

## Stanislaus County High Deductible Health Plan Options for 2010

### Comparison of HDHP Plans with Health Savings Accounts (HSA)

Effective Date	01/01/2010	01/01/2010	
Carrier Name	Kaiser Permanente	Anthem Blue Cross	
Plan Name	HDHP HMO	Lumenos HDHP PPO	
	Schedule of Benefits	In-Network Benefits	Out-of-Network Benefits
<b>General Plan Information</b>			
Annual Deductible/Individual	\$1,250	\$1,250 combined in/out of network	\$1,250 combined in/out of network
Annual Deductible/Family	\$2,500	\$2,500 combined in/out of network	\$2,500 combined in/out of network
Coinsurance	100%	90%	70%
Office Visit/Exam	\$20 copay after cal yr deductible	90% covered after cal yr deductible	70% covered after cal yr deductible
Outpatient Specialist Visit	\$20 copay after cal yr deductible	90% covered after cal yr deductible	70% covered after cal yr deductible
Annual Out-of-Pocket Limit/Individual	\$3,000	\$2,500	\$5,000
Annual Out-of-Pocket Limit/Family	\$6,000	\$5,000	\$10,000
Deductible Included in Out-of-Pocket Limits	Yes	Yes	Yes
Lifetime Plan Maximum	Unlimited	\$5,000,000 combined in/out of network	\$5,000,000 combined in/out of network
<b>Outpatient Services</b>			
<b>Preventive Services</b>			
Well-Child Care	\$10 copay through age 23 months (deductible waived)	100% covered (deductible waived)	70% covered after cal yr deductible
Immunizations	100% covered (deductible waived)	100% covered (deductible waived)	70% covered after cal yr deductible
Well Woman Exams	\$20 copay (deductible waived)	100% covered (deductible waived)	70% covered after cal yr deductible
Mammograms	\$10 copay (deductible waived)	100% covered (deductible waived)	70% covered after cal yr deductible
Adult Periodic Exams with Preventive Tests	\$20 copay (deductible waived)	100% covered (deductible waived)	70% covered after cal yr deductible
Diagnostic X-Ray and Lab Tests	\$10 copay; \$50 copay for MRI, CT and PET scans after cal yr deductible (deductible waived for preventive screenings)	90% covered after cal yr deductible	70% covered after cal yr deductible
<b>Maternity Care</b>			
Pregnancy and Maternity Care (Pre-Natal Care)	\$10 copay (deductible waived)	90% covered after cal yr deductible	70% covered after cal yr deductible
<b>Inpatient Hospital Services</b>			
Inpatient Hospitalization	\$250 copay per admit after cal yr deductible	90% covered after cal yr deductible	70% covered after cal yr deductible
Pre-Authorization of Services Required	Yes	Yes	Yes
Semi-Private Room & Board; Including Services and Supplies	\$250 copay per admit after cal yr deductible	90% covered after cal yr deductible	70% covered after cal yr deductible
<b>Surgical Services</b>			
Outpatient Facility Charge	\$150 copay per procedure after cal yr deductible	90% covered after cal yr deductible	70% covered after cal yr deductible; If performed in Ambulatory Surgical Center - \$350 benefit max per day

<b>Emergency Services</b>			
Emergency Room	\$100 copay after cal yr deductible	90% covered after cal yr deductible	90% covered after cal yr deductible
Ambulance			
Air	\$100 copay/ trip after cal yr deductible	90% covered after cal yr deductible	90% covered after cal yr deductible
Ground	\$100 copay/ trip after cal yr deductible	90% covered after cal yr deductible	90% covered after cal yr deductible
<b>Urgent Care</b>			
Urgent Care Facility	\$20 copay after cal yr deductible	90% covered after cal yr deductible	70% covered after cal yr deductible
<b>Mental Health Benefits</b>			
Inpatient Care	\$250 copay per admit after cal yr deductible	90% covered after cal yr deductible	70% covered after cal yr deductible
Outpatient Care	\$20 copay individual visits/ \$10 copay group visits after cal yr deductible	90% covered after cal yr deductible	70% covered after cal yr deductible
<b>Substance Abuse</b>			
<b>Inpatient Care</b>			
Inpatient Hospitalization	Detox Only	90% covered after cal yr deductible	70% covered after cal yr deductible
Inpatient Detoxification Services	\$250 copay per admit after cal yr deductible	90% covered after cal yr deductible	70% covered after cal yr deductible
<b>Outpatient Care</b>			
Outpatient Services	\$20 copay individual visits/ \$5 copay group visits after cal yr deductible	90% covered after cal yr deductible	70% covered after cal yr deductible
<b>Prescription Drug Benefits</b>			
<b>Prescription Drug Deductible</b>	Subject to Plan Annual Deductible	See Annual Plan Deductible	See Annual Plan Deductible
Generic	\$10 copay after cal yr deductible	\$10 copay after cal yr deductible	\$10 copay after cal yr deductible + 30% of remaining Rx covered expense & any costs in excess of max amount allowed
Brand (Formulary/Preferred)	\$30 copay after cal yr deductible	\$30 copay after cal yr deductible	\$30 copay after cal yr deductible + 30% of remaining Rx covered expense & any costs in excess of max amount allowed
Brand (Non-Formulary/Non-preferred)	N/A	\$50 copay after cal yr deductible	\$50 copay after cal yr deductible + 30% of remaining Rx covered expense & any costs in excess of max amount allowed
Number of Days Supply	30 days	30 days	30 days
<b>Mail Order</b>			
Generic	\$20 copay after cal yr deductible	\$10 copay after cal yr deductible	\$10 copay after cal yr deductible + 30% of remaining Rx covered expense & any costs in excess of max amount allowed
Brand (Formulary/Preferred)	\$60 copay after cal yr deductible	\$60 copay after cal yr deductible	\$60 copay after cal yr deductible + 30% of remaining Rx covered expense & any costs in excess of max amount allowed
Brand (Non-Formulary/Non-preferred)	N/A	\$100 copay after cal yr deductible	\$100 copay after cal yr deductible + 30% of remaining Rx covered expense & any costs in excess of max amount allowed
Number of Days Supply	31 - 100 days	90 days	90 days

<b>Other Services and Supplies</b>			
Durable Medical Equipment & Prosthetic Devices	80% covered after cal yr deductible	90% covered after cal yr deductible; \$5,000 benefit max per cal yr combined in/out of network; Benefit max does not apply to Prosthetics	70% covered after cal yr deductible; \$5,000 benefit max per cal yr combined in/out of network; Benefit max does not apply to Prosthetics
Home Health Care	100% covered after cal yr deductible ; up to 100 visits per cal yr	90% covered after cal yr deductible; up to 100 visits per cal yr combined in/out of network	70% covered after cal yr deductible; up to 100 visits per cal yr combined in/out of network
Skilled Nursing or Extended Care Facility	\$250 copay per admit after cal yr deductible ; up to 100 days per benefit period	90% covered after cal yr deductible; up to 100 days per cal yr combined in/out of network	70% covered after cal yr deductible; up to 100 days per cal yr combined in/out of network
Hospice Care	100% covered after cal yr deductible	90% covered after cal yr deductible	70% covered after cal yr deductible
Chiropractic Services	Not covered	90% covered after cal yr deductible; up to 24 visits per cal yr combined in/out of network with Physical & Occupational therapy	70% covered after cal yr deductible; up to 24 visits per cal yr combined in/out of network with Physical & Occupational therapy; \$25 benefit max per visit
Acupuncture	Not covered	90% covered after cal yr deductible; up to 12 visits per cal yr combined in/out of network; \$30 benefit max per visit	70% covered after cal yr deductible; up to 12 visits per cal yr combined in/out of network; \$30 benefit max per visit

**Vision**

<b>Copay</b> Examination	\$20 copay after cal yr deductible	100% covered (deductible waived) screening only	70% covered after cal yr deductible (screening only)
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**Hearing**

Screening	\$20 copay after cal yr deductible	100% covered - deductible waived (screening only)	70% covered after cal yr deductible (screening only)
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**Infertility**

Diagnosis	Not covered	Not covered	Not covered
Treatment	Not covered	Not covered	Not covered

**Outpatient Rehabilitative Therapy Services**

Physical/Occupational	\$20 copay after cal yr deductible	90% covered after cal yr deductible; up to 24 visits per cal yr combined in/out of network with Chiropractic & Occupational therapy	70% covered after cal yr deductible; up to 24 visits per cal yr combined in/out of network with Chiropractic & Occupational therapy; \$25 benefit max per visit
Speech	\$20 copay after cal yr deductible	90% covered after cal yr deductible	70% covered after cal yr deductible

**Semi-monthly Rates:**

*Employee Only	\$211.33	\$241.65
*Employee +1	\$422.66	\$483.28
*Family	\$570.59	\$652.43
CUSTOMER SERVICE #s	800-464-4000	866-207-9878
Internet WEB sites	<a href="http://www.kp.org">www.kp.org</a>	<a href="http://www.anthem.com/ca">www.anthem.com/ca</a>

**HDHP MEDICAL COVERAGE - 100% COUNTY PAID AT LOWEST COST HDHP PLAN**

**HDHP CREDIT = BASE COVERAGE AT LOWEST COST HDHP OPTION (KAISER HDHP) PER SEMI MONTHLY**

*Employee Only	\$211.33
*Employee +1	\$422.66
*Family	\$570.59

*\*Disclaimer: The information described on this page is only intended to be a summary of your benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review your Summary Plan Description (SPD) for a complete summary of your benefits. If the information on this page conflicts in any way with the Summary Plan Description (SPD), the contract provisions of the appropriate policy or plan document (available with your employer) will prevail.*

## What is a Health Savings Account (HSA)?

An HSA is a savings account that works in conjunction with a High Deductible Health Plan (HDHP). You can use it to pay for qualified medical expenses\* for yourself and your dependents.

1. The funds in your HSA account are not considered part of your wages, so they're not subject to federal income taxes.
2. HSA funds used to pay for qualified medical expenses\* are not subject to taxes.
3. Any investment earnings in an HSA are tax-free as long as they're used for qualified medical expenses.
4. In 2010, the maximum annual contribution amounts are \$3,050 for eligible individuals and \$6,150 for families. For individuals age 55 or over, a catch-up contribution of \$1,000 per year is available.
5. You and/or your employer can elect to contribute any dollar amount, from zero up to the maximum annual contribution amount, each year.
6. Voluntary contributions can be made using pretax payroll deductions or you can make tax-deductible contributions directly to your account.
7. Any unused funds can be rolled over to the next plan year, to help you save for future qualified medical expenses\*.
8. The account is portable; your funds go with you even if you change employers.

You can use the funds in your HSA to pay for any qualified medical expenses,\* even those not covered by your health plan. (Expenses for services not covered by your health plan do not contribute to your health plan deductible or out-of-pocket maximum.)

Most out-of-pocket medical expenses qualify, including:

- ▶ Deductibles, copayments, and coinsurance
- ▶ Physicals and well-child exams
- ▶ Preventive screenings
- ▶ Hospital visits
- ▶ Non-cosmetic dental and orthodontic services
- ▶ Glasses and LASIK eye surgery
- ▶ Prescription medications

2010 County Contribution:

Half of the deductible amount, \$625 for individual / \$1,250 for family, will be deposited into your HSA account on 1/1/2010, the remaining balance will be deposited semi-monthly beginning 7/14/2010.

\*See IRS Publication 502 for a complete list of Section 213(d) qualified medical expenses. Visit [www.irs.gov/publications](http://www.irs.gov/publications) to view or download a copy.