

Health Plan Benefits Summary for Anne Arundel County Government/ Library/Community College

This outline is intended as a summary only. For complete details, including a list of all exclusions and limitations, you may request an applicable Evidence of Coverage and Group Certificate by contacting our Member Services Department via e-mail at memberservices@mamsi.com or by phone at 1-800-331-2102.

Benefit	The Plan Pays: ¹
Outpatient Services	
Primary Care Physician Office Visits	100% after \$5 Copayment
Well Child Care	100% after \$5 Copayment
Routine Physical Exams	100% after \$5 Copayment
Specialist Office Visits	100% after \$5 Copayment
OB/GYN Office Visits ²	100% after \$5 Copayment
Urgent Care Facility Visits	100% after \$15 Copayment
Outpatient Hospital Visits, Including Lab Tests/X-rays	Covered in full
Outpatient Surgery Visits	Covered in full
Diagnostic Lab Tests and X-rays—Office Visit	100% after \$5 Copayment
Speech, Occupational, Physical Therapy ³	100% after \$5 Copayment, up to 60 visits per Contract Year
Chiropractic Visits	100% after \$5, up to \$500.00 per Contract Year
Routine Maternity Care ⁴	100% after \$5 Copayment for initial visit only; all other non-office visit Copayments apply
Infertility Services ⁵	100% after \$5 Copayment
Acupuncture ⁶	100% after \$5 Copayment
Eye Refraction Exams	100% after \$25 Copayment
Inpatient Services	
Inpatient Hospitalization	100%
Emergency Room Visits ⁷	100% after \$25 Copayment for services that meet definition of Emergency services – waived if admitted to Hospital
Skilled Nursing Facility	100% up to 100 days per Contract Year
Diabetic Supplies	
Generic Diabetic Supplies or Refills	100% after: \$5 Copayment per 31-day supply; \$15 Copayment per 90-day supply.
Brand Name Diabetic Supplies or Refills	100% after: \$20 Copayment per 31-day supply; \$60 Copayment per 90-day supply.
Mental Illness, Emotional Disorder, Drug Abuse and Alcohol Abuse	
Inpatient Mental Illness	100%
Inpatient Substance Abuse	100%
Outpatient Mental Illness	100% after: \$15 Copayment for visits 1-5; \$25 Copayment for visits 6-30; \$35 Copayment for visits in excess of 30- unlimited visits.
Outpatient Substance Abuse and Drug Abuse	100% after: \$15 Copayment for visits 1-5; \$25 Copayment for visits 6-30; \$35 Copayment for visits in excess of 30 – unlimited visits.
Other Services	
Home Health Care	100%
Durable Medical Equipment	100%
Ambulance Service	Covered in full if Medically Necessary
Transplants	All non-experimental solid organ and bone marrow transplants when deemed Medically Necessary by the Plan. Subject to applicable Copayments.
Contract Year Annual Out-of-Pocket Maximum	
Single	\$1,100
Double	\$2,200
Parent/Child	\$1,900
Family	\$3,600

Evidence of Coverage Form No. 0401154-0498MD. Prescription Drug Rider Form No. 044339-0700MD.

Notes:

¹ You must use a participating Primary Care Physician who must provide or coordinate your medical care, including referrals for specialty, Hospital, or other medical care, with the exception of the OB/GYN visit as detailed in this outline.

² Female Members may have direct access to a participating OB/GYN or a participating certified nurse midwife without the requirement that a referral be made by the member's primary care physician for OB/GYN care. The care shall be Medically Necessary, including, but not limited to, routine care. If the member requires the services of another specialty provider, the member's primary care physician must determine the necessity of a referral. No Copayment required for participating certified nurse/midwife services.

³ Up to 60 combined visits per Contract Year. Limits do not apply to speech therapy services related to cleft lip, cleft palate or both or for Habilitative Services for children under the age of nineteen (19).

⁴ Routine services consist of office visits, one office sonogram (as part of prenatal care) and laboratory work. Other non-routine services are subject to the applicable Copayment for each visit.

⁵ Artificial insemination is covered for a maximum of six (6) cycles per member per lifetime. Covered in-vitro fertilization services are limited to three (3) attempts per live birth, not to exceed a maximum lifetime benefit of \$100,000.

⁶ Covered only for postoperative and chemotherapy nausea and vomiting, nausea of pregnancy, postoperative dental pain, and as part of a comprehensive treatment program for chronic pain, up to 12 visits per Contract Year.

⁷ For services related to conditions that meet the Plan definition of a Medical Emergency. Copayment waived if admitted to the Hospital. Services related to conditions that do not meet the Plan definition of a Medical Emergency are not covered.