

# County Health Pool

## PPO Plan A Benefit Summary

Effective January 1, 2012



	PPO PLAN A	
	IN-NETWORK	OUT-OF-NETWORK
<b>ANNUAL DEDUCTIBLE</b>		
Individual	None	\$2,000
Family	None	\$6,000 aggregate
<b>OUT-OF-POCKET ANNUAL MAXIMUM</b>		
Individual	\$2,000. Copayments do not apply to the out-of-pocket maximum	\$8,000, including deductible. Co-payments do not apply to the out-of-pocket maximum.
Family	\$6,000 aggregate. Copayments do not apply to out-of-pocket maximum	\$24,000 aggregate, including deductible. Co-payments do not apply to the deductible or the out-of-pocket maximum.
<b>LIFETIME MAXIMUM</b>	None	None
<b>Pre-Cert Penalty</b>	None	May be balance billed, see Plan Document for details
<b>COVERED PROVIDERS</b>	Anthem Blue Cross and Blue Shield Blue Preferred PPO Provider Network. Consult <a href="http://www.anthem.com">www.anthem.com</a> or call Customer Service at 1-866-698-0087	All eligible providers licensed or certified to provide covered benefits
<b>MEDICAL OFFICE VISITS</b>	\$25 per office visit copayment, 80/20% for all other eligible services (e.g., laboratory and x-ray services)	60/40% after deductible
<b>PREVENTIVE CARE</b>		
Children's services (age/visit limitations apply)	100% covered, not subject to co-payment or co-insurance	60/40% not subject to deductible, includes immunizations (up to age 13)
Adults' services (age/visit limitations apply)	100% covered, not subject to co-payment or co-insurance	Not covered except for mammogram screening PSA, colorectal cancer screenings. See SPD for benefit limit.
	Covered preventive care services include those that meet the requirements of federal and state law including certain screenings, immunizations and office visits; and are not subject to coinsurance or deductible.	Covered preventive care services include those that meet the requirements of federal and state law including certain screenings, immunizations and office visits
<b>MATERNITY</b>		
Prenatal care	\$25 per office visit copayment, 80/20% for all other eligible services (e.g., laboratory and x-ray services)	60/40% after deductible
Delivery & inpatient care	80/20% after \$350 per admission co-payment	60/40% after \$1,500 per admission co-payment subject to deductible
<b>PRESCRIPTION DRUGS</b> (Level of coverage and restrictions on prescriptions)	Prescription drugs have a separate \$25 deductible, combined for retail and mail order.	

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Inpatient care	Included with inpatient hospital benefit	Included with inpatient hospital benefit
Outpatient care	<p>Per prescription at a participating pharmacy up to a 30-day supply:</p> <p>Tier 1 generic formulary \$10 or 10% copayment, whichever is the higher amount. Tier 2 brand formulary \$25 or 20% copayment. Tier 3 non-formulary \$35 or 40% copayment.</p>	Not covered
Prescription Mail Service	<p>Per prescription through the mail-order service up to a 90-day supply.</p> <p>Tier 1 generic formulary \$25 copayment. Tier 2 brand formulary \$60 copayment. Tier 3 non-formulary \$115 copayment</p> <p>Includes coverage for smoking Cessation Benefit</p> <p>If you choose a brand-name drug or your provider prescribes a brand-name drug, and a generic formulary drug is available, you pay the brand formulary tier 2 copayment plus the retail cost difference between the brand-name drug and generic substitute. If you choose a non-formulary drug or your provider prescribes a non-formulary drug, and a formulary drug is available, you pay the non-formulary tier 3 copayment plus the retail cost difference between the non-formulary drug and formulary substitute.</p> <p>For drugs on our approved list, call customer service toll free at 1-866-698-0087. Covered only when received from a participating pharmacy.</p>	Not covered
<b>INPATIENT HOSPITAL</b>	80/20% after \$350 per admission co-payment, limited to two co-pays per calendar year	60/40% after \$1,500 per admission co-payment, subject to deductible
<b>OUTPATIENT/AMBULATORY SURGERY</b>	80/20% after \$250 per visit co-payment	60/40% after \$1,500 per visit co-payment, subject to deductible.
<b>LABORATORY AND X-RAY</b>		
Inpatient care	Included with inpatient hospital benefit	Included with inpatient hospital benefit
Outpatient care	80/20%	60/40% after deductible
<b>EMERGENCY CARE (Emergency Room)</b>	80/20% after \$100 co-payment per emergency room visit, waived if admitted	Paid as in network benefit. Subject to deductible.

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<b>AMBULANCE</b> Ground	100% after \$500 co-pay per trip co-payment	100% after \$500 co-pay per trip co-payment
Air	80/20%	80/20%, not subject to deductible,
<b>URGENT, NON-ROUTINE, AFTER HOURS - OUTPATIENT CARE</b>	\$25 per office visit copayment + 80/20% for all other eligible services (e.g., laboratory and x-ray services)	60/40% after deductible
<b>MENTAL HEALTH CARE</b> Inpatient care	80/20% after \$350 per admission copayment, limited to two co-pays per calendar year.	60/40% after \$1500 per admission, subject to deductible.
Outpatient facility	\$25 co-payment per office visit (80/20% all other eligible services, including facility care)	60/40% after deductible
<b>ALCOHOL &amp; SUBSTANCE ABUSE</b> Inpatient Care	80/20% after \$350 per admission copayment, limited to two co-pays per calendar year.	60/40% after \$1500 per admission, subject to deductible.
Outpatient facility	\$25 co-payment per office visit (80/20% all other eligible services, including facility care)	60/40% after deductible.
<b>PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY</b> Inpatient	Included with inpatient hospital benefit	Included with inpatient hospital benefit
Outpatient	\$25 per office visit copayment + 80/20% for all other eligible services (e.g., laboratory and x-ray services), limited to 30 visits each (PT, OT, ST) per calendar year in- and out-of-network combined	60/40% after deductible, limited to 30 visits each (PT, OT, ST) per calendar year in- and out-of-network combined
<b>DURABLE MEDICAL EQUIPMENT/ OXYGEN</b> Inpatient care	Included with inpatient hospital benefit	Included with inpatient hospital benefit
Outpatient care	80/20%	Not covered
<b>ORGAN TRANSPLANTS</b>	80/20% after \$500 per admission co-payment	Not covered
<b>HOME HEALTH CARE</b>	\$25 per visit copayment + 80/20% for all other eligible services (e.g., laboratory and x-ray services), limited to 60 visits per calendar year	Not covered
<b>HOSPICE CARE</b> Inpatient Care	80/20%	60/40% after deductible
Outpatient care	80/20%	60/40% after deductible
<b>SKILLED NURSING FACILITY CARE</b>	80/20% after \$500 per admission co-payment, or \$150 per admission if transferred directly from an inpatient acute facility. Limited to 30 days per calendar year in- and out-of-network combined	60/40% after \$1,500 per admission co-payment, co-payment waived if transferred directly from an inpatient acute facility. Limited to 30 days per calendar year in- and out-of-network combined

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CHIROPRACTIC CARE & ACUPUNCTURE CARE	\$25 copayment per office visit + 80/20% for all other eligible expenses, limited to 30 visits per calendar year in- and out-of-network combined	60/40% after deductible, limited to 30 visits per calendar year in- and out-of-network combined
SECOND SURGICAL OPINION	When a member desires another professional opinion, they may obtain a second surgical opinion	When a member desires another professional opinion, they may obtain a second surgical opinion
TREATMENT OF AUTISM SPECTRUM DISORDERS	Benefit level and coverage meets the requirements of federal and state laws. More information on this benefit can be found in the Plan Document.	Benefit level and coverage meets the requirements of federal and state laws. More information on this benefit can be found in the Plan Document
Your plan may exclude coverage for certain treatments, diagnoses, or services not noted. The benefits shown in this summary may only be available if required plan procedures are followed (e.g. plans may require prior authorization or use of specified providers or facilities).		

This form is not a contract, and is only a summary. The contents of this form are subject to the provisions of the Plan Document and Summary Plan Description which contains all terms, covenants, and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted. The benefits shown in this summary may only be available if required plan procedures are followed (e.g. plans may require prior authorization or use of specified providers or facilities). Consult the actual Plan Document and Summary Plan Description to determine the exact terms and conditions of coverage. The County Health Pool Plan Document may be accessed at [www.ctsi.org](http://www.ctsi.org). You may also contact Anthem Customer Service at 1-866-698-0087.