STANISLAUS COUNTY EPO MEDICAL BENEFITS SCHEDULE
2015

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
No benefits will be paid for any member of a Family Unit until the Family Unit deductible has been met regardless of the number of participants it takes to meet the family deductible.		
COPAYMENTS: One copayment per provider or specialty group is charged per day.		
Visits: If multiple visits occur on the same day, each visit counts toward the applicable benefit limit.		
Urgent Care	$20	Not Covered
Physician Visits	$20	Not Covered
Specialist Visits	$20	Not Covered
Outpatient Services/Office Visit	$20	Not Covered
Outpatient Surgery	$100	Not Covered
Emergency Room	$75	$75
The Emergency room copayment is waived if the patient is admitted to the Hospital on an emergency basis. The utilization review administrator, Health Care Strategies must be notified within 48 hours of the admission, even if the patient is discharged within 24 hours of the admission.		
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR (CY)		
Per Covered Person	$1500	NA
Per Family Unit	$3000	NA
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%. • Cost containment penalties • Copayments applied to Acupuncture • Copayments applied to Chiropractic Care		
COVERED CHARGES		
Hospital Services		
Inpatient Hospital Includes room and board for private and semi-private rooms; Acute Rehab, Inpatient Professional Services, Medically Necessary Private Duty Nursing, Ancillary Services, Supplies.	100% after $150 copayment at Hospital's contracted rate	Not Covered
Intensive Care Unit	100% after $150 copayment at Hospital's contracted rate	Not Covered
Outpatient Surgery Facility Performed in Outpatient Hospital or Ambulatory Surgery Center.	100% after $100 copayment Facility's contracted rate	Not Covered
Emergency Room Visit	100% after $75 copayment (waived if admitted)	100% after $75 copayment (waived if admitted)
Urgent Care	100% after $20 copayment	Not Covered
Skilled Nursing Facility	100% after $200 copayment at facility's contracted rate 100 days maximum per CY	Not Covered
Physician Services		
Office visits	100% after $20 copayment	Not Covered
Specialist office visits	100% after $20 copayment	Not Covered
Inpatient visits	100%	Not Covered
Outpatient Surgery	100% after $100 copayment	Not Covered
Inpatient Surgery	100%	Not Covered
Allergy Office Visit	100% after $20 copayment	Not Covered
Allergy testing	100% after $20 copayment	Not Covered
Allergy Serum/Injections only	100% after $10 copayment	Not Covered
Allergy Injection as part of the office visit (includes serum).	100%	Not Covered
Diagnostic Testing (X-ray, Lab)	100% after $10 copayment	Not Covered

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
High-tech radiology	100% after $25 copayment	Not Covered
Hearing Aid Services (up to a maximum of $5,000 of benefits in a Calendar Year) See coverage, exclusions and limitations on plan document	100%	Not Covered
Infertility Services (Including hospital charges, office visits, diagnostic lab & X-ray, outpatient hospital or ambulatory surgery center).	Not Covered	Not Covered
Infertility Drug Coverage	Not Covered	Not Covered
Home Health Care	100% 100 visits maximum per CY 3 visits maximum per day	Not Covered
Infusion Services (Outpatient) Requires skilled or medical administration.	100% after $10 copayment	Not Covered
Home Infusion Includes Infusions and Supplies.	100%	Not Covered
Hospice Care	100%	Not Covered
Respite Care	100% Up to 5 consecutive days for each approved admission.	Not Covered
Injections and Immunizations Non-routine, Includes Travel Immunizations. **Office Visit** **Provided during an Office Visit** **Injection only** (Cost of administration and materials or Office Visit Cost Share, whichever is less**.**	 100% after $20 copayment 100% after $20 copayment 100% after $10 copayment	 Not Covered Not Covered Not Covered
Ambulance Service Includes Ground and Air Ambulance.	100% after $50 copayment per trip	100% after $50 copayment per trip
Nutritionist Consultations For diagnoses of diabetes and renal disease.	100% after $15 copayment	Not Covered
Health Education Includes classes for Self management of Asthma, Diabetes and Coronary Disease.	100%	Not Covered
House Calls	100%	Not Covered
Vision Exam (includes refraction)	100% after $10 copayment	Not Covered
Hemodialysis		
Nephrologist Visit - Routine	100%	Not Covered
Nephrologist Visit - Non-Routine	100% after $20 copayment	Not Covered
Cardiac Rehabilitation	100% after $20 copayment	Not Covered
Respiratory/Pulmonary Therapy	100% after $20 copayment	Not Covered
Chemotherapy/Radiation	100%	Not Covered
Wig After Chemotherapy	100%	Not Covered
Acupuncture (covered **only** for the treatment of nausea or chronic pain**).**	100% after $20 copayment	Not Covered
Occupational Therapy	100% after $20 copayment	Not Covered
Speech Therapy	100% after $20 copayment	Not Covered
Physical Therapy	100% after $20 copayment	Not Covered
Biofeedback (Medical and Mental Health Services)	100% after $20 copayment	Not Covered

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Jaw Joint/TMJ **Office Visit** **Outpatient Surgery** **Inpatient Surgery**	 100% after $20 copayment 100% after $100 copayment 100% after $200 copayment	Not Covered
Durable Medical Equipment (including diabetic testing supplies).	100% after $20 copayment	Not Covered
Sexual Dysfunction Limit:8 doses,30 days	40%	Not Covered
Breast Pump and Supplies	100%	Not Covered
Prosthetics /Orthotics Includes medically necessary eyewear for diagnoses of aniridia and aphakia; colostomy/ostomy and urological supplies.	100%	Not Covered
Spinal Manipulation Chiropractic (Self Referred Visits).	100% after $15 copayment 20 visits maximum per CY Appliances limited to $50 per CY.	Not Covered
Special Oral Foods – Amino Acid modified products.	100%	Not Covered
Family Planning		
Consultations, Counseling or Diaphragm fitting	100%	Not Covered
Contraceptive devices/injections Administered by a Physician.	100%	Not Covered
Tubal Ligation	100%	Not Covered
Elective Abortion Office Visit **Outpatient Surgery** **Inpatient Hospital**	100% after $20 copayment 100% after $100 copayment 100% after $200 copayment	Not Covered Not Covered Not Covered
Pregnancy (Including dependent daughters)		
Office Visit to confirm pregnancy	100% after $20 copayment	Not Covered
Pre-natal Care (does not include all pregnancy-related issues) and one Post Partum visit.	100%	Not Covered
Delivery	100% after $200 copayment	Not Covered
Mental Disorders		
Inpatient	100% after $200 copayment	Not Covered
Intensive Outpatient/ Partial Hospitalization	100%	Not Covered
Outpatient	100% after $20 copayment individual therapy $10 copayment group therapy	Not Covered
Substance Abuse		
T**ransitional Residential** Detox covered under medical benefits.	100% after $50 copayment	Not Covered
Intensive Outpatient/Partial Hospitalization	100% after $5 copayment per day	Not Covered

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Outpatient	100% after $20 copayment individual therapy $5 copayment group therapy	Not Covered
Preventive Care		
Routine Well Adult Care (Including Well Woman) Includes vision and hearing screenings. See Vision Exams for Refractions.	100% deductible waived	Not Covered
Routine Well Child Care Includes vision and hearing screenings.	100% deductible waived	Not Covered
Immunizations (preventive) Applies to Adults and Children	100% deductible waived	Not Covered
Preventive screenings as recommended by Centers for Disease Control and HRSA**.**	100% deductible waived	Not Covered
Routine Well Newborn Care	100% deductible waived	Not Covered
For a complete listing of routine preventive services, go to: https://www.healthcare.gov/what-are-my-preventive-care-benefits. Preventive Lab and X-ray screenings not specifically listed under the Preventive Screenings section are treated the same as non-preventive Lab and X-ray Services. Frequency and Age Limits managed by Network Provider except where noted As stated under the United States Preventive Services Task Force recommendations & HRSA (Health Resources and Services Administration. Note: Mammograms are allowed annually for ages 40 and over Hearing Exams are allowed annually Preventive Care services are not subject to the deductible		
Bariatric Surgery		
Office Visit	100% after $20 copayment	Not Covered
Outpatient Surgery	100% after $125 copayment	Not Covered
Inpatient Hospital	100% after $200 copayment	Not Covered
Travel and Lodging for Bariatric Surgery Includes coverage for recipient and companion/parent for transportation and lodging. Must travel more than 50 miles away from your home for surgery. Daily expenses for transportation and lodging are not covered.		
Transportation Limits Coverage includes one pre-surgical visit, actual surgery and initial post-surgical follow-up visit for patient (maximum 3 trips); actual surgery and initial post-surgical follow-up visit for companion (maximum 2 trips).	Maximum of $130 for each round-trip	Not Covered
Limits Lodging Coverage includes one hotel room, double occupancy for patient/companion, up to 2 days per trip for one pre-surgical visit and post-surgical follow-up visit; one hotel room, double occupancy, for companion, up to 4 days, for patient surgery.	Up to $100 per day	Not Covered

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Organ Transplants		
Office Visit	100% after $20 copayment	Not Covered
Outpatient Surgery	100% after $100 copayment	Not Covered
Inpatient Hospital	100% after $200 copayment	Not Covered
Travel and Lodging for Organ Transplants Includes coverage for recipient, care-giver and donor for transportation, lodging and daily expenses. Daily expenses include incidental expenses such as meals and does not include personal expenses.		
Transportation Limits	None	Not Covered
Lodging Limits	None	Not Covered
Daily Expense Limits	Reimbursement up to $50 per day per person	Not Covered
Other Services		
Accidental Injury to Teeth Repair of sound and natural teeth directly related to an accidental injury.		Not Covered
Office Visit	100% after $20 copayment	Not Covered
Outpatient Surgery	100% after $20 copayment	Not Covered
Inpatient Hospital	100%	Not Covered
Blood and Blood Products	100%	Not Covered
Growth Hormone	=Formulary Generic/Brand	Not Covered
Smoking Cessation (We do cover smoking cessation drugs at the generic or brand cost share (as appropriate). Effective 1/1/2012 participation in a smoking cessation program is no longer required for the Plan coverage of smoking cessation drugs and OTC products. However, Medical Groups may strongly encourage or make a clinical decision to require a Participant participate in a behavioral modification program prior to writing a prescription. This applies for all HP products including Self-Funded Accounts.)	=Formulary Generic/Brand	Not Covered
Weight Loss	Not Covered	Not Covered
Vision Hardware – Frames, Eyeglass Lenses and Contact Lenses.	Not Covered	Not Covered

PRESCRIPTION DRUG BENEFIT SCHEDULE

PRESCRIPTION DRUG BENEFIT		
	PARTICIPATING	**NON-PARTICIPATING**
Female Contraceptive Drugs		
Generic and Single Source Brand Contraceptive Drugs **(30, 60, or 90 day supply)**	100% copayment waived	Not Covered
Emergency Contraception*	100% copayment waived	Not Covered
Pharmacy Option (up to 30 Day Supply)		
Generic Drugs (also includes syringes for diabetics)	$10 copayment	Not Covered
Formulary Brand Name Drugs (Prior Authorization Required)	$25 copayment	Not Covered
Pharmacy Option (31 to 60 Day Supply)		
Generic Drugs (also includes syringes for diabetics)	$20 copayment	Not Covered
Formulary Brand Name Drugs (Prior Authorization Required)	$50 copayment	Not Covered
Pharmacy Option (61 to 100 Day Supply)		
Generic Drugs (also includes syringes for diabetics)	$30 copayment	Not Covered
Formulary Brand Name Drugs (Prior Authorization Required)	$75 copayment	Not Covered
Mail Order Option (up to 30 Day Supply)		
Generic Drugs (also include syringes for diabetics)	$10 copayment	Not Covered
Formulary Brand Drugs (Prior Authorization Required)	$25 copayment	Not Covered
Mail Order Option (31 to 100 Day Supply)		
Generic Drugs (also include syringes for diabetic) (	$20 copayment	Not Covered
Formulary Brand Drugs (Prior Authorization Required)	$50 copayment	Not Covered
For items or injections dispensed by Pharmacy and requiring skilled administration in the Physician's Office (Implantable contraceptives, administered meds, etc.) Office Visit Cost Share for administration may apply.		
* With prescription, no cost share. Without prescription, Participant pays retail cost **Refer to the Prescription Drug Section for details on the Prescription Drug benefit.**		

The following over-the-counter drugs are covered at 100% at a Participating Pharmacy when prescribed by a physician for preventive services, including:

- Aspirin to reduce the risk of heart attack
- Oral Fluoride for children to reduce the risk of tooth decay
- Folic acid for women to reduce the risk of birth defects
- Iron supplements for children to reduce the risk of anemia
- Vitamin D
- Female contraceptives that are approved by the Food and Drug Administration (FDA) and are generally available over-the-counter (spermicides, female condoms and sponges)