

# MONTGOMERY COUNTY 2010 Summary of MEDICAL / DENTAL / VISION PLAN OPTIONS

*See the Plan Document for a full description of benefits. In the event any benefit summary contained herein differs from the official text of the Plan, the official text shall prevail.*

MEDICAL PLAN:	LOW DEDUCTIBLE Medical Plan		HIGH DEDUCTIBLE Medical Plan	
	IN PPO NETWORK	OUT OF PPO NETWORK	IN PPO NETWORK	OUT OF PPO NETWORK
<b>Pre-existing Condition Clause</b>	First 18 Months Not Covered	First 18 Months Not Covered	First 18 Months Not Covered	First 18 Months Not Covered
<b>Calendar Year Deductible =CY</b> PPO Deductible can be used to satisfy Non-PPO Deductible	\$250.00 Per Person	\$500.00 Per Person +\$450.00 Per Hospital Confinement	\$1,000.00 Per Person	\$2,000.00 Per Person + \$450.00 Per Hospital Confinement
<b>Family calendar year Deductible maximum</b>	NO	NO	YES -A maximum of 3 family participants must meet deductible	YES -A maximum of 3 family participants must meet deductible
<b>Plan pays Co -Insurance percentage @</b>	90%	50%	90%	50%
<b>You Pay Co-insurance @</b>	10%	50%	10%	50%
<b>Deductible + Co-Insurance Out of Pocket (Does Not Include Per hospital confinement non PPO deductible, office Co-Pays or emergency room deductible)</b>	\$2,250.00 per person / No Maximum family limit on deductibles and co-insurance + office co-pays & emergency room co-pay	\$8,000.00 per person / No Maximum family limit - Unlimited + per-confinement deductible & emergency room co-pay	\$2,000.00 per person to a maximum of 3 family participants + office co-pays & emergency room co-pay	\$5,750.00 per person to a maximum of 3 family participants + per-confinement deductible, & emergency room co-pay
<b>Family cap co - insurance maximum</b>	NO	NO	YES - A maximum of 3 family participants must meet co-insurance	YES - A maximum of 3 family participants must meet co-insurance
<b>Plan Will Pay 100% When Qualified &amp; Eligible Expenses Reach</b>	\$20,000.00	\$15,000.00	\$10,000.00	\$7,500.00
<b>Lifetime Maximum</b>	\$2,000,000.00	\$2,000,000.00	\$2,000,000.00	\$2,000,000.00
<b>Physician Office Visit Co-Pay</b>	\$25.00 Co-Pay + Subject to CY Deductible & Co-Insurance	No Co-Pay + Subject to Deductible & Co-Insurance	\$25.00 Co-Pay + Subject to CY Deductible & Co-Insurance	No Co-Pay +Subject to CY Deductible & Co-Insurance
<b>Emergency Room Charges / \$150.00 co pay per ER visit / Co-pay does not apply toward calendar year deductible or co-insurance maximums</b>	\$150.00 Co-pay + Subject to CY Deductible & Co-insurance	\$150.00 Co-pay + Subject to CY Deductible & Co-insurance	\$150.00 Co-pay + Subject to CY Deductible & Co-insurance	\$150.00 Co-pay + Subject to CY Deductible & Co-insurance
<b>Annual Wellness Benefit</b>	\$750.00 Maximum on Eligible Benefits. \$25.00 office co-pay / Not Subject to Deductible, 100% co-insurance	None	\$750.00 Maximum on Eligible Benefits. \$25.00 office co-pay / Not Subject to Deductible, 100% co-insurance	None
<b>Employee Assistance Program E.A.P</b>	8 free visits to an E.A.P provider per person per problem. No office co-pay. Must use E.A.P before access to the medical program	None	8 free visits to an E.A.P provider per person per problem. No office co-pay. Must use E.A.P before access to the medical program	None
<b>Mental Nervous, Substance and Alcohol Abuse / Calendar Year Maximum Benefit \$5,000 for Both In-Patient &amp; Out-Patient Combined</b>	Out-Patient Office Visit - Plan Pays 80% to maximum of \$80.00 Per Visit Maximum / \$5,000.00 Per Year Maximum / In-Patient 80% Co-Insurance at PPO Only	None	Out-Patient Office Visit - Plan Pays 80% to maximum of \$80.00 Per Visit Maximum / \$5,000.00 Per Year Maximum / In-Patient 80% Co-Insurance at PPO Only	None
<b>Retail Prescriptions Co-Pays 30-Day Supply</b> Not subject to Deductible or Co-Insurance	<u>Generic</u> 10% ,no less than \$15.00 <u>Preferred Name Brand</u> 20%,no less than \$25.00 <u>Non-Preferred Name Brand</u> 30%,no less than \$35.00	None	<u>Generic</u> 10% ,no less than \$15.00 <u>Preferred Name Brand</u> 20%,no less than \$25.00 <u>Non-Preferred Name Brand</u> 30%,no less than \$35.00	None
<b>Mail Order Prescriptions 90-Day Supply Co-Pays</b> Not subject to Deductible or Co-Insurance	<u>Generic</u> \$15.00 <u>Preferred Name Brand</u> \$25.00 <u>Non-Preferred Name Brand</u> \$35.00	None	<u>Generic</u> \$15.00 <u>Preferred Name Brand</u> \$25.00 <u>Non-Preferred Name Brand</u> \$35.00	None
<b>IF YOUR PRESCRIPTION COSTS LESS THAN THE CO-PAY, YOU WILL ONLY BE CHARGED THE PRICE OF THE PRESCRIPTION</b>				
<b>MEDICAL PREMIUMS</b>	<b>Monthly</b>		<b>Monthly</b>	
Employee Only	\$75.00		0	
EE and Child(ren)	\$210.00		\$70.00	
EE and Spouse	\$220.00		\$80.00	
EE and Family	\$355.00		\$150.00	
<b>DENTAL PLAN:</b>	<b>CS - 600 DHMO / Humana CompBenefits</b>		<b>Schedule - 75 / Indemnity -Humana CompBenefits</b>	
	See the Plan Summary for benefits.		See the Plan Summary for benefits.	
<b>PREMIUMS</b>	<b>Monthly</b>		<b>Monthly</b>	
Employee Only	\$12.00		\$20.56	
Employee + 1	\$21.44		\$40.84	
Employee + 2 or more	\$29.58		\$60.32	
<b>VISION PLAN:</b>	<b>Plan 1 - 12/12/24 United Healthcare Vision</b>		<b>Plan 2 - 12/12/12 United Healthcare Vision</b>	
	See the Plan Summary for benefits.		See the Plan Summary for benefits.	
<b>PREMIUMS</b>	<b>Monthly</b>		<b>Monthly</b>	
Employee Only	\$8.75		\$11.45	
EE and Family	\$21.75		\$25.80	