Summary of Prescription Coverage (CVS/Caremark)

Copays

	In-Network	Out-of-Network
Generic	$15/prescription (retail) $30/prescription (mail order)	Applicable copayment, plus charges in excess of allowed amount
Formulary Brand Name	$35/prescription (retail) $70/prescription (mail order)	Applicable copayment, plus charges in excess of allowed amount
Non-formulary Brand Name	$50/prescription (retail) $100/prescription (mail order)	Applicable copayment, plus charges in excess of allowed amount
Specialty	Applicable copayment	Applicable copayment, plus charges in excess of allowed amount

The County still offers you the option to fill your prescriptions via a retail pharmacy or by mail order. In addition to mail order, you will now also be able to refill maintenance medications of a 90-day supply at a local CVS Pharmacy instead of having them shipped to your home.

Flexible Spending Accounts

These accounts allow you to use tax-free dollars to pay for certain kinds of benefits and expenses which you normally pay for with out-of-pocket, taxable dollars.

Health Care Spending Account
(maximum contribution- $2,750)

_____ ÷ _____ = _____
(total expense) (# of pays through June 30, 2021) Per Pay Election

Dependent Day Care Spending Account
(maximum contribution-$5,000)

_____ ÷ _____ = _____
(total expense) (# of pays through June 30, 2021) Per Pay Election

Phone: 800-815-3023
Website: www.myplans.cbiz.com

Deferred Compensation

To enroll or change a current enrollment in a 457 plan, contact Scott Wamboldt or sign up for a meeting with him during his next visit to the Human Resources Office.

R. Scott Wamboldt
410-274-9568
WambolR@Nationwide.com

Washington County MARYLAND

Summary of Healthcare Coverage for Plan Year 2020-2021

Below lists our Medical, Prescription, Dental & Vision Providers. For more information regarding these providers, please refer to the summary pages that follow.

Medical
Aetna will continue as our medical provider.

Prescription
CVS/Caremark will be our new prescription drug provider.

Dental
Delta Dental will continue as our dental provider.

Vision
United Healthcare Vision will remain as our vision care provider.

Important Eligibility Information

You may change your dependents or enroll/cancel coverage in the Medical, Dental, Vision, and Flex Spending plans during open enrollment or when you experience a qualifying event (marriage, divorce, birth, etc.). You must contact the Human Resources Department within 31 days of the qualifying event to request a change to your Medical, Dental, Vision, and Flex Spending Plans. If you do not notify the Human Resources Department in 31 days, you will be required to wait until open enrollment to change coverage.

Medical/Dental/Vision/Flex Spending- children are covered until they reach age 26 (last day of the month in which they turn 26).

Summary of Medical Coverage (Aetna)

Biweekly Rates

	Low Option (Aetna Select)	High Option (Open Choice)
Employee Only	$27.54	$48.96
Employee & Spouse	$53.98	$95.96
Employee & Child(ren)	$50.12	$89.11
Employee & Family	$77.66	$138.07

Copays, Deductibles, & Covered Services

	Low Option	High Option	
	In-Network Only	In-Network	Out-of-Network
Deductibles	$0	$0	Individual: $250 Family: $750
PCP	$30	$35	70% after Deductible
Teladoc	$20	$25	N/A
Specialist	$35	$40	70% after Deductible
Urgent Care	$35	$35	70% after Deductible
Emergency Room (Emergency Care)	$200	$200	Paid at In-Network Level for Emergency
Well Child Visits	100%, no copay	100%, no copay	70% after Deductible
Adult Routine Physical Exam	100%, no copay	100%, no copay	70% after Deductible

After Open Enrollment, you will be receiving new Aetna ID Cards that will also include the new copay information along with CVS/Caremark's Prescription Information.

Did you know?

Services at an Emergency room usually cost at least twice as much as a local Urgent Care of Local Clinic? Urgent Care Centers can treat the following conditions:

- Illness
  - Colds, Flu, Strep Throat, Bronchitis, Sinus Infections, Ear Infections, Allergies
- Injury
  - Bites and Stings, Broken Bones, Cuts and Scrapes, Strains and Sprains, X-rays

Summary of Dental Coverage (Delta Dental)

Biweekly Rates

	Low Option	High Option
Employee Only	$6.19	$7.75
Employee & Spouse	$11.83	$15.48
Employee & Child(ren)	$10.99	$14.39
Employee & Family	$17.02	$22.28

Deductibles

Low Plan: $50 per person/$150 per family each plan year

High Plan: PPO Dentist: $50 per person/$150 per family each plan year
Non-PPO Dentist: $100 per person/$300 per family each plan year

Benefits & Covered Services

	Low Plan		High Plan	
	PPO	NON-PPO	PPO	NON-PPO
Diagnostic & Preventive Services (Exams, Cleanings, X-rays, Sealants)	80%	80%	100%	80%
Basic Services (Fillings)	80%	80%	90%	70%
Endodontics (Root Canals)	80%	80%	90%	70%
Periodontics (Gum Treatment)	80%	80%	90%	70%
Oral Surgery	80%	80%	90%	70%
Major Services (Crowns, Inlays, Onlays, and Cast Restorations)	50%	50%	80%	60%
Prosthondontics (Bridges, Dentures, and Implants)	50%	50%	80%	60%

Maximums

$1,000 per person each plan year (July 1- June 30)

No Coverage for Braces

Summary of Vision Coverage (United Healthcare Vision)

Biweekly Rates

	Low Option (24)	High Option (12)
Employee Only	$2.58	$3.30
Employee & Spouse	$4.17	$5.23
Employee & Child(ren)	$4.37	$5.48
Employee & Family	$5.65	$8.20

Coverage Comparisons

	Low Option (24)	High Option (12)
Copays for In-Network Services		
Exam	$0	$0
Materials	$0	$0
Benefit Frequency		
Comprehensive Exam	Once every 24 months	Once every 12 months
Spectacle Lenses	Once every 24 months	Once every 12 months
Frame	Once every 24 months	Once every 12 months
Contact Lenses In lieu of Eye Glasses	Once every 24 months	Once every 12 months
Frame Benefit		
Private Practice Provider	$130 retail frame allowance	$130 retail frame allowance
Retail Chain Provider	$130 retail frame allowance	$130 retail frame allowance

Lens Options

Standard scratch-resistant coating- covered in full. Other optional lens upgrades may be offered at a discount

Out of Network Reimbursements

- Exam: $40.00
- Frames: $45.00
- Single Vision Lenses: $40.00
- Bifocal Lenses: $60.00
- Trifocal Lenses: $80.00
- Lenticular Lenses: $80.00
- Elective Contacts In lieu of Eye Glasses: $125.00
- Necessary Contacts In lieu of Eye Glasses: $210.00