STANISLAUS COUNTY HDHP 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.		
DEDUCTIBLE, PER CALENDAR YEAR (CY), applies to all services except preventative.		
Per Covered Person	$1250	N/A
Per Family Unit	$2500	N/A
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.		
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.		
Office visits	$20	N/A
Inpatient	$150	N/A
Emergency Room visits	$75	N/A
Urgent Care visits	$20	N/A
MAXIMUM OUT-OF- POCKET, PER CALENDAR YEAR (CY)		
Per Covered Person	$3000	N/A
Per Family Unit	$6000	N/A
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. All Services except Preventive and other Services with a $0 Cost Share apply to the Out–of Pocket Maximum.		
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 • Copayment 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 per admit and calendar year (CY) deductible (only 1 copayment per Hospital admission will apply).	Not Covered
Intensive Care Unit	100% after $150 copayment per admit and CY deductible (only 1 copayment per Hospital admission will apply).	Not Covered
Outpatient Surgery Facility Performed in Outpatient Hospital or Ambulatory Surgery Center.	100% after $100 copayment and CY deductible	Not Covered
Emergency Room Visit	100% after $75 copayment (waived if admitted) and CY deductible	100% after $75 copayment and CY deductible
Emergency Ambulance Includes Ground and Air Ambulance	100% after $50 copayment per trip and CY deductible	100% after $50 copayment per trip and CY deductible
Urgent Care	100% after $20 copayment and CY deductible	Not Covered

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Reconstructive Surgery Includes procedures to improve function and change appearance for conditions due to disease, trauma, congenital/developmental anomalies, post-mastectomy (to produce symmetrical appearance only) and Medically Necessary surgery.		
Office Visit	100% after $20 copayment and CY deductible	Not Covered
Outpatient Surgery	100% after $100 copayment and CY deductible	Not Covered
Inpatient Hospital	100% after $150 copayment and CY deductible	Not Covered
Skilled Nursing Facility	100% after $200 copayment per admit and CY deductible, 100- days maximum per CY.	Not Covered
Physician Services		
Office visits	100% after $20 copayment and CY deductible	Not Covered
Specialist office visits	100% after $20 copayment and CY deductible	Not Covered
Outpatient Surgery Performed in Outpatient Hospital or Ambulatory Surgery Center.	100% after $100 copayment and CY deductible	Not Covered
Allergy testing	100% after $20 copayment and CY deductible	Not Covered
Allergy Serum/Injections only	100% after $10 copayment and CY deductible	Not Covered
Diagnostic Testing (X-ray & Lab)	100% after $10 copayment and CY deductible	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% after CY deductible	Not Covered
High-tech radiology	100% after $25 copayment and CY deductible	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% after CY deductible 100 visits maximum per CY 3 visits maximum per day.	Not Covered

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Infusion Services (Outpatient)	100% after $10 copayment and CY deductible	Not Covered
Home Infusion	100% after CY deductible	Not Covered
Hospice Care	100% after CY deductible	Not Covered
Respite Care	100% after CY deductible Up to 5 consecutive days for each approved admission.	Not Covered
Injections and Immunizations Non-routine, includes travel immunizations		
Office Visit	100% after $20 copayment and CY deductible	Not Covered
Provided during an office visit	100% after $20 copayment and CY deductible	Not Covered
Injection Only (Materials and administrations)	100% after $10 copayment and CY deductible	Not Covered
Nutritionist Consultations For diagnoses of diabetes & renal disease.	100% after $15 copayment and CY deductible.	Not Covered
Health Education Includes classes for Self management of Asthma, Diabetes and Coronary Disease.	100% deductible waived	Not Covered
House Calls	100% after CY deductible	Not Covered
Vision Exam (includes refraction)	100% after $10 copayment and CY deductible	Not Covered
Hemodialysis		
Nephrologist visit - Routine	100% after CY deductible	Not Covered
Nephrologist visit – Non - Routine	100% after $20 copayment and CY deductible	Not Covered
Cardiac Rehabilitation	100% after $20 copayment and CY deductible	Not Covered
Respiratory/Pulmonary Therapy	100% after $20 copayment and CY deductible	Not Covered
Chemotherapy/Radiation	100% after CY deductible	Not Covered
Wig After Chemotherapy	80% after CY deductible	Not Covered
Acupuncture (covered **only** for the treatment of nausea or chronic pain**)**	100% after $20 copayment and CY deductible	Not Covered
Occupational Therapy No visit maximum	100% after $20 copayment and CY deductible	Not Covered
Speech Therapy No visit maximum	100% after $20 copayment and CY deductible	Not Covered

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Physical Therapy No visit maximum	100% after $20 copayment and CY deductible	Not Covered
Biofeedback Includes Medical and Mental Health Services	100% after $20 copayment and CY deductible	Not Covered
Jaw Joint/TMJ		
Office Visit	100% after $20 copayment and CY deductible	Not Covered
Outpatient surgery	100% after $100 copayment and CY deductible	Not Covered
Inpatient surgery	100% after $200 copayment and CY deductible	Not Covered
Durable Medical Equipment (including diabetic testing supplies)	100% after $20 copayment and CY deductible	Not Covered
Sexual Dysfunction Device Limit: 8 doses,30 days	40% after CY deductible	Not Covered
Breast Pump and Supplies	100% deductible waived	Not Covered
Prosthetics/Orthotics Includes medically necessary eyewear for diagnoses of aniridia and aphakia; colostomy/ostomy and urological supplies.	100% after CY deductible	Not Covered
Spinal Manipulation Chiropractic (Self Referred Visits)	100% after $15 copayment and CY deductible (20 visit maximum per CY) Appliances limited to $50 per CY deductible waived.	Not Covered
Special Oral Foods – Amino Acid modified products	100% after CY deductible	Not Covered
Family Planning		
Consultations or Diaphragm Fitting	100% deductible waived	Not Covered
Contraceptive devices/injections administered by a Physician	100% deductible waived	Not Covered
Tubal Ligation	100% deductible waived	Not Covered
Elective Abortion – Office	100% after $20 copayment and CY deductible	Not Covered
Elective Abortion – Outpatient Surgery	100% after $100 copayment and CY deductible	Not Covered
Elective Abortion – Inpatient Hospital	100% after $200 copayment and CY deductible	Not Covered
Pregnancy (Including dependent daughters)		
Office Visit to confirm pregnancy	100% after $20 copayment and CY deductible	Not Covered
Pre-natal Care (does not include all pregnancy-related issues) and one Post Partum visit	100% deductible waived	Not Covered
Delivery Hospital Inpatient Includes contracted Birthing Center if available	100% after $200 admission copayment and CY deductible	Not Covered

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Mental Disorders		
Inpatient	100% after $200 copayment per admission and CY deductible	Not Covered
I**ntensive Outpatient/Partial Hospitalization**	100% after CY deductible	Not Covered
Outpatient	100% after $20 copayment for individual therapy/ $10 copayment for group therapy and CY deductible	Not Covered
Substance Abuse		
Transitional Residential Detox covered under-medical benefits	100% after $50 copayment per admission and CY deductible	Not Covered
Intensive Outpatient/ Partial Hospitalization Includes all services provided during the day	100% after $5 copayment per day and CY deductible	Not Covered
Outpatient	100% after $20 copayment for ind. therapy/ $5 copayment for group therapy and CY deductible	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% after CY deductible	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 and CY deductible	Not Covered
Outpatient Surgery	100% after $125 copayment per procedure and CY deductible	Not Covered
Inpatient Hospital	100% after $200 copayment per admit and CY deductible	Not Covered

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
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
Organ Transplants		
Office Visit	100% after $20 copayment and CY deductible	Not Covered
Outpatient Surgery	100% after $100 copayment per procedure and CY deductible	Not Covered
Inpatient Hospital	100% after $200 copayment per admit and CY deductible	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	NA
Lodging Limits	None	NA
Daily Expense Limits	Reimbursement up to $50 per day per person	NA
Other Services		
Accidental Injury to Teeth Repair of sound and natural teeth directly related to an accidental injury. **Office Visit** **Outpatient Surgery** **Inpatient Hospital**	 Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered
Blood and Blood Products	100% after deductible	Not Covered
Growth Hormone	=Formulary Generic/Brand	Not Covered
Smoking Cessation	=Formulary Generic/Brand	Not Covered
Weight Loss	Not Covered	Not Covered
Items or Injections requiring skilled administration in the Physician's Office and dispensed by Pharmacy.	100% after CY deductible	Not Covered
Vision Hardware - Frames, Eyeglass Lenses and Contact Lenses	Not Covered	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.		

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% - deductible waived	Not Covered
Emergency Contraception*	100% - deductible waived	Not Covered
Pharmacy Option (up to 30 Day Supply)		
Generic Drugs (includes syringes for diabetics)	$10 copayment after CY deductible	Not Covered
Formulary Brand Name Drugs (Prior Authorization Required)	$25 copayment after CY deductible	Not Covered
Pharmacy Option (31 to 60 Day Supply)		
Generic Drugs (also includes syringes for diabetics)	$20 copayment after CY deductible	Not Covered
Formulary Brand Name Drugs (Prior Authorization Required)	$50 copayment after CY deductible	Not Covered
Pharmacy Option (61 to 100 Day Supply)		
Generic Drugs (also includes syringes for diabetics)	$30 copayment after CY deductible	Not Covered
Formulary Brand Name Drugs (Prior Authorization Required)	$75 copayment after CY deductible	Not Covered
Mail Order Option (up to 30 Day Supply)		
Generic Drugs	$10 copayment after CY deductible	Not Covered
Formulary Brand Name Drugs (Prior Authorization Required)	$25 copayment after CY deductible	Not Covered
Mail Order Option (31 to 100 Day Supply)		
Generic Drugs	$20 copayment after CY deductible	Not Covered
Formulary Brand Name Drugs (Prior Authorization Required)	$50 copayment after CY deductible	Not Covered
* 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)