Delaware County Government

Benefit Summary - Effective 10/1/10

Covered Services & Benefit Limits	Encircle (Facility) In-Network Level	Encore In-Network Level	Out of Network
Deductible per person per Calendar Year	$200	$300	$400
Deductible per Family Unit per Calendar Year	$400	$600	$800
Maximum Out-of-Pocket Limit per person Per Calendar Year	$550 *(excluding deductible)*	$1,100 *(excluding deductible)*	$2,200 *(excluding deductible)*
Maximum Out-of-Pocket Limit per Family Unit Per Calendar Year	$1,100 *(excluding deductible)*	$2,200 *(excluding deductible)*	$4,400 *(excluding deductible)*
Maximum Lifetime Benefit Amount while covered under this Plan	$5,000,000		
Please Note: *The In-Network & Out-of-Network Deductible & Out-of-Pocket Limits do not accumulate together & therefore are satisfied separately*			
Please Note: *Copayments Do Not Apply Toward the Maximum Out-of-Pocket Limit*			
Hospital Inpatient Facility Charges	After Deductible, 90%	After Deductible, 80%	After Deductible, 70%
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Primary Care Physician and Specialist Office Visits *(Includes office visit charge only)*	Not Currently Available	$20 Copay, 100% *(No Deductible)*	After Deductible, 70%
All Services in Primary Care Physician and Specialist Office	Not Currently Available	After Deductible, 90%	After Deductible, 70%
Inpatient Physician Visits and other Outpatient Physician Services	Not Currently Available	After Deductible 90%	After Deductible 70%
Urgent Care Facility *(includes office visit charge only)*	Not Currently Available	$35 Copay, 100% *(No Deductible)*	After Deductible, 70%
Emergency Room Services *(Copay Waived If Admitted)*	$100 Copay, then after Deductible, 90%	$100 Copay, then after Deductible, 80%	$100 Copay, then after Deductible, 70%
Ambulance	Not Currently Available	After Deductible, 90%	After Deductible, 90%
Chiropractic Care *(Limited to 12 visits per Calendar Year)* (copay Includes office only -- other services are applicable Deducible/Coinsurance)	Not Currently Available	$20 Copay, 100% *(No Deductible)*	After Deductible, 70%
Physical Therapy/Occupational Therapy *(limited to 60 visits per Calendar Year combined)*	After Deductible, 90%	After Deductible, 80%	After Deductible, 70%
Speech Therapy *(limited to 20 visits per Calendar Year)*	After Deductible, 90%	After Deductible, 80%	After Deductible, 70%
All Other Therapy Services *(Dialysis, Chemotherpy, Radiation Therapy)*	After Deductible, 90%	After Deductible, 80%	After Deductible, 70%
Allergy Services *(Testing/Treatment/Serum/Injections with no office charge)*	Not Currently Available	After Deductible, 90%	After Deductible, 70%
Extended Care Facility/Rehabilitation Facility *(Calendar Year Maximum - 60 Days Combined)*	After Deductible, 90%	After Deductible, 80%	After Deductible, 70%
Home Health Care	Not Currently Available	After Deductible, 90%	After Deductible, 70% (30 visit limit per Calendar Year)
Hospice Facility *(With 6 month Life Expectancy)*	After Deductible, 90%	After Deductible, 80%	After Deductible, 70%
Hospice Services Home *(with 6 mo life expectancy)*	Not Currently Available	After Deductible, 90%	After Deductible, 70%
Medical Supplies/Durable Medical Equipment	Not Currently Available	After Deductible, 80%	After Deductible, 70%
Organ Transplants *(Limited to $1,000,000 Lifetime Maximum)*	After Deductible, 90%	After Deductible, 80%	After Deductible, 70%
Maternity Services	Same as any other illness	Same as any other illness	Same as any other illness
Mental Health and Substance Abuse			
Mental Health and Substance Abuse Inpatient	After Deductible, 90%	After Deductible 80%	After Deductible , 70%
Mental Health and Substance Abuse Office Visits	Not Currently Available	$20 Copay, 100% *(No Deductible)*	After Deductible, 70%
Mental Health and Substance Abuse Outpatient Services	Not Currently Available	After Deductible, 90%	After Deductible, 70%
Wellness/Preventive Services			
Wellness/Preventive Services - physician recommended exams & immunizations and screenings	Not Currently Available	$20 Copay, 100% *(No Deductible)*	After Deductible, 70%
Prescription Drugs			
Retail Pharmacy - *30 Day Supply*	$5 Generic Copay / $25 Preferred Brand Copay / $35 Non-Preferred Brand		
Retail and Mail Order Specialty Drugs - *30 Day Supply*	$5 Generic Copay / $25 Preferred Brand Copay / $35 Non-Preferred Brand		
Mail Order Pharmacy - *90 Day Supply*	$10 Generic Copay / $50 Preferred Brand Copay / $70 Non-Preferred Brand Copay		
Prescription Drugs purchased at a Non-Network Pharmacy	Reimbursed at 50% after Out-of-Network Deductible		
Dental Services	$1,500 Calendar Year Max / $1,000 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.

7/30/2010