

## CHS - 2010 BASIC MEDICAL PLAN

<b>Deductible</b> Must be satisfied once per calendar year. Does not include Copayments, penalties, charges in excess of allowable amounts, and non-Covered Charges.	\$1,200 per Individual / \$2,400 per Family
<b>Out-of-Pocket Maximum</b> Does not include Deductibles, Copayments, penalties, charges in excess of allowable amounts, and non-Covered Charges.	\$6,000 per Individual / \$12,000 per Family per year
<b>Lifetime Plan Maximum</b>	\$2,000,000 INN / \$1,000,000 OON / Covered Person

Hospital Services	CHS	Network Providers	Non-Network Providers
<b>Inpatient</b> (if service <i>can be</i> provided at CHS)	80%	80% after \$5,000 copayment	50% after \$5,000 copayment
<b>Inpatient</b> (if service <i>cannot be</i> provided at CHS)	N/A	80% after \$800 copayment	50% after \$800 copayment
<b>Outpatient Surgery</b>	80%	80% after \$800 copayment	50% after \$800 copayment
<b>Mental Health/Substance Abuse</b>	80%	80% after \$800 copayment	50% after \$800 copayment
<b>Hospital Emergency Room</b>	80% after \$100 copayment (copayment waived if admitted)		
<b>Urgent Care Benefit</b> (Physician/Facility/Diagnostic Services)	Actual coverage is determined by the bill submitted by provider/facility		
<b>Weight Loss Surgery</b> \$25,000 Maximum Benefit	80%	80% after \$2,500 copayment	None
<b>Diagnostic Services (X-Ray &amp; Lab)</b>	80%	80% after deductible	50% after deductible
<b>Precertification Penalty</b>	Failure to obtain precertification will result in denial of claims		

Physician Services	CHS	Network Providers	Non Network Providers
<b>Office Visits</b> includes lab and x-ray services, special diagnostic testing and consultation performed in the physician's office and billed by the physician for services performed the day of the visit.	N/A	80% after deductible	50% after deductible
<b>Surgery/Inpatient Visits</b>	N/A	80% after deductible	50% after deductible
<b>Mental Health/Substance Abuse Outpatient Visits</b>	N/A	80% after deductible	50% after deductible
<b>Chiropractic Care</b> (limited to 25 visits/year)	N/A	80% after deductible	50% after deductible

Wellness Services	CHS	Network Providers	Non Network Providers
<b>Preventive Services</b> (includes lab and professional fees) Annual Physical Exams, Mammographies, Pap Tests, PSAs, Routine Immunizations Wellness benefit limited to \$500 per person per year for ages 6 and over. Routine colonoscopies not subject to wellness benefit limit.	N/A	80%	No OON Benefit
<b>Preventive Services - Routine colonoscopies</b> (not subject to Wellness benefit limit) (Limited to once every ten years for individuals 50 years and older)	80%	80%	No OON Benefit

Other Covered Services	CHS	Network Providers	Non Network Providers
<b>Skilled Nursing Facility /Rehab</b> (limited to 120 days/occurrence)	80%	80% after deductible	50% after deductible
<b>Home Health Care</b> (limited to \$10,000 per year)	80%	80% after deductible	50% after deductible
<b>Home Infusion Services</b>	N/A	80% after deductible	50% after deductible
<b>Hospice Care</b> (limited to \$10,000 per lifetime)	80%	80% after deductible	50% after deductible
<b>Durable Medical Equipment and Prosthetics</b>	N/A	80% after deductible	50% after deductible
<b>Outpatient Therapy Services: Speech, Occupational and Physical</b> (each service limited to 30 visits/year)	80%	80% after deductible	50% after deductible
<b>Chemotherapy, Dialysis, Radiation and Respiratory Therapy</b>	80%	80% after deductible	50% after deductible
<b>Other covered services and supplies</b>	N/A	80% after deductible	50% after deductible

Prescription Drugs	Network Pharmacies		
	<b>Deductible</b>	<b>\$150 per Individual / \$450 per Family</b>	
	<b>Copays</b>	<b>Retail</b>	<b>Mail</b>
	Generic Rx	\$15	\$30
	Preferred Brand Rx	\$30	\$60
	Non-Preferred Rx	\$50	\$100
	Specialty Rx	\$80 per 30 day supply	