

**County Health Pool**  
**PPO Plan B1000 Benefit Summary**  
 Effective January 1, 2011



	PPO PLAN B1000	
	IN-NETWORK	OUT-OF-NETWORK
<b>ANNUAL DEDUCTIBLE</b>		
Individual	\$1,000	\$2,000
Family	\$2,000	\$4,000 aggregate
<b>OUT-OF-POCKET ANNUAL MAXIMUM</b>		
Individual	\$3,000, including deductible. Copayments do not apply to the deductible or out-of-pocket maximum	\$10,000, including deductible.
Family	\$8,000, including deductible. Copayments do not apply to the deductible or out-of-pocket maximum	\$26,000, including deductible
<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>	\$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
<b>PREVENTIVE CARE</b>		
Children's services (age/visit limitations apply)	100% covered, not subject to co-payment, co-insurance or deductible	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, co-insurance or deductible.  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.	Not covered except for mammogram screening, PSA and colorectal cancer screening. 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.
<b>MATERNITY</b>		
Prenatal 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
Delivery & inpatient care	80/20% after deductible	60/40% after deductible
<b>PRESCRIPTION DRUGS</b> (Level of coverage and restrictions on prescriptions)	Prescription drugs have a separate \$50 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 20% copayment, whichever is the higher amount.                      Tier 2 brand formulary \$25 or 30% copayment.                      Tier 3 non-formulary \$35 or 50% 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 deductible	60/40% after deductible
<b>OUTPATIENT/AMBULATORY SURGERY</b>	80/20% after deductible	60/40% after deductible
<b>LABORATORY AND X-RAY</b>	80/20% after deductible	60/40% after deductible
<b>Inpatient care</b>	80/20% after deductible	60/40% after deductible
<b>Outpatient care</b>	80/20% after deductible	60/40% after deductible
<b>EMERGENCY CARE (Emergency Room)</b>	80/20% after deductible	Paid as in network benefit.

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<b>AMBULANCE</b>		
Ground	80/20% after deductible	80/20% after deductible
Air	80/20% after deductible	80/20% after deductible
<b>URGENT, NON-ROUTINE, AFTER HOURS - OUTPATIENT CARE</b>	\$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
<b>MENTAL HEALTH CARE</b>		
Inpatient care	80/20% after deductible	60/40% after deductible
Outpatient facility	\$35 co-payment per office visit, 80/20% after deductible for all other eligible services, including facility care	60/40% after deductible
<b>ALCOHOL &amp; SUBSTANCE ABUSE</b>		
Inpatient Care	80/20% after deductible	60/40% after deductible
Outpatient facility	\$35 co-payment per office visit, 80/20% after deductible for all other eligible services, including facility care	60/40% after deductible
<b>PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY</b>		
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
<b>ORGAN TRANSPLANTS</b>	80/20% after deductible	Not covered
<b>HOME HEALTH CARE</b>	\$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

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<b>HOSPICE CARE</b> Inpatient Care	80/20% after deductible	60/40% after deductible
Outpatient care	80/20% after deductible	60/40% after deductible
<b>SKILLED NURSING FACILITY CARE</b>	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
<b>CHIROPRACTIC CARE &amp; ACUPUNCTURE CARE</b>	\$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
<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
<b>TREATMENT OF AUTISM SPECTRUM DISORDERS</b>	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.