

# County Health Pool

## PPO Plan A Benefit Summary

Effective January 1, 2009



	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>	Plan pays \$2,000,000	Plan pays \$2,000,000
<b>LIFETIME TRANSPLANT BENEFIT</b>	Plan pays \$1,000,000 per member, per transplant	Not covered
<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)	\$25 per office visit copayment + 80/20% for all other eligible services (e.g., laboratory and x-ray services), includes immunizations (up to age 13)	60/40% not subject to deductible, includes immunizations (up to age 13)
Adults' services (age/visit limitations apply)	\$25 per office visit copayment + 80/20% for all other eligible services (e.g., laboratory and x-ray services). Mammogram screening and PSA covered at 80/20% not subject to deductible. See SPD for benefit limit	Not covered except for mammogram screening and PSA. See SPD for benefit limit.
<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
<b>PRESCRIPTION DRUGS</b> (Level of coverage and restrictions on prescriptions)		
Inpatient care	Included with inpatient hospital benefit	Included with inpatient hospital benefit

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<b>PRESCRIPTION DRUGS</b> Outpatient care	Per prescription at a participating pharmacy up to a 30-day supply:  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.	Not covered
<b>Prescription Mail Service</b>	Per prescription through the mail-order service up to a 90-day supply. Tier 1 generic formulary \$25 copayment. Tier 2 brand formulary \$60 copayment. Tier 3 non-formulary \$115 copayment  Prescription drugs have a separate \$25 deductible, combined for retail and mail order.  Includes coverage for smoking Cessation Benefit \$250 per member, per calendar year \$500 per lifetime  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.  For drugs on our approved list, call customer service toll free at 1-866-698-0087. Covered only when received from a participating pharmacy.	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
<b>OUTPATIENT/AMBULATORY SURGERY</b>	80/20% after \$250 per visit co-payment	60/40% after \$1,500 per visit co-payment
<b>LABORATORY AND X-RAY</b>		
<b>Inpatient care</b>	Included with inpatient hospital benefit	Included with inpatient hospital benefit
<b>Outpatient care</b>	80/20%	60/40% after deductible
<b>EMERGENCY CARE</b>	80/20% after \$100 co-payment per emergency	80/20% after \$100 co-payment per emergency

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(Emergency Room)	room visit, waived if admitted	room visit, waived if admitted
AMBULANCE Ground	100% after \$200 per trip co-payment	100% after \$200 per trip co-payment
Air	80/20%, maximum benefit of \$10,000 per trip	80/20%, not subject to deductible, maximum benefit of \$10,000 per trip
URGENT, NON-ROUTINE, AFTER HOURS - OUTPATIENT CARE	\$25 per office visit copayment + 80/20% for all other eligible services (e.g., laboratory and x-ray services)	60/40% after deductible
MENTAL HEALTH CARE	Eligible expenses for other mental health care do not apply to the out-of-pocket maximum	
Inpatient care	50/50% after \$500 per admission copayment, limited to 45 full or 90 partial days per calendar year combined with Alcohol Abuse benefits	Not covered
Outpatient care	50/50%, limited to 30 visits with no less than \$1,000 in benefits per calendar year	Not covered
ALCOHOL & SUBSTANCE ABUSE	Eligible expenses for alcohol & substance abuse do not apply to the out-of-pocket maximum	
Inpatient Care	Alcohol abuse: 50/50% after \$500 admission copayment, limited to 45 days per year or 90 partial days per calendar year combined with Mental Health Care benefits  Substance abuse: 50/50%, limited to 30 days per calendar year or 60 days per lifetime	Not covered  Not covered
Outpatient care	50/50% up to a maximum of 20 visits per calendar year, with no less than \$500 in benefits for alcohol abuse; up to a maximum of 15 visits per calendar year for substance abuse	Not covered
PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY		
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
DURABLE MEDICAL EQUIPMENT		
Inpatient care	Included with inpatient hospital benefit	Included with inpatient hospital benefit
Outpatient care	80/20%, limited to a maximum payment of \$3,000 per calendar year, not combined with oxygen. Prosthetic devices are not subject to the maximum payment but do reduce the maximum payment of \$3,000	Not covered

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<b>OXYGEN</b>		
Inpatient care	Included with hospital benefit	Included with hospital benefit
Outpatient care	80/20%, limited to a maximum payment of \$5,000 per calendar year, not combined with durable medical equipment	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
<b>CHIROPRACTIC CARE</b>	\$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
<b>SECOND SURGICAL OPINION</b>	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
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.