



Maryland Health Insurance Plan

Sales Training Manual

2011 – 2012 Plan Year

Administered by



MHIP – Maryland

Table of Contents

Maryland Health Insurance Plan

| | PAGE(S) |
|---|----------------|
| What's New for The 2011/2012 Plan Year? | i |
| Overview | 1 |
| Membership / Coverage Changes | 2 |
| Eligibility | 3 – 4 |
| Qualifying Medical Conditions | 5 |
| Effective Dates | 6 |
| Waiting Periods and Waivers | 7 |
| MHIP Portfolio of Products/ MHIP Federal & MHIP Federal+ | 8 |
| MHIP + | 9 |
| Deductibles / Out of Pocket Max / Coinsurance | 10 |
| Types of Plans | 11 – 15 |
| Out of Area Coverage | 16 |
| ID Cards | 16 – 17 |
| MHIP Premium Payments | 18 |
| Broker Filing Procedures | 19 – 20 |
| Policy Terminations | 20 |
| Contacts | 21 |

MHIP – Maryland

What's New for the 2011/2012 Plan Year

Rate Changes

- MHIP+ Plans 1 & 2 = 7% increase
- MHIP+ Plans 3 - 6 = 7% increase
- MHIP Standard Plans : PPO Plans = 7%increase ; HMO Plans = 7% increase; HDP plan = 10% increase
- MHIP Federal = No Change

New Products

- HealthyBlue
 - HealthyBlue triple option is being introduced as a new product available to members in the MHIP Standard plan option. (It is modeled after the Consumer Direct HealthyBlue Triple Option product.)
 - HealthyBlue allows the member to control costs and see both in-network and out of network providers.
 - Members pay nothing when seeing their primary care physician for routine and preventive care visits. Members will have access to certain benefits without meeting a deductible such as visits to their personal PCP, cancer screenings, lab tests, X-rays, urgent care and visits to the emergency room.
 - Members can also qualify for a Healthy Reward of up to \$300 per person and up to \$700 an entire family.
 - Members can get certain generic drugs for common chronic diseases like asthma, high blood pressure, high cholesterol, diabetes and depression at \$0 copay.
- MHIP Federal
 - \$500 PPO option has been added.
 - Two MHIP Federal + plans (both \$500 PPO) have also been added, providing lower rates for those with limited or moderate income who qualify financially.

* The MHIP materials have been updated on the MHIP website at <http://www.marylandhealthinsuranceplan.net>.*

MHIP – Maryland

Overview

The state legislature created the Maryland Health Insurance Plan (MHIP) in 2002 for residents who cannot obtain individual health insurance. In some cases, an individual may have a medical condition that automatically qualifies them or they have been denied coverage because of pre-existing medical conditions that put the individual at high risk. In others, private individual coverage is available, but the benefits are limited because of an individual's health condition.

In 2010, the Patient protection and Affordable Care Act (PPACA) established a federal high risk pool for citizens and lawful residents who have a pre-existing medical condition and have been without individual health insurance coverage for at least six months.

A Board of Directors governs the plan. CareFirst BlueCross BlueShield (CareFirst) and CareFirst BlueChoice, Inc, (CareFirst BlueChoice) administer MHIP's benefits on behalf of the State.

Jurisdiction

This is a Maryland-based product.

Medical Underwriting

No medical underwriting is required; however, an applicant must qualify under the guidelines stated below and must provide acceptable documentation.

Calendar or Plan Year

Plan Year (July 1 – June 30)

Membership Types

There is a four tier rate structure:

- Individual
- Individual & Child(ren)
- Individual & Spouse
- Family

Rates for multiple-member policies are determined based upon the age of the oldest applicant.

Note: MHIP does not offer domestic partner coverage.

MHIP – Maryland

Membership / Coverage Type Changes

Once an applicant becomes enrolled in the Plan, the type of coverage that the applicant selects remains in effect until the next Plan Year begins.

If all persons on the application are accepted by MHIP and a new policy is issued, then all of the services rendered prior to the new policy's effective date will not be credited towards:

- The new policy's deductible;
- The new policy's out-of-pocket limit; or,
- Any of the new policy's benefit maximums.

A member is allowed to select or change the type of coverage under the Plan either (i) at the time of the member's initial enrollment in the Plan; (ii) during the Plan's annual Open Enrollment period or (iii) if the member experiences a qualified event such as a change in his or her marital status or the number of eligible Dependents.

To change a member's type of coverage during the Plan Year due to a qualified event, the member must complete an [Enrollment Coverage Change Form](#) and submit it to the Plan Administrator within 31 days of the event. Qualified events are listed as follows:

- Change of Marital Status
- Dependent Children (Birth or Adoption)
- Death or Age of Majority of Unmarried Dependent
- Spouse's or Dependent's Loss of Other Coverage*

***Note:** A spouse's or other dependent's voluntary termination of other health insurance coverage is not a qualified event, unless it is the result of their termination from employment.

Members added as a result of a qualifying event will be subject to a 6-month pre-existing condition waiting period unless they've had creditable coverage. (Newborns and newly adopted children are exempt from the pre-existing condition waiting period if they were added within 31 days of the birth or adoption.)

Open Enrollment Period

- Open enrollment is held annually in the month of May; however, new applicants can enroll throughout the year.
- During open enrollment, current members may make a change that does not meet the qualified events change.
- Re-qualification for MHIP+. Members who are enrolled in an MHIP+ option will be required to submit an annual MHIP+ Re-Certification in order to re-qualify financially for the MHIP+ program.
- If a recertification is not provided timely, the MHIP+ participant is placed into a standard MHIP option and charged a standard rate effective July 1, and must reapply for MHIP+ to be *prospectively* re-enrolled in MHIP+ in a future month.

MHIP – Maryland

Eligibility and Other Ways to Qualify

Eligibility

There are a few requirements to meet before someone can enroll in MHIP. First, the person needs to be a Maryland resident for a specified period of time. Next, the applicant must meet **one** of the following requirements:

- Be a Maryland resident for at least 6 months.
- Have one of the medical conditions listed on the next page.
- Have been denied coverage by another health plan for medical reasons within the last six months.
- Be enrolled in or have the opportunity to enroll in individual health insurance that:
 - Permanently limits, restricts or blocks the applicant's coverage for a specific medical condition.
 - Has benefits that are similar to MHIP but costs the applicant more than the standard MHIP premium due to the applicant's health condition.
- Be a child who qualifies for medical reasons, and submits an application through a parent or guardian.

In addition, to qualify for the MHIP Federal program, you must:

- Be a citizen or national of the United States or lawfully present in the United States as well as a Maryland resident; and
- Have not had health insurance for a continuous six-month period of time prior to the date you apply to the MHIP Federal program.
- MHIP Federal is an individual policy only.

Other ways to qualify

So long as the applicant is a Maryland resident, the applicant can bypass the above requirements and qualify for MHIP if:

- The applicant recently lost his or her employer-sponsored group insurance, has 18 months of continuous health coverage, and the available continuation benefits which the applicant elected under that plan have run out (HIPAA eligible), or
- The applicant is switching from a high risk pool in another state, it's been less than 63 days since that coverage ended and the applicant plans to live here permanently; or
- The applicant has a pension from the Pension Benefit Guaranty Corporation (PBGC), is at least 55 years old and not entitled to Medicare*, or
- The applicant's job has been certified by the Department of Labor as affected by competition from international trade*.

** Applicants may be eligible for a federal program called the Health Coverage Tax Credit (HCTC)*

MHIP – Maryland

Residency Requirements and Documentation

Maryland Residency Requirements and Documentation:

Prospective applicants:

- Must be a resident of the State of Maryland for at least 6 months and have proof of residency. Proof or documentation can be in the form of:
 - a current Maryland driver's license or MD ID
 - Copy of lease or rental agreement issued more than 6 months ago
 - a Maryland State Income Tax Return
 - property tax bills
 - utility bills
 - pay stubs
 - voter's registration card

- Applicants applying for MHIP Federal must be a current Maryland resident for at least 1 day and be a citizen of the United States or lawfully present in the United States.

- Cannot be enrolled in, or eligible for:
 - Medicare
 - Medicaid
 - the Maryland Children's Health Program (MCHP) or
 - Comparable employer-sponsored group health insurance.

Exception: If the applicant is in the initial waiting period for group coverage with a new employer and meet any of the other eligibility requirements, they may apply to MHIP for coverage during that waiting period.

- Dependants are eligible from age 0 – 23 years old and unmarried. A dependant may only be older than 23 if they are incapable of self-support due to physical or mental incapacity.

IMPORTANT:

- Eligible Child -
The child will be enrolled in a child only policy. The entire family does not become eligible because of the child
- Eligible Spouse –
If one spouse qualifies, both can enroll

Exception to the State Residency Requirement

- The six-month residency requirement is waived under one of the following two circumstances:
 - namely for those who have recently exhausted their group coverage or COBRA (i.e., HIPAA eligible)
 - who are eligible for the Federal Health Coverage Tax Credit.

- MHIP Federal required that the applicant only be a Maryland resident, so there is no 6-month residency requirement for these products.

MHIP – Maryland

Qualifying Medical Conditions

Behavioral Health (Psychiatric)

- o Bipolar Disorder
- o Bulimia/Anorexia
- o Chemical Dependency
- o Creutzfeldt-Jakob Disease
- o Dementia
- o Disorders From Organic Brain Syndrome
- o Pick's Disease
- o Psychotic Disorders
- o Wernicke-Kosakoff Syndrome
- o Any other behavioral health in-patient treatment within the last 12 months

Blood/Blood Forming

- o Aplastic Anemia
- o Hemochromatosis
- o Hemophilia
- o Sickle Cell Disease

Cardiovascular

- o Angina Pectoris
- o Cardiomyopathy
- o Congestive Heart Failure
- o Coronary Artery Disease
- o Coronary Insufficiency
- o Coronary Occlusion
- o Pacemaker

Endocrine (Hormonal)

- o Addison's Disease
- o Cystic Fibrosis
- o Diabetes (Type I or II)
- o Porphyria
- o Wilson's Disease

Gastrointestinal

- o Ascites
- o Banti's Disease or Syndrome
- o Cirrhosis of the Liver
- o Crohn's Disease
- o Esophageal Varices
- o Hepatitis B or C
- o Ulcerative Colitis

Infectious

- o AIDS
- o HIV Positivity

Musculoskeletal/Connective

- o Ankylosing Spondylitis
- o Lupus Erythematosus Disseminate
- o Rheumatoid Arthritis
- o Scleroderma

Neoplasm (Cancers)

- o Cancer (except skin cancer) treated or diagnosed within the past 5 years
- o Melanoma
- o Hodgkin's Disease
- o Leukemia
- o Multiple Myeloma
- o Non-Hodgkin's Lymphoma
- o Wilm's Tumor

Neurologic

- o Alzheimer's Disease
- o Amyotrophic Lateral Sclerosis (ALS) (Lou Gehrig's Disease)
- o Friederich's Ataxia
- o Guillain Barre Syndrome
- o Huntington's Chorea
- o Hydrocephalus
- o Multiple Sclerosis
- o Muscular Dystrophy
- o Myasthenia Gravis
- o Myotonia
- o Palsy
- o Paraplegia
- o Parkinson's Disease
- o Quadriplegia
- o Stroke
- o Syringomyelia
- o Tay-Sachs Disease

Pulmonary (Lung)

- o Chronic Obstructive Pulmonary Disease
- o Emphysema

Other

- o Kidney Disease requiring Dialysis
 - o Major Organ Transplant
 - o Pregnancy
-

MHIP – Maryland

General Effective Date

- If the Plan received a completed MHIP application on or before the 15th day of the month, coverage will begin on the first day of the following month.
- If the Plan receives a completed MHIP application after the 15th day of the month, coverage will begin on the first day of the second month following receipt of that MHIP application.
- In both cases, the premium must be paid before coverage becomes effective.
- Exception: Applicants may be eligible for an earlier effective date if they have recently exhausted their group health coverage, COBRA or State Continuation coverage (HIPAA eligible).

Waiting Periods

- If an applicant was previously uninsured for more than 63 days, then the applicant may have to wait for six months before coverage is provided for charges associated with any pre-existing medical condition(s).
- Pregnancy is not subject to the pre-existing condition waiting period.
- MHIP Federal policies are not subject to the pre-existing condition waiting period.
- The member will be responsible for paying plan premiums during the six month pre-existing condition waiting period for all other pre-existing health conditions. If the member had recent health coverage, under the HIPAA requirements, the member will need to include documentation with his or her application that proves that he or she meets the HIPAA requirements under prior coverage to have the waiting period waived.
- If an applicant does not wish to be subject to the pre-existing condition coverage waiting period, and the applicant also does not meet the HIPAA requirements or lacks recent prior coverage, then the applicant may choose to pay a higher premium for the first 12 months of his or her MHIP coverage. Paying the higher premium allows the applicant to purchase an endorsement to “buydown” his or her MHIP coverage that eliminates the pre-existing condition waiting period. An applicant must indicate on the application form whether the applicant wishes to purchase an endorsement to eliminate the pre-existing condition after the application has been submitted.

HIPAA Eligible Effective Dates

Applicants who are HIPAA-eligible and submit their applications ahead of the last day of COBRA coverage can pick up coverage the day after their COBRA expires so that there is no lapse in coverage.

HIPAA-eligible applicants who submit their applications after their COBRA coverage has lapsed will be eligible to begin coverage on the next available coverage date (1st of the month depending on when their application is received).

Here are two examples to illustrate how this would work:

| Applicant's coverage terms on... | Application is received on... | CareFirst will... |
|----------------------------------|-------------------------------|---|
| June 12 | June 10 | <ul style="list-style-type: none"> • Honor the effective date of June 13 if the applicant doesn't want a break in coverage OR • Make the effective date July 1 |
| June 18 | June 16 | <ul style="list-style-type: none"> • Honor the effective date of June 19 if the applicant doesn't want a break in coverage OR • Make the effective date August 1 as we received the application after the 15th of the month |

MHIP – Maryland

Waiver of Waiting Period Pertaining to HIPAA Eligibility

If an individual chooses to apply for MHIP, he/she may be eligible for a waiver of the pre-existing condition exclusion.

To qualify for this waiver, he/she must:

- Meet ALL of the criteria listed below in HIPAA Eligibility Requirements.
- Submit evidence of prior creditable coverage (Certificate of Creditable Coverage) with the application. If there is a delay in obtaining the Certificate of Creditable Coverage, the application should be submitted with a letter regarding the prior coverage and a statement that the Certificate of Creditable Coverage has been requested.

If an applicant does not meet the HIPAA eligibility requirements because the applicant has less than 18 months of credible coverage, the pre-existing condition exclusion will still be reduced by the period of time that the applicant was covered under recent prior credible coverage.

HIPAA Eligibility Requirements:

- Have 18 or more months of creditable coverage with the most recent coverage under a group employer sponsored plan, governmental plan, church plan, or a health benefit plan offered in conjunction with any of these plans. Certificates of creditable coverage must indicate at least 18 months of aggregate creditable coverage.
- Have elected and exhausted health insurance benefits through a COBRA or similar group, state or federal continuation plan, including the Federal Employee Health Benefits Program (FEHBP), FEHBP Temporary Continuation of Coverage (TCC) or state continuation coverage, if available. Have no more than a 63-day break in coverage.
- Not be eligible for Medicare A or B, Medicaid, or any other employer sponsored plan.
- Not be covered by any other health insurance plan.
- Not have had prior insurance coverage terminated because of failure to pay the required premium or because of fraud.

NOTE: If the prospect is unable to show proof of prior coverage, then the pre-existing waiting period will NOT be waived.

MHIP – Maryland

2011/2012 MHIP Portfolio of Products

MHIP Standard Products

- PPO \$500
- PPO \$1,000
- HDP \$2,600
- HMO
- Healthy Blue*

* New for 2011/2012

MHIP Governmental Unit Payer Product

- HMO*

Comments:

- Exclusively for current MADAP HMO members and ALL new MADAP enrollees
 - Product benefits exactly the same as current HMO with higher premium
- * New for 2011/2012

MHIP + Products

- PPO \$200 (Plans 1 & 2)
- PPO \$500 (Plans 3 & 5)
- HMO (Plans 4 & 6)

Where multiple plans are listed next to the product, the only difference is in premium charged; not benefit plan design

MHIP Federal Products

- PPO \$500 *
- HDP \$1,500

MHIP Federal + Plans

- PPO \$500 (Plan 1)*
- PPO \$500 (Plan 2)*

Comments:

- Three new plan options being added.
- Benefit design is exactly the same as MHIP Standard \$500 PPO for all three
- The only differences in the plan are premiums

* New for 2011/2012

MHIP Federal & MHIP Federal+

What is it?

If you qualify for MHIP through medical eligibility or health condition eligibility, you may also qualify for a temporary federal high risk pool program administered by MHIP, called MHIP Federal. The temporary federal risk pool offers similar benefits as other MHIP plan options, but has different premiums and cost sharing. See the MHIP application booklet for further information about the MHIP Federal Plan option and rates.

** MHIP Federal offers individual coverage only**

MHIP Federal Qualifications

To qualify for the MHIP Federal program, you must:

- Qualify for MHIP through medical condition eligibility or health condition eligibility (see item 5B on page 3 of the MHIP application form);
- Meet all of the other eligibility requirements for MHIP;
- Be a citizen or national of the United States or lawfully present in the United States; and
- Be a Maryland resident; and
- Have not had health insurance for a continuous six-month period of time prior to the date that you apply to the MHIP Federal program.

If you believe that you are eligible for the MHIP Federal program and would like to apply to the program, you must:

- Complete this application form;
- Submit this application form to MHIP along with your MHIP application form; and
- Include the additional required documentation for the MHIP Federal program.

MHIP – Maryland

MHIP+

What is it?

MHIP+ is open only to those found eligible for MHIP who also have limited or moderate income. MHIP+ offers the same type of coverage as standard MHIP, but with reduced premiums and out-of-pocket expenses. If the applicant wishes to apply for the reduced premiums under MHIP+, the applicant must complete both the MHIP and MHIP+ applications with all required documentation as outlined on the form.

In the event the applicant does not qualify for MHIP+, they will be enrolled in the plan option selected on this MHIP application.

Below are the options available to limited or moderate income MHIP members.

MHIP + Plan Options

- Use the MHIP+ Plan Option Chart, below, to determine their available plan.
- Find the applicant's household size and then locate the column to the right with a household income. Example: A family of four with a household income of \$56,000 only qualifies for Plans 5 or 6.
- Use the MHIP+ rate charts located in MHIP Application Booklet pages 13 and 14 to determine their premium.
- Find the Plan that is available to the applicant. Next locate the applicant's age and move to the column that reflects the applicant's policy type.
- Then, select the plan available to the applicant based on the Plan Option Chart, or any higher plan. Example: A family of four with a household income of \$38,000 qualifies for Plan 2. That family may select Plan 2, 3 or 4, but may not select Plan 1.

| MHIP+ Plan Option Chart | | | | |
|-------------------------|----------|----------|-------------|-------------|
| Household Size | Plan 1 | Plan 2 | Plan 3 or 4 | Plan 5 or 6 |
| 1 | \$16,335 | \$21,780 | \$27,225 | \$32,670 |
| 2 | \$22,065 | \$29,420 | \$36,775 | \$44,130 |
| 3 | \$27,795 | \$37,060 | \$46,325 | \$55,590 |
| 4 | \$33,525 | \$44,700 | \$55,875 | \$67,050 |
| 5 | \$39,255 | \$52,340 | \$65,425 | \$78,510 |
| 6 | \$44,985 | \$59,980 | \$74,975 | \$89,970 |
| 7 | \$50,715 | \$67,620 | \$84,525 | \$101,430 |
| 8 | \$56,445 | \$75,260 | \$94,075 | \$112,890 |

MHIP – Maryland

Deductible, Out-of-Pocket Max & Co- insurance

- The member can select the deductible and out-of-pocket maximum from a choice of three different options to help meet the member's budget considerations. The \$200 Deductible PPO is only available to qualified MHIP+ members who can document limited or low income. The HMO benefit option has a prescription deductible only, and once met, copays apply.
- Families do not contribute more than the equivalent of two members' deductibles regardless of the number of family members covered by the policy.
- The deductible in the HDP is satisfied through a combination of payments for both medical and prescription drug Covered Services (the "Combined Deductible"). Once the member has met this individual or Family Combined Deductible, any applicable coinsurance or copays will apply.

Note: In many cases, before the Plan pays for Covered Services, the member must meet a deductible for medical and/or prescription drug services each Plan Year (July 1st through June 30th). If a member joins the Plan part way through the Plan year, the member has the remainder of the Plan year to satisfy the deductible. With the exception of the HDP Benefit Option, the medical and prescription drug deductibles are separate.

- The medical deductible is included in the out-of-pocket maximum. For Two Party/Family coverage, the out-of-pocket maximum is always twice that of the individual. HSA compatible-Two Party/Family out-of-pocket can be reached by one or more members of the family and the benefits are payable for the remainder of the plan year at 100% of the allowed benefit.
- The annual Out-of-Pocket Maximum is the most members will pay for their share of medical benefits during a single Plan Year, except for Emergency Service Copays. Thereafter, the Plan will pay 100% of Covered Services according to the Plan's Allowed Benefits for services provided by both in-network and out-of-network providers.
- Under the HDP Benefit Option, the entire Combined Deductible will count towards the Out-of-Pocket Maximum. HDP Benefit Option Members, who request a Brand Name drug when a generic equivalent is available, will, after their Deductible has been met, is required to pay the difference in price between the Brand Name drug and the generic equivalent. This amount does not contribute to the Out-of-Pocket Maximum.
- There is a \$100,000 annual prescription drug maximum for all options.
The Deductible and Out-of-Pocket options are shown below:

| Benefit Option | Individual Prescription Drug Out-of-Pocket Maximum |
|---|--|
| \$200 Deductible PPO (MHIP+ Only) | \$1,500 |
| \$500 Deductible PPO | \$2,000 |
| \$1,000 Deductible PPO | \$2,000 |
| HealthyBlue Triple Option | \$1,500 per member or \$3,000 per family medical and prescription drug deductible |
| HMO | \$2,000 |
| \$1,500 Deductible HDP (MHIP Federal Only) | \$1,500 medical and prescription drug deductible (out-of-pocket maximum is same as initial deductible). |
| \$2,600 HDP | No Prescription Drug Out-of-Pocket Maximum. The Medical Benefit Out-of-Pocket Maximum of \$4,600 per Member or \$9,200 per family for the HDP Benefit Option combines both medical and prescription drug out-of-pocket costs. |

MHIP – Maryland



Summary of Benefits: MHIP Federal Plans July 1 – June 30 Plan Contract Year

MHIP Federal Plans (individual coverage only)

| Benefits | HDP \$1,500 | PPO \$500 | PPO \$500 MHIP Federal+ Plans 1 & 2 |
|--|--|--|--|
| Contract Year Medical Deductible | \$1,500 | \$500 | \$500 |
| Contract Year Pharmacy Deductible | N/A | \$100 | \$100 |
| Out-of-Pocket Medical Maximum | \$1,500 (same as the combined medical and pharmacy deductible) | \$3,000 | \$3,000 |
| Out-of-Pocket Prescription Drug Copay Maximum | | \$2,000 | \$2,000 |
| Annual Prescription Drug Maximum | \$100,000 | | |
| Lifetime Maximum | \$2 million | | |
| Prescription Drug Copay | Short Term: \$0 copay* 90-day supply: \$0 copay* *If a member requests a brand name drug when a lower cost generic drug is available, the member will be required to pay the difference in cost between the two drugs. | Short Term: \$15 generic; \$35 preferred brand name; \$75 non-preferred brand name plus difference between the price of the brand name and generic drug; \$125 select brand name 90-day supply: \$30 generic; \$70 preferred brand name; \$150 non-preferred brand name plus difference between the price of the brand name and generic drug; \$250 select brand name | |
| Annual Physical Exam and Certain Preventive Services | Coinsurance: 0% in-network 0% out-of-network | \$10 copay in-network Coinsurance: 40% out-of-network | \$10 copay in-network Coinsurance: 40% out-of-network |
| Primary Care Physician (PCP) | Coinsurance: 0% in-network 0% out-of-network | Coinsurance: 20% in-network 40% out-of-network | Coinsurance: 20% in-network 40% out-of-network |
| Specialty Care Physician (SCP) | Coinsurance: 0% in-network 0% out-of-network | Coinsurance: 20% in-network 40% out-of-network | Coinsurance: 20% in-network 40% out-of-network |
| Physician Inpatient Visits | Coinsurance: 0% in-network 0% out-of-network | Coinsurance: 20% in-network 40% out-of-network | Coinsurance: 20% in-network 40% out-of-network |
| Emergency Room Visits | \$75 copay prior to deductible being satisfied, 0% coinsurance in-network and out-of-network after deductible satisfied | Coinsurance: 20% in/out-of-network and \$75 copay | Coinsurance: 20% in/out-of-network and \$75 copay |
| Hospital | Coinsurance: 0% in-network 0% out-of-network | Coinsurance: 20% in-network 40% out-of-network | Coinsurance: 20% in-network 40% out-of-network |
| Outpatient Lab and Diagnostic Services | Coinsurance: 0% in-network 0% out-of-network | Coinsurance: 20% in-network 40% out-of-network | Coinsurance: 20% in-network 40% out-of-network |
| Outpatient Surgery | Coinsurance: 0% in-network 0% out-of-network | Coinsurance: 20% in-network 40% out-of-network | Coinsurance: 20% in-network 40% out-of-network |
| Maternity | Coinsurance: 0% in-network 0% out-of-network | Coinsurance: 20% in-network 40% out-of-network | Coinsurance: 20% in-network 40% out-of-network |
| Chemotherapy | Coinsurance: 0% in-network 0% out-of-network | Coinsurance: 20% in-network 40% out-of-network | Coinsurance: 20% in-network 40% out-of-network |
| Outpatient Mental Health & Substance Abuse Treatment | Coinsurance: 0% in-network 0% out-of-network | Coinsurance: 30% in-network 50% out-of-network | Coinsurance: 30% in-network 50% out-of-network |

If a member of a PPO or HDP benefit option uses an out-of-network provider, the member may be required to pay the difference between the provider's charges and the allowed payment.

For more information contact (443) 738-0667 or (888) 444-9016

5

MHIP – Maryland



Summary of Benefits: MHIP+* Plans

July 1 – June 30 Plan Contract Year

| Benefits | Plans 1 and 2 | Plans 3 and 5 | Plans 4 and 6 |
|--|---|--|--|
| | PPO \$200 | PPO \$500 | HMO |
| Contract Year Medical Deductible | \$200 per person or \$400 for a family | \$500 per person or \$1,000 for a family | None |
| Contract Year Pharmacy Deductible | None | \$100 per person | \$250 per person with \$500 family maximum |
| Out-of-Pocket Medical Maximum | \$1,000 per person with \$2,000 family maximum | \$3,000 per person with \$6,000 family maximum | None |
| Out-of-Pocket Prescription Drug Copay Maximum | \$1,500 per person | \$2,000 per person | \$2,000 per person |
| Annual Prescription Drug Maximum | \$100,000 per person | | |
| Lifetime Maximum | \$2 million | | |
| Prescription Drug Copay | Short term: \$10 generic; \$25 preferred brand name; \$50 non-preferred brand name plus difference between the price of the brand name and generic drug; \$75 select brand name 90-day supply: \$20 generic; \$50 preferred brand name; \$100 non-preferred brand name plus difference between the price of the brand name and generic drug; \$150 select brand name | Short term: \$15 generic; \$35 preferred brand name; \$75 non-preferred brand name plus difference between the price of the brand name and generic drug; \$125 select brand name 90-day supply: \$30 generic; \$70 preferred brand name; \$150 non-preferred brand name plus difference between the price of the brand name and generic drug; \$250 select brand name | |
| Annual Physical Exam and Certain Preventive Services | \$10 copay in-network Coinsurance: 40% out-of-network | \$10 copay in-network Coinsurance: 40% out-of-network | \$10 copay |
| Primary Care Physician (PCP) | Coinsurance: 20% in-network 40% out-of-network | Coinsurance: 20% in-network 40% out-of-network | \$25 copay |
| Specialty Care Physician (SCP) | Coinsurance: 20% in-network 40% out-of-network | Coinsurance: 20% in-network 40% out-of-network | \$35 copay |
| Physician Inpatient Visits | Coinsurance: 20% in-network 40% out-of-network | Coinsurance: 20% in-network 40% out-of-network | None |
| Emergency Room Visit | Coinsurance: 20% in/out-of-network and \$75 copay | Coinsurance: 20% in/out-of-network and \$75 copay | \$75 copay |
| Hospital | Coinsurance: 20% in-network 40% out-of-network | Coinsurance: 20% in-network 40% out-of-network | \$250 per admission copay |
| Outpatient Lab and Diagnostic Services | Coinsurance: 20% in-network 40% out-of-network | Coinsurance: 20% in-network 40% out-of-network | \$25 copay |
| Outpatient Surgery | Coinsurance: 20% in-network 40% out-of-network | Coinsurance: 20% in-network 40% out-of-network | \$35 copay |
| Maternity | Coinsurance: 20% in-network 40% out-of-network | Coinsurance: 20% in-network 40% out-of-network | \$25 copay (initial visit only) |
| Chemotherapy | Coinsurance: 20% in-network 40% out-of-network | Coinsurance: 20% in-network 40% out-of-network | \$5 copay |
| Outpatient Mental Health & Substance Abuse Treatment | Coinsurance: 30% in-network 50% out-of-network | Coinsurance: 30% in-network 50% out-of-network | 30% coinsurance |

If a member of a PPO benefit option uses an out-of-network provider, the member may be required to pay the difference between the provider's charges and the allowed payment.

6

* For moderate and lower income members.

MHIP – Maryland



Summary of Benefits: MHIP Standard Plans July 1 – June 30 Plan Contract Year

| Benefits | PPO \$500 | PPO \$1,000 | HDP \$2,600 | HMO |
|--|--|---|---|--|
| Contract Year Medical Deductible | \$500 per person or \$1,000 per family | \$1,000 per person or \$2,000 per family | \$2,600 per person or \$5,200 per family | None |
| Contract Year Pharmacy Deductible | \$100 per person | \$250 per person with \$500 family maximum | \$5,200 per family | \$250 per person with \$500 family maximum |
| Out-of-Pocket Medical Maximum | \$3,000 per person with \$6,000 family maximum | \$3,500 per person with \$7,000 family maximum | \$4,600 per person or \$9,200 per family maximum | None |
| Out-of-Pocket Prescription Drug Copay Maximum | \$2,000 per person | \$2,000 per person | \$2,000 per person | \$2,000 per person |
| Annual Prescription Drug Maximum | \$100,000 per person | | | |
| Lifetime Maximum | \$2 million | | | |
| Prescription Drug Copay | Short term: \$15 generic; \$35 preferred brand name; \$75 non-preferred brand name plus difference between the price of the brand name and generic drug; \$125 select brand name 90-day supply: \$30 generic; \$70 preferred brand name; \$150 non-preferred brand name plus difference between the price of the brand name and generic drug; \$250 select brand name | | | |
| Annual Physical Exam and Certain Preventive Services | \$10 copay in-network Coinsurance: 40% out-of-network | \$10 copay in-network Coinsurance: 40% out-of-network | \$10 copay in-network Coinsurance: 40% out-of-network | \$10 copay |
| Primary Care Physician (PCP) | Coinsurance: 20% in-network 40% out-of-network | Coinsurance: 20% in-network 40% out-of-network | Coinsurance: 20% in-network 40% out-of-network | \$25 copay |
| Specialty Care Physician (SCP) | Coinsurance: 20% in-network 40% out-of-network | Coinsurance: 20% in-network 40% out-of-network | Coinsurance: 20% in-network 40% out-of-network | \$35 copay |
| Physician Inpatient Visits | Coinsurance: 20% in-network 40% out-of-network | Coinsurance: 20% in-network 40% out-of-network | Coinsurance: 20% in-network 40% out-of-network | None |
| Emergency Room Visit | Coinsurance: 20% in/out-of-network and \$75 copay | Coinsurance: 20% in/out-of-network and \$75 copay | Coinsurance: 20% in/out-of-network and \$75 copay | \$75 copay |
| Hospital | Coinsurance: 20% in-network 40% out-of-network | Coinsurance: 20% in-network 40% out-of-network | Coinsurance: 20% in-network 40% out-of-network | \$250 per admission copay |
| Outpatient Lab and Diagnostic Services | Coinsurance: 20% in-network 40% out-of-network | Coinsurance: 20% in-network 40% out-of-network | Coinsurance: 20% in-network 40% out-of-network | \$25 copay |
| Outpatient Surgery | Coinsurance: 20% in-network 40% out-of-network | Coinsurance: 20% in-network 40% out-of-network | Coinsurance: 20% in-network 40% out-of-network | \$35 copay |
| Maternity | Coinsurance: 20% in-network 40% out-of-network | Coinsurance: 20% in-network 40% out-of-network | Coinsurance: 20% in-network 40% out-of-network | \$25 copay (initial visit only) |
| Chemotherapy | Coinsurance: 20% in-network 40% out-of-network | Coinsurance: 20% in-network 40% out-of-network | Coinsurance: 20% in-network 40% out-of-network | \$5 copay |
| Outpatient Mental Health & Substance Abuse Treatment | Coinsurance: 30% in-network 50% out-of-network | Coinsurance: 30% in-network 50% out-of-network | Coinsurance: 30% in-network 50% out-of-network | 30% coinsurance |

If a member of a PPO or HDP benefit option uses an out-of-network provider, the member may be required to pay the difference between the provider's charges and the allowed payment.

MHIP – Maryland



Summary of Benefits: MHIP Standard Plans July 1 – June 30 Plan Contract Year

| Benefits | PPO \$500 | PPO \$1,000 | HDP \$2,600 | HMO |
|--|--|---|---|--|
| Contract Year Medical Deductible | \$500 per person or \$1,000 per family | \$1,000 per person or \$2,000 per family | \$2,600 per person or \$5,200 per family | None |
| Contract Year Pharmacy Deductible | \$100 per person | \$250 per person with \$500 family maximum | \$5,200 per family | \$250 per person with \$500 family maximum |
| Out-of-Pocket Medical Maximum | \$3,000 per person with \$6,000 family maximum | \$3,500 per person with \$7,000 family maximum | \$4,600 per person or \$9,200 per family maximum | None |
| Out-of-Pocket Prescription Drug Copay Maximum | \$2,000 per person | \$2,000 per person | \$2,000 per person | \$2,000 per person |
| Annual Prescription Drug Maximum | \$100,000 per person | | | |
| Lifetime Maximum | \$2 million | | | |
| Prescription Drug Copay | Short term: \$15 generic; \$35 preferred brand name; \$75 non-preferred brand name plus difference between the price of the brand name and generic drug; \$125 select brand name 90-day supply: \$30 generic; \$70 preferred brand name; \$150 non-preferred brand name plus difference between the price of the brand name and generic drug; \$250 select brand name | | | |
| Annual Physical Exam and Certain Preventive Services | \$10 copay in-network Coinsurance: 40% out-of-network | \$10 copay in-network Coinsurance: 40% out-of-network | \$10 copay in-network Coinsurance: 40% out-of-network | \$10 copay |
| Primary Care Physician (PCP) | Coinsurance: 20% in-network 40% out-of-network | Coinsurance: 20% in-network 40% out-of-network | Coinsurance: 20% in-network 40% out-of-network | \$25 copay |
| Specialty Care Physician (SCP) | Coinsurance: 20% in-network 40% out-of-network | Coinsurance: 20% in-network 40% out-of-network | Coinsurance: 20% in-network 40% out-of-network | \$35 copay |
| Physician Inpatient Visits | Coinsurance: 20% in-network 40% out-of-network | Coinsurance: 20% in-network 40% out-of-network | Coinsurance: 20% in-network 40% out-of-network | None |
| Emergency Room Visit | Coinsurance: 20% in/out-of-network and \$75 copay | Coinsurance: 20% in/out-of-network and \$75 copay | Coinsurance: 20% in/out-of-network and \$75 copay | \$75 copay |
| Hospital | Coinsurance: 20% in-network 40% out-of-network | Coinsurance: 20% in-network 40% out-of-network | Coinsurance: 20% in-network 40% out-of-network | \$250 per admission copay |
| Outpatient Lab and Diagnostic Services | Coinsurance: 20% in-network 40% out-of-network | Coinsurance: 20% in-network 40% out-of-network | Coinsurance: 20% in-network 40% out-of-network | \$25 copay |
| Outpatient Surgery | Coinsurance: 20% in-network 40% out-of-network | Coinsurance: 20% in-network 40% out-of-network | Coinsurance: 20% in-network 40% out-of-network | \$35 copay |
| Maternity | Coinsurance: 20% in-network 40% out-of-network | Coinsurance: 20% in-network 40% out-of-network | Coinsurance: 20% in-network 40% out-of-network | \$25 copay (initial visit only) |
| Chemotherapy | Coinsurance: 20% in-network 40% out-of-network | Coinsurance: 20% in-network 40% out-of-network | Coinsurance: 20% in-network 40% out-of-network | \$5 copay |
| Outpatient Mental Health & Substance Abuse Treatment | Coinsurance: 30% in-network 50% out-of-network | Coinsurance: 30% in-network 50% out-of-network | Coinsurance: 30% in-network 50% out-of-network | 30% coinsurance |

If a member of a PPO or HDP benefit option uses an out-of-network provider, the member may be required to pay the difference between the provider's charges and the allowed payment.

MHIP – Maryland



Summary of Benefits: MHIP Standard Plans (continued) July 1 – June 30 Plan Contract Year

HealthyBlue Triple Option

| Benefits | Option 1 | Option 2 | Option 3 |
|--|---|--|--|
| Provider Network | BlueChoice with Referrals | BlueChoice without Referrals | Out-of-Network |
| Contract Year Medical Deductible | \$1,500 Individual; \$3,000 Family | \$2,000 Individual; \$4,000 Family | \$2,500 Individual; \$5,000 Family |
| Contract Year Pharmacy Deductible | | Covered under Option 1 | Covered under Option 1 |
| Out-of-Pocket Medical Maximum | \$4,500 Individual; \$9,000 Family | \$6,000 Individual; \$12,000 Family | \$7,500 Individual; \$15,000 Family |
| Out-of-Pocket Prescription Drug Copay Maximum | | Covered under Option 1 | Covered under Option 1 |
| Annual Prescription Drug Maximum | \$100,000 per person | | |
| Lifetime Maximum | \$2 million | | |
| Prescription Drug Copay | \$0 HealthyBlue select generics (and not subject to deductible) for Asthma, Blood Pressure, Cholesterol, Depression & Diabetes Short term: \$4 Generics, \$45 Preferred Brand, \$65 Non-Preferred Brand; 90-day supply: \$8 Generics; \$90 Preferred brand name; \$130 non-preferred brand name | | |
| Annual Physical Exam and Certain Preventive Services | No charge | No charge | Not covered |
| Primary Care Physician (PCP) | No charge | No charge | Deductible, then \$20 copay |
| Specialty Care Physician (SCP) | \$20 copay | Deductible, then \$20 copay | Deductible, then \$20 copay |
| Physician Inpatient Visits | Deductible, then \$20 copay | Deductible, then \$100 copay | Deductible, then \$150 copay |
| Emergency Room Visits | \$100 copay | \$100 copay | \$100 copay |
| Hospital | Deductible, then \$300 per day up to 5 days | Deductible, then \$500 per day up to 5 days | Deductible, then \$700 per day up to 5 days |
| Outpatient Lab and Diagnostic Services | No charge | No charge | Deductible, then no charge |
| Outpatient Surgery | Outpatient Facility Services: Deductible, then \$20 copay Outpatient Professional Services at an Outpatient Facility: Deductible, then \$20 copay | Outpatient Facility Services: Deductible, then \$100 copay Outpatient Professional Services at an Outpatient Facility: Deductible, then \$100 copay | Outpatient Facility Services: Deductible, then \$150 copay Outpatient Professional Services at an Outpatient Facility: Deductible, then \$150 copay |
| Maternity | Prenatal & Postnatal office visits: Deductible, then \$20 copay Delivery & Facility Services: Deductible, then \$300/day up to 5 days | Prenatal & Postnatal office visits: Paid as Option 1* deductible, then \$20 copay Delivery & Facility Services: Paid as Option 1* deductible, then \$300/day up to 5 days | Prenatal & Postnatal office visits: Deductible, then \$20 copay Delivery & Facility Services: Deductible, then \$700/day up to 5 days |
| Chemotherapy | \$20 copay | Deductible, then \$100 copay | Deductible, then \$150 copay |
| Outpatient Mental Health & Substance Abuse Treatment | Deductible, then \$20 copay | Paid as Option 1* deductible, then \$20 copay | Deductible, then \$20 copay |
| Vision - Routine exam (1 visit/benefit period) | \$10/visit at participating Davis Vision providers | \$10/visit at participating Davis Vision providers | Plan pays \$33, member pays balance |
| Eyeglasses and Contact Lenses | Discounts from participating Davis Vision providers | Discounts from participating Davis Vision providers | Plan pays allowance based on purchase, members pays balance |

Please note: When the Allowed Benefit is less than the copay listed, your payment will not be more than the Allowed Benefit.
*For certain services the Option 1 deductible applies.

MHIP – Maryland

* Note: Complete coverage and exclusion information can be found in the Certificates of Coverage which can be found at:

- [Certificate of Coverage - HMO/HealthyBlue](#)
- [Certificate of Coverage – PPO/HDP](#)
- [Certificate of Coverage – Federal](#)

Out-of-Area Coverage

The Maryland Health Insurance Plan PPO product benefits travel easily by leveraging a program developed by Blue Cross and Blue Shield plans throughout the USA for national electronic data delivery system called BlueCard.

BlueCard advantages:

- Speeds the payment of a member's claim if the member receives treatment outside of the CareFirst service area
- Helps members receive maximum benefits and savings
- No claims have to be filed and the member cannot be billed for charges above the Plan's approved amount when a CareFirst member receives care from a provider who participates with the local BCBS plan

CareFirst BlueChoice members who are traveling outside of the BlueChoice service area may obtain emergency and urgent care services from a provider participating with an on-site Blue Cross and/ or Blue Shield licensee (Host Blue) wherever available. Services that are not emergency or Urgent Care are not covered through the BlueCard Program.




ID Cards

Shown on the following page are the ID cards for BluePreferred, BlueChoice and HealthyBlue:




- Dual-logo ID cards with either CareFirst BlueCross BlueShield, CareFirst BlueChoice and MHIP
- Participating providers will recognize the Blue logos which will make getting care and filing claims easier for MHIP members
- "Business as usual" from a provider perspective

MHIP – Maryland


BLUEPREFERRED

| | | |
|---|--|---|
|  | |  |
| Member Name | | |
| Member ID | | |
| Group | | |
| (Bin #011834 PCN #0300-0000) BCBS Plan 080/580 | | |
| | |  |

BLUECHOICE

| | | |
|---|-------|---|
|  | |  |
| Member Name | | |
| Member ID | PCP | |
| Group | | |
| (Bin #011834 PCN #0300-0000) BCBS Plan 080/580 | Copay | |
| | |  |

HEALTHYBLUE

| | | | | |
|---|---|---|-------------|---|
|  |  | CareFirst BlueChoice. CareFirst BlueCross BlueShield | HealthyBlue |  |
| Member Name | | | | |
| Member ID | PCP Name | | | |
| Group | | | | |
| (Bin #011834 PCN #0300-0000) BCBS Plan 080/580 | Copay | | | |
| | |  | | |

MHIP – Maryland

MHIP Premium Payments

- Premium payments should not be mailed with the applications. After submission of the application and upon approval, CareFirst BlueCross BlueShield (CareFirst) will send the applicant a letter indicating the amount of their monthly premium (with and without the pre-ex buy down if applicable) and where payments should be sent. As a reminder, when payments are made, they should be made to the Maryland Health Insurance Plan, not CareFirst.
- Shown below is a copy of the bill.


MHIP
 Maryland Health Insurance Plan
 Administered by CareFirst BlueCross BlueShield
 and CareFirst BlueChoice, Inc.

10455 Mill Run Circle - RR-291
Owings Mills, MD 21117-9685


CareFirst BlueCross BlueShield


CareFirst BlueChoice

INVOICE NO: 012221668

>0000040 7349520 001 92022 000040

Tom Munn
123 Baker Street
Anywhere, MD 21999

COVERAGE PAGE NO: 1
 COVERAGE PERIOD: July 1, 2009 - July 31, 2009

SUBSCRIBER ID: 9019999999
 GROUP NUMBER: 0LXA
 DATE PREPARED: 08/27/2009

| SUMMARY OF PAYMENT DUE | | |
|----------------------------------|------------|----------------------------------|
| | DATE | AMOUNT |
| PRIOR AMOUNT BILLED | 08/27/2009 | \$126.00 |
| PAYMENTS RECEIVED/ADJUSTMENTS | | \$0.00 |
| BALANCE FORWARD | | \$126.00 |
| TOTAL AMOUNT FOR COVERAGE PERIOD | | \$252.00 |
| TOTAL AMOUNT DUE BY | 07/01/2009 | TOTAL AMOUNT DUE \$378.00 |

| TOTAL AMOUNT FOR COVERAGE PERIOD | | | |
|---|-----------------|---------------|-----------------|
| | CURRENT | RETROACTIVITY | AMOUNT |
| Medical | \$252.00 | \$0.00 | \$252.00 |
| Drug | | | |
| TOTAL AMOUNT FOR COVERAGE PERIOD | \$252.00 | \$0.00 | \$252.00 |

FOR QUESTIONS ON THIS INVOICE CALL: Member (888) 456-2024

YOUR PREMIUM BILL IS PAYABLE IN FULL AND DUE AS OF THE DUE DATE WRITTEN ABOVE. PAST DUE PREMIUMS MAY RESULT IN CANCELLATIONS.

CareFirst BlueCross BlueShield is the business name of Group Hospitalization and Medical Services, Inc.

MHIP – Maryland

Process and Final Steps for Broker Submitted Applications

The process and final steps for new applications submitted by Brokers are shown below:

| STEP | ACTION |
|------|---|
| 1. | <p>Complete application and include attached proof that the applicant is a Maryland resident (proves six months of Maryland residency) such as: Maryland drivers license or Maryland ID card, utility bill, rental agreement, voter's registration card, pay stubs, Maryland income tax return, property and property taxes.</p> <ul style="list-style-type: none"> • Only original copies of MHIP applications will be accepted. Photocopies, faxes and email submissions are NOT acceptable. |
| 2. | <p>If the applicant is applying for separate coverage for an individual dependent child, attach a copy of the child's birth certificate or adoption papers.</p> |
| 3. | <p>If applying as medical eligible, the applicant should attach a letter from a carrier showing denial, restricted coverage, or an exclusionary rider or statement, which indicates that the applicant is paying a higher premium than MHIP's standard premium because of a medical condition.</p> <p>If applying as a HIPAA eligible, applicant should attach all Certificates of Credible Coverage showing eighteen (18) months of creditable coverage. If applicant cannot get a Certificate of Coverage, the applicant can prove that he or she has credible coverage and has exhausted COBRA (if offered) by providing any combination of the following:</p> <ul style="list-style-type: none"> • Summary plan description forms from the applicant's previous health plan that show s the applicant's termination date • Correspondence from the applicant's previous health plan that shows the applicant's termination date • Pay stubs showing deductions for health insurance • Health insurance identification card that shows the applicant's effective and termination dates • Medical records showing heath coverage • Third party statements verifying the coverage. |
| 4. | <p>The Maryland Health Insurance Plan offers individuals with moderate or low income the opportunity to pay reduced plan premiums and out-of-pocket expenses by offering an optional premium subsidy program, called MHIP+, to those who qualify. For more information refer to the application. If the applicant meets these requirements, he or she must complete an MHIP+ application and include documentation of his or her income.</p> |
| 5. | <p>Have the applicant sign the MHIP, MHIP+ or MHIP Federal Enrollment Application Form. Additionally, please make sure to fill out the broker information in its entirety at the bottom of page 6 of the application.</p> |
| 6. | <p>Mail the Application and all the required documentation to:</p> <p>Attn: Broker Sales CareFirst BlueCross BlueShield 10455 Mill Run Circle, MailStop 01-415 Owings Mills, MD 21117-9685</p> |

MHIP – Maryland

MHIP Broker Compensation

- A W9 must be completed and on file in order for payment to be remitted to any brokers. A W9 will be requested by CareFirst broker accounting department upon submission of your first application.
- Payment for MHIP is made 60 days after the enrollment date.

If you have additional concerns regarding commissions, please call:
Individual Sales Broker Hotline: 1 -800-628-4925.

Termination of Insured's Coverage

The policy terminates:

- For non-payment of premiums within the 60-day grace period.
- When the member is no longer a resident of Maryland.
- When the member requests it.
- On the date of the member's death.
- When a change in state law requires cancellation of the MHIP plan.
- When dependent reaches the age of 23 unless the dependent is unable to support him or herself due to physical or mental incapacity which occurred while MHIP coverage was in effect.
- When the member or the member's dependent(s) perform an act or practice that constitutes fraud or if the member made an intentional misrepresentation of material fact in his or her application for plan coverage.
- When the member becomes eligible for coverage under Medicare, the Maryland Medical Assistance Program or Maryland Children's Health Program.
- When the member becomes covered under other coverage that is substantially similar to MHIP coverage.
- When the member becomes eligible for comparable employer-sponsored coverage. An exception to this provision exists if the member is eligible for the tax credit for health insurance costs under Section 35 of the Internal Revenue Code and the member's employer pays for less than 50% of the cost of the coverage. In this case the member will not be subject to termination of coverage.

MHIP – Maryland

CONTACTS

Individual Broker Sales

Individual Broker Sales Hotline

800-628-4925

Customer Service

MHIP Member Services

443-725-1010

888-456-2024

Status – Application Processing

MHIP Application Status

443-725-1005

888-678-1240

Sales

Applying for an MHIP plan

443-738-0667

888-444-9016