

County Health Pool HDHP/HSA 2500 Benefit Summary

Effective January 1, 2009



	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. The family deductible amount is met as follows: when one individual has satisfied the family deductible, that family member and all other family members are eligible for 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. The family deductible amount is met as follows: when one individual has satisfied the family deductible, that family member and all other family members are eligible for benefit.
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. The family out-of-pocket annual maximum amount is met as follows: when one individual has satisfied the family out-of-pocket maximum, that family member and all other family members are eligible for benefit.	\$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. The family out-of-pocket annual maximum amount is met as follows: when one individual has satisfied the family out-of-pocket maximum, that family member and all other family members are eligible for benefit.
LIFETIME MAXIMUM	Plan pays \$2,000,000	Plan pays \$2,000,000
LIFETIME TRANSPLANT BENEFIT	Plan pays \$1,000,000 per member, per transplant	Not covered
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 877-811-3106	All eligible providers licensed or certified to provide covered benefits
MEDICAL OFFICE VISITS	80/20% after deductible	60/40% after deductible

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PREVENTIVE CARE Children's services up to age 13 (age and visit limitations apply) Adults' services (age and visit limitations apply)	80/20% not subject to deductible 80/20% after deductible. Mammogram screening and prostate screening are covered, which are not subject to deductible or coinsurance.	60/40% not subject to deductible Not covered except for mammogram screening and prostate screening, which are not subject to deductible or coinsurance.
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. The following applies to the above: Includes coverage for smoking cessation prescription legend drugs. \$250 per member per calendar year, \$500 per lifetime. For drugs on our approved list, call customer service at 877-811-3106.	Not covered Not covered
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	Out-of-network emergency care is paid as in-network
AMBULANCE Ground	80/20% after deductible	60/40% after deductible
Air	80/20% after deductible, maximum benefit of \$10,000 per trip	60/40% after deductible, maximum benefit of \$10,000 per trip

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URGENT, NON-ROUTINE, AFTER HOURS - OUTPATIENT CARE	80/20% after deductible	60/40% after deductible
MENTAL HEALTH CARE Inpatient care	80/20% after deductible, limited to 45 full or 90 partial days per calendar year combined with Alcohol Abuse benefits	Not covered
Outpatient care	80/20% after deductible, limited to 30 visits per calendar year, with no less than \$1,000 in benefits	Not covered
ALCOHOL & SUBSTANCE ABUSE Inpatient Care	Alcohol abuse: 80/20% after deductible, limited to 45 days per year or 90 partial days per calendar year combined with Mental Health Care benefits	Not covered
Outpatient care	Substance abuse: 80/20% after deductible, limited to 30 days per calendar year or 60 days per lifetime 80/20% after deductible, limited to a maximum of 20 visits per calendar year, with no less than \$500 in benefits for alcohol abuse; limited to a maximum of 15 visits per calendar year for substance abuse	Not covered
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 Inpatient care	Included with inpatient hospital benefit	Included with inpatient hospital benefit
Outpatient care	80/20% after deductible, limited to a maximum payment of \$3,000 per calendar year. Prosthetic devices are not subject to the maximum payment but do reduce the maximum payment of \$3,000	Not covered
OXYGEN Inpatient care	Included with inpatient hospital benefit	Included with inpatient hospital benefit
Outpatient care	80/20% after deductible, limited to a maximum payment of \$5,000 per calendar year, not combined with durable medical equipment	Not covered
ORGAN TRANSPLANTS	80/20% after deductible	Not covered

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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	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
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 1-877-811-3106.