

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

The County 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 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 BlueCard PPO network:</b> Ohio, Indiana, Kentucky, as well Worldwide Coverage under the BlueCard 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 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>  <b>Anthem</b>            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  <b>Area Network Hospitals:</b>  <b>Anthem</b>            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	1-855-639-9715	
WEBSITE:	<a href="http://www.anthem.com">www.anthem.com</a>	

**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**

Individual \$1,500  
Emp+one/family \$3,000

CO-INSURANCE 30%, except where noted.

**ANNUAL OUT-OF-POCKET MAXIMUM  
(including deductible)**

Individual \$3,600  
Emp+1/Family \$5,200

The annual out-of-pocket maximum applies to all covered services including 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**

Individual \$3,000  
Emp+one/Family \$6,000

CO-INSURANCE 40%, except where noted.

**ANNUAL OUT-OF-POCKET MAXIMUM  
(including deductible)**

Individual \$7,200  
Emp+one/Family \$10,400

The annual out-of-pocket maximums applies to all covered services including s prescription drug expenses, penalty amounts and services reimbursed at 50%.

1. The deductible on network services does apply to the deductible on non-network services.
2. The deductible on non-network services does 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):

Unlimited

Unlimited

OVERAGE DEPENDENT CHILDREN:

Eligible dependents are covered until age \_26\_\_ (End of Month) due to Federal regulations

Eligible dependents are covered until age \_26\_\_ (End of Month) due to Federal regulations

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

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.

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

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

DEPENDENTS RESIDING OUT OF AREA:

Employees and dependents residing out of area may receive network benefits through any c BlueCard Worldwide Coverage 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 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. Drugs covered under Medco	Covered, subject to deductible and co-insurance. Drugs covered under Medco
<b>PRESCRIPTION DRUGS</b>		
Retail - 30 day supply: Generic	70% / 30%; (subject to deductible and coinsurance) once OOP met covered at 100%	
Brand Formulary	70% / 30%; (subject to deductible and coinsurance) once OOP met covered at 100%	Not covered, must use Network pharmacy
Non-formulary	70% / 30%; (subject to deductible and coinsurance) once OOP met covered at 100%	
Mail Order - 90 day supply: Generic	70% / 30%; (subject to deductible and coinsurance) once OOP met covered at 100%	
Brand Formulary	70% / 30%; (subject to deductible and coinsurance) once OOP met covered at 100%	
Non-formulary	70% / 30%; (subject to deductible and coinsurance) once OOP met covered at 100%	
Retail - 90 day supply: Generic	70% / 30%; (subject to deductible and coinsurance) once OOP met covered at 100%	
Brand Formulary	70% / 30%; (subject to deductible and coinsurance) once OOP met covered at 100%	
Non-formulary	70% / 30%; (subject to deductible and coinsurance) once OOP met covered at 100%	
<i>(excludes all weight loss prescriptions)</i>	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 deductible and co-insurance. One per benefit period.

OFFICE VISITS	NETWORK	NON-NETWORK
PRIMARY CARE PHYSICIANS SPECIALISTS	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
CHIROPRACTOR	Covered, subject to deductible and co-insurance;  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 coinsurance;  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
HOSPITAL AND FACILITY CHARGES		
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)
PHYSICIAN CHARGES		
<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	Covered, subject to deductible and co-insurance.	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, subject to deductible and co-insurance
PHYSICAL THERAPY SERVICES		
A. Inpatient	Physical Medicine & Rehabilitative medicine Covered, subject to deductible and co-insurance; maximum 30 days per benefit period (combined with Non-Network benefits)	Physical Medicine & Rehabilitative medicine Covered, subject to deductible and co-insurance; maximum 30 days per benefit period (combined with Non-Network benefits)
B. Outpatient	Covered, subject to deductible and co-insurance; maximum 60 visits per benefit period: 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; subject to deductible and co-insurance.	All covered persons; subject to deductible and co-insurance.
URGENT CARE	Covered, subject to deductible and co-insurance.	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)	Covered subject to deductible and co-insurance; waived if admitted Prudent Layperson guidelines apply, all services will be paid at the in network level of benefits (accidental injury and medical emergency diagnoses pay as emergency).	Covered subject to deductible and co-insurance; waived Prudent Layperson guidelines apply, all services will be paid at the in network level of benefits (accidental injury and medical emergency diagnoses pay as emergency).
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, subject to deductible and co-insurance;	Covered, subject to deductible and co-insurance;
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. (includes Glucose monitor if not in DM program)	Covered, subject to deductible and co-insurance. (includes Glucose monitor if not in DM 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; no limit per lifetime	Covered, subject to deductible and co-insurance; no limit per lifetime
HUMAN ORGAN TRANSPLANTS (patient meets criteria)	Covered at 99% 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)	Covered, subject to deductible and co-insurance.	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> <p>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>		