



Health Benefit Options

**CHARLES COUNTY
COMMISSIONERS**

Employees

2014–2015



Benefits Comparison Summary

Benefits	PREFERRED PROVIDER NETWORK	
	In-Network	Out-of-Network
INPATIENT HOSPITALIZATION	100% up to 365 days	80% after deductible up to 365 days
INPATIENT MEDICAL/SURGICAL	100% AB (Allowed Benefit)	80% AB (Allowed Benefit) after deductible
EMERGENCY SERVICES (Life Threatening)	ER: Accident – 100% AB after \$75 copay ER: Medical Emergency – 100% AB after \$75 copay (copay waived if admitted)	ER: Accident – 100% AB after \$75 copay ER: Medical Emergency – 80% AB after deductible (copay waived if admitted)
PRIMARY CARE Office Visit Specialist Office Visit	\$15 copay per visit \$20 copay per visit	80% AB after deductible
OUTPATIENT SURGERY	100% AB	80% AB after deductible
MATERNITY CARE	100% AB; Includes Pre- & Postnatal	80% AB after deductible; Includes Pre- & Postnatal
DIAGNOSTIC X-RAY & LAB	Office – \$15 copay per visit Outpatient Facility – \$50 copay per visit	80% AB after deductible
OTHER DIAGNOSTIC (MRI, CAT Scan, Pet Scan)	Office – \$30 copay per visit Outpatient Facility – \$50 copay per visit	80% AB after deductible
WELL CHILD CARE	Covered in full	80% AB (deductible waived)
ROUTINE PHYSICALS	Covered in full	80% AB after deductible
ALLERGY TESTING	100% AB	80% AB after deductible
PHYSICAL/OCCUPATIONAL/SPEECH THERAPY (PT, OT, ST)	100% AB after copay per visit, 100 visits per calendar year	80% AB after deductible, 100 visits per calendar year
CHIROPRACTIC CARE	\$20 copay per visit	80% AB after deductible
RADIATION/CHEMOTHERAPY/RENAL DIALYSIS	100% AB after copay per visit	80% AB after deductible
DURABLE MEDICAL EQUIPMENT	100% AB	80% AB after deductible
PRESCRIPTION DRUGS (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	\$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
INPATIENT PSYCHIATRIC	*100% up to 365 days	*80% after deductible up to 365 days
OUTPATIENT PSYCHIATRIC	*\$15 copay per visit	*80% of AB after deductible
ALCOHOL/SUBSTANCE ABUSE REHABILITATION	*See Psychiatric Benefits	*See Psychiatric Benefits
PLAN PROVISIONS Copays	\$15 PCP Office visit, \$20 Specialist Office visit, \$25 Practitioner outpatient department, \$35 Hospital outpatient department	N/A
Calendar Year Deductible	None	\$200 Individual per year, \$400 Family Aggregate
Coinsurance	100%	80%/20%
Out-of-Pocket Maximum (Includes Deductible)	\$1,000 Individual per year, \$2,000 Family Aggregate	\$1,000 Individual per year, \$2,000 Family Aggregate
DEPENDENT AGE LIMIT	End of the month in which they turn 26	End of the month in which they turn 26
COST CONTAINMENT	N/A	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 change without notice. 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-

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

Covered in full

Covered in full

ER: 100% after \$50 copay; waived if admitted
 Urgent Care Center – \$10 PCP, \$15 Specialist

\$10 PCP
 \$15 Specialist

\$10 PCP/\$15 Specialist

Covered in full

Office – \$10 copay per visit
 Outpatient Facility – \$30 copay per visit

Office – \$20 copay per visit
 Outpatient Facility – \$30 copay per visit

Covered in full

Covered in full

Allergy Testing/Injections/Serum
 \$10 PCP/\$15 copay specialist

\$15 copay, 30 visits per condition, per calendar year

\$15 copay; 20 visits per calendar year

\$15 copay per visit

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

*Covered in full

*\$10 copay per visit

*See Psychiatric Benefits

\$10 PCP, \$15 Specialist, \$50 ER

None

N/A

\$2,000 Individual / \$6,000 Family

End of the month in which they turn 26

All cost containment performed by HMO

During open enrollment you may choose one of these two medical plans:

CareFirst BlueCross BlueShield PPN

CareFirst BlueChoice, Inc. (HMO)

Then, when you need medical care if you choose:

PPN
 You May Receive Care

In-Network Out-of-Network

CareFirst BlueChoice, Inc. (HMO)
 You Must Receive Care

In-Network

Subject to the contract between CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc. and

Select Vision Summary of Benefits

	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 (Aphakic)	\$181.00	\$50.00	\$231.00
Contact Lenses (per pair)	Medically Indicated*		\$352.00
	Cosmetic – Single Vision Lenses (Instead of frames and lenses)		\$97.00
Benefit Period for Frames and Lenses	Benefits for frames, lenses, and contact lenses are available once every 12 months.		
Eye Exam	Benefits for eye exam is once every 12 months.		100% of Allowed Benefit (any additional charge for contact lens exam not covered)

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

Regional Traditional Dental Summary of Benefits

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



The CareFirst BlueCross BlueShield
family of health care plans

www.carefirst.com