

CHS - 2010 PREMIER MEDICAL PLAN

Deductible Must be satisfied once per calendar year. Does not include Copayments, penalties, charges in excess of allowable amounts, and non-Covered Charges.	\$500 per Individual / \$1,000 per Family		
Out-of-Pocket Maximum Does not include Deductibles, Copayments, penalties, charges in excess of allowable amounts, and non-Covered Charges.	\$5,000 per Individual / \$10,000 per Family per year		
Lifetime Plan Maximum	\$2,000,000 INN / \$1,000,000 OON / Covered Person		
Hospital Services	CHS	Network Providers	Non-Network Providers
Inpatient (if service <i>can be</i> provided at CHS)	80%	80% after \$5,000 copayment	50% after \$5,000 copayment
Inpatient (if service <i>cannot be</i> provided at CHS)	N/A	80% after \$800 copayment	50% after \$800 copayment
Outpatient Surgery	80%	80% after \$800 copayment	50% after \$800 copayment
Mental Health/Substance Abuse	80%	80% after \$800 copayment	50% after \$800 copayment
Hospital Emergency Room	80% after \$100 copayment (copayment waived if admitted)		
Urgent Care Benefit (Physician/Facility/Diagnostic Services)	Actual coverage is determined by the bill submitted by provider/facility		
Weight Loss Surgery \$25,000 Maximum Benefit	80%	80% after \$2,500 copayment	None
Diagnostic Services (X-Ray & Lab)	80%	80% after deductible	50% after deductible
Precertification Penalty	Failure to obtain precertification will result in denial of claims		
Physician Services	CHS	Network Providers	Non Network Providers
Office Visits 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	\$35 copayment	50% after deductible
Surgery/Inpatient Visits	N/A	80% after deductible	50% after deductible
Mental Health/Substance Abuse Outpatient Visits	N/A	\$35 copayment	50% after deductible
Chiropractic Care (limited to 25 visits/year)	N/A	\$35 copayment	50% after deductible
Wellness Services	CHS	Network Providers	Non Network Providers
Preventive Services (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.	N/A	\$50 copayment	No OON Benefit
Preventive Services - Routine colonoscopies (not subject to Wellness benefit limit) <i>(Limited to once every ten years for individuals 50 years and older)</i>	80%	80%	No OON Benefit
Other Covered Services	CHS	Network Providers	Non Network Providers
Skilled Nursing Facility /Rehab (limited to 120 days/occurrence)	80%	80% after deductible	50% after deductible
Home Health Care (limited to \$10,000 per year)	80%	80% after deductible	50% after deductible
Home Infusion Services	N/A	80% after deductible	50% after deductible
Hospice Care (limited to \$10,000 per lifetime)	80%	80% after deductible	50% after deductible
Durable Medical Equipment and Prosthetics	N/A	80% after deductible	50% after deductible
Outpatient Therapy Services: Speech, Occupational and Physical (each service limited to 30 visits/year)	80%	80% after deductible	50% after deductible
Chemotherapy, Dialysis, Radiation and Respiratory Therapy	80%	80% after deductible	50% after deductible
Other covered services and supplies	N/A	80% after deductible	50% after deductible
Prescription Drugs	Network Pharmacies		
	Deductible	\$150 per Individual / \$450 per Family	
	Copays	Retail	Mail
	Generic Rx	\$15	\$30
	Preferred Brand Rx	\$30	\$60
	Non-Preferred Rx	\$50	\$100
	Specialty Rx	\$80 per 30 day supply	