Delaware County Government

Benefit Summary - Proposed Effective 8/1/11 Cardinal Care

Covered Services & Benefit Limits	Cardinal Care In-Network Level	Out of Network
Deductible per person per Calendar Year	$750	$2,000
Deductible per Family Unit per Calendar Year	$1,500	$4,000
Maximum Out-of-Pocket Limit per person Per Calendar Year	$750 *(excluding deductible)*	$2,000 *(excluding deductible)*
Maximum Out-of-Pocket Limit per Family Unit Per Calendar Year	$1,500 *(excluding deductible)*	$4,000 *(excluding deductible)*
Maximum Annual 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, 80%	After Deductible, 60%
Hospital Outpatient Facility Charges	After Deductible, 80%	After Deductible, 60%
Primary Care Physician and Specialist Office Visits *(Includes office visit charge only)*	$20 Copay, 100% *(No Deductible)*	After Deductible, 60%
All Services in Primary Care Physician and Specialist Office	After Deductible, 80%	After Deductible, 60%
Inpatient Physician Visits and other Outpatient Physician Services	After Deductible, 80%	After Deductible, 60%
Urgent Care Facility *(includes office visit charge only)*	$35 Copay, 100% *(No Deductible)*	After Deductible, 60%
Emergency Room Services *(Copay Waived If Admitted)*	$100 Copay, then after Deductible, 80%	
Ambulance	After Deductible, 80%	
Chiropractic Care *(Limited to 12 visits per Calendar Year)*	$20 Copay, 100% *(No Deductible)*	After Deductible, 60%
Physical Therapy/Occupational Therapy *(limited to 60 visits per Calendar Year combined)*	After Deductible, 80%	After Deductible, 60%
Speech Therapy *(limited to 20 visits per Calendar Year)*	After Deductible, 80%	After Deductible, 60%
All Other Therapy Services *(Dialysis, Chemotherpy, Radiation Therapy)*	After Deductible, 80%	After Deductible, 60%
Allergy Services *(Testing/Treatment/Serum/Injections with no office charge)*	After Deductible, 80%	After Deductible, 60%
Extended Care Facility/Rehabilitation Facility *(Calendar Year Maximum - 60 Days Combined)*	After Deductible, 80%	After Deductible, 60%
Home Health Care	After Deductible, 80% (unlimited)	After Deductible, 60% (30 visit limit per Calendar Year)
Hospice Facility *(With 6 month Life Expectancy)*	After Deductible, 80%	After Deductible, 60%
Hospice Services Home *(with 6 mo life expectancy)*	After Deductible, 80%	After Deductible, 60%
Medical Supplies/Durable Medical Equipment	After Deductible, 80%	After Deductible, 60%
Organ Transplants *(Limited to $1,000,000 Lifetime Maximum)*	After Deductible, 80%	After Deductible, 60%
Maternity Services	Same as any other illness	Same as any other illness
Mental Health and Substance Abuse		
Mental Health and Substance Abuse Inpatient	After Deductible, 80%	After Deductible, 60%
Mental Health and Substance Abuse Office Visits	$20 Copay, 100% *(No Deductible)*	After Deductible, 60%
Mental Health and Substance Abuse Outpatient Services	After Deductible, 80%	After Deductible, 60%
Wellness/Preventive Services		
Wellness/Preventive Services - physician recommended exams & immunizations and screenings	No Deductible, 100%	After Deductible, 60%
Prescription Drugs		
Retail Pharmacy - *30 Day Supply*	$10 Generic Copay / $35 Preferred Brand Copay / $50 Non-Preferred Brand	
Retail and Mail Order Specialty Drugs - *30 Day Supply*	$10 Generic Copay / $35 Preferred Brand Copay / $50 Non-Preferred Brand	
Mail Order Pharmacy - *90 Day Supply*	$20 Generic Copay / $70 Preferred Brand Copay / $100 Non-Preferred Brand Copay	
Prescription Drugs purchased at a Non-Network Pharmacy	Reimbursed at 50% after Out-of-Network Deductible	

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.