



# Health Benefit Options

*Charles County Commissioners*

Employees  
2013–2014

# Benefits Comparison Summary

Benefits	In-Network	PREFERRED PROVIDER
<b>INPATIENT HOSPITALIZATION</b>	100% up to 365 days	
<b>INPATIENT MEDICAL/SURGICAL</b>	100% AB (Allowed Benefit)	
<b>EMERGENCY SERVICES (Life Threatening)</b>	ER: Accident - 100% AB within 72 hours ER: Medical Emergency - 100% AB after copay	
<b>PRIMARY CARE</b> Office Visit Specialist Office Visit	\$15 copay per visit	
<b>OUTPATIENT SURGERY</b>	100% AB	
<b>MATERNITY CARE</b>	100% AB; Includes Pre- & Postnatal	
<b>DIAGNOSTIC X-RAY &amp; LAB</b>	Office - \$15 copay per visit Outpatient Facility - \$35 copay per visit	
<b>WELL CHILD CARE</b>	\$15 copay per visit	
<b>ROUTINE PHYSICALS</b>	\$15 copay per visit	
<b>ALLERGY TESTING</b>	100% AB	
<b>PHYSICAL/OCCUPATIONAL/SPEECH THERAPY (PT, OT, ST)</b>	100% AB after copay per visit, 100 visits per calendar year	
<b>CHIROPRACTIC CARE</b>	\$15 copay per visit	
<b>RADIATION/CHEMOTHERAPY/RENAL DIALYSIS</b>	100% AB after copay per visit	
<b>DURABLE MEDICAL EQUIPMENT</b>	100% AB	
<b>PRESCRIPTION DRUGS</b> (When filled by Participating Pharmacies)	\$5 copay Generic/\$20 copay Formulary Brand \$35 copay Non-Formulary Brand 3 copays for 90-day maintenance supply at retail 2 copays for 90-day maintenance supply at mail order	
<b>INPATIENT PSYCHIATRIC</b>	*100% up to 365 days	
<b>OUTPATIENT PSYCHIATRIC</b>	*\$15 copay per visit	
<b>ALCOHOL/SUBSTANCE ABUSE REHABILITATION</b>	*See Psychiatric Benefits	
<b>PLAN PROVISIONS</b> Copays	\$15 Office visit, \$25 Practitioner outpatient department, \$35 Hospital outpatient department	
Calendar Year Deductible	None	
Coinsurance	100%	
Out-of-Pocket Maximum (Includes Deductible)	\$1,000 Individual per year, \$2,000 Family Aggregate	
<b>DEPENDENT AGE LIMIT</b>	End of the month in which they turn 26	
<b>COST CONTAINMENT</b>	N/A	

The above serves as a comparison only. Please consult each plan benefit guide for full details, particularly in regard to exclusions, limitations, and additional coverage.

Benefits subject to the contract between CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc. and Charles County Commissioners.

AB = Allowed Benefit

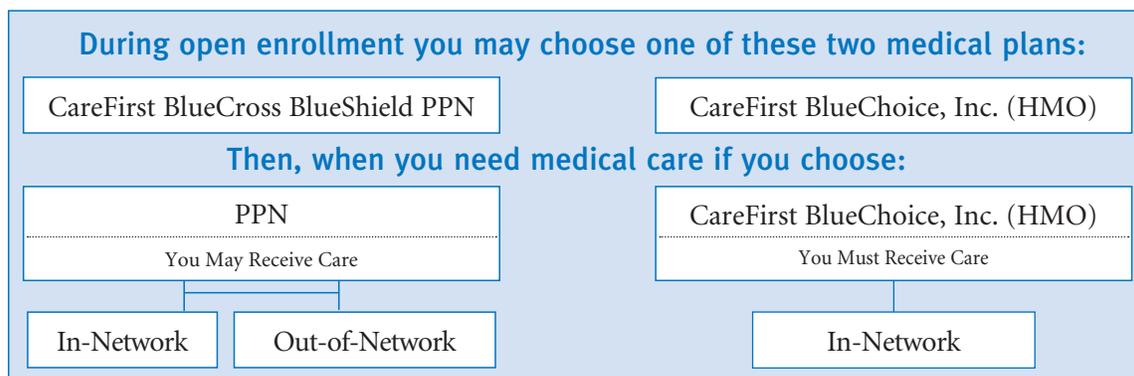
\*Benefits will be managed through Magellan Behavioral Health. All inpatient psychiatric/alcoholism treatment requires preauthorization by Magellan Behavioral Health: (800) 245-7013.

**WIDER NETWORK**

**Out-of-Network**

**CAREFIRST BLUECHOICE, INC. (HMO)**  
**An Independent Licensee of the BlueCross and BlueShield Association**

80% after deductible up to 365 days	Covered in full
80% AB (Allowed Benefit) after deductible	Covered in full
ER: Accident - 100% AB within 72 hours ER: Medical Emergency - 80% AB after deductible	ER: 100% after \$25 copay; waived if admitted Urgent Care Center – \$5 PCP, \$10 Specialist
80% AB after deductible	\$5 PCP \$10 Specialist
80% AB after deductible	\$5 PCP/\$10 Specialist
80% AB after deductible; Includes Pre- & Postnatal	\$10 copay per visit (up to \$100 per pregnancy)
80% AB after deductible	Covered in full
80% AB (deductible waived)	\$5 copay per visit
80% AB after deductible	\$5 PCP/\$10 Specialist
80% AB after deductible	Allergy Testing/Injections/Serum \$5 PCP/\$10 copay specialist
80% AB after deductible, 100 visits per calendar year	\$10 copay, 30 visits per condition, per calendar year
80% AB after deductible	\$10 copay; 20 visits per calendar year
80% AB after deductible	\$10 copay per visit
80% AB after deductible	Covered in full – no max
\$5 copay Generic/\$20 copay Formulary Brand \$35 copay Non-Formulary Brand 3 copays for 90-day maintenance supply at retail 2 copays for 90-day maintenance supply at mail order	\$5 copay Generic/\$20 copay Formulary Brand \$35 copay Non-Formulary Brand 3 copays for 90-day maintenance supply at retail 2 copays for 90-day maintenance supply
*80% after deductible up to 365 days	*Covered in full
*80% of AB after deductible	*\$5 copay per visit
*See Psychiatric Benefits	*See Psychiatric Benefits
N/A	\$5 PCP, \$10 Specialist, \$25 ER
\$200 Individual per year, \$400 Family Aggregate	None
80%/20%	N/A
\$1,000 Individual per year, \$2,000 Family Aggregate	N/A
End of the month in which they turn 26	End of the month in which they turn 26
N/A	All cost containment performed by HMO



## Summary of Benefits: Select Vision

	Lenses	Frames	Total Allowance
SINGLE	\$52.00	\$50.00	\$102.00
BIFOCAL	\$82.00	\$50.00	\$132.00
TRIFOCAL	\$101.00	\$50.00	\$151.00
CATARACT (APHAIC)	\$181.00	\$50.00	\$231.00
CONTACT LENSES (PER PAIR)	Medically Indicated*		\$352.00
	Cosmetic – Single Vision Lenses		\$97.00
BENEFIT PERIOD FOR FRAMES AND LENSES	Benefits for frames, lenses, and contact lenses are available once every 12 months		
EYE EXAM	100% of Allowed Benefit (any additional charge for contact lenses exam not covered) Benefit for eye exam - once every 12 months		

\* Following cataract surgery or when visual acuity is correctable to at least 20/70 in the better eye only by use of contact lenses.

## Summary of Benefits: Regional Traditional Dental

<b>BENEFIT PERIOD DEDUCTIBLES: CLASS II-IV</b> Individual Deductible Family Deductible	\$25 \$75
<b>REIMBURSEMENT LEVELS</b> Class I – Preventative & Diagnostic Services	100% Allowed Benefit (AB), no deductible
Class II – Basic Services Periodontal Services	100% AB after deductible 80% AB after deductible
Class III – Major Surgical Services	80% AB after deductible
Class IV – Major Restorative Services	50% AB after deductible
Class V – Orthodontic Services	50% AB, no deductible
<b>BENEFIT PERIOD MAXIMUM: CLASS I-IV</b> <b>LIFETIME MAXIMUM: CLASS V</b>	\$1,500 \$1,500
<b>BENEFIT PERIOD</b>	July 1st -June 30th



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[www.carefirst.com](http://www.carefirst.com)

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