County Health Pool
PPO Plan B500 Benefit Summary
Effective January 1,2011

	PPO PLAN B500	
	IN-NETWORK	OUT-OF-NETWORK
ANNUAL DEDUCTIBLE Individual Family	 $500 $1,000	 $2,000 $4,000 aggregate
OUT-OF-POCKET ANNUAL MAXIMUM Individual Family	 $2,500, including deductible. Copayments do not apply to the deductible or out-of-pocket maximum $7,000, including deductible. Copayments do not apply to the deductible or out-of-pocket maximum	 $9,000, including deductible. $25,000, including deductible
LIFETIME MAXIMUM	None	None
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)	 100% covered, not subject to co-payment, deductible or co-insurance. 100% covered, not subject to co-payment, deductible, or co-insurance 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.	 60/40% not subject to deductible, includes immunizations (up to age 13) Not covered except for mammogram screening, PSA and 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.
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)	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	Per prescription at a participating pharmacy up to a 30-day supply: Tier 1 generic formulary $10 or 15% copayment, whichever is the higher amount. Tier 2 brand formulary $25 or 25% copayment. Tier 3 non-formulary $35 or 45% 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 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 Air	 80/20% after deductible 80/20% after deductible	 80/20% after deductible 80/20% after deductible
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 Outpatient facility	 80/20% after deductible $35 co-payment per office visit, 80/20% after deductible for all other eligible services, including facility care	 60/40% after deductible 60/40% after deductible
ALCOHOL & SUBSTANCE ABUSE Inpatient Care Outpatient facility	 80/20% after deductible $35 co-payment per office visit, 80/20% after deductible for all other eligible services, including facility care	 60/40% after deductible 60/40% after deductible
PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY Inpatient Outpatient	 80/20% after deductible $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 60/40% after deductible, limited to 30 visits each (PT, OT, ST) per calendar year in- and out-of-network combined
DURABLE MEDICAL EQUIPMENT/OXYGEN Inpatient care Outpatient care	 80/20% after deductible 80/20% after deductible	 60/40% after deductible Not covered
ORGAN TRANSPLANTS	80/20% after deductible	Not covered

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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 & ACUPUNCTURE	$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
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. You may also contact Anthem Customer Service at 1-866-698-0087.