

**MONTGOMERY COUNTY HEALTH PLAN**  
**Summary of Benefits Effective July 1, 2011**

**The Buy-up Plan**

MONTGOMERY COUNTY HEALTH PLAN		
BASIC DESCRIPTION OF PLANS	NETWORK	NON-NETWORK
<p><b>Montgomery County Health Plan</b> is a self-funded benefit plan administered by Anthem Insurance Company.</p> <p>Each employee must select the Anthem plan which best suits their needs and the needs of their eligible family members.</p> <p><b>Service Area:</b>  <b>Anthem's network:</b> Ohio, Indiana, Kentucky, as well as any contracting PPO provider of BlueCard 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 BlueCard 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><b>Montgomery County Network Hospitals:</b>  <u>Anthem</u>            Children's Medical Center            Dayton Heart Hospital now part of Good Samaritan            Good Samaritan Hospital            Grandview Hospital            Kettering Medical Center            Miami Valley Hospital            Southview Hospital            Sycamore Hospital            Medical Center at Elizabeth Place</p> <p><b>Area Network Hospitals:</b>  <u>Anthem</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"> <li>* Elective Hospital admissions</li> <li>* Emergency admissions (Anthem must be notified within 48 hours)</li> <li>* OB related medical stay, including childbirth</li> <li>* Newborn stays beyond discharge of mother</li> <li>* Inpatient rehabilitation admissions</li> <li>* Inpatient skilled nursing facility admission</li> <li>* Private duty nursing</li> <li>* Plastic/reconstructive surgeries</li> <li>* Certain DME/Prosthetics</li> </ul> <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, 2011 - June 30, 2012	July 1, 2011 - June 30, 2012
PRE-EXISTING CONDITIONS	There are no specific pre-existing condition requirements, however, general exclusions do apply.	
Customer Service: Medical and Pharmacy		1-855-639-9715
WEBSITE:		<a href="http://www.anthem.com">www.anthem.com</a>

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

The terms copayment, 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 co-payment or the 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.

<b>ANNUAL DEDUCTIBLE</b>	
Per individual	\$500
Per Family	\$1,000
CO-INSURANCE 20%, except where noted.	
<b>ANNUAL OUT-OF-POCKET MAXIMUM (including deductible)</b>	
Per Individual	\$2,500
Per Family	\$5,000
The annual out-of-pocket maximums applies to all covered services except prescription drug expenses and co-pays and penalty amounts	

**NON-NETWORK**

Covered individuals/family are required to pay the applicable co-payment or the 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.

<b>ANNUAL DEDUCTIBLE</b>	
Per individual	\$1,000
Per Family	\$2,000
CO-INSURANCE 40%, except where noted.	
<b>ANNUAL OUT-OF-POCKET MAXIMUM (including deductible)</b>	
Per Individual	\$5,000
Per Family	\$10,000
The annual out-of-pocket maximums applies to all covered services except prescription drug expenses and co-pays, penalty amounts	

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.
5. Copayments DO NOT accumulate toward annual out-of-pocket maximums.

ANNUAL MAXIMUM (except where noted):

\$1,000,000 (combined with Non-Network)

\$1,000,000 (combined with Network)

LIFETIME MAXIMUM (except where noted):

Unlimited

Unlimited

OVERAGE DEPENDENT CHILDREN:

Eligible dependents are covered until age 26 (End of Month) due to Federal regulations

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State of Ohio requires public employee benefit plans to offer parents whose employer sponsored health insurance includes an age limit, the option of covering their dependent children up to age 28.

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For more information on eligibility and cost for dependents 26 to 28 call 937-225-4018.

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DEPENDENTS RESIDING OUT OF AREA:

Employees and dependents residing out of area may receive network benefits through any contracting Anthem 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 1-855-639-9715 or visit the website at [www.anthem.com](http://www.anthem.com) and select your state of residence.

DESCRIPTION OF SERVICES	NETWORK	NON-NETWORK	
<b>WELLNESS/PREVENTIVE*</b>			
WELL BABY & WELL-CHILD CARE	Covered in full, no copay	Not Covered	
ANNUAL PHYSICAL EXAM	Covered in full (not covered if exam is for medical research, employment, or life insurance). No co-pay.	Not Covered	
IMMUNIZATIONS	Covered in full, no copay	Not Covered	
ROUTINE EYE EXAM	Covered in full (exam only) one per benefit period (contact lens exam requires additional fee). No co-pay.	Not Covered	
ROUTINE HEARING TEST	Covered in full; one per benefit period. No co-pay.	Not Covered	
PAP TEST OR PROSTATE EXAM (including office visit)	Covered in full, no copay	Not Covered	
MAMMOGRAM	Covered in full, no copay	Not Covered	
COLONOSCOPY / COLORECTAL SCREENING	Covered in full, no copay	Not Covered	
OSTEOPOROSIS BONE SCAN	Covered in full, no copay	Not Covered	
SMOKING CESSATION	Covered, Copay office visit - Prescription covered under Medco	Covered, subject to deductible and co-insurance Drugs covered under Medco	
<b>PRESCRIPTION DRUGS Adminstor by MEDCO</b>			
Retail - 30 day supply: Generic	\$7.50 co-pay	Not covered, must use Network pharmacy	
Brand Formulary	\$30 co-pay		
Non-formulary	\$50 co-pay		
Mail Order - 90 day supply: Generic	\$15 co-pay		
Brand Formulary	\$75 co-pay		
Non-formulary	\$125 co-pay		
Retail - 90 day supply: Generic	\$22.50 co-pay		
Brand Formulary	\$90 co-pay		
Non-formulary	\$150 co-pay		
(excludes all weight loss prescriptions)	Includes contraceptives, immuno-suppressive agents and human growth hormones;		
	As for diabetic supplies, the below is the coverage we have on the Rx side:		
	OTC Diabetic Supplies (Select Exceptions Only)		
	Alcohol Swabs		INCLUDE
	Lancets		INCLUDE
	Urine/Blood Test Strips & Tapes	INCLUDE	
	Blood Glucose Testing Monitors	INCLUDE	
	Continuous Glucose Monitor/Transmitters/Sensors (i.e. Guardian, Freestyle Navigator, Seven Plus)	INCLUDE	
	Insulin Syringes with or without Needles	INCLUDE	
	OTC Hyperglycemic products (i.e. Insta-Glucose)	INCLUDE	
	Below are items NOT covered:		
	GlucoWatch Products	EXCLUDE	
	Insulin pumps DCRS ONLY	EXCLUDE	
	Insulin pumps supplies DCRS ONLY	EXCLUDE	

\* Wellness claims must be filed as preventive to be covered at 100%; claims filed with a diagnosis will be subject to co-payment or deductible and co-insurance. One per benefit period.

OFFICE VISITS	NETWORK	NON-NETWORK
PRIMARY CARE PHYSICIANS SPECIALISTS	\$15 Copayment \$30 Copayment	Covered subject to deductible and co-insurance Covered subject to deductible and co-insurance
CHIROPRACTOR	\$30 Copayment office visit; no limit on number of  25 visit maximum per plan year (includes all services performed by a chiropractor) Combined In & Out-of-Network. Subject to medical review after 25 visits	Covered, subject to deductible and  25 visit maximum per plan year (includes all services performed by a chiropractor) Combined In & Out-of-Network. Subject to medical review after 25 visits
<b>HOSPITAL AND FACILITY CHARGES</b>		
INPATIENT HOSPITAL	Semi-Private room for unlimited days subject to deductible and co-insurance	Semi-Private room for unlimited days subject to deductible and co-insurance
INTENSIVE CARE	Covered, subject to deductible and co-insurance	Covered, subject to deductible and co-insurance
HOSPITAL ANCILLARY SERVICES (Operating room, drugs, dressing, etc.)	Covered, subject to deductible and co-insurance	Covered, subject to deductible and co-insurance
PRE-ADMISSION TESTING	Covered, subject to deductible and co-insurance	Covered, subject to deductible and co-insurance
NEWBORN NURSERY CARE	Covered, subject to deductible and co-insurance	Covered, subject to deductible and co-insurance
DIAGNOSTIC X-RAY & LAB (inpatient)	Covered, subject to deductible and co-insurance	Covered, subject to deductible and co-insurance
RADIATION, CHEMO & DIALYSIS	Covered, subject to deductible and co-insurance	Covered, subject to deductible and co-insurance
SKILLED NURSING FACILITY	Covered, subject to deductible and co-insurance; maximum 180 days per benefit period (combined with Non-Network)	Covered, subject to deductible and co-insurance; maximum 180 days per benefit period (combined with Network)
<b>PHYSICIAN CHARGES</b>		
<b>SURGERY &amp; ANESTHESIA</b> Inpatient	Covered, subject to deductible and co-insurance.	Covered, subject to deductible and co-insurance.
Outpatient	Covered, subject to deductible and co-insurance.	Covered, subject to deductible and co-insurance.
PHYSICIANS VISIT IN HOSPITAL (non-surgical)	Covered, subject to deductible and co-insurance.	Covered, subject to deductible and co-insurance.
ASSISTANT SURGEON (medically necessary)	Covered, subject to deductible and co-insurance.	Covered, subject to deductible and co-insurance.
SECOND SURGICAL OPINION	\$15/\$30 Copayment in office setting; subject to deductible and co-insurance in hospital	Covered, subject to deductible and co-insurance.

PHYSICIAN CHARGES	NETWORK	NON-NETWORK
DIAGNOSTIC X-RAY & LAB (outpatient)	Covered, subject to deductible and co-insurance.	Covered at 100%
PHYSICAL THERAPY SERVICES		
A. Inpatient	Physical Medicine & Rehabilitative medicine Covered, subject to deductible and co-insurance; maximum 60 days per benefit period (combined with Non-Network benefits)	Physical Medicine & Rehabilitative medicine Covered, subject to deductible and co-insurance; maximum 60 days per benefit period (combined with Network).
B. Outpatient	\$30 Copayment or covered, subject to deductible and co-insurance (place of service) C1: independent therapy provider; maximum 60 visits per benefit period combined: physical, occupational and speech; (combined with Non-Network)	Covered, subject to deductible and co-insurance; maximum 60 visits per benefit period: physical, occupational and speech; (combined with Network).
<b>OTHER SERVICES</b>		
MATERNITY CARE	All covered persons; delivery and hospitalization covered subject to deductible and co-insurance; \$15 copayment for office visit to determine pregnancy, then office visits are covered in full	All covered persons; subject to deductible and co-insurance
URGENT CARE	\$35 Copayment for each visit to after hours clinic or Urgent Care Center.	Covered at Network level; you will be required to pay for the service then submit claim for reimbursement.
EMERGENCY ROOM (appropriate criteria must be met)	\$175 Copayment per visit; waived if admitted, then inpatient benefits apply, reduced to 50% if Urgent Care visited within 48 hours prior to ER visit (requires review).	Covered, at the network level; if admitted, you must notify the Pre-Certification Center within 48 hours otherwise a \$400 penalty applies.
AMBULANCE	Covered, subject to deductible and co-insurance; emergency transportation only (ground or air)	Covered as network benefit, subject to network deductible and co-insurance; emergency transportation only (ground or air)
ALLERGY SERVICES		
Testing	Covered, subject to deductible and co-insurance;	Covered, subject to deductible and co-insurance;
Injections and Serum	Covered in full for injections and serum	for testing, injections and serum.
BLOOD	Covered, subject to deductible and co-insurance;	Covered, subject to deductible and co-insurance;
DURABLE MEDICAL EQUIPMENT, MEDICAL SUPPLIES AND APPLIANCES	Covered, subject to deductible and co-insurance.	Covered, subject to deductible and co-insurance. (includes Glucose monitor if not in Disease Management program)
EMERGENCY ACCIDENT DENTAL TREATMENT	Covered, subject to deductible and co-insurance (routine, normal dental care is not covered).	Covered as network benefit, subject to network deductible and co-insurance (routine, normal dental care is not covered).
HOME HEALTH CARE / PRIVATE DUTY NURSING	Covered, subject to deductible and co-insurance; maximum 90 visits per benefit period combined with Non-network	Covered, subject to deductible and co-insurance; maximum 90 visits per benefit period combined with Non-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)	Covered at 100% subject to deductible when BDCT facility is used no deductible. Pre-certification required (tissue and organ)	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.
<b>MENTAL HEALTH and/or SUBSTANCE ABUSE</b>	<b>ALL CONTRACTING NETWORK PROVIDERS</b> If a person is chronic, not treatable, not significantly responsive to short term treatment or is not compliant to treatment plan, there is no coverage.	<b>ALL LICENSED PSYCHIATRISTS/QUALIFIED PSYCHOLOGIST</b> If a person is chronic, not treatable, not significantly responsive to short term treatment or is not compliant to treatment plan, there is no coverage.
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)	\$15 Copayment per office visit.	Covered, subject to deductible and co-insurance.
<p>This summary describes the features of the program available beginning July 1, 2011. 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.</p>		