	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.					
<b>Allergy Testing</b>	\$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)
<b>Nutritional Counseling &amp; Health Education</b>	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.					
<b>WOMAN'S SERVICES</b>					
<b>Well Woman Visits</b>	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	Not covered	100% of allowed benefit
One per plan year or as necessary based on a women's health status, needs, and risk factors. Allows women to obtain recommended preventive services that are age and developmentally appropriate including preconception counseling, tobacco cessation counseling and interpersonal & domestic violence screening & counseling.					
<b>Mammography (Preventive)</b>	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
<b>Mammography (Diagnostic)</b>	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
<b>In Vitro Fertilization (IVF) &amp; Artificial Insemination (AI)** (requires preauthorization)</b>	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Up to 3 attempts of IVF and/or AI per live birth. Contact CareFirst for further details and limitations.					
<b>STI Screening &amp; Counseling</b>	100% of allowed benefit	Not Covered	100% of allowed benefit	Not Covered	100% of allowed benefit
Counseling and screening for sexually active women as mandated by PPACA.					

SLEOLA (JANUARY 1, 2014 TO DECEMBER 31, 2014)

CAREFIRST

Benefit	PPO	PPO	POS	POS	EPO
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Contraceptive Counseling	100% of allowed benefit	Not Covered	100% of allowed benefit	Not Covered	100% of allowed benefit
	Includes pre-conception counseling, IUD insertion and tubal ligation. For information on coverage of prescription contraceptives, refer to the Prescription Drug section of this guide.				
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, endometrial biopsy and vasectomy.				
Prenatal Care (Mandated)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
	Radiology (i.e., obstetrical ultrasounds) and high-risk prenatal services may be subject to coinsurance.				
	Routine prenatal obstetrical office visits, all lab services explicitly identified in the health reform law including gestational diabetes screening, tobacco cessation counseling specific to pregnant women, and certain immunizations.				
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
	Includes delivery services, hospital stay, and other postnatal care and services.				
Breastfeeding Support, Supplies & Counseling (in conjunction with each birth)	100% of allowed benefit	Not Covered	100% of allowed benefit	Not Covered	100% of allowed benefit
	Covers the cost of rental/purchase of certain breastfeeding equipment through the insurance carrier's durable medical equipment partner(s). Contact CareFirst for additional details.				
<b>THERAPIES (Preauthorization Required)</b>					
Benefit Therapies	\$25 copay when preauthorized by the Plan	80% of allowed benefit after deductible	\$25 copay when preauthorized by the Plan	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 preauthorized after the 6th visit, based on medical necessity; 50 visits per plan year combine for PT/OT/Speech Therapy; Speech Therapy must be preauthorized from the first visit with exceptions and close monitoring for special situations (e.g., trauma, brain injury) for additional visits.				
<b>HOSPITAL - INPATIENT SERVICES (Preauthorization Required)</b>					
Inpatient Care	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
	Inpatient care primarily for or solely for rehabilitation is not covered.				
Hospitalization	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
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
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.				
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.				
<b>HOSPITAL - OUTPATIENT SERVICES</b>					
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
Outpatient Surgery (Preauthorization Required)	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

SLEOLA (JANUARY 1, 2014 TO DECEMBER 31, 2014)

CAREFIRST

Benefit	PPO		POS		EPO
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
<b>EMERGENCY TREATMENT</b>					
Urgent Care Centers	\$20 copay	80% of allowed benefit after deductible	\$20 copay	80% of allowed benefit after deductible	\$20 copay
Emergency Room (ER) Services - Inside and outside of service area ***	\$50 copay for ER Facility plus \$50 for ER Physician Services	\$50 copay for ER Facility plus \$50 for ER Physician Services	\$50 copay for ER Facility plus \$50 for ER Physician Services	\$50 copay for ER Facility plus \$50 for ER Physician Services	\$50 copay for ER Facility plus \$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 - Emergency Transport	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit
Ambulance Services - Non-Emergency Transport	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
<b>OTHER SERVICES &amp; SUPPLIES (Preauthorization Required)</b>					
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 CareFirst See Behavioral Health Benefits Section.				Inpatient care: 100% of allowed benefit 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
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
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
Contact CareFirst for details on covered items.					
Extended Care Facility	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Skilled nursing care and extended care facility benefits are limited to 180 days per benefit period as long as skilled nursing care is medically necessary. Inpatient care primarily for or solely for rehabilitation is not covered.					
Home Health Care	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Home Health Care benefits are limited to 120 days per plan year.					
Hospice Care	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Medical Supplies	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Includes, but not limited to, surgical dressings; casts; splints; syringes; dressings for cancer, burns, or diabetic ulcers; catheters, colostomy bags; oxygen; supplies for renal dialysis equipment and machines; and all diabetic supplies as mandated by Maryland law.					
Outpatient Prescription Drugs	Covered separately from Plan See Prescription Drug Benefits Section.				
Private Duty Nursing	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Second Surgical Opinion (No Preauthorization Required)	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit
Whole Blood Charges (No Preauthorization Required)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
<b>VISION SERVICES &amp; SUPPLIES</b>					
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)	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 (per pair - 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
	Frames: Plan pays up to \$45 (available once every plan year)			Aphakic - aspheric	\$162.00
				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 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 (JANUARY 1, 2014 TO DECEMBER 31, 2014)

UnitedHealthcare

Benefit	PPO		POS		EPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Plan Year Deductible</b>						
Individual	None	\$125	None	\$125	None	None
Family	None	\$250	None	\$250	None	None
<b>Plan Year Out-of-Pocket Coinsurance &amp; Deductible Combined Maximum</b>	Any charges above the plan's Allowed Benefit are not counted towards the out-of-pocket maximum.					
Individual	None	\$1,500	None	\$1,500	None	None
Family	None	\$3,000	None	\$3,000	None	None
<b>Plan Year Copayment Out-of-Pocket Maximum</b>						
Individual	\$1,000	None	\$1,000	None	\$1,000	\$1,000
Family	\$2,000	None	\$2,000	None	\$2,000	\$2,000
<b>Lifetime Maximum</b>	Unlimited					
<b>National Network</b>	Yes	Yes	Yes	Yes	Yes	Yes
<b>Primary Care Physician Required</b>	No	No	No	No	No	Yes
<b>COMMON AND PREVENTIVE SERVICES</b>						
<b>Primary Care Physician's (PCP) Office Visit</b>	\$15 copay	80% of allowed benefit after deductible	\$15 copay	80% of allowed benefit after deductible	\$15 copay	80% of allowed benefit after deductible
<b>Specialist Office Visit</b>	\$25 copay	80% of allowed benefit after deductible	\$25 copay	80% of allowed benefit after deductible	\$25 copay	80% of allowed benefit after deductible
<b>Adult Physical Exams &amp; Associated Lab Work</b>	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	Not covered	100% of allowed benefit	100% of allowed benefit
One exam per plan year for all members and their dependents age 22 and older.						
<b>Well Baby/Child Visits</b>	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	Not covered	100% of allowed benefit	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.						
<b>Immunizations* and Vaccines</b>	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	100% of allowed benefit
Contact UnitedHealthcare for a detailed list.						
<b>Hearing Examinations &amp; Hearing Aids (No exam copay for children when part of well-child visit.)</b>	\$15 copay (PCP) or \$25 copay (Specialists) for exam	80% of allowed benefit after deductible for exam	\$15 copay (PCP) or \$25 copay (Specialists) for exam	80% of allowed benefit after deductible for exam	\$15 copay (PCP) or \$25 copay (Specialists) for exam	80% of allowed benefit after deductible for exam
	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	Not covered, except for hearing aids as mandated for minor children	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	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.						
<b>Allergy Testing</b>	\$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)	80% of allowed benefit after deductible
<b>Nutritional Counseling &amp; Health Education</b>	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible
Contact UnitedHealthcare for details.						
<b>WOMAN'S SERVICES</b>						
<b>Well Woman Visits</b>	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	Not covered	100% of allowed benefit	100% of allowed benefit
One per plan year or as necessary based on a women's health status, needs, and risk factors. Allows women to obtain recommended preventive services that are age and developmentally appropriate including preconception counseling, tobacco cessation counseling and interpersonal & domestic violence screening & counseling.						
<b>Mammography (Preventive)</b>	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible
<b>Mammography (Diagnostic)</b>	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible
<b>In Vitro Fertilization (IVF) &amp; Artificial Insemination (AI)*** (requires preauthorization)</b>	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible
Up to 3 attempts of IVF and/or AI per live birth. Contact UnitedHealthcare for further details and limitations.						
<b>STI Screening &amp; Counseling</b>	100% of allowed benefit	Not Covered	100% of allowed benefit	Not Covered	100% of allowed benefit	100% of allowed benefit
Counseling and screening for sexually active women as mandated by PPACA.						
<b>Contraceptive Counseling</b>	100% of allowed benefit	Not Covered	100% of allowed benefit	Not Covered	100% of allowed benefit	100% of allowed benefit
Includes pre-conception counseling, IUD insertion and tubal ligation. For information on coverage of prescription contraceptives, refer to the Prescription Drug section of this guide.						
<b>Family Planning &amp; Fertility Testing</b>	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible
Family planning benefits include: sperm count hysterosalpingography, endometrial biopsy and vasectomy.						
<b>Prenatal Care (Mandated)</b>	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible
Routine prenatal obstetrical office visits, all lab services explicitly identified in the health reform law including gestational diabetes screening, tobacco cessation counseling specific to pregnant women, and certain immunizations.						
Radiology (i.e., obstetrical ultrasounds) and high-risk prenatal services may be subject to coinsurance.						
<b>Maternity Benefits</b>	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible
Includes delivery services, hospital stay, and other postnatal care and services.						
<b>Breastfeeding Support, Supplies &amp; Counseling (in conjunction with each birth)</b>	100% of allowed benefit	Not Covered	100% of allowed benefit	Not Covered	100% of allowed benefit	100% of allowed benefit
Covers the cost of rental/purchase of certain breastfeeding equipment through the insurance carrier's durable medical equipment partner(s). Contact UnitedHealthcare for additional details.						
<b>THERAPIES (Preauthorization Required)</b>						
<b>Benefit Therapies</b>	\$25 copay when preauthorized by the Plan	80% of allowed benefit after deductible	\$25 copay when preauthorized by the Plan	80% of allowed benefit after deductible	\$25 copay when preauthorized by the Plan	80% of allowed benefit after deductible
<b>Habilitative Services***</b>	Covers children under age 19 with congenital or genetic birth defects.					Not subject to 50 visits per plan year limit.
<b>Physical Therapy (PT), Occupational Therapy (OT) &amp; Speech Therapy</b>	PT/OT services must be preauthorized after the 6th visit, based on medical necessity; 50 visits per plan year combine for PT/OT/Speech Therapy. Speech Therapy must be preauthorized from the first visit with exceptions and close monitoring for special situations (e.g., trauma, brain injury) for additional visits.					

UnitedHealthcare					
Benefit	PPO In-Network	PPO Out-of-Network	POS In-Network	POS Out-of-Network	EPO In-Network
<b>HOSPITAL - INPATIENT SERVICES (Preauthorization Required)</b>					
Inpatient Care	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Inpatient care primarily for or solely for rehabilitation is not covered.					
Hospitalization	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Anesthesia	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Surgery	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
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.					
Organ Transplant	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
Benefit is per calendar year for cornea, kidney, bone marrow, heart, heart-lung, single or double lung, liver and pancreas.					
<b>HOSPITAL - OUTPATIENT SERVICES</b>					
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
Outpatient Surgery (Preauthorization Required)	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
<b>EMERGENCY TREATMENT</b>					
Urgent Care Centers	\$20 copay	80% of allowed benefit after deductible	\$20 copay	80% of allowed benefit after deductible	\$20 copay
Emergency Room (ER) Services - Inside and outside of service area ***	\$50 copay for ER Facility plus \$50 for ER Physician Services	\$50 copay for ER Facility plus \$50 for ER Physician Services	\$50 copay for ER Facility plus \$50 for ER Physician Services	\$50 copay for ER Facility plus \$50 for ER Physician Services	\$50 copay for ER Facility plus \$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 - Emergency Transport	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit
Ambulance Services - Non-Emergency Transport	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
<b>OTHER SERVICES &amp; SUPPLIES (Preauthorization Required)</b>					
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 UnitedHealthcare Benefits Section. See Behavioral Health				Inpatient care: 100% of allowed benefit 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
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
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
Contact Aetna for details on covered items.					
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.					
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
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 (No Preauthorization Required)	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit	100% of allowed benefit
Whole Blood Charges (No Preauthorization Required)	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit	80% of allowed benefit after deductible	100% of allowed benefit
<b>VISION SERVICES &amp; SUPPLIES</b>					
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)	80% of allowed benefit after deductible	\$15 copay (PCP) or \$25 copay (Specialists)
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
Vision - Routine Any services that deal with correcting vision.	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					

SLEOLA (JANUARY 1, 2014 TO DECEMBER 31, 2014)  
BENEFIT CHART FOOTNOTES

\* Immunizations: Covered immunizations are determined by following the Immunization Schedules of the Centers for Disease Control and Prevention. Contact your plan for up-to-date information on covered immunizations. The immunization benefit includes 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.

\*\*\*Emergency services or medical emergency is defined as: 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: 1) placing the patient's health in jeopardy; 2) Serious impairment of bodily functions; or 3) Serious dysfunction of any bodily organ or part.

\*\*\*\* Newborns' and Mothers' Health Protection Act Notice. See page 68 of the July 1, 2013 to December 31, 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 legally married couple if: 1) There is a history of infertility throughout the most recent two years of marriage; 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.

**Below are the resources used to determine the list of services that are covered with zero cost-share to our members:**

Taken from the Federal Register, a group health plan must provide benefits for and prohibit cost sharing with respect to:

1. Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF).
2. Immunizations that appear on the Immunization Schedules of the Centers for Disease Control and Prevention.
3. With respect to infants, children, adolescents, and women, preventive care and screenings provided for in the guidelines supported by the Health Resources and Services Administration (HRSA).

**SLEOLA (JANUARY 1, 2014 TO DECEMBER 31, 2014)**  
**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 allowed benefit when preauthorized by the Plan	80% of allowed benefit
Partial Hospitalization Services	100% of allowed benefit	80% of allowed benefit
Residential Crisis Services	100% of allowed benefit	80% of allowed benefit
Outpatient Facility	100% of allowed benefit	80% of allowed benefit
Office and Professional Services (excluding Intensive Outpatient Services)	\$15 copay	80% of allowed benefit
Intensive Outpatient Services	\$15 copay	80% of allowed benefit
Outpatient Medication Management Services	\$15 copay	80% of allowed benefit
<b>Plan Year Deductible</b>		
Individual	None	\$250
Family	None	\$500
Combined with Medical		
<b>Please Year Out-of-Pocket Coinsurance &amp; Deductible Combined Maximum</b>		
Individual	None	\$3,000
Family	None	\$6,000
Combined with Medical		
<b>Plan Year Copayment Out-of-Pocket Maximum</b>		
Individual	\$1,000	None
Family	\$2,000	None
Combined with Medical		
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
Partial Hospitalization Services and 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
Outpatient Medication Management Services	\$15 copay	No Out-Of-Network Coverage
<b>Plan Year Deductible</b>		
Individual	None	No Out-Of-Network Coverage
Family		No Out-Of-Network Coverage
<b>Out-of-Pocket Coinsurance Maximum</b>		
Individual	None	No Out-Of-Network Coverage
Family	None	No Out-Of-Network Coverage
<b>Plan Year Copayment Out-of-Pocket Maximum</b>		
Individual	\$1,000	No Out-Of-Network Coverage
Family	\$2,000	No Out-Of-Network Coverage
Combined with Medical		
Lifetime Maximum	Unlimited	No Out-Of-Network Coverage

**SLEOLA (JANUARY 1, 2014 TO DECEMBER 31, 2014)**

**PRESCRIPTION DRUG BENEFITS**

**Copayments at Retail Pharmacies**

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

**Copayments through Voluntary Mail Order Program**

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

**Out-of-Pocket Maximum:**

**\$350**

**Out-of-Pocket Maximum:**

This means that when the total amount of copays you and your covered dependents pay during the plan year reaches \$350, you and your covered dependents will not pay any more copays for eligible prescriptions for the remainder of the plan year.