County Health Pool PPO Plan A

Effective January 1, 2021

In-network coverage only listed below
Please see full benefit summary for out-of-network coverage

Medical Coverage
No individual / No family deductible
$3,500 individual / $9,000 family out-of-pocket (OOP) maximum (Rx deductible, copay and coinsurance do apply to OOP maximum; once OOP maximum has been met, medical, Rx copays and coinsurance do not apply.)
80%/20% coinsurance for covered procedures with various copayments
$25 office visit copay (80%/20% coinsurance for all other services [i.e., lab and X-ray services])
100% covered preventive services (Covered preventive care services include those that meet the requirements of federal and state law, including certain screenings, immunizations, contraceptives and office visits; and are not subject to copay, coinsurance or deductible.)

Prescription Coverage
$50 annual prescription deductible (combined retail and mail order)
(Rx copays do apply to medical OOP maximum.)

Retail Prescription Coverage
Per prescription at a participating pharmacy up to a 30-day supply
Tier 1 generic formulary $10 or 10% copay, whichever is the higher amount
Tier 2 brand formulary $25 or 20% copay, whichever is the higher amount
Tier 3 non-formulary $35 or 40% copay, whichever is the higher amount

Mail Order Prescription Coverage
Per prescription through the mail-order service up to a 90-day supply
Tier 1 generic formulary $25 copay
Tier 2 brand formulary $60 copay
Tier 3 non-formulary $115 copay

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County Health Pool PPO Plan B500

Effective January 1, 2021

In-network coverage only listed below
Please see full benefit summary for out-of-network coverage

Medical Coverage
$500 individual deductible / $1,000 family deductible
$3,750 individual / $9,500 family out-of-pocket (OOP) maximum (Medical and Rx copays, deductible and coinsurance do apply to OOP maximum; once OOP maximum has been met, medical Rx and copays, and coinsurance do not apply.)
80%/20% coinsurance for covered procedures with various copays
$35 office visit copay (80%/20% after deductible for all other services [i.e., lab and X-ray services])
$200 copay then deductible and 80%/20% coinsurance for high-tech labs and X-rays (MRIs, PET scans, CT scans, etc.)
100% covered preventive services (Covered preventive care services include those that meet the requirements of federal and state law, including certain screenings, immunizations, contraceptives and office visits; and are not subject to copays, coinsurance or deductible.)

Prescription Coverage
$75 annual prescription deductible (combined retail and mail order)
(Rx copays do apply to medical OOP maximum.)

Retail Prescription Coverage
Per prescription at a participating pharmacy up to a 30-day supply.
Tier 1 Generic formulary $10 or 15% copay, whichever is the higher amount
Tier 2 Brand formulary $25 or 25% copay, whichever is the higher amount
Tier 3 Non-formulary $35 or 45% copay, whichever is the higher amount

Mail Order Prescription Coverage
Per prescription through the mail-order service up to a 90-day supply
Tier 1 Generic formulary $25 copay
Tier 2 Brand formulary $60 copay
Tier 3 Non-formulary $115 copay

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County Health Pool PPO Plan B1000

Effective January 1, 2021

In-network coverage only listed below
Please see full benefit summary for out-of-network coverage

Medical Coverage
$1,000 individual deductible / $2,000 family deductible
$4,250 individual / $10,500 family out-of-pocket (OOP) maximum (Medical and Rx copays, deductible and coinsurance do apply to OOP maximum; once OOP maximum has been met, medical Rx and copays, and coinsurance do not apply.)
80%/20% coinsurance for covered procedures with various copays
$35 office visit copay (80%/20% after deductible for all other services [i.e., lab and X-ray services])
$200 copay then deductible and 80%/20% coinsurance for high-tech labs and X-rays (MRIs, PET scans, CT scans, etc.)
100% covered preventive services (Covered preventive care services include those that meet the requirements of federal and state law, including certain screenings, immunizations, contraceptives and office visits; and are not subject to copays, coinsurance or deductible.)
Prescription Coverage
$75 annual prescription deductible (combined retail and mail order)
(Rx copays do apply to medical OOP maximum.)

Retail Prescription Coverage
Per prescription at a participating pharmacy up to a 30-day supply
Tier 1 generic formulary $10 or 20% copay, whichever is the higher amount
Tier 2 brand formulary $25 or 30% copay, whichever is the higher amount
Tier 3 non-formulary $35 or 50% copay, whichever is the higher amount

Mail Order Prescription Coverage
Per prescription through the mail-order service up to a 90-day supply
Tier 1 generic formulary $25 copay
Tier 2 brand formulary $60 copay
Tier 3 non-formulary $115 copay

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County Health Pool PPO Plan B1500

Effective January 1, 2021

In-network coverage only listed below
Please see full benefit summary for out-of-network coverage

Medical Coverage
$1,500 individual deductible / $3,000 family deductible
$4,750 individual / $11,500 family out-of-pocket (OOP) maximum (Medical and Rx copays, deductible and coinsurance do apply to OOP maximum; once OOP maximum has been met, medical Rx and copays, and coinsurance do not apply.)
80%/20% coinsurance for covered procedures with various copays
$35 office visit copay (80%/20% after deductible for all other services [i.e., lab and X-ray services])
$200 copay then deductible and 80%/20% coinsurance for high-tech labs and X-rays (MRIs, PET scans, CT scans, etc.)
100% covered preventive services (Covered preventive care services include those that meet the requirements of federal and state, law including certain screenings, immunizations, contraceptives and office visits; and are not subject to copays, coinsurance or deductible.)

Prescription Coverage
$75 annual prescription deductible (combined retail and mail order)
(Rx copays do apply to medical OOP maximum.)

Retail Prescription Coverage
Per prescription at a participating pharmacy up to a 30-day supply
Tier 1 generic formulary $10 or 20% copay, whichever is the higher amount
Tier 2 brand formulary $25 or 30% copay, whichever is the higher amount
Tier 3 non-formulary $35 or 50% copay, whichever is the higher amount

Mail Order Prescription Coverage
Per prescription through the mail-order service up to a 90-day supply
Tier 1 generic formulary $25 copay
Tier 2 brand formulary $60 copay
Tier 3 non-formulary $115 copay

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County Health Pool PPO Plan B2000

Effective January 1, 2021

In-network coverage only listed below
Please see full benefit summary for out-of-network coverage

Medical Coverage
$2,000 individual deductible / $4,000 family deductible
$5,250 individual / $12,000 family out-of-pocket (OOP) maximum (Medical and Rx copays, deductible and coinsurance do apply to OOP maximum; once OOP maximum has been met, medical Rx and copays, and coinsurance do not apply.)
80%/20% coinsurance for covered procedures with various copays
$35 office visit copay (80%/20% after deductible for all other services [i.e., lab and X-ray services])
$200 copay then deductible and 80%/20% coinsurance for high-tech labs and X-rays (MRIs, PET scans, CT scans ,etc.)
100% covered preventive services (Covered preventive care services include those that meet the requirements of federal and state law, including certain screenings, immunizations, contraceptives and office visits; and are not subject to copays, coinsurance or deductible.)

Prescription Coverage
$75 annual prescription deductible (combined retail and mail order)
(Rx copays do apply to medical OOP maximum.)

Retail Prescription Coverage
Per prescription at a participating pharmacy up to a 30-day supply
Tier 1 generic formulary $10 or 20% copay, whichever is the higher amount
Tier 2 brand formulary $25 or 30% copay, whichever is the higher amount
Tier 3 non-formulary $35 or 50% copay, whichever is the higher amount

Mail Order Prescription Coverage
Per prescription through the mail-order service up to a 90-day supply
Tier 1 generic formulary $25 copay
Tier 2 brand formulary $60 copay
Tier 3 non-formulary $115 copay

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County Health Pool PPO Plan HDHP 2000

Effective January 1, 2021

In-network coverage only listed below
Please see full benefit summary for out-of-network coverage
Note : *This plan is compatible with a Health Savings Account*

Medical Coverage
$2,000 individual deductible / $4,000 family deductible (If you select family membership, no individual deductible applies and the family deductible must be met before CHP provides benefits.)
$5,000 individual / $6,850 family out-of-pocket (OOP) maximum (Deductible and coinsurance do apply to OOP maximum; if you select family membership, no individual OOP applies and the family OOP annual maximum must be met which includes family deductible.)
80%/20% coinsurance for covered procedures after deductible has been met
100% covered preventive services (Covered preventive care services include those that meet the requirements of federal and state law, including certain screenings, immunizations, contraceptives and office visits; and are not subject to coinsurance or deductible.)

Prescription Coverage
Must meet medical deductible before coinsurance is applied to prescription coverage.

Retail Prescription Coverage
Per prescription at a participating pharmacy up to a 30-day supply
80%/20% coinsurance after medical deductible has been met

Mail Order Prescription Coverage
Per prescription through the mail-order service up to a 90-day supply
80%/20% coinsurance after medical deductible has been met

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County Health Pool PPO Plan HDHP 2500

Effective January 1, 2021

In-network coverage only listed below
Please see full benefit summary for out-of-network coverage
Note : *This plan is compatible with a Health Savings Account*

Medical Coverage
$2,500 individual deductible / $5,000 family deductible (If you select family membership, no individual deductible applies and the family deductible must be met before CHP provides benefits.)
$5,000 individual / $6,850 family out-of-pocket (OOP) maximum (Deductible and coinsurance do apply to OOP maximum; if you select family membership, no individual OOP applies and the family OOP annual maximum must be met which includes family deductible.)
80%/20% coinsurance for covered procedures after deductible has been met
100% covered preventive services (Covered preventive care services include those that meet the requirements of federal and state law, including certain screenings, immunizations, contraceptives and office visits; and are not subject to coinsurance or deductible.)

Prescription Coverage
Must meet medical deductible before coinsurance is applied to prescription coverage

Retail Prescription Coverage
Per prescription at a participating pharmacy up to a 30-day supply
80%/20% coinsurance after medical deductible has been met

Mail Order Prescription Coverage
Per prescription through the mail-order service up to a 90-day supply
80%/20 % coinsurance after medical deductible has been met

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County Health Pool PPO Plan HDHP 2800E

Effective January 1, 2021

In-network coverage only listed below
Please see full benefit summary for out-of-network coverage
Note : *This plan is compatible with a Health Savings Account*

Medical Coverage
$2,800 individual deductible / $5,600 family deductible (If you select family membership, when one family member meets one-half of the family deductible, that family member is eligible for benefits; the remaining family members are eligible for benefits when they individually satisfy their individual deductible or collectively satisfy the balance of the family deductible.)
$5,600 individual / $11,200 family out-of-pocket (OOP) maximum (If you select family membership, no one family member may contribute more than his individual coinsurance maximum toward meeting the family OOP annual maximum.)
80%/20% coinsurance for covered procedures after deductible has been met
100% covered preventive services (Covered preventive care services include those that meet the requirements of federal and state law, including certain screenings, immunizations, contraceptives and office visits; and are not subject to coinsurance or deductible.)

Prescription Coverage
Must meet medical deductible before coinsurance is applied to prescription coverage

Retail Prescription Coverage
Per prescription at a participating pharmacy up to a 30-day supply
80%/20% co-insurance after medical deductible has been met

Mail Order Prescription Coverage
Per prescription through the mail-order service up to a 90-day supply
80%/20 % coinsurance after medical deductible has been met

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County Health Pool Dental Plan A

Effective January 1, 2021

Dental Coverage
$50 individual / family deductible (maximum of 3 X $50)
$1,500 annual maximum amount covered by CHP/Anthem per individual
100% coverage for cleanings once every 6 months (Oral exams, X-rays, and space maintainers also covered 100%.)
80%/20% after deductible for covered general, restorative, endodontic, oral surgery, and periodontal services
50% after deductible for covered prosthodontic services
50% after deductible for covered orthodontic services for eligible dependent children ($1,000 lifetime maximum per individual)

Note: Some surgical procedures (i.e., surgical extraction of impacted wisdom teeth) will be covered under the CHP medical plan

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County Health Pool Dental Plan B

Effective January 1, 2021

Dental Coverage
$50 individual / family deductible (maximum of 3 X $50)
$1,500 annual maximum amount covered by CHP/Anthem per individual
100% coverage for cleanings once every 6 months (Oral exams, X-rays, and space maintainers also covered 100%.)
80%/20% after deductible for covered general, restorative, endodontic, oral surgery, and periodontal services
No coverage for prosthodontic services
No coverage for orthodontic services

Note: Some surgical procedures (i.e., surgical extraction of impacted wisdom teeth) will be covered under the CHP medical plan

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County Health Pool Vision

Effective January 1, 2021

In-network coverage through Vision Service Plan (VSP)

Vision Coverage
Examination
$15 copay per eye exam once every 12 months

Eyeglass Lenses and Frames
$15 copay for eyeglass lenses once every 12 months
$150 allowance for eyeglass wide selection frames once every 24 months $170 allowance for eyeglass VSP featured frames once every 24 months 20% savings on the amount exceeding the VSP allowance

Contact Lenses
No copay for contact lenses $150 allowance for contacts once every 12 months in lieu of eyeglass lenses/frames
Up to $60 out-of-pocket (OOP) cost for contact lens exam (fitting and evaluation)

Laser Vison Correction Discounts
15% off regular price or 5% off promotional price at VSP-contracted facilities
Additional discounts and savings are available through VSP at www.vsp.com or VSP customer service 1-800-877-7195

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