

**Board of County Commissioners of Washington County, Maryland  
Welfare Benefit Plan**

<b>HIGH OPTION SCHEDULE OF MEDICAL BENEFITS</b>	
<p>You are entitled to the Covered Services described in this booklet. Covered Services are subject to the Deductible, Coinsurance and Copays indicated. Services that are not listed in this Summary Plan Description, or are listed in the Limitations and Exclusions are not Covered Services.</p>	
<p><b>Utilization Management Requirements:</b> Certain Utilization Management Requirements apply to hospital admissions and certain outpatient services. When the Utilization Management Requirements are not met, payments may be denied.</p>	
<b>Individual Lifetime Maximums</b>	
Overall Medical Maximum	Unlimited
Organ Transplants – Travel, meals, lodging	\$10,000
Infertility Services	\$100,000
<b>Individual Calendar Year Maximums</b>	
Cardiac rehabilitation	36 visits
Chiropractic Care	24 visits
Home Health Care	40 visits
Diabetes Management/Patient Education	20 visits
Occupational Therapy	60 visits
Physical therapy	60 visits
Speech therapy	60 visits
Wig	\$350
<b>Other Individual Maximums</b>	
Hearing Aids (per ear) – for children under age 19	1 every 36 months
Hearing Aids (per ear) – for adults age 19 and over	1 every 5 years

TYPE OF EXPENSE	HIGH OPTION PLAN	
	IN-NETWORK	OUT-OF-NETWORK
<b>Medical Deductible, Per Calendar Year</b>		
Per Individual	0	\$250
Per Family	0	\$750
Copays, penalties for non-certified hospital admissions, and charges in excess of the Allowed Benefit may not be used to satisfy the Deductible.		
<b>Out-of-Pocket Maximum, Per Calendar Year</b>		
Per Individual	0	\$1,250
Per Family	0	\$3,750
The Out-of-Pocket Maximum is the amount you are responsible for paying for a covered service. Expenses for the following services do not count towards the OOP Maximum, deductible, copays, pre-certification penalties, non-covered services, infertility treatment and charges in excess of the Allowed Benefit.		
TYPE OF EXPENSE	IN-NETWORK	OUT-OF-NETWORK
<b>Hospital and Other Facility Expenses</b>		
Inpatient	\$100 copay, then 100% of Allowed Benefit Pre-certification required	70% of Allowed Benefit Subject to deductible Pre-certification required
Rehabilitation Facility	100% of Allowed Benefit Pre-certification required	70% of Allowed Benefit Subject to deductible Pre-certification required
Emergency Room	\$100 copay, then 100% of Allowed Benefit	\$100 copay, then 100% of Allowed Benefit
Outpatient	100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Extended Care/Skilled Nursing Facility	100% of Allowed Benefit Pre-certification required	70% of Allowed Benefit Subject to deductible Pre-certification required
Ambulatory Surgical Facility	100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Clinic Visit	\$20 copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Therapies – Chemotherapy, Radiation therapy, Renal dialysis	100% of Allowed Benefit Pre-certification required	70% of Allowed Benefit Subject to deductible Pre-certification required
Occupational Therapy (limited to 60 visits per Calendar Year)	\$20 copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible

TYPE OF EXPENSE	HIGH OPTION PLAN	
	IN-NETWORK	OUT-OF-NETWORK
<b>Hospital and Other Facility Expenses</b>		
Physical Therapy (limited to 60 visits per Calendar Year)	\$20 copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Pulmonary Rehabilitation Therapy (limited to 60 visits per Calendar Year)	\$20 copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Speech Therapy (limited to 60 visits per CalendarYear)	\$20 copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
<b>Professional Expenses</b>		
Anesthesia Inpatient and Outpatient	100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Chiropractic Care (limited to 24 visits per Calendar Year)	\$20 copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Emergency Care in the Emergency Room	100% of Allowed Benefit	100% of Allowed Benefit
Physician Home Visit following - Childbirth - Testicular surgery	100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Physician Visit – Inpatient	100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Physician Visit – Office	\$20 copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Oral Surgery	100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Occupational Therapy (limited to 60 visits per Calendar]Year)	\$20 copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Physical Therapy (limited to 60 visits per Calendar Year)	\$20 copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Pulmonary Rehabilitation Therapy (limited to 60 visits per Calendar Year)	\$20 copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Speech Therapy (limited to 60 visits per CalendarYear)	\$20 copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Therapies – Chemotherapy, Radiation therapy, Renal dialysis	100% of Allowed Benefit Pre-certification required	70% of Allowed Benefit Subject to deductible Pre-certification required
Second Surgical Opinion	\$20 copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Surgery, inpatient	100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Surgical Assistant – inpatient or outpatient	100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Surgery, outpatient hospital Pre-certification required for organ biopsies	100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Surgery, physician’s office	100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible

TYPE OF EXPENSE	HIGH OPTION PLAN	
	IN-NETWORK	OUT-OF-NETWORK
<b>Other Eligible Expenses</b>		
Acupuncture	Not covered	Not covered
Allergy Testing	100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Allergy Shots/Serum	100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Ambulance	100% of Allowed Benefit	100% of Billed Amount Subject to deductible
Cardiac Rehabilitation (maximum of 36 visits per Calendar Year)	\$20 copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Cleft Palate or Cleft Lip Treatment (Includes orthodontics, oral surgery, otologic, audiological and speech therapy for dependent under age 19)	Same as any other illness	70% of Allowed Benefit Subject to deductible
Clinical Trials	100% of Allowed Benefit Pre-certification required	70% of Allowed Benefit Subject to deductible Pre-certification required
Diagnostic tests, radiology, pathology – Inpatient or outpatient hospital	100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Durable Medical Equipment (DME) (Pre-certification is required for DME in excess of \$1,000)	100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Hearing Aid (Please refer to Other Individual Maximums)	100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Hearing exam, fitting related to hearing aid (Does not apply to maximum for hearing aid)	100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Home Health Care (maximum of 40 days per Calendar Year)	100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible Pre-certification required
Home Infusion Therapy	100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Hospice Care Inpatient/Outpatient Bereavement Counseling Family Counseling	100% of Allowed Benefit	100% of Allowed Benefit Pre-certification required
Injectables	\$20 copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Laboratory, X-Rays and Diagnostic Tests (not included with physician office visit)	100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Medical Supplies	100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Oral Surgery (includes removal of impacted teeth)	100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Orthotic shoes (limited to full and parital shoe inserts, lifts, diabetic shoes and shoes attached to a brace)	100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible

TYPE OF EXPENSE	HIGH OPTION PLAN	
	IN-NETWORK	OUT-OF-NETWORK
<b>Other Eligible Expenses (con't)</b>		
Patient Education/Nutritional Counseling	\$20 copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Pre-admission Testing	100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Private Duty Nursing	100% of Allowed Benefit Pre-certification required	70% of Allowed Benefit Subject to deductible Pre-certification required
Prosthetic Device	100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Temporomandibular Joint Disorder (TMJ) (does not include dental services)	100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Urgent Care Centers	\$35 copay per visit, then 100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Wig (maximum of \$350)	100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
<b>Maternity Services</b>		
Inpatient Hospital - Newborn expenses are paid under the mother until the mother leaves the hospital	\$100 copay, then 100% of Allowed Benefit Pre-certification required	70% of Allowed Benefit Subject to deductible Pre-certification required
Birthing Center	100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Delivery	\$20 copay, then 100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Anesthesia	100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Laboratory, x-rays, diagnostic tests	100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Office Visits	\$20 copay for initial visit to determine pregnancy, thereafter 100%	70% of Allowed Benefit Subject to deductible
<b>Organ Transplants</b>		
Inpatient Hospital	\$100 copay, then 100% of Allowed Benefit Pre-certification required	70% of Allowed Benefit Subject to deductible Pre-certification required
Anesthesia	100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Transplant procedure	100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Laboratory, x-rays, diagnostic tests	100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Travel, lodging, meals (Lifetime maximum of \$10,000 per transplant)	100% of Allowed Benefit	100% of Allowed Benefit
Donor expenses	100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Procurement	100% of Allowed Benefit	100% of Allowed Benefit

TYPE OF EXPENSE	HIGH OPTION PLAN	
	IN-NETWORK	OUT-OF-NETWORK
<b>Mental Health and Substance Abuse</b>		
Inpatient hospital	\$100 copay, then 100% of Allowed Benefit Pre-certification required	70% of Allowed Benefit Subject to deductible Pre-certification required
Partial hospitalization	100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Inpatient visits	100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Outpatient visits	\$20 copay, then 100% of Allowed Benefit Pre-certification required	70% of Allowed Benefit Subject to deductible Pre-certification required
Psychiatric testing	100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
<b>Infertility Services</b>		
Artificial and Intrauterine Insemination , In-vitro Fertilization	100% of Allowed Benefit Pre-certification required	70% of Allowed Benefit Subject to deductible Pre-certification required
Laboratory, x-rays, diagnostic tests	100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
<b>Preventive Care</b>		
Adult and Child Wellness - Physical Exam - Routine Screenings - Routine lab tests and x-rays - Immunizations	\$20 copay, then 100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Colorectal Screening (includes all related services)	100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Routine tests and immunizations (if billed separately from exam)	100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Routine GYN Exam and Pap Test	100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible
Screening Mammogram	100% of Allowed Benefit	70% of Allowed Benefit Subject to deductible

**Notes:**

1. Benefits for services provided by a participating provider are payable as shown in the Schedule of Benefits. Please refer to your PPO directory for a list of participating providers. Verify the provider participates with the PPO (ask the provider or call the PPO) before you receive services to obtain In-Network benefits.
2. The physician office visit copay includes diagnostic radiology, pathology and laboratory and other services performed in the office and billed by the physician.
3. Anesthesia, x-rays, laboratory, emergency room services, and other diagnostic services (including consultants) rendered at a PPO facility will be paid at the In-Network benefit level.
4. If it is verified by CFA that the service needed is not available in the Network, benefits will be paid at the In-Network benefit level. To qualify for this benefit one of the following situations must apply:
  - There is no specialist of the type needed in the PPO network; or
  - There is no In-Network provider for the service needed within 25 miles from the

Member's residence.

A Service Availability Form must be completed and sent to CFA. You may obtain a Service Availability Form at [www.cfablue.com](http://www.cfablue.com)

5. Involuntary Out-of-Network emergency care on an inpatient or outpatient basis will be paid at the In-Network benefit level. "Involuntary treatment may arise when a patient's physical condition is such that:
- He cannot render a decision; or
  - the delay to obtain care from an In-Network provider would be considered life-threatening as determined by a medical practitioner.

If you are confined in an Out-of-Network Hospital after you receive emergency care, THP must be notified within one business day or on the same day of admission if reasonable possible. THP's BetterCARE Medical Management may elect to transfer you to an In-Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the Out-of-Network Hospital after the date THP's BetterCARE Medical Management decides a transfer is medically appropriate, benefits will not be available for the remainder of the admission.

Prescription Drug Benefits– Administered by Express Scripts	Co-payment per Prescription	
	Retail 31- day supply	Mail Order 90 - day supply
Generic drugs	\$10	\$20
Preferred Brand Name	\$20	\$40
Non-preferred Brand Name	\$35	\$70