

County Health Pool
HDHP/HSA 2500 Benefit Summary
 Effective January 1,2012



| | HDHP/HSA 2500 PLAN | |
|--------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | IN-NETWORK | OUT-OF-NETWORK |
| ANNUAL DEDUCTIBLE | | |
| Individual | \$2,500 per individual | \$5,000 |
| Family | \$5,000 per individual or family If you select family membership, no individual deductible applies and the family deductible must be met before CHP provides benefits. | \$10,000 per individual or family If you select family membership, no individual deductible applies and the family deductible must be met before CHP provides benefits. |
| OUT-OF-POCKET ANNUAL MAXIMUM | | |
| Individual | \$5,000 per individual includes deductible and coinsurance. | \$10,000 includes deductible and coinsurance. |
| Family | \$10,000 per individual or family includes deductible and coinsurance. If you select family membership, no individual out-of-pocket annual maximum applies and the family out-of-pocket annual maximum must be met before CHP provides benefits. | \$20,000 includes deductible and coinsurance. If you select family membership, no individual out-of-pocket annual maximum applies and the family out-of-pocket annual maximum must be met before CHP provides benefits. |
| LIFETIME MAXIMUM | None | None |
| Pre-Cert Penalty | None | May be balance billed, see Plan Document for details |
| COVERED PROVIDERS | Anthem Blue Cross and Blue Shield Blue Preferred PPO Provider Network. Consult www.anthem.com or call Customer Service at 1-866-698-0087 | All eligible providers licensed or certified to provide covered benefits |
| MEDICAL OFFICE VISITS | 80/20% after deductible | 60/40% after deductible |
| PREVENTIVE CARE | | |
| Children's services up to age 13 (age and visit limitations apply) | 100% covered, not subject to co-payment, deductible or co-insurance. | 60/40% not subject to deductible |
| Adult's services(age and visit limitations apply) | 100% covered, not subject to co-payment, deductible or co-insurance. Covered preventive care services include those that meet the requirements of federal and state law including certain screenings, immunizations and office visits; and are not subject to coinsurance or deductible. | Not covered except for mammogram screening, PSA or colorectal cancer screening which are not subject to deductible or coinsurance. Covered preventive care services include those that meet the requirements of federal and state law including certain screenings, immunizations and office visits. |

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| | IN-NETWORK | OUT-OF-NETWORK |
| MATERNITY | | |
| Prenatal care | 80/20% after deductible | 60/40% after deductible |
| Delivery & inpatient care | 80/20% after deductible | 60/40% after deductible |
| PRESCRIPTION DRUGS (Level of coverage and restrictions on prescriptions) | | |
| Inpatient care | Included with inpatient hospital benefit | Included with inpatient hospital benefit |
| Outpatient care | Retail Pharmacy Drugs: 80/20% after deductible for up to a 30 day supply Specialty Pharmacy Drugs – 80/20% after deductible per 30 day supply from Anthem's Specialty Pharmacy. Specialty Pharmacy Drugs are not available at a retail pharmacy or from a mail-order pharmacy. | Not covered Not covered |
| Prescription Mail Service | 80/20% after deductible for up to a 90 day supply. Specialty pharmacy drugs are not available through the mail-order service. | Not covered |
| | The following applies to the above: Includes coverage for smoking cessation | Not covered |
| | For drugs on our approved list, call customer service at 1-866-698-0087. | |
| INPATIENT HOSPITAL | 80/20% after deductible | 60/40% after deductible |
| OUTPATIENT/AMBULATORY SURGERY | 80/20% after deductible | 60/40% after deductible |
| LABORATORY AND X-RAY | | |
| Inpatient care | 80/20% after deductible | 60/40% after deductible |
| Outpatient care | | |
| EMERGENCY CARE (Emergency Room) | 80/20% after deductible | Paid as in network benefit |
| AMBULANCE | | |
| Ground | 80/20% after deductible | 80/20% after deductible |
| Air | 80/20% after deductible | 80/20% after deductible |
| URGENT, NON-ROUTINE, AFTER HOURS - OUTPATIENT CARE | 80/20% after deductible | 60/40% after deductible |
| MENTAL HEALTH CARE | | |
| Inpatient care | 80/20% after deductible | 60/40% after deductible |
| Outpatient facility | 80/20% after deductible | 60/40% after deductible |

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| | IN-NETWORK | OUT-OF-NETWORK |
| ALCOHOL & SUBSTANCE ABUSE | | |
| Inpatient Care | 80/20% after deductible | 60/40% after deductible |
| Outpatient facility | 80/20% after deductible | 60/40% after deductible |
| PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY | | |
| Inpatient | Included with inpatient hospital benefit, limited to 30 non-acute inpatient days per calendar year in and out-of-network combined | Included with inpatient hospital benefit, limited to 30 non-acute inpatient days per calendar year in and out-of-network combined |
| Outpatient | 80/20% after deductible, limited to 30 visits each (PT, OT, ST) per calendar year in and out-of-network combined | 60/40% after deductible, limited to 30 visits each (PT, OT, ST) per calendar year in and out-of-network combined |
| DURABLE MEDICAL EQUIPMENT/OXYGEN | | |
| Inpatient care | Included with inpatient hospital benefit | Included with inpatient hospital benefit |
| Outpatient care | 80/20% after deductible | Not covered |
| ORGAN TRANSPLANTS | 80/20% after deductible | Not covered |
| HOME HEALTH CARE | 80/20% after deductible, limited to 60 visits per calendar year | Not covered |
| HOSPICE CARE | | |
| Inpatient Care | 80/20% after deductible | 60/40% after deductible |
| Outpatient care | 80/20% after deductible | 60/40% after deductible |
| SKILLED NURSING FACILITY CARE | 80/20% after deductible, limited to 30 days per calendar year in and out-of-network combined | 60/40% after deductible, limited to 30 days per calendar year in and out-of-network combined |
| CHIROPRACTIC CARE & ACUPUNCTURE CARE | 80/20% after deductible, limited to 30 visits per calendar year in and out-of-network combined | 60/40% after deductible, limited to 30 visits per calendar year in and out-of-network combined |
| SECOND SURGICAL OPINION | When a member desires another professional opinion, they may obtain a second surgical opinion | When a member desires another professional opinion, they may obtain a second surgical opinion |
| TREATMENT OF AUTISM SPECTRUM DISORDERS | Benefit level and coverage meets the requirements of federal and state laws. More information on this benefit can be found in the Plan Document. | Benefit level and coverage meets the requirements of federal and state laws. More information on this benefit can be found in the Plan Document |

Your plan may exclude coverage for certain treatments, diagnoses, or services not noted. The benefits shown in this summary may only be available if required plan procedures are followed (e.g. plans may require prior authorization or use of specified providers or facilities).

This form is not a contract, and is only a summary. The contents of this form are subject to the provisions of the Plan Document and Summary Plan Description which contains all terms, covenants, and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted. The benefits shown in this summary may only be available if required plan procedures are followed (e.g. plans may require prior authorization or use of specified providers or facilities). Consult the actual Plan Document and Summary Plan Description to determine the exact terms and conditions of coverage. The County Health Pool Document is available at www.ctsi.org. You may also contact Anthem Customer Service at 1-866-698-0087