

Preferred Provider Network (PPN)

CHARLES COUNTY COMMISSIONERS

Summary of Benefits

Services	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 Preferred Brand \$35 copay Non-preferred 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 Preferred Brand \$35 copay Non-preferred 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 the contract between CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc. and Charles County Commissioners.

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