

Health Benefit Summary

Effective July 1, 2005



Maryland Health Insurance Plan

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This Health Benefit Summary is intended to service as a quick reference guide. It is not a substitution for or amendment to the benefits outlined in the Certificate of Coverage. If there is conflicting language between the Health Benefit Summary and the Certificate of Coverage, the Certificate of Coverage (and any of its amendments) controls. If you have any questions about the information contained in the Health Benefit Summary please consult your Certificate of Coverage.

MHP Health Benefit Summary

	EPO Network Plan	\$500 PPO Plan	\$1,000 PPO Plan	High Deductible Health Plan
Annual Medical Deductible				
Individual	None	\$500	\$1,000	\$1,200
Family	None	\$1,000	\$2,000	\$2,400
Annual Pharmacy Deductible				
Individual	\$250	\$100	\$250	Combined with medical
Family	\$500	None	\$500	Combined with medical
Out-of-Pocket Maximum*				
Individual	None	\$2,000	\$2,500	\$2,500
Family	None	\$4,000	\$5,000	\$5,000
<i>*Once out-of-pocket maximum is met, services are paid at 100% of allowable charges by MPC.</i>				
Lifetime Maximum (Combined all benefit plans)	\$2 million per member	\$2 million per member		\$2 million per member

Member Responsibility	EPO Network Plan	Both \$500 & \$1,000 PPO Plans <i>(Coinsurance applies after Annual Medical Deductible has been satisfied.)</i>		High Deductible Health Plan <i>(Coinsurance applies after Annual Combined Deductible has been satisfied.)</i>	
		In Network	Out of Network	In Network	Out of Network
Facility Services					
Inpatient					
Hospital (Semi-private Room & Board) 365 days / Plan year	\$250 copay	20%	40%	20%	40%
Skilled Nursing Facility – 100 days / Plan year	No copay	20%	40%	20%	40%
Hospice	No copay	20%	40%	20%	40%
Outpatient					
Hospital / Clinic / Ambulatory Surgical Center	\$20 copay	20%	40%	20%	40%
Professional Services					
Inpatient					
Medical Services	No copay	20%	40%	20%	40%
Surgery	No copay	20%	40%	20%	40%
Anesthesia / Assistant Surgeon	No copay	20%	40%	20%	40%
Blood and Blood Products	No copay	20%	40%	20%	40%
Laboratory and Radiology	No copay	20%	40%	20%	40%
Radiation / Chemotherapy	No copay	20%	40%	20%	40%
Therapy (Respiratory / Infusion / Renal Dialysis)	No copay	20%	40%	20%	40%

Outpatient					
Medical Services	\$30 copay /Specialist services \$20 copay /Primary Care services	20%	40%	20%	40%
Surgery	\$30 copay	20%	40%	20%	40%
Anesthesia /Assistant Surgeon	\$30 copay	20%	40%	20%	40%
Radiation /Chemotherapy	\$5 copay	20%	40%	20%	40%
Therapy (Respiratory / Infusion / Renal Dialysis)	No copay	20%	40%	20%	40%
Laboratory and Radiology	\$20 copay	20%	40%	20%	40%
Preventive Services					
Child					
Exam Only – 0 to 24 months	\$10 copay	\$10 copay*	40%	\$10 copay**	40%
Exam Only – 24 months and older	\$20 copay	20%	40%	20%	40%
Exam with Immunization – 24 months to 13 years	\$10 copay	\$10 copay*	40%	\$10 copay**	40%
Exam with Immunization – 13 years and older	\$20 copay	20%	40%	20%	40%
		<i>*These services are covered by Plan prior to satisfying Annual Medical Deductible.</i>		<i>**These services are covered by Plan prior to satisfying Annual Combined Deductible.</i>	
Adult					
Adult Physical Exam (1 per Plan year)	\$20 copay /Primary Care services	20%	40%	20%	40%
Adult Immunization (Part of exam)	No copay	20%	40%	20%	40%
Routine Gynecological Exam (1 per Plan year) including Cervical Cancer Screen	\$20 copay	20%	40%	20%	40%
Prostate and Colon Cancer Screenings	\$20 copay /Primary Care services	20%	40%	20%	40%
Mammography	\$20 copay	20%	40%	20%	40%
Maternity and Related Services					
Initial Prenatal Visit					
Prenatal Visits and Postnatal Check-up	\$20 copay	20%	40%	20%	40%
Inpatient Hospital or Birthing Center	No copay for Maternity / \$250 Hospital copay still applies	20%	40%	20%	0%
Family Planning					
Insertion and Removal of Contraceptive Devices	\$20 copay	20%	40%	20%	40%
Oral Contraceptives (see Pharmacy Program)					
Infertility Testing and Diagnosis	\$20 copay /Primary Care services \$30 copay /Specialist services	20%	40%	20%	40%
Emergency Services					
Emergency Room Visit With Admission	No copay for ER / \$250 Hospital copay still applies	20%	40%	20%	40%
Emergency Room Visit Without Admission	\$75 copay	20% + \$75 copay		20% + \$75 copay	
Urgent Care Centers	\$35 copay	20% + \$35 copay		20% + \$35 copay	
Provider Office	\$20 copay	20%	40%	20%	40%
					<i>Continued on back</i>

Member Responsibility	EPO Network Plan	Both \$500 & \$1,000 PPO Plans <i>(Coinsurance applies after Annual Medical Deductible has been satisfied.)</i>		High Deductible Health Plan <i>(Coinsurance applies after Annual Combined Deductible has been satisfied.)</i>	
		In Network	Out of Network	In Network	Out of Network
		Rehabilitation Services Physical / Speech / Occupational Therapy (30 visits each per diagnosis per Plan year)	\$20 copay	30%	50%
Cardiac / Pulmonary / Neurological Therapy	\$30 copay	20%	40%	20%	40%
Chiropractic (20 visits per diagnosis per Plan year)	\$20 copay	30%	50%	30%	50%
Other Allergy Testing	\$20 copay / Primary Care services \$30 copay / Specialist services	20%	40%	20%	40%
Allergy Injections	No copay	20%	40%	20%	40%
Ambulance Transport	No copay	20%	40%	20%	40%
Diabetes Equipment	No copay	20%	40%	20%	40%
Diabetes Supplies (see Pharmacy Program)					
Durable Medical Equipment	No copay	20%	40%	20%	40%
Disposable Medical Supplies	No copay	20%	40%	20%	40%
Hearing Aids	No copay	20%	40%	20%	40%
Home Health	No copay	20%	40%	20%	40%
Medical Vision Services	\$20 copay / Primary Care services \$30 copay / Specialist services	20%	40%	20%	40%
Orthotics	No copay	20%	40%	20%	40%
Prosthetic Devices	No copay	20%	40%	20%	40%
Behavioral Health Services Inpatient Psychiatric or Chemical Dependency Treatment (60 days combined per Plan year)	\$250 copay	20%	40%	20%	40%
Outpatient Treatment	30% of allowable charges	30%	50%	30%	50%
Medication Management	\$30 copay	20%	40%	20%	40%
Prescription Drugs	<i>Copays below apply after Annual Pharmacy Deductible has been satisfied.</i>	<i>Copays below apply after Annual Pharmacy Deductible has been satisfied.</i>		<i>Copays below apply after Annual Combined Deductible has been satisfied.</i>	
31-day Supply Generic	\$15 copay	\$15 copay		\$15 copay	
Preferred Brand	\$20 copay	\$20 copay		\$20 copay	
Non-preferred Brand	\$35 copay	\$35 copay		\$35 copay	
Maintenance Supply Generic	\$30 copay	\$30 copay		\$30 copay	
Preferred Brand	\$40 copay	\$40 copay		\$40 copay	
Non-preferred Brand	\$70 copay	\$70 copay		\$70 copay	

Note: A non-participating or Out-of-Network provider may charge more than the Plan's allowable charges. You are responsible for any charges above the Plan's allowable charges.