

**County Health Pool**  
**HDHP/HSA 2500 Benefit Summary**  
 Effective January 1, 2010



	HDHP/HSA 2500 PLAN	
	IN-NETWORK	OUT-OF-NETWORK
<b>ANNUAL DEDUCTIBLE</b>		
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.
<b>OUT-OF-POCKET ANNUAL MAXIMUM</b>		
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.
<b>LIFETIME MAXIMUM</b>	Plan pays \$4,000,000 per member	Plan pays \$4,000,000 per member
<b>LIFETIME TRANSPLANT BENEFIT</b>	Plan pays \$4,000,000 per member	Not covered
<b>Pre-Cert Penalty</b>	None	May be balance billed, see Plan Document for details
<b>COVERED PROVIDERS</b>	Anthem Blue Cross and Blue Shield Blue Preferred PPO Provider Network. Consult <a href="http://www.anthem.com">www.anthem.com</a> or call Customer Service at 877-811-3106	All eligible providers licensed or certified to provide covered benefits
<b>MEDICAL OFFICE VISITS</b>	80/20% after deductible	60/40% after deductible

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<b>PREVENTIVE CARE</b> 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% not subject to deductible. Mammogram screening, PSA and colorectal cancer screening are covered, which are not subject to deductible or coinsurance.	60/40% not subject to deductible  Not covered except for mammogram screening, PSA and colorectal cancer screening which are not subject to deductible or coinsurance.
<b>MATERNITY</b> Prenatal care  Delivery & inpatient care	80/20% after deductible  80/20% after deductible	60/40% after deductible  60/40% after deductible
<b>PRESCRIPTION DRUGS</b> (Level of coverage and restrictions on prescriptions)  Inpatient care  Outpatient care  Prescription Mail Service	Included with inpatient hospital benefit  <b>Retail Pharmacy Drugs:</b> 80/20% after deductible for up to a 30 day supply <b>Specialty Pharmacy Drugs</b> – 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.  80/20% after deductible for up to a 90 day supply. Specialty pharmacy drugs are not available through the mail-order service.  <b>The following applies to the above:</b> 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.	Included with inpatient hospital benefit  Not covered  Not covered  Not covered  Not covered
<b>INPATIENT HOSPITAL</b>	80/20% after deductible	60/40% after deductible
<b>OUTPATIENT/AMBULATORY SURGERY</b>	80/20% after deductible	60/40% after deductible
<b>LABORATORY AND X-RAY</b> Inpatient care  Outpatient care	80/20% after deductible	60/40% after deductible
<b>EMERGENCY CARE (Emergency Room)</b>	80/20% after deductible	Paid as in network benefit
<b>AMBULANCE</b>  Ground	80/20% after deductible, maximum benefit of \$500 per trip	80/20% after deductible, maximum benefit of \$500 per trip

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Air	80/20% after deductible, maximum benefit of \$10,000 per trip	80/20% after deductible, maximum benefit of \$10,000 per trip
URGENT, NON-ROUTINE, AFTER HOURS - OUTPATIENT CARE	80/20% after deductible	60/40% after deductible
<b>MENTAL HEALTH CARE</b>		
Inpatient care	80/20% after deductible	60/40% after deductible
Outpatient care	80/20% after deductible	60/40% after deductible
<b>ALCOHOL &amp; SUBSTANCE ABUSE</b>		
Inpatient Care	80/20% after deductible	60/40% after deductible
Outpatient care	80/20% after deductible	60/40% after deductible
<b>PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY</b>		
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
<b>DURABLE MEDICAL EQUIPMENT</b>		
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
<b>OXYGEN</b>		
Inpatient care	<b>Included with inpatient hospital benefit</b>	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
HOME HEALTH CARE	80/20% after deductible, limited to 60 visits per calendar year	Not covered

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<b>HOSPICE CARE</b>		
Inpatient Care	80/20% after deductible	60/40% after deductible
Outpatient care	80/20% after deductible	60/40% after deductible
<b>SKILLED NURSING FACILITY CARE</b>	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
<b>CHIROPRACTIC CARE</b>	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
<b>SECOND SURGICAL OPINION</b>	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](http://www.ctsi.org). You may also contact Anthem Customer Service at 1-877-811-3106.