

MONTGOMERY COUNTY HEALTH PLAN

Summary of Benefits Effective July 1, 2010

VALUE PLAN

MONTGOMERY COUNTY HEALTH PLAN		
BASIC DESCRIPTION OF PLANS	NETWORK	NON-NETWORK
<p>Montgomery County Health Plan is a self-funded benefit plan administered by Aetna Life Insurance Company.</p> <p>Each employee must select the Aetna plan which best suits their needs and the needs of their eligible family members.</p> <p>Service Area: Aetna's network: Ohio, Indiana, Kentucky, as well as any contracting PPO provider of another Aetna plan nationally.</p>	<p>Employees and their dependents may choose to receive care from any participating physician or hospital. If you receive care from a participating provider, network benefits apply. The network is Open Choice PPO.</p> <p>Members may seek care from any participating provider without obtaining a referral and receive network benefits. Network preventive services are covered 100%.</p> <p>Precertification is the responsibility of the participating provider.</p> <p>Montgomery County Network Hospitals: <u>Aetna</u> Children's Medical Center Dayton Heart Hospital Good Samaritan Hospital Grandview Hospital Kettering Medical Center Miami Valley Hospital Southview Hospital Sycamore Hospital</p> <p>Area Network Hospitals: <u>Aetna</u> Atrium Medical Center Clinton Memorial Hospital Greene Memorial Hospital Springfield Regional Medical Center Upper Valley Medical Center Wayne Hospital Wilson Memorial Hospital</p>	<p>Employees and their dependents may choose to receive care from any licensed physician or hospital. If you receive care from a Non-Network physician, Non-network benefits apply.</p> <p>Pre-certification for the following services is the responsibility of the employee/dependent:</p> <ul style="list-style-type: none"> * Elective Hospital admissions * Emergency admissions (Aetna must be notified within 48 hours) * OB related medical stay, including childbirth * Newborn stays beyond discharge of mother * Inpatient rehabilitation admissions * Inpatient Hospice * Inpatient skilled nursing facility admission * Home Healthcare Services * Private duty nursing * UPPP surgery (uvulopalatopharyngoplasty) * Plastic/reconstructive surgeries * Certain DME/Prosthetics <p>For emergency medical admissions you must notify the Pre-Certification Center within 48 hours. If the pre-certification is not obtained there is a non-compliance penalty of \$400.</p> <p>In addition, the employee/dependent is responsible for the costs of any services determined to be medically unnecessary or the actual cost of the service, whichever is less.</p>
BENEFIT PERIOD	July 1 - June 30	July 1 - June 30
PRE-EXISTING CONDITIONS	There are no specific pre-existing condition requirements, however, general exclusions do apply.	
Customer Service: Medical and Pharmacy	1-800-348-3666	
WEBSITE:	www.aetna.com, select Open Choice PPO	

**Deductible, Co-insurance,
Out-of-Pocket Maximums**

The terms deductible and co-insurance are used to describe what the employee/dependent is required to pay toward covered services.

NETWORK

Covered individuals/family are required to pay the applicable annual deductible and co-insurance for covered services. However, after the out-of-pocket maximum is reached, the eligible benefits are covered at 100% of Reasonable and Customary Charge (R&C) during the benefit year (July 1 - June 30) except where noted.

ANNUAL DEDUCTIBLE	
Per individual	\$1,000
Per Family	\$2,000
CO-INSURANCE 30%, except where noted.	
ANNUAL OUT-OF-POCKET MAXIMUM (including deductible)	
Per Individual	\$3,000
Per Family	\$6,000
The annual out-of-pocket maximums applies to all covered services except prescription drug expenses, penalty amounts and services reimbursed at 50%.	

NON-NETWORK

Covered individuals/family are required to pay the applicable annual deductible and co-insurance for covered services. However, after the out-of-pocket maximum is reached, the eligible benefits are covered at 100% of Reasonable and Customary Charge (R&C) during the benefit year (July 1 - June 30) except where noted. Any charges above R&C are the member's responsibility.

ANNUAL DEDUCTIBLE	
Per individual	\$2,000
Per Family	\$4,000
CO-INSURANCE 40%, except where noted.	
ANNUAL OUT-OF-POCKET MAXIMUM (including deductible)	
Per Individual	\$6,000
Per Family	\$12,000
The annual out-of-pocket maximums applies to all covered services except prescription drug expenses, penalty amounts and services reimbursed at 50%.	

1. The deductible on network services does not apply to the deductible on non-network services.
2. The deductible on non-network services does not apply to network services.
3. Co-insurance on network services applies only to network annual out-of-pocket maximums, except where noted.
4. Co-insurance on non-network services applies only to non-network annual out-of-pocket maximums, except where noted.

ANNUAL MAXIMUM (except where noted): \$1,000,000 (combined with Non-Network) \$1,000,000 (combined with Network)

LIFETIME MAXIMUM (except where noted): \$5,000,000 (combined with Non-Network) \$5,000,000 (combined with Network)

*UNMARRIED DEPENDENT CHILDREN: To age 19; or To age 19; or
 To age 24 if full time student To age 24 if full time student
 * Effective July 1, 2010 dependents, up to the day they turn 28, may be eligible for healthcare coverage under Montgomery County plans. To be eligible, the dependent must be unmarried, either a resident of Ohio or a full-time student, and not eligible for medicare, medicaid or other employer sponsored healthcare.
 For more information on eligibility and cost, call 225-4018.

DEPENDENTS RESIDING OUT OF AREA: Employees and dependents residing out of area may receive network benefits through any contracting Aetna PPO providers, otherwise covered at non-network level. Emergency services paid at network level. If no network providers are available, services are covered at 80%.
 Call 1-800-348-3666 or visit the website at www.aetna.com and select your state of residence.

DESCRIPTION OF SERVICES	NETWORK	NON-NETWORK
WELLNESS/PREVENTIVE*		
WELL BABY & WELL-CHILD CARE	Covered in full, no deductible or co-insurance	Not Covered
ANNUAL PHYSICAL EXAM	Covered in full (not covered if exam is for medical research, employment, or life insurance).	Not Covered
IMMUNIZATIONS	Covered in full, no deductible or co-insurance	Not Covered
ROUTINE EYE EXAM	Covered in full (exam only) one per benefit period (contact lens exam requires additional fee)	Not Covered
ROUTINE HEARING TEST	Covered in full; one per benefit period	Not Covered
PAP TEST OR PROSTATE EXAM (including office visit)	Covered in full, no deductible or co-insurance	Not Covered
MAMMOGRAM	Covered in full, no deductible or co-insurance	Not Covered
COLONOSCOPY / COLORECTAL SCREENING	Covered in full, no deductible or co-insurance	Not Covered
OSTEOPOROSIS BONE SCAN	Covered in full, no deductible or co-insurance	Not Covered
SMOKING CESSATION	Covered, subject to deductible and co-insurance Prescription smoking cessation drugs covered under prescription drug plan, limited to one 3 month treatment plan per calendar year.	Covered, subject to deductible and co-insurance Prescription smoking cessation drugs not covered
PRESCRIPTION DRUGS		Not covered, must use Network pharmacy
Retail - 30 day supply: Generic	70% / 30%; minimum \$15, maximum \$100	
Brand Formulary	70% / 30%; minimum \$15, maximum \$100	
Non-formulary	70% / 30%; minimum \$15, maximum \$100	
Mail Order - 90 day supply: Generic	70% / 30%; minimum \$30, maximum \$200	
Brand Formulary	70% / 30%; minimum \$30, maximum \$200	
Non-formulary	70% / 30%; minimum \$30, maximum \$200	
<i>(excludes all weight loss prescriptions)</i>	Includes contraceptives, immuno-suppressive agents and human growth hormones;	
	Both Rx Drug and Mail Order covers supplies and equipment for a Disease Management Program (diabetes). Diabetic supplies include but are not limited to, lancets and auto lancing devices, glucose test strips, blood glucose monitors.	

* Wellness claims must be filed as preventive to be covered at 100%; claims filed with a diagnosis will be subject to deductible and co-insurance.

OFFICE VISITS

PRIMARY CARE PHYSICIANS
SPECIALISTS

CHIROPRACTOR
Office Visit

HOSPITAL AND FACILITY CHARGES

INPATIENT HOSPITAL

INTENSIVE CARE

HOSPITAL ANCILLARY SERVICES
(Operating room, drugs, dressing, etc.)

PRE-ADMISSION TESTING

NEWBORN NURSERY CARE

DIAGNOSTIC X-RAY & LAB
(inpatient)

RADIATION, CHEMO & DIALYSIS

SKILLED NURSING FACILITY

PHYSICIAN CHARGES**SURGERY & ANESTHESIA**

Inpatient

Outpatient

PHYSICIANS VISIT IN HOSPITAL
(non-surgical)

ASSISTANT SURGEON
(medically necessary)

SECOND SURGICAL OPINION

NETWORK

Covered with diagnosis, subject to deductible and co-insurance.

Covered, subject to deductible and co-insurance; no limit on number of visits, subject to medical review after 25 visits (combined with spinal manipulations and Non-Network benefits)

Semi-Private room for unlimited days
subject to deductible and co-insurance

Covered, subject to deductible and co-insurance

Covered, subject to deductible and co-insurance

Covered, subject to deductible and co-insurance

Covered, subject to deductible and co-insurance

Covered, subject to deductible and co-insurance

Covered, subject to deductible and co-insurance

Covered, subject to deductible and co-insurance;
maximum 180 days per benefit period (combined with Non-Network)

Covered, subject to deductible and co-insurance.

Covered, subject to deductible and co-insurance.

Covered, subject to deductible and co-insurance.

Covered, subject to deductible and co-insurance.

Covered, subject to deductible and co-insurance.

NON-NETWORK

Covered with diagnosis, subject to deductible and co-insurance.

Covered, subject to deductible and co-insurance; no limit on number of visits, subject to medical review after 25 visits (combined with spinal manipulations and Network benefits)

Semi-Private room for unlimited days
subject to deductible and co-insurance

Covered, subject to deductible and co-insurance

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Covered, subject to deductible and co-insurance;
maximum 180 days per benefit period (combined with Network)

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Covered, subject to deductible and co-insurance.

PHYSICIAN CHARGES

DIAGNOSTIC X-RAY & LAB
(outpatient)

PHYSICAL THERAPY SERVICES

A. Inpatient

B. Outpatient

OTHER SERVICES

MATERNITY CARE

URGENT CARE

EMERGENCY ROOM

(appropriate criteria must be met)

AMBULANCE

ALLERGY SERVICES

Testing

Injections and Serum

BLOOD

DURABLE MEDICAL EQUIPMENT,
MEDICAL SUPPLIES AND APPLIANCESEMERGENCY ACCIDENT DENTAL
TREATMENTHOME HEALTH CARE / PRIVATE
DUTY NURSING**NETWORK**

Covered, subject to deductible and
co-insurance

Physical Medicine & Rehabilitative medicine
Covered, subject to deductible and co-insurance;
maximum 60 days per benefit period
(combined with Non-Network benefits)

Covered, subject to deductible and co-insurance; maximum
60 visits per benefit period: physical, occupational and
speech; (combined with Non-Network).

All covered persons; subject to deductible and
co-insurance.

Covered, subject to deductible and co-insurance.

Covered subject to deductible and co-insurance; waived
if admitted to hospital as an inpatient, then inpatient
benefits apply.

Covered, subject to deductible and co-insurance;
emergency transportation only (ground or air)

Covered, subject to deductible and co-insurance;
Covered, subject to deductible and co-insurance;

Covered, subject to deductible and co-insurance;

Covered, subject to deductible and co-insurance.
(includes Glucose monitor if not in DM program)

Covered, subject to deductible and co-insurance
(routine, normal dental care is not covered).

Covered, subject to deductible and co-insurance;
maximum 90 visits per benefit period combined; 4
hours of home health care services equal one visit and
8 hours of skilled care services equal one PDN visit
(combined with Non-Network).

NON-NETWORK

Covered, subject to deductible and
co-insurance

Physical Medicine & Rehabilitative medicine
Covered, subject to deductible and co-insurance; maximum
60 days per benefit period (combined with Network).

Covered, subject to deductible and co-insurance; maximum
60 visits per benefit period: physical, occupational and
speech; (combined with Network).

All covered persons; subject to deductible and
co-insurance.

Covered at Network level; you will be required to pay for
the service then submit claim for reimbursement.

Covered, at the network level; if admitted, you must notify
the Pre-Certification Center within 48 hours otherwise
a \$400 penalty applies.

Covered as network benefit, subject to network
deductible and co-insurance; emergency transportation
only (ground or air)

Covered, subject to deductible and co-insurance;
Covered, subject to deductible and co-insurance;

Covered, subject to deductible and co-insurance;

Covered, subject to deductible and co-insurance.
(includes Glucose monitor if not in DM program)

Covered as network benefit, subject to network deductible
and co-insurance (routine, normal dental care is not covered).

Covered, subject to deductible and co-insurance;
maximum 90 visits per benefit period combined; 4
hours of home health care services equal one visit and
8 hours of skilled care services equal one PDN visit
(combined with Network).

OTHER SERVICES	NETWORK	NON-NETWORK
HOSPICE (inpatient or outpatient)	Covered, subject to deductible and co-insurance;	Covered, subject to deductible and co-insurance;
HUMAN ORGAN TRANSPLANTS (patient meets criteria)	Institute of Excellence (IOE) 100%, no deductible. Non IOE, but Aetna network, 70% after deductible all to a maximum of \$1,000,000 (applies to lifetime max.) Pre-certification required (tissue and organ)	Not Covered
INFERTILITY SERVICES/DRUGS	Diagnosis and treatment subject to deductible and co-insurance. Oral infertility drugs subject to co-insurance. Injectable infertility drugs, artificial insemination, ovulation induction, ART, ZIFT, GIFT, etc. covered subject to deductible and 50% co-insurance and a \$20,000 maximum per benefit period, does not apply to annual out-of-pocket maximum (network and non- network and non-network combined).	Diagnosis and treatment subject to deductible and co-insurance. Oral infertility drugs are NOT covered. Injectable infertility drugs, artificial insemination, ovulation induction, ART, ZIFT, GIFT, etc. covered subject to deductible and 50% co-insurance and a \$20,000 maximum per benefit period, does not apply to annual out-of-pocket maximum (network and non-network combined).
BARIATRIC SERVICES	Covered, subject to deductible and 50% co-insurance; \$20,000 lifetime maximum includes services and/or surgery relating to complications; no retail or mail order prescription drug coverage, does NOT apply to annual out-of-pocket maximum.	Not Covered
STERILIZATION	Covered, subject to deductible and co-insurance.	Covered, subject to deductible and co-insurance.
VOLUNTARY TERMINATION OF PREGNANCY	Covered, subject to deductible and co-insurance.	Covered, subject to deductible and co-insurance.
MENTAL HEALTH and/or SUBSTANCE ABUSE	ALL CONTRACTING NETWORK PROVIDERS	ALL LICENSED PSYCHIATRISTS/QUALIFIED PSYCHOLOGIST
A. Mental Health and/or Substance Abuse (inpatient)	Covered, subject to deductible and co-insurance.	Covered, subject to deductible and co-insurance.
B. Mental Health and/or Substance Abuse (outpatient)	Covered, subject to deductible and co-insurance.	Covered, subject to deductible and co-insurance.

This summary describes the features of the program available beginning July 1, 2010. This benefit description is intended to be a brief outline of benefits available to eligible employees and their eligible dependents. It does not include all of the benefits or exclusions. The entire provisions of benefits and exclusions are contained in the Summary Plan Document (SPD). In the event of a conflict, between the SPD and this description, the terms of the SPD will prevail.

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