

HOWARD COUNTY EMPLOYEES**BENEFITS EFFECTIVE FEBRUARY 1, 2010****Anthem Policy # 00103487; 00103477; 00103476; 00103475; 00103473**

Medical Benefits		
	In Network	Out-of-Network
Deductible	\$750 per Person \$1,500 per Family	\$1,500 per Person \$3,000 per Family
Out of Pocket Max	\$2,500 per Person \$5,000 per Family	\$5,000 per Person \$10,000 per Family
Plan Maximum	\$2,000,000	
Precertification	No Precertification penalty when using In Network Providers.	
	Member must Pre-Certify all services from Non-Network Providers.	
Copayments		
Primary Care Office Visit Copayment	\$30 copay - All inclusive	Member pays 50%
Specialist Visits	\$30 copay	Member pays 50%
Physician Home Visits	\$30 copay	Member pays 50%
Urgent Care Facilities	\$50	Member pays 50%
Hospital Emergency Room	\$100	Member pays 50%
Inpatient Hospital	Member pays 20% after ded.	Member pays 50% after ded.
Outpatient Surgery	Member pays 20% after ded.	Member pays 50% after ded.
Family Planning	No Coverage	No Coverage
Medically Necessary Ambulance Transport	Covered in Full - No deductible, No co-insurance	
Allergy Injection Serum	\$30 office visit copay	Member pays 50%
Diabetic Supplies	Member pays 20%	Member pays 50%

**Actual policy provisions prevail over any and all summary plan descriptions.

	In Network	Out-of-Network
	Prescription Drug Card	
Participating Pharmacy		
30 day supply	\$10 Generic Formulary	
	\$20 Brand Formulary	
	\$30 Non-Formulary	
90 day supply	\$20 Generic Formulary (2 copays)	
mail order	\$40 Brand Formulary	
	\$60 Non-Formulary	
Routine Care	Unlimited-in network subject to	
	\$30 office visit copay	
Emergency Illness	\$100 ER copay-covers all services	
	rendered; facility, professional;	
	waived if admitted	
Therapy Services	**Physical/Occupational 60 visits Paid in full not subject to a co-pay	
(Radiation, Chemo, and	**Spinal manipulation 12 visits	
Dialysis do not go to max.)	Speech 20 visits, No dollar maximums	
Maternity	Same as any other condition	
Medical Aids	No sublimits - 20% co-ins. In network	
	No sublimits - 50% co-ins. Out of network	
	No sublimits	
Mental Health	\$30 copay or ded./co-ins. - same as any other condition	
Substance Abuse	\$30 copay or ded./co-ins. - same as any other condition	
	30 inpatient days	
TMJ	No Sublimits	
Home Health Care	No Sublimits	
	Subject to professional and ancillary copayments	
Accidental Dental	Facility - 20% after ded. in network	Facility - 50% after ded. out of network
	State Mandated Changes	
Colorectal Screening	Colorectal cancer exams and lab tests are covered under preventative care services, subject to applicable copay.	
Morbid Obesity Surgical Treatment	Persisted for at least 5 years	
	Unsuccessful non-surgical treatment for at least 18 months	
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	In Network	Out-of-Network
	Vision	
	Frequency for exams and lenses is once every 12 months. Frames every 24 months.	
Exam	\$10	Up to \$35
Lenses	\$20	
Single Vision		Up to \$25
Bifocal (pair)		Up to \$40
Progressive (pair)		Up to \$40
Trifocal (pair)		Up to \$55
Lenticular		Up to \$80
Frames		Up to \$45
Contact Lenses		
Elective	\$20	Up to \$105
Non-Elective	\$20	Up to \$210
Wholesale Frame Allowance	\$40 toward more expensive frames	N/A
	Dental	
Deductible	\$25 per person \$75 per family	
Maximum Payment per Calendar Year	\$2,000 per person Not including Orthodontia	
Lifetime Orthodontia Max	\$1,000	
Routine Exams	Covered at 100% Not Subject to Deductible	
All Other Services	Covered at 80% Subject to Deductible	
Orthodontia	Covered at 50% Not Subject to Deductible	
Customer Service: 1-800-227-6219 Indiana Providers: www.anthem-inc.com		
Vision: www.anthem.com (Anthem Blue Vision)		
Out-of-State Providers: www.bluecares.com		
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Important Notice

*Report All status changes to Personnel Department within 30 days of event: marriage, divorce, birth, death, etc.