BENEFIT SUMMARY

IN-NETWORK BENEFITS

All services and supplies must be provided or authorized by your network Primary Care Physician

OUT-OF-NETWORK BENEFITS

All eligible charges are subject to an annual deductible.

MONTGOMERY COUNTY PUBLIC SCHOOLS
BENEFIT SUMMARY

PRUDENTIAL PLUS

[Effective January 1, 1999, administration of the negotiated health plan was turned over to Blue Cross/Blue Shield. Except as provided otherwise in Article 24, all health benefits, provisions, and conditions remain unchanged.]

Ed. 1/94

BENEFIT SUMMARY	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
PROVIDER SERVICES		
Provider Office Visits (including periodic physical examinations, pap smears, immunizations, injections, well baby care, diagnostic X-ray and lab, and physical and speech therapy[1])	100% after $10 copayment per visit	80% (periodic physical exams, immunizations, pap smears, well baby care not covered)
Hospital Visits (including surgical procedures, assistant surgeon, anesthesia, and newborn care)	100%	80% (well baby care not covered)
Maternity (including pre-natal, delivery, and post-natal care)	100% after $10 copayment for the first visit	80%
Psychiatric Care		
Inpatient 30-day maximum per calendar year[2]	100% first 15 days 80% next 15 days	80% first 15 days 50% next 15 days
Partial Hospitalization 30-day maximum per calendar year	100% first 15 days 80% next 15 days	80% first 15 days 50% next 15 days
Outpatient	100% first 3 visits 80% each visit thereafter	80% first 3 visits 65% next 17 visits 50% each visit thereafter
Inpatient alcohol and drug-related care 45-day maximum per calendar year[3] (11-day maximum for emergency care or detoxification per calendar year)	100% first 15 days 80% next 30 days	80% first 15 days 50% next 30 days
HOSPITAL SERVICES (Inpatient)		
Room and board (semi-private room), intensive care, pre-admission testing, all other hospital charges	100%	80%
Newborn care	100%	80% (up to 7 days for well baby care)
Psychiatric Care		
Inpatient 30-day maximum per calendar year[2]	100% first 15 days 80% next 15 days	80% first 15 days 50% next 15 days
Partial Hospitalization 30-day maximum per calendar year	100% first 15 days 80% next 15 days	80% first 15 days 50% next 15 days
Alcohol and drug-related care 45-day maximum per calendar year[3] (11-day maximum for emergency care or detoxification per calendar year)	100% first 15 days 80% next 30 days	80% first 15 days 50% next 30 days
HOSPITAL SERVICES (Outpatient)		
Surgery (services and supplies)	100%	80%
Emergency Room (see NOTE below)	100% after $25 copayment per visit	80%
Alcohol and drug-related care Up to the lesser of 45 visits or $4,500 in a calendar year[3]	100%	80%

NOTE CONCERNING EMERGENCY ROOM: In-network benefits are available for Emergency Room charges only for medical emergencies; if the Emergency Room is used for a condition that is not a medical emergency, out-of-network benefits apply. A medical emergency is generally defined as a sickness or injury of such a nature that failure to get immediate medical care could put a person's life in danger or cause serious harm to bodily functions. Some examples of a medical emergency are: apparent heart attack, severe bleeding, sudden loss of consciousness, severe or multiple injuries, convulsions, apparent poisoning. Some examples of conditions that are not considered medical emergencies are: colds, influenza, ordinary sprains, ear infections, nausea, headaches.

INFORMATION CONCERNING PRUPASS: The out-of-network benefits include PruPASS, Prudential's Patient Advisory Support Service program. Whenever you or one of your dependents faces confinement in a hospital or needs non-emergency surgery, call PruPASS for a pre-admission and concurrent hospitalization review or a second surgical opinion. If you do not use PruPASS, eligible charges for hospitalization may be reduced for days not pre-certified, and eligible charges for elective surgery may also be reduced. See your Booklet/Certificate for details.

All benefits are subject to Coordination of Benefits.

APPENDIX D

	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
OTHER SERVICES		
Convalescent Nursing Home Care	100% up to 100 days per period of care[3]	80% up to 60 days per period of care[4]
Alcohol and drug-related care in an Intermediate Care Facility (ICF) 90-day maximum per calendar year[2,4]	100% first 30 days 80% next 60 days	80% first 30 days 50% next 60 days $175 per day eligible charge limit
Home Health Care	100%	80% up to 60 visits per calendar year[3]
Hospice Care $7,400 maximum benefit per period of care	100%	80%
Outpatient Private Duty Nursing	100%	80% $10,000 annual eligible charge limit[3]
Ambulance	100%	80%
Chemo/Radiation Therapy	100%	80%
Diagnostic X-ray and Lab (other than office visit)	100%	80%
Physical and Speech Therapy[1] (other than office visit)	100%	80%
Annual deductible per calendar year	None	$300 per individual $600 per family
100% Benefit Feature	After an individual has incurred $5,000 of eligible charges in a calendar year (not including copayments, deductibles and any charges already payable at 100%) the plan pays 100% of remaining eligible charges in that year[5]	
Individual Lifetime Maximum	Unlimited	$1,000,000

[1]Physical therapy (office and non-office visits combined) has a 90-day maximum per condition per calendar year. Speech therapy (office and non-office visits combined) has a 90-day maximum per condition per calendar year.

[2]Benefits for alcohol and drug abuse-related care will not be provided for more than a combined lifetime total of 180 days/visits.

[3]This limit applies to all days or visits used or charges incurred, whether benefits for those days or visits are provided in-network or out-of-network.

[4]If the only stay is in an ICF, then the stated benefits apply. If a hospital is also used, each day of a hospital inpatient stay reduces by two the number of days available for ICF services.

[5]Benefits for eligible charges for outpatient psychiatric care will not increase to 100%, but will continue to be paid at the percentages shown in this Benefit Summary. However, these charges in excess of the deductible will count toward the $10,000.

APPENDIX D

DEFINITIONS

COORDINATION OF BENEFITS

The total benefits payable under this plan for a covered person when combined with other group health insurance plan benefits will not exceed 100% of allowable expenses.

COPAYMENT

The amount which a patient is required to pay to a network provider at the time of service.

DEDUCTIBLE

The amount of the covered charges which you and/or your eligible dependent(s) must pay before benefits are paid by the plan.

INTERMEDIATE CARE FACILITY (ICF) SERVICES

This means only continuous treatment at an ICF of not less than three hours and not more than twelve hours in a 24-hour period. It does not include a hospital inpatient stay.

100% BENEFIT FEATURE

A feature under which the plan pays 100% of remaining eligible charges in a calendar year after an individual has incurred a specified amount of eligible charges (not including copayments, deductibles, and any charges already payable at 100%).

NOTE: Eligible charges for outpatient psychiatric care will not be paid at 100% but will continue to be paid at the percentages shown in the Benefit Summary. However, these charges (in-network and out-of-network) will count toward the specified amount of eligible charges.

SERVICES NOT COVERED

The services and supplies briefly described below are not covered under the plan. These services and supplies are:

- For any work-connected injury or for any sickness covered by Workers' Compensation or similar law;
- Furnished by governmental plans;
- Not medically necessary or experimental or educational in nature;
- Above the provider's usual charge;
- Above the prevailing charge for the service in the area;
- Furnished by a close relative;
- For blood that has been replaced;
- For dental services, including those for Temporomandibular Joint Disorders (TMJD) or malocclusion. This does not apply to treatment of malignancies or accident-related injuries;
- For treatment of foot conditions except metabolic or peripheral vascular disease or open cutting operations;
- For eye or hearing examinations, the routine purchase of eyeglasses, or for radial keratotomy;
- For cosmetic surgery, except for certain accidental injuries, birth abnormalities or defects, or reconstructive surgery;
- For surgery for sex changes or to reverse a previous surgery for voluntary sterilization;
- For sickness or injury resulting from war or any act of war;
- For custodial care;
- For any sickness or injury for which charges were incurred, or services received or treatment given, for medical care within 90 days of the date you become covered, if your plan has a pre-existing condition provision. However, this provision will not apply to the first $1,000 of benefits payable. When you enroll, you will be informed whether this provision applies to your employer's plan. In no event will this provision apply for more than 12 months from the date you become covered.

This Benefit Summary provides a brief outline of the services covered by Prudential Plus. Refer to your Prudential Plus Handbook for information regarding the administration of the plan. When your coverage becomes effective, you will receive a Group Insurance Booklet/Certificate describing your coverage in greater detail. The complete terms of the coverage will be governed by a group insurance contract form 83500 COV 1004 issued by The Prudential Insurance Company of America.

APPENDIX D

Point-Of-Service Medical Plan

New plan combines best of HMOs and indemnity

A new health care option is now available to MCPS employees. The Prudential-Plus Plan (Pru Plus), is a managed care point-of-service (POS) plan that combines the best features of an HMO and an indemnity insurance plan.

With the Pru Plus POS plan, members receive two levels of health care coverage. There is an in-network, HMO-like component, offering a full range of services either provided or authorized by your primary care physician. This is coupled with an out-of-network coverage, similar to traditional indemnity insurance, that provides payment for treatments received from non participating physicians or not authorized by your primary care physician.

It is your decision whether to stay in-network or go outside to a particular doctor or for a specialized service. The cost to you will vary depending on the manner of treatment chosen.

The in-network component offers several advantages over traditional health care:

(1) Your individual primary care physician manages your care; treating you when sick or injured, referring you to specialists when needed, and arranging hospitalization as required. The primary care physician handles the paperwork. There are no claim forms or waiting for reimbursement.

(2) Cost to you is lower in-network. In most cases you will be required to pay only a $10 co-payment when service is rendered.

(3) Preventive care (physicals, immunizations, well-child care, etc.) is covered. Many feel this is the most important aspect of a successful long-term health care program.

The out-of-network coverage provides flexibility and control. It allows you to see any doctor you choose. Your cost will be higher on the out-of-network schedule of benefits. You will be required to meet an annual deductible of $300 for an individual and $600 for a family, and, in most cases, be responsible for 20 percent of the cost.

Employees can use the current open enrollment period to elect Pru Plus coverage effective January 1,1994.

Time to Enroll in the New Health Plan Extended

The Board of Education has improved the employee benefit plan (EBP) by approving the Prudential Plus (Pru Plus) medical plan and medical spending accounts (MSA). Details of the new plans are outlined in this newsletter. Each of these new features may benefit you and your family, so be sure to take the time to investigate them.

The Board has agreed to extend the deadline for employees to enroll in the Pru Plus plan to December 20. This extended opportunity is available to employees who wish to switch from their current carrier to the Pru Plus plan, but *does not* apply to the other medical plans. Changes to enrollment status, addition of dependents, and transfers between the other plans will not be allowed at this time. Deadlines to enroll in MSA and dependent care assistance (DCA) plan have also been extended to December 20th. Please note that MSAs are not available to employees enrolled in the Prudential indemnity plan. DCAs are available to all full-time employees.

Recent Improvements to POS Plan Design

Some improvements have been made to the Pru Plus plan since it was first announced. The individual lifetime out-of-network maximum benefit has been increased from $1 to $2 million. The $7,400 maximum benefit per period of care for hospice care has been removed, and the 11 day maximum for inpatient alcohol and drug related detoxification has been eliminated.

POS: the bottom line

The Board has agreed to pay 90 percent of the cost of POS coverage for all eligible employees. Employee biweekly cost for POS coverage will be:

	10 month	12 month
Single Coverage	**$16.88**	**$12.98**
Employee Plus One Dependent	**33.90**	**26.08**
Family Coverage	**44.52**	**34.25**

APPENDIX D

Point-of-Service Q & A

Q. What are the advantages of the Point-of-Service plan relative to the indemnity plan?

The main advantages are lower premium cost and the availability of services traditionally associated with HMOs, particularly the preventive care (physical exams, well child care, immunizations, etc.) The out-of-network benefit of the point-of-service (POS) plan is similar to the indemnity benefit, but some costs are higher, such as the individual and family deductibles, and some coverages are reduced, such as the surgical and mental health benefits.

You should compare the indemnity plan features with POS out-of-network benefits. Make an informed decision based on your personal situation and needs to determine whether the lower premium cost and in-network/HMO-like benefits outweigh the higher deductible and reduced coverage in some areas. Wise use of the medical spending account will help offset some of the potentially higher out-of-pocket costs.

Q. What are the advantages of the Point-of-Service plan relative to an HMO? I am happy with my HMO coverage.

The in-network benefit of the POS plan operates very much like your HMO and offers such traditional HMO features as: well care, lower cost, and little or no paperwork. The out-of-network benefit provides additional flexibility and control. If you choose to go out-of-network, you will be covered and receive reimbursement for your care, subject to deductibles and co-payments. This is important if you have a favorite doctor or specialist who is not a member of the network.

You should compare your HMO coverage with the POS coverage and make a decision based on your individual circumstances.

Q. How do I select a primary care physician?

Consult the list of participating Pru Plus primary care physicians to select a physician convenient for you and your family. Each covered family member can choose a different primary care physician (PCP). Children can have a pediatrician as their PCP; women may select an OB/GYN specialist as a second PCP.

Pru Plus has a network of more than 900 health care providers serving the MCPS employment area. Prudential has agreed to work with MCPS to identify those doctors most used by employees and attempt to bring these doctors into the Pru Plus network.

Q. My current doctor is not a Pru Plus participating provider. May I still see this doctor?

Yes, but in order to receive the maximum benefit all non life-threatening care must be provided or arranged by a Pru Plus provider. Your claim for reimbursement will be processed on the out-of-network schedule of benefits.

Q. What about emergency medical care?

You are covered for medical emergencies anywhere in the world under Pru Plus. In case of medical emergency, seek treatment at the nearest emergency facility. Care furnished in the first 48 hours will be eligible for in-network benefits regardless of location or provider. You must notify your primary care physician within the first 48 hours so that continuation of necessary medical services can be authorized beyond 48 hours on the in-network schedule of benefits.

A medical emergency is defined as a sickness or injury that if not immediately treated could result in death or serious injury.

Heart attack, severe bleeding, loss of consciousness, and severe or multiple injuries are examples of medical emergencies. Colds, flu, ordinary sprains, nausea, headaches, and term pregnancy are not considered emergencies.

Q. Are there restrictions on coverage for pre-existing medical conditions?

There are no restrictions on coverage for pre-existing conditions for current members of the employee benefit plan who use an open season to change health plans, or for new members who join an HMO, or for new members who join the POS plan and receive in-network care.

There are exclusions for pre-existing conditions for new members who join the indemnity plan, or join the POS plan and receive care out-of-network. The exclusions apply to both major medical and hospital benefits. Please refer to the plan documents for definitions and details.

With respect to the above, a newly added spouse or dependent is considered a new member in the employee benefit plan.