County Health Pool
PPO Plan B1000 Benefit Summary
Effective January 1, 2010

	PPO PLAN B1000	
	IN-NETWORK	OUT-OF-NETWORK
ANNUAL DEDUCTIBLE Individual Family	 $1,000 $2,000	 $2,000 $4,000 aggregate
OUT-OF-POCKET ANNUAL MAXIMUM Individual Family	 $3,000, including deductible. Copayments do not apply to the deductible or out-of-pocket maximum $8,000, including deductible. Copayments do not apply to the deductible or out-of-pocket maximum	 $10,000, including deductible. $26,000, including deductible
LIFETIME MAXIMUM	Plan pays $4,000,000 per member	Plan pays $4,000,000 per member
LIFETIME TRANSPLANT BENEFIT	Plan pays $4,000,000 per member	Not covered
Pre-Cert Penalty	None	May be balance billed, see Plan Document for details
COVERED PROVIDERS	Anthem Blue Cross and Blue Shield Blue Preferred PPO Provider Network. Consult www.anthem.com or call Customer Service at 1-866-698-0087	All eligible providers licensed or certified to provide covered benefits
MEDICAL OFFICE VISITS	$35 per office visit copayment,80/20% after deductible for all other eligible services (e.g., laboratory and x-ray services)	60/40% after deductible
PREVENTIVE CARE Children's services (age/visit limitations apply) Adults' services (age/visit limitations apply)	 $35 per office visit copayment,80/20% not subject to deductible for all other eligible services (e.g., laboratory and x-ray services), includes immunizations (up to age 13) $35 per office visit copayment,80/20% not subject to deductible for all other eligible services (e.g., laboratory and x-ray services). See SPD for benefit limit.	 60/40% not subject to deductible, includes immunizations (up to age 13) Not covered except for mammogram screening, PSA and colorectal cancer screening. See SPD for benefit limit.
MATERNITY Prenatal care Delivery & inpatient care	 $35 per office visit copayment, 80/20% after deductible for all other eligible services (e.g., laboratory and x-ray services) 80/20% after deductible	 60/40% after deductible 60/40% after deductible
PRESCRIPTION DRUGS (Level of coverage and restrictions on prescriptions) Inpatient care	 Included with inpatient hospital benefit	 Included with inpatient hospital benefit

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PRESCRIPTION DRUGS Outpatient care	Prescription drugs have a separate $50 deductible, combined for retail and mail order. Per prescription at a participating pharmacy up to a 30-day supply: Tier 1 generic formulary $10 or 20% copayment, whichever is the higher amount. Tier 2 brand formulary $25 or 30% copayment. Tier 3 non-formulary $35 or 50% copayment.	Not covered
Prescription Mail Service	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. 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
INPATIENT HOSPITAL	80/20% after deductible	60/40% after deductible
OUTPATIENT/AMBULATORY SURGERY	80/20% after deductible	60/40% after deductible
LABORATORY AND X-RAY Inpatient care Outpatient care	 80/20% after deductible 80/20% after deductible	 60/40% after deductible 60/40% after deductible
EMERGENCY CARE (Emergency Room)	80/20% after deductible	Paid as in network benefit.

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AMBULANCE		
Ground	80/20% after deductible, maximum benefit of $500 per trip	80/20% after deductible, maximum benefit of $500 per trip
Air	80/20% after deductible, maximum benefit of $10,000 per trip	80/20% after deductible, maximum benefit of $10,000 per trip
URGENT, NON-ROUTINE, AFTER HOURS - OUTPATIENT CARE	$35 per office visit copayment, 80/20% after deductible for all other eligible services (e.g., laboratory and x-ray services)	60/40% after deductible
MENTAL HEALTH CARE		
Inpatient care	80/20% after deductible	60/40% after deductible
Outpatient care	80/20% after $35 co-payment per office visit, subject to deductible	60/40% after deductible
ALCOHOL & SUBSTANCE ABUSE		
Inpatient Care	80/20% after deductible	60/40% after deductible
Outpatient care	80/20% after $35 co-payment per office visit, subject to deductible	60/40% after deductible
PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY		
Inpatient	80/20% after deductible	60/40% after deductible
Outpatient	$35 per office visit copayment, 80/20% after deductible 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	80/20% after deductible	60/40% after deductible
Outpatient care	80/20% after deductible, 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
OXYGEN		
Inpatient care	80/20% after deductible	60/40% after deductible

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Outpatient care	80/20% after deductible, limited to a maximum payment of $5,000 per calendar year, not combined with durable medical equipment	Not covered
ORGAN TRANSPLANTS	80/20% after deductible	Not covered
HOME HEALTH CARE	$35 per visit copayment, 80/20% after deductible for all other eligible services (e.g., laboratory and x-ray services), limited to 60 visits per calendar year	Not covered
HOSPICE CARE Inpatient Care Outpatient care	 80/20% after deductible 80/20% after deductible	 60/40% after deductible 60/40% after deductible
SKILLED NURSING FACILITY CARE	80/20% after deductible, limited to 30 days per calendar year in- and out-of-network combined	60/40% after deductible, limited to 30 days per calendar year in- and out-of-network combined
CHIROPRACTIC CARE	$35 copayment per office visit,80/20% after deductible 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
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. You may also contact Anthem Customer Service at 1-866-698-0087.