Delaware County Government

Benefit Summary - Effective 8/1/10

Covered Services & Benefit Limits	In-Network Level	Out of Network
Deductible per person per Calendar Year	$200	$400
Deductible per Family Unit per Calendar Year	$400	$800
Maximum Coinsurance per person Per Calendar Year	$550 *(excluding deductible)*	$1,100 *(excluding deductible)*
Maximum Coinsurance per Family Unit Per Calendar Year	$1,100 *(excluding deductible)*	$2,200 *(excluding deductible)*
Maximum Lifetime Benefit Amount while covered under this Plan	$5,000,000	
Please Note: The In-Network & Out-of-Network Deductible & Coinsurance Limits do not accumulate together & therefore are satisfied separately		
Please Note: Copayments (other than those for Prescription Drugs) apply the Maximum Coinsurance Limit		
Hospital Inpatient Facility Charges	After Deductible, 90%	After Deductible, 70%
Hospital Outpatient Facility Charges	After Deductible, 90%	After Deductible, 70%
Physician Office Visits *(Includes all services in office)*	$20 Copay, 100%	After Deductible, 70%
Inpatient Physician Visits and other than in office services	After Deductible, 90%	After Deductible 70%
Urgent Care Facility	$35 Copay, 100%	$35 Copay, 100%
Emergency Room Services *(Copay Waived If Admitted)*	$100 Copay, 100%	$100 Copay, 100%
Ambulance	100% *(No Deductible)*	100% *(No Deductible)*
Chiropractic Care *(Limited to 12 visits per Calendar Year)*	$20 Copay, 100%	After Deductible, 70%
Physical Therapy/Occupational Therapy *(limited to 60 visits per Calendar Year combined)*	$20 Copay, 100%	After Deductible, 70%
Speech Therapy *(limited to 20 visits per Calendar Year)*	$20 Copay, 100%	After Deductible, 70%
All Other Therapy Services *(Dialysis, Chemotherpy, Radiation Therapy)*	*Copayment charged is based on where the service is rendered*	*Copayment charged is based on where the service is rendered*
Allergy Services *(Testing/Treatment/Serum/Injections with no office charge)*	100% *(No Deductible)*	After Deductible, 70%
Extended Care Facility/Rehabilitation Facility *(Calendar Year Maximum - 60 Days Combined)*	After Deductible, 90%	After Deductible, 70%
Home Health Care	After Deductible, 90%	After Deductible, 70% *(30 visit per year limit)*
Hospice Services *(With 6 month Life Expectancy)*	100% *(No Deductible)*	100% *(No Deductible)*
Medical Supplies/Durable Medical Equipment	After Deductible, 80%	After Deductible 60%
Organ Transplants *(Limited to $1,000,000 Lifetime Maximum)*	*100% up to Maximum Allowable Amount -- See Plan for details*	*After Deductible, 50% up to Maximum Allowable Amount - see Plan for details*
Maternity Services	After Deductible, 90%	After Deductibe, 70%
Mental Health and Substance Abuse		
Mental Health and Substance Abuse Inpatient	After Deductible, 90%	After Deductible , 70%
Mental Health and Substance Abuse Office Visits	$20 Copay, 100%	After Deductible, 70%
Mental Health and Substance Abuse Outpatient Services	$20 Copay, 100%	After Deductible, 70%
Wellness/Preventive Services		
Wellness/Preventive Services - physician recommended exams & immunizations and screenings	$20 Copay, 100%	After Deductible, 70%
Prescription Drugs		
Retail Pharmacy - *30 Day Supply*	$5 Generic Copay / $20 Preferred Brand Copay / $30 Non-Preferred Brand	
Retail and Mail Order Specialty Drugs - *30 Day Supply*	$5 Generic Copay / $20 Preferred Brand Copay / $30 Non-Preferred Brand	
Mail Order Pharmacy - *90 Day Supply*	$10 Generic Copay / $40 Preferred Brand Copay / $60 Non-Preferred Brand Copay	
Prescription Drugs purchased at a Non-Network Pharmacy	Reimbursed at 50%, after Deductible	
Dental Services	$1,500 Calendar Year Max / $1,500 Lifetime Orthodontic Max *(limited to under age 19)*	
	No Deductible / Diagnostic/Preventive Services 100% / General, Restorative, Endodontic, Oral Surgery, Periodontal Services 80% / Prosthodontics 50% / Orthodontia 50%	

This summary is designed only as a quick reference.
If there is a discrepancy between this summary and the plan document, the plan document will prevail.