

HOWARD COUNTY EMPLOYEES

SUMMARY PLAN DESCRIPTION

	In Network	Out-of-Network
Deductible	\$1,500 per Person \$3,000 per Family	\$3,000 per Person \$6,000 per Family
Out of Pocket Max	\$4,000 per Person \$8,000 per Family	\$8,000 per Person \$16,000 per Family
Plan Maximum	Unlimited	Unlimited
Precertification	No Precertification penalty when using In Network Providers. Member must Pre-Certify all services from Non-Network Providers.	
	<u>Copayments</u>	
Primary Care Office Visit Copayment	\$30 copay - All inclusive	Member pays 50%
Specialist Visits	\$30 copay	Member pays 50%
Physician Home Visits	\$30 copay	Member pays 50%
Urgent Care Facilities	\$50	Member pays 50%
Hospital Emergency Room	\$100	Member pays 50%
Inpatient Hospital	Member pays 20% after ded.	Member pays 50% after ded.
Outpatient Surgery	Member pays 20% after ded.	Member pays 50% after ded.
Family Planning	No Coverage	No Coverage
Medically Necessary Ambulance Transport	Subject to Ded. and benefit percentage	
Allergy Injection Serum	\$30 office visit copay	Member pays 50%
Diabetic Supplies	Member pays 20%	Member pays 50%
**Actual policy provisions prevail over any and all summary plan descriptions.		
	<u>Prescription Drug Card</u>	
Participating Pharmacy		
30 day supply	\$10 Generic Formulary \$30 Brand Formulary \$60 Non-Formulary	
90 day supply	\$10 Generic Formulary (1 copay)	
mail order	\$75 Brand Formulary \$180 Non-Formulary	

	In Network		Out-of-Network	
Routine Care	Unlimited-in network subject to \$30 office visit copay			
Emergency Illness	\$100 ER copay and coinsurance if applicable			
Therapy Services	Physical/Occupational 60 visits			
(Radiation, Chemo, and Dialysis do not go to max.)	Spinal manipulation 12 visits			
	Speech 20 visits, No dollar maximums			
Maternity	Additional maternity-related services are subject to Ded. And coinsurance based on place of service (i.e., ultrasound and false labor)			
Medical Aids	No sublimits - 20% co-ins. In network		No sublimits - 50% co-ins. Out of network	
Mental Health	\$30 copay or ded./co-ins. - same as any other condition			
Substance Abuse	\$30 copay or ded./co-ins. - same as any other condition			
	30 inpatient days			
TMJ	No Sublimits			
Home Health Care	No Sublimits; Subject to professional and ancillary copayments			
Accidental Dental	Facility - 20% after ded. in network		Facility - 50% after ded. out of network	
Colorectal Screening	Colorectal cancer exams and lab tests are covered under preventative care services, subject to applicable copay.			
Morbid Obesity Surgical Treatment	Persisted for at least 5 years; Unsuccessful non-surgical treatment for at least 18 months			
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	In Network		Out-of-Network	
	<u>Vision</u>			
	Frequency for exams and lenses is once every 12 months. Frames every 24 months.			
Exam	\$10		Up to \$35	
Lenses	\$20			
Single Vision			Up to \$25	
Bifocal (pair)			Up to \$40	
Progressive (pair)			Up to \$40	
Trifocal (pair)			Up to \$55	
Lenticular			Up to \$80	
Frames			Up to \$45	
Contact Lenses				
Elective	\$20		Up to \$105	
Non-Elective	\$20		Up to \$210	
Wholesale Frame Allowance	\$40 toward more expensive frames		N/A	
	<u>Dental</u>			
	\$25 per person			
	\$75 per family			
Deductible				
	\$2,000 per person			
Maximum Payment per Calendar Year				
Not including Orthodontia	\$1,000			
Lifetime Orthodontia Max	Covered at 100%			
Routine Exams				
Not Subject to Deductible	Covered at 80%			
All Other Services				
Subject to Deductible	Covered at 50%			
Orthodontia				
Not Subject to Deductible				
Customer Service: 1-800-227-6219	Out-of-State Providers: www.bluecares.com			
Vision: www.anthem.com (Anthem Blue Vision)				
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