# County Health Plan
## (Open Access Plus Plan)

### BENEFIT HIGHLIGHTS

| | In-Network | Out-of-Network |
|---|---|---|
| **PHYSICIAN OFFICE SERVICES** | | |
| **Office Visit** | | |
| Includes Office Surgery if done in office | | |
| Primary Care Provider | $25 copayment | 70% after deductible |
| Specialist | $50 copayment | 70% after deductible |
| **Preventive Care** | | |
| Routine Examinations, Well-Child Care* | | |
| Primary Care Provider | 100 % | In-Network coverage only |
| Specialist | 100 % | In-Network coverage only |
| *Pap Smears, Mammograms, and Prostate Specific Antigen Tests (PSA's) are covered Out-of-network. | 100% no deductible if billed by independent diagnostic facility or outpatient hospital | 70% after deductible |
| **Therapies** | | |
| Short-term Rehabilitative Therapies (Maximums apply to Home, Office and Outpatient Settings): Physical/ Occupational/ Chiropractic: 30 visits per Contract Period/ Speech Therapy: 30 visits per Contract Period | | |
| Primary Care Provider | $25 copayment | 70% after deductible |
| Specialist | $50 copayment | 70% after deductible |
| **URGENT CARE CENTERS AND EMERGENCY ROOM** | | |
| Urgent Care Centers | $50 copayment per visit | $50 copayment per visit |
| Emergency Room Visit *(copayment waived if admitted)* | $150 copayment per visit | $150 copayment *(70% after deductible if not true emergency)* |
| **AMBULATORY SURGICAL CENTER** | 80% after deductible | 70% after deductible |
| **INPATIENT AND OUTPATIENT HOSPITAL SERVICES** | | |
| Hospital Facility and Hospital Based Services | 80% after deductible | 70% after deductible |
| Outpatient Clinic Services | 80% after deductible | 70% after deductible |
| Professional Services | 80% after deductible | 70% after deductible |
| Hospital and Professional Outpatient Labs and Mammograms | 100% no deductible | 70% after deductible |
| All other Diagnostic services - X-rays, CAT/PET scans and MRIs | 80% after deductible | 70% after deductible |
| **OTHER SERVICES** | | |
| Skilled Nursing Facility ***(60 days per Contract Period)*** | 80% after deductible | 70% after deductible |

| | In-Network | Out-of-Network |
|---|---|---|
| Home Health Care, Durable Medical Equipment and Hospice | 80% after deductible | 70% after deductible |
| **Ambulance** | 80% after deductible (*70% after deductible if not true emergency)* | 80% after deductible *(70% after deductible if not true emergency)* |
| **Maternity** | | |
| Maternity Delivery includes Prenatal and Post-delivery care | | |
| Hospital Services (Delivery) | 80% after deductible | 70% after deductible |
| Professional Services (Delivery) | 80% after deductible | 70% after deductible |
| **Transplants** | | |
| Performed at LifeSource Center | 100% no deductible | 70% after deductible |
| Hospital Services | 80% after deductible | 70% after deductible |
| Professional Services | 80% after deductible | 70% after deductible |
| **Infertility and Sexual Dysfunction Services** | | |
| ***Up to $5,000 per Lifetime**** | | |
| Primary Care Provider | $25 copayment | 70% after deductible |
| Specialist | $50 copayment | 70% after deductible |
| Inpatient and Outpatient Facilities | 80% after deductible | 70% after deductible |
| Inpatient and Outpatient Professional Services | 80% after deductible | 70% after deductible |

***The following Deductibles and Coinsurance Maximums only apply to the services listed previously:***

| | | |
|---|---|---|
| **Lifetime Benefit Maximum** | **UNLIMITED** | **UNLIMITED** |
| **Deductibles** | | |
| Individual (per Contract Period) | $850 | $1,700 |
| Family (per Contract Period) | $2,550 | $5,100 |
| **Coinsurance Maximum** | | |
| Individual (per Contract Period) | $3,000 | $6,000 |
| Family (per Contract Period) | $9,000 | $18,000 |

***The Deductibles and Coinsurance Maximums noted above do NOT apply to the services below:***

**Vision Care**

Comprehensive Eye Exam (every 12 months) $25 deductible per exam-any vision provider **(No Network applies to this benefit only)**

**Routine vision benefit includes one complete exam including basic vision screening and refraction. Expenses incurred for charges made for the purchase of eyeglasses, contact lenses (including fitting) and frames are excluded.**

| **PRESCRIPTION DRUGS- Retail (up to 30 day supply)** | | **Administered by Caremark** |
|---|---|---|
| Infertility Drugs up to $5,000 Lifetime Maximum | | |
| Tier 1 (Generic) | $10 copayment | Copayment + charge over In-network allowed amount |
| Tier 2 (Preferred Brand) | $45 copayment | Copayment + charge over In-network allowed amount |
| Tier 3 (Brand) | $60 copayment | Copayment + charge over In-network allowed amount |

| **PRESCRIPTION DRUGS- MAIL ORDER DRUG (MOD)** (90 day supply) | | **Administered by Caremark** |
|---|---|---|
| Tier 1 (Generic) | $20 copayment | In-Network Coverage only |
| Tier 2 (Preferred Brand) | $90 copayment | In-Network Coverage only |
| Tier 3 (Brand) | $120 copayment | In-Network Coverage only |

| **Mental Health Services** | | |
|---|---|---|
| Office (30 visits per Contract Period) | $50 copayment | 70% coinsurance |
| Inpatient/Outpatient (30 Days per Contract Period) | 80% coinsurance | 70% coinsurance |
| **Intensive Outpatient Mental Health** (Maximum: up to 3 programs per contract year) | 80% after $50 per program copay | 70% after $50 per program deductible |

| **Substance Abuse Services** | | |
|---|---|---|
| Office Visit | $50 copayment | 70% coinsurance |
| Inpatient/Outpatient | 80% coinsurance | 70% coinsurance |
| Intensive Outpatient Substance Abuse (Maximum: up to 3 programs per Contract year) | 80% after $50 per program copay | 70% after $50 per program deductible |
| **Substance Abuse Contract Period Maximum** | **$8,000** | |
| **Substance Abuse Lifetime Maximum** | **$16,000** | |

**Routine Preventive Care for children under age 2 (including immunization):**
(Covers for each member up to 24 months of age including periodic assessments and immunizations. Benefits are limited to six well-baby visits for members through 12 months old and three well-child visits for members 13 months up to 24 months.)

**Routine Preventive Care for children and adults 2 & older:**
(Covers one routine physical examination and related diagnostic services per benefit period).

****Coinsurance for Out-of-Network is based on Maximum Reimbursable Charge**

*****Infertility and Sexual Dysfunction Services- Coverage will be provided for the following services:**

- Testing and treatment services performed in connection with an underlying medical condition.
- Testing performed specifically to determine the cause of infertility. Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition)

**EXCLUSIONS**- What is not covered? (by way of example but not limited to):
***Your plan provides coverage for medically necessary services. Your plan does not provide coverage for the following except as required by law:***

1. Care for health conditions that are required by state or local law to be treated in a public facility.
2. Care required by state or federal law to be supplied by a public school system or school district.
3. Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
4. Treatment of an illness or injury which is due to war, declared or undeclared.

5. Charges for which you are not obligated to pay or for which you are not billed or would not have been billed except that you were covered under this Agreement.
6. Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
7. Any services and supplies for or in connection with experimental, investigational or unproven services. Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Healthplan Medical Director to be: Not demonstrated, through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed; or Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use; or The subject of review or approval by an Institutional Review Board for the proposed use
8. Cosmetic Surgery and Therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
9. The following services are excluded from coverage regardless of clinical indications: Acupressure; Dance therapy, movement therapy; Applied kinesiology; Rolfing.
10. Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental x-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. However, charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within 6 months of the accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
11. Unless otherwise covered as a basic benefit, reports, evaluations, physical examinations, or hospitalization not required for health reasons, including but not limited to employment, insurance or government licenses, and court ordered, forensic, or custodial evaluations.
12. Court ordered treatment or hospitalization, unless such treatment is being sought by a Participating Physician
13. Infertility services, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
14. Reversal of male and female voluntary sterilization procedures.
15. Transsexual surgery, including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
16. Medical and hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the Agreement.
17. Non-medical counseling or ancillary services, including, but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return-to-work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays, autism or mental retardation.
18. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including, but not limited to routine, long-term or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.

19. Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, and skin preparations
20. Private hospital rooms and/or private duty nursing
21. Personal or comfort items such as personal care kits provided on admission to a hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of illness or injury.
22. Artificial aids, including but not limited to corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
23. Hearing aids, including, but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
24. Aids or devices that assist with non-verbal communications, including, but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
25. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post cataract surgery).
26. Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
27. Treatment by acupuncture.
28. All non-injectable prescription drugs, injectable prescription drugs that do not require physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs. Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
29. Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs .Genetic screening or pre-implantation genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically-linked inheritable disease.
30. Dental implants for any condition. Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the Healthplan Medical Director's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
31. Blood administration for the purpose of general improvement in physical condition. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
32. Cosmetics, dietary supplements and health and beauty aids. All nutritional supplements and formulae are excluded, except for infant formula needed for the treatment of inborn errors of metabolism.
33. Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
34. Telephone, e-mail & Internet consultations and telemedicine.
35. Massage Therapy
36. Cognitive Therapy

Preventive Health Benefits
Wellness Exams & Immunizations

| | Birth to 2 years | Ages 3 to 10 | Ages 11 to 18 | Ages 19 and older |
|---|---|---|---|---|
| Well-baby/Well-child/Well-person exams | Birth, 1, 2, 4, 6, 9, 12, 15, 18, & 24 months. Additional visit at 2-4 days for infants discharged less than 48 hours after delivery | Once a year for children ages 3-5 & every 2 years for children ages 6-10 | Once a year | Periodic visits, depending on your age |
| Diptheria, tetanus, and acellular pertussis (DTaP) | 2, 4, & 6 months & between 15 & 18 months | Between ages 4 & 6 | Tetanus - diptheria - acellular pertussis (Tdap) given once, ages 11-64 | Tetanus - diptheria (Td) every 10 years; Tdap given once, ages 11-64 |
| Haemophilus influenzae b (Hib) | 2, 4, & 6 months & between 12 & 15 months | | | |
| Hepatitis A | Between 12 & 23 months | | | May be required for persons at risk |
| Hepatitis B virus (HBV) | At birth, 1-4 months & 6-8 months | Between ages 3 & 10 if not previously immunized | Between ages 11 & 18 if not previously immunized | May be required for persons at risk |
| HPV (Gardasil) | | Girls 9 -10, as your doctor advises | Girls and women ages 11 - 12, catch up ages 13 -26 | Catch up, women through age 26 |
| Influenza vaccine | Annually between 6 & 23 months | | | Ages 19 & 49, as your doctor advises; age 50 & older, annually |
| Measles-mumps-rubella (MMR) | Between 12 & 15 months | Between ages 4 & 6 or 11 & 12 if not given earlier | If not already immune | Rubella (German measles) women of childbearing age if not immune |
| Meningococcal (MCV4) | | | Between ages 11-12 or prior to high school (age 15); college freshman living in dorms | |
| Pneumococcal conjugate (PCV) pneumonia | 2, 4 & 6 months & between 12 & 15 months | | | Age 65 & older, once (or younger than 65 for those with risk factors) |
| Pollovirus (IPV) | 2 & 4 months & between 6 & 18 months | Between ages 4 & 6 | | |
| Rotavirus (RotaTeq) | 2, 4 & 6 months | | | |

| | Birth to 2 years | Ages 3 to 10 | Ages 11 to 18 | Ages 19 and older |
|---|---|---|---|---|
| Varicella (chickenpox) | Between 12 & 15 months | Between ages 4 & 6 | Second dose catch up or if no evidence of prior immunization or chickenpox | Second dose catch up or if no evidence of prior immunization or chickenpox |
| Zoster | | | | Age 60+ |
| Blood pressure | | At each visit | Once a year | Every 2 years or as your doctor advises |
| Cholesterol | | Selective screening of children at risk due to family history | | Complete lipoprotein profile, fasting non-fasting at ages 20 & older, every 5 years |
| Colon Cancer | | | | Colorectal cancer screening at ages 50 and older:<br>• Sigmoidoscopy once every 5 years<br>• Colonoscopy once every 10 years<br>• Fecal occult blood test annually<br>• Barium enema once every 5 years |
| Diabetes | | | | 45 & older, or if history of risk factor, every 3 years |
| Fluoride | Evaluate for sufficient fluoride in drinking water | | | |
| Hearing | Newborn & as doctor advises | 4, 5, 6, 8, & 10 or as doctor advises | 12, 15 & 18 or as doctor advises | 65 & older or as your doctor advises |
| Hemoglobin or hematocrit | | | Once a year for females after menarche | |
| PSA | | | | Once a year for men 50+ or any age with risk factors |
| Size measure-ments | Weight, length & head circumference at each visit | Height and weight at each visit | Height and weight once a year | Height and weight periodically, include BMI |
| Vision | | 3, 4, 5, 6, 8 & 10 or as doctor advises | 12, 15 & 18 or as doctor advises | By Snellen chart ages 65 & older, as often as your doctor advises |

## WOMEN'S HEALTH

| | Ages 19 and older |
|---|---|
| Chlamydia | Sexually active females under age 25 |
| Mammogram | Women ages 40 & older, annually |
| Osteoporosis | Age 65 or older (or at 60 for women at risk) |
| Pap Test | Women ages 19-64 at least every 3 years |

For additional information on what is covered by your plan, please review your Summary of Benefits. This summary contains highlights only. The specific terms of coverage, exclusions and limitations, including legislated benefits, are included in the Summary Plan Description or Insurance certificate.

These preventive health benefits are based on recommendations from the Advisory Committee on Immunization Practices, U.S. and other nationally recognized authorities. This document is a general guide. Always discuss your preventive care needs with your doctor.