

County Health Pool
HDHP/HSA 2500 Benefit Summary
 Effective January 1,2011



	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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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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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