Stanislaus County
Medical Benefits
HDHP Option

The following summary of benefits is a brief outline of the maximum amounts or special limits that may apply to benefits payable under the Plan. For a detailed description of each covered service, please refer to **Comprehensive Medical Benefits**, **Defined Terms**, and **Plan Exclusions**.

Plan Features	In-Network Benefits (Anthem Network)	Out-of-Network Benefits
Deductible per Calendar Year	$1,250 per individual $2,500 per Family Unit Once the family Deductible has been met by any number of individuals, the Deductible is met for all	Does not apply
Network Copayment	$20 per Physician office visit "Per visit" means per Provider per day.	Does not apply
Percentage Coinsurance	The Plan pays 100% of the allowable Network fee for most covered services and supplies. See individual service type for details.	Does not apply
Medical Out-of-Pocket (OOP) Limit Including Medical and Prescription Drug Copays, per Calendar Year	$3,000 per individual $6,000 per Family Unit **Out-of-Pocket limit does not apply to:** Deductible, acupuncture and chiropractic care Copayments, penalties for failure to follow pre-authorization, specific benefits as noted in the Schedule of Benefits, any expenses for which benefits were initially paid at 100% of Allowed Charges, and any expenses more than Plan Maximums or over URC amounts. Once the Out-of-Pocket limit is met, the remainder of the Covered Charges are payable at 100% of the Allowed Charges for the remainder of the Calendar Year.	Does not apply

Plan Features	In-Network Benefits (Anthem Network)	Out-of-Network Benefits
Cost Management Services Program/Pre-notification	This mandatory program requires a phone call before the Covered Person is admitted to a Hospital/facility or before a surgical procedure is scheduled to be performed in an inpatient setting. Please contact the POMCO Benefit Management Program toll-free at 1.844.344.8045. Services will be denied for non-compliance with this requirement. <u>Pre-certification is required for the following services</u>: Acupuncture Biofeedback Genetic Testing Hospitalizations Impotence surgery Morbid obesity services MRA (magnetic resonance angiography) MRI (magnetic resonance imaging) MRS (magnetic resonance spectroscopy) Nuclear Cardiac Imaging PET/CAT scans Private duty nursing Skilled Nursing Facility stays Sleep disorder studies Substance Use Disorder/Mental Disorder inpatient admissions Transplants, including but not limited to organ and stem cell transplants	

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Service Type	**In-Network Benefits (Anthem Network)**	**Out-of-Network Benefits**
Acupuncture	$ 20 Copay, then 100% of Allowed Charges, after Deductible Does not apply to Out-of-Pocket Maximum.	Not covered
	☎ Benefit is limited to the treatment of nausea or chronic pain.	
Allergy Injections	$10 Copay, then 100% of Allowed Charges after Deductible Copay is waived if the injection is part of an office visit.	Not covered
Allergy Serum	$10 Copay, then 100% of Allowed Charges after Deductible	Not covered
Allergy Testing	$20 Copay, then 100% of Allowed Charges after Deductible	Not covered
Ambulance	$50 Copay, then 100% of Allowed Charges after Deductible	$50 Copay, then 100% of Allowed Charges after Deductible
	Professional and volunteer ambulance, train, and air ambulance are covered.	
Ambulatory Surgical Center, Freestanding	$100 Copay, then 100% of Allowed Charges after Deductible	Not covered
Anesthesia	100% of Allowed Charges after Deductible	Not covered
	Coverage is also available for administration of anesthesia for non-surgical procedures when found Medically Necessary according to Plan provisions.	
Biofeedback	$20 Copay, then 100% of Allowed Charges after Deductible	Not covered
	☎ Biofeedback will only be approved for Medical and Mental Health services.	
Blood and Blood Product Services	100% of Allowed Charges after Deductible	Not covered
Cardiac Rehabilitation • **Freestanding Facility**	$20 Copay, then 100% of Allowed Charges after Deductible	Not covered
• **Outpatient Hospital**	$20 Copay, then 100% of Allowed Charges after Deductible	Not covered
• **Physician Office**	$20 Copay, then 100% of Allowed Charges after Deductible	Not covered
Chemotherapy • **Freestanding Facility**	100% of Allowed Charges after Deductible	Not covered
• **Outpatient Hospital**	100% of Allowed Charges after Deductible	Not covered
• **Physician Office**	100% of Allowed Charges after Deductible	Not covered
Chiropractic Care	$15 Copay, then 100% of Allowed Charges after Deductible Does not apply to Out-of-Pocket Maximum.	Not covered
	Benefits are limited to total of 20 visits per Covered Person per Calendar Year. Appliances limited to $50 per Calendar Year after Deductible. Maintenance Care is not covered.	

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Service Type	**In-Network Benefits (Anthem Network)**	**Out-of-Network Benefits**
Clinical Trials (Excludes the Actual Clinical Trial)	100% of Allowed Charges after Deductible Only covers Routine Patient Costs in connection with an Approved Clinical Trial for a Qualified Individual. Out-of-Network is only available if an In-Network Provider is unavailable.	Not covered
Consultation • **Inpatient Consultation**	$20 Copay, then 100% of Allowed Charges after Deductible	Not covered
• **Outpatient/Office**	$20 Copay, then 100% of Allowed Charges after Deductible	Not covered
• **Second Surgical, Voluntary**	$20 Copay, then 100% of Allowed Charges after Deductible	Not covered
Contact Lenses/Eyeglasses Following Intraocular/ Cataract Surgery	100% of Allowed Charges after Deductible	Not covered
Dental Care, Limited • **Inpatient Hospital**	$200 Copay, then 100% of Allowed Charges after Deductible	Not covered
• **Inpatient Surgery**	100% of Allowed Charges after Deductible	Not covered
• **Office Visit**	$20 copay, then 100% of Allowed Charges after Deductible	Not covered
• **Outpatient Surgery**	$100 copay, then 100% of Allowed Charges after Deductible	Not covered
	☎ For dental Injury to Sound Natural Teeth.	
Diabetic Education	100% of Allowed Charges	Not covered
Diabetic Supplies/Equipment	Not a separate benefit. Medically Necessary glucometers and insulin pumps are covered under the Durable Medical Equipment benefit. Syringes are covered under the Medical Supplies (home use) benefit or Prescription Drug Benefits. Additional diabetic supplies are covered under your Prescription Drug Benefits.	
Diagnostic Testing • **Genetic Testing**	$10 Copay, then 100% of Allowed Charges after Deductible	Not covered
• **Independent/Free-standing Laboratory**	$10 Copay, then 100% of Allowed Charges after Deductible	Not covered
• **Laboratory**	$10 Copay, then 100% of Allowed Charges after Deductible	Not covered
• **Machine Testing**	$10 Copay, then 100% of Allowed Charges after Deductible	Not covered
• **Outpatient Hospital**	$10 Copay, then 100% of Allowed Charges after Deductible	Not covered
• **Professional Interpretation**	100% of Allowed Charges after Deductible	Not covered
• **X-ray**	$10 Copay, then 100% of Allowed Charges after Deductible	Not covered

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Service Type	**In-Network Benefits (Anthem Network)**	**Out-of-Network Benefits**
• **PET/MRA/MRS/CAT scans**	$25 Copay, then 100% of Allowed Charges after Deductible	Not covered
	☎ Please refer to the Cost Management Section for procedures that require precertification. Excludes services covered under the Preventive Care provisions of the Plan.	
Dialysis • **Freestanding Facility**	$20 Copay, then 100% of Allowed Charges after Deductible	Not covered
• **Outpatient Hospital**	$20 Copay, then 100% of Allowed Charges after Deductible	Not covered
• **Physician Office**	$20 Copay, then 100% of Allowed Charges after Deductible	Not covered
Dietary Counseling for Renal Disease	$15 Copay, then 100% of Allowed Charges after Deductible	Not covered
Durable Medical Equipment	$20 Copay, then 100% of Allowed Charges after Deductible	Not covered
• **Oxygen**	$20 Copay, then 100% of Allowed Charges after Deductible	Not covered
	Excludes services covered under the Preventive Care provision of the Plan.	
Food Products (Aminoacidopathies Formula, Nutritional Products and Modified Solid Food Products)	100% of Allowed Charges after Deductible	Not covered
Foot Care and Podiatry Services	Per service type rendered. Routine foot care is not covered. **Exception:** Routine foot care is covered for patients with severe systemic disorders, such as diabetes. Foot Orthotics are specifically excluded.	
Hearing Aid Services	100% of Allowed Charges after Deductible	Not covered
	Services limited to $5,000 per Calendar Year. Includes adjustments and repair and exam for the hearing aid.	
Home Health Care	100% of Allowed Charges after Deductible	Not covered
	Limited to 100 visits per Covered Person per Calendar Year and 3 visits per Covered Person per day. <u>One HHC visit equals:</u> • Up to four hours of home health aid care; or • Each visit by other covered members of the HHC team. Services must be in lieu of Hospitalization or inpatient SNF care.	
Hospice Care	100% of Allowed Charges after Deductible	Not covered
	Bereavement counseling is covered for covered family members. Respite care limited to five consecutive days per approved admission.	

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Service Type	**In-Network Benefits (Anthem Network)**	**Out-of-Network Benefits**
Hospital Facility • **Inpatient Hospital**	$150 Copay, then 100% of Allowed Charges after Deductible	Not covered
	☎ Room and Board charge limited to actual semi-private or ICU rate. The charge for a private room is based on the Hospital's average semi-private room rate or 80% of its lowest daily rate if it does not have semi-private accommodations. A Medically Necessary private room is covered. Excludes Limited Dental Care, Morbid Obesity Treatment, Skilled Nursing Facility, TMJ, Transplants and Abortion benefits.	
• **Outpatient Hospital** • Clinic	$20 Copay, then 100% of Allowed Charges after Deductible	Not covered
	Clinic room only; related services are allowed per service type (examples include but are not limited to X-ray and diagnostic testing).	
• Diagnostic Testing	See Diagnostic Testing	Not covered
• Emergency Room for Emergency Condition and Related Charges	$75 Copay, then 100% of Allowed Charges after Deductible	$75 Copay, then 100% of Allowed Charges after Deductible
	Benefit Copayment is waived if the Covered Person is admitted as an inpatient into the treating Hospital directly from the emergency room.	
• Emergency Room for non-Emergency Condition and Related Charges	$75 Copay, then 100% of Allowed Charges after Deductible	Not covered
• Outpatient Surgical Center	$100 Copay, then 100% of Allowed Charges after Deductible	Not covered
• Other Outpatient Hospital Services and Supplies	100% of Allowed Charges after Deductible	Not covered
Impotency Devices	40% of Allowed Charges after Deductible	Not covered
	☎ Impotency surgery.	
Infertility Services	Not covered	Not covered
In-Hospital/Facility Physician's Care	100% of Allowed Charges after Deductible	Not covered
	Coverage is only provided for visits for days approved for a covered inpatient stay.	
IV (Infusion) Therapy	$10 Copay, then 100% of Allowed Charges after Deductible	Not covered
Massage Therapy	Not covered	Not covered
Maternity Care • **Initial Diagnostic Office Visit, Physician Charge**	$20 Copay, then 100% of Allowed Charges after Deductible	Not covered

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Service Type	In-Network Benefits (Anthem Network)	Out-of-Network Benefits
• **Inpatient Hospital**	$150 Copay, then 100% of Allowed Charges after Deductible	Not covered
	☎ Room and Board charge limited to actual semi-private or ICU rate. The charge for a private room is based on the Hospital's average semi-private room rate or 80% of its lowest daily rate if it does not have semi-private accommodations. A Medically Necessary private room is covered. This benefit includes certified Birthing Centers. Maternity is covered the same as any other Illness.	
• **Prenatal Care and One Postpartum Care Visit, Physician Charge**	100% of Allowed Charges	Not covered
• **Delivery, Physician Charge**	100% of Allowed Charges after Deductible	Not covered
	Related testing is covered separately per service type rendered (sonograms have no frequency limit).	
Medical/Surgical Supplies	$20 Copay, then 100% of Allowed Charges after Deductible	Not covered
Mental Disorder Treatment • **Inpatient** • General Hospital or Private Proprietary Psychiatric Facility	$150 Copay, then 100% of Allowed Charges after Deductible	Not covered
• Partial Hospitalization or Intensive Outpatient	100% of Allowed Charges after Deductible	Not covered
	☎ Room and Board charge limited to actual semi-private or ICU rate. The charge for a private room is based on the Hospital's average semi-private room rate or 80% of its lowest daily rate if it does not have semi-private accommodations.	
• **Inpatient, Physician Charge**	100% of Allowed Charges after Deductible	Not covered
• **Outpatient/Office**	Individual Therapy: $20 Copay, then 100% of Allowed Charges after Deductible Group Therapy: $10 Copay, then 100% of Allowed Charges after Deductible	Not covered
	Services must be rendered and billed by a California State licensed mental health professional performing services within the scope of their license. For services rendered and billed outside of California State the Provider must be operating within the scope of their license and operating according to the laws of the jurisdiction where the services are rendered. Services billed by a Hospital or a mental health facility, Physician's corporation, or clinic for the services of a similarly licensed Provider will also be covered.	
• **Psychological Testing**	$20 Copay, then 100% of Allowed Charges after Deductible	Not covered

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Service Type	**In-Network Benefits (Anthem Network)**	**Out-of-Network Benefits**
Newborn Care		
• **Circumcision**	100% of Allowed Charges	Not covered
• **Hospital**	100% of Allowed Charges	Not covered
• **Physician**	100% of Allowed Charges	Not covered
	Limited to Allowed Charges made by a Physician for routine pediatric care after birth while the newborn child is Hospital-confined up to four days. If the baby's routine care is extended due to the mother's continued stay, benefits will not be paid even if the mother was needed to provide basic care, such as breastfeeding. Routine newborn care billed by an anesthesiologist or the delivering Physician is not covered.	
Nursing, Private Duty		
• **Inpatient**	$150 Copay, then 100% of Allowed Charges after Deductible ☎	Not covered
• **Outpatient**	Not covered	Not covered
Obesity Treatment, Morbid		
• **Inpatient Hospital**	$200 Copay, then 100% of Allowed Charges after Deductible	Not covered
• **Inpatient Surgery**	100% of Allowed Charges after Deductible	Not covered
• **Office Visit**	$20 Copay, then 100% of Allowed Charges after Deductible	Not covered
• **Outpatient Surgery**	$125 Copay, then 100% of Allowed Charges after Deductible	Not covered
• **Transportation**	Maximum of $130 each round-trip. (Maximum of 2 trips)	Not covered
• **Travel and Lodging**	Lodging limited to $100 per day. Travel must be more than 50 miles away from home. Benefit includes recipient's and companion's/parent transportation and lodging. Daily expenses for transportation are not covered.	Not covered
	☎weight reduction surgery. Medically Necessary (as determined by the Claims Administrator) surgical charges for Morbid Obesity will be covered.	
Occupational Therapy		
• **Freestanding Facility**	$20 Copay, then 100% of Allowed Charges after Deductible	Not covered
• **Outpatient Hospital**	$20 Copay, then 100% of Allowed Charges after Deductible	Not covered
• **Physician Office**	$20 Copay, then 100% of Allowed Charges after Deductible	Not covered
	Maintenance Care is not covered.	
Orthotics	100% of Allowed Charges after Deductible	Not covered
Physical Rehabilitation Facility, Inpatient	See skilled Nursing Facility	Not covered

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Service Type	**In-Network Benefits (Anthem Network)**	**Out-of-Network Benefits**
Physical Therapy • **Freestanding Facility**	$20 Copay, then 100% of Allowed Charges after Deductible	Not covered
• **Outpatient Hospital**	$20 Copay, then 100% of Allowed Charges after Deductible	Not covered
• **Physician Office**	$20 Copay, then 100% of Allowed Charges after Deductible	Not covered
	Maintenance Care is not covered.	
Physician Care • **Emergency Room** • Emergency Condition and Related Charges	100% of Allowed Charges after Deductible	Not covered
• Non-Emergency Condition and Related Charges	100% of Allowed Charges after Deductible	Not covered
• **Home Visit**	100% of Allowed Charges after Deductible	Not covered
• **Office, Clinic or Elsewhere**	$20 Copay, then 100% of Allowed Charges after Deductible	Not covered
	Services must be given and billed by a covered healthcare Provider and found Medically Necessary according to Plan provisions in an office, clinic, home or elsewhere. Outpatient Mental Disorder care, outpatient Substance Use Disorder care, outpatient consultations, surgical and obstetrical procedures, outpatient emergency room visits, rehabilitation therapy, Urgent Care Facility Physician charges and chiropractic care are not covered under this benefit.	
• **Urgent Care** (Physician Charges)	See Urgent Care Facility	Not covered
Preadmission Testing	100% of Allowed Charges after Deductible	Not covered
	Must be: o Performed on an outpatient basis within 7 days before a scheduled Hospital confinement; o Your Physician ordered the tests; and o Physically present at the Hospital for the tests. Covered Charges for this testing will be payable even if tests show the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required.	
Prescription Drugs with COB	Not covered	Not covered
Preventive Care (Includes all Ancillary Charges)	Please see www.HealthCare.gov/center/regulations/prevention.html for complete listing and frequencies, unless listed below.	
• **Contraceptive Management**	100% of Allowed Charges	Not covered
	Medical benefits only: FDA-approved injectable contraceptives and contraceptive devices. Allowable Charges related to Physician or clinic contraceptive services, including the measuring, fitting or insertion or removal of covered devices and the purchase of covered devices, are covered. This is covered as a service of the professional Provider who administers them.	

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Service Type	In-Network Benefits (Anthem Network)	Out-of-Network Benefits
• **Nutritional Counseling (for adults with risk factors and for adults and children with obesity)**	100% of Allowed Charges	Not covered
	Limited to four wellness visits per Covered Person per Calendar Year.	
• **Routine Adult Physical (over age 18)**	100% of Allowed Charges	Not covered
	Includes routine exam and related screening tests based on current medical standards for preventive care. Immunizations follow the recommendations set by the Department of Health and Human Services Centers for Disease Control (CDC).	
• **Routine Child Care (up to age 19)**	100% of Allowed Charges	Not covered
	Coverage for health care visits and related testing follows the guidelines of the American Academy of Pediatrics (AAP). Coverage for immunizations follows the recommendations set by AAP or as set by the Department of Health and Human Services Centers for Disease Control (CDC). Routine newborn care is covered as shown above.	
• **Routine Vision Care – Exam Only (including refraction)**	$10 Copay, then 100% of Allowed Charges after Deductible	Not covered
• **Tobacco Cessation Counseling**	100% of Allowed Charges	Not covered
	Limited to two attempts per Calendar Year. Each attempt includes a maximum of four intermediate or intensive sessions.	
Prosthetics	100% of Allowed Charges after Deductible	Not covered
Pulmonary Rehabilitation		
• **Freestanding Facility**	$20 Copay, then 100% of Allowed Charges after Deductible	Not covered
• **Outpatient Hospital**	$20 Copay, then 100% of Allowed Charges after Deductible	Not covered
• **Physician Office**	$20 Copay, then 100% of Allowed Charges after Deductible	Not covered
	Related testing procedures will be considered separately as diagnostic testing. Related Physician exams and evaluations will be considered separately as Physician visits.	
PUVA (Psoralen & Ultraviolet Radiation Light Therapy)	$20 Copay, then 100% of Allowed Charges after Deductible	Not covered
Radiation Therapy		
• **Freestanding Facility**	100% of Allowed Charges after Deductible	Not covered
• **Outpatient Hospital**	100% of Allowed Charges after Deductible	Not covered
• **Physician Office**	100% of Allowed Charges after Deductible	Not covered
Refractive Surgery	Not covered	Not covered

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Service Type	In-Network Benefits (Anthem Network)	Out-of-Network Benefits
Respiratory/Inhalation Therapy		
• **Freestanding Facility**	$20 Copay, then 100% of Allowed Charges after Deductible	Not covered
• **Outpatient Hospital**	$20 Copay, then 100% of Allowed Charges after Deductible	Not covered
• **Physician Office**	$20 Copay, then 100% of Allowed Charges after Deductible	Not covered
Skilled Nursing Facility (SNF), Inpatient	$200 Copay, then 100% of Allowed Charges after Deductible	Not covered
	☎ Limited to 100 day limit per Calendar Year from admission date. Room and Board charge limited to actual semi-private rate. Coverage for a private room will be limited to the facility's average semi-private room rate or 80% of its lowest daily rate if it does not have semi-private accommodations. A Medically Necessary private room is covered.	
• **Outpatient Services**	Benefits for outpatient SNF are the same as the benefits for outpatient Hospital diagnostic X-ray, laboratory, pathology, physical therapy, occupational therapy, speech therapy, cardiac rehabilitation, radiation therapy, and inhalation therapy services shown previously in this section.	
Speech Therapy		
• **Freestanding Facility**	$20 Copay, then 100% of Allowed Charges after Deductible	Not covered
• **Outpatient Hospital**	$20 Copay, then 100% of Allowed Charges after Deductible	Not covered
• **Physician Office**	$20 Copay, then 100% of Allowed Charges after Deductible	Not covered
Substance Use Disorder Treatment		
• **Detoxification**	See type of service rendered	Not covered
• **Inpatient Facility** • General Hospital or Certified Alcohol/ Substance Use Disorder Facility Program	$150 Copay, then 100% of Allowed Charges after Deductible	Not covered
• Partial Hospitalization/ Intensive Outpatient	$5 Copay per day, then 100% of Allowed Charges after Deductible	Not covered
• Transitional Residential Facility	$50 copay, then 100% of Allowed Charges after Deductible	Not covered
	☎ Room and Board charge limited to actual semi-private or ICU rate. The charge for a private room is based on the Hospital's average semi-private room rate or 80% of its lowest daily rate if it does not have semi-private accommodations.	
• **Inpatient Physician**	100% of Allowed Charges after Deductible	Not covered

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Service Type	**In-Network Benefits (Anthem Network)**	**Out-of-Network Benefits**
• **Outpatient/Office**	Individual Therapy: $20 Copay, then 100% of Allowed Charges after Deductible Group Therapy: $5 Copay, then 100% of Allowed Charges after Deductible	Not covered
Surgical Charge Benefit • **Assistant Surgeon**	100% of Allowed Charges after Deductible	Not covered
• **Surgeon** • Inpatient	100% of Allowed Charges after Deductible	Not covered
• Office	$20 Copay, then 100% of Allowed Charges after Deductible	Not covered
• Outpatient	100% of Allowed Charges after Deductible	Not covered
	☎ Please refer to the Cost Management Section for procedures that require precertification.	
Therapeutic Injections	$10 Copay, then 100% of Allowed Charges after Deductible	Not covered
TMJ • **Inpatient Surgery**	$200 Copay, then 100% of Allowed Charges after Deductible	Not covered
• **Office Visit**	$20 Copay, then 100% of Allowed Charges after Deductible	Not covered
• **Outpatient Surgery**	$100 Copay, then 100% of Allowed Charges after Deductible	Not covered
	☎Benefits are not available for services that are dental in nature.	
Transplants • **Inpatient Hospital**	$200 Copay, then 100% of Allowed Charges after Deductible	Not covered
• **Inpatient Surgery**	100% of Allowed Charges after Deductible	Not covered
• **Office Visit**	$20 Copay, then 100% of Allowed Charges after Deductible	Not covered
• **Outpatient Surgery**	$100 Copay, then 100% of Allowed Charges after Deductible	Not covered
• **Transplant Travel Benefit**	Travel and lodging are covered for the Covered transplant recipient, care-giver and donor. Meals are covered up to a maximum of $50 per day per person for the Covered transplant recipient, care-giver and donor. Personal expenses excluded.	Not covered
	☎	
Urgent Care Facility	$20 Copay, then 100% of Allowed Charges after Deductible	Not covered
	One combined Copay per date of service applies to all services billed by the facility/Physician. Includes all covered facility/Physician charges performed in the Urgent Care Facility.	
Vision Therapy	Not covered	Not covered

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Service Type	**In-Network Benefits (Anthem Network)**	**Out-of-Network Benefits**
Voluntary or Elective Abortion		
• **Inpatient Hospital**	$200 Copay, then 100% of Allowed Charges after Deductible	Not covered
• **Inpatient Surgery**	100% of Allowed Charges after Deductible	Not covered
• **Office Visit**	$20 Copay, then 100% of Allowed Charges after Deductible	Not covered
• **Outpatient Surgery**	$100 Copay, then 100% of Allowed Charges after Deductible	Not covered
	☎	
Voluntary or Elective Sterilization (Female)	100% of Allowed Charges	Not covered
	Includes all related services such as anesthesia and facility charges.	
Voluntary or Elective Sterilization (Male)	Per service type rendered	Not covered
Wigs	80% of Allowed Charges after Deductible	Not covered
	For charges associated with the initial purchase of a wig for cancer patients.	

PRESCRIPTION DRUG BENEFITS

The Plan will follow the provision of federal Patient Protection and Affordable Care Act as it pertains to the preventive care provisions of the Plan. No patient cost share is required for Generic drugs mandated as covered under this provision. If a Generic version is not available or would not be medically appropriate for the patient as determined by the attending Physician, the Brand Name drug will be available at no cost share, subject to reasonable medical management approval by CVS Health. Contact CVS Health Customer Service Department toll-free at 1.866.475.0056 for details.					
Any one retail Pharmacy prescription or refill is limited to a 30-day supply. Any one mail order prescription or refill is limited to a 100-day supply. Some covered Prescription Drugs have a quantity limit under the Plan. For additional information on medications that have quantity limits you may call CVS Health Customer Service at 1.866.475.0056.					
Covered Drugs and Supplies	**Network Only**				
Prescription Drug Benefit (CVS Health)	**Note:** *You must pay applicable Deductible and Copayments. The Plan pays the balance of Allowable Fees.* Subject to Deductible, then Copayments per retail and mail order prescription:				
	Retail (30 days)	**Retail (31-60 days)**	**Retail (61-100 days)**	**Mail Order (30 days)**	**Mail Order (31-100 days)**
Generic Drugs	$10	$20	$30	$10	$20
Preferred Brand Name Drug	$25	$50	$75	$25	$50
Non-Preferred Brand Name Drug	$25	$50	$75	$25	$50
Prescription Drug Out-of-Pocket Limit	Combined with Medical Out-of-Pocket Limit				
	Once the Out-of-Pocket limit is met, the remainder of the Covered Charges are payable at 100% of the Allowed Charges for the remainder of the Calendar Year.				
	Benefit includes coverage for: Oral contraceptives Growth Hormone Minoxidil/Rogaine (medically necessary) Retin A (medically necessary) Smoking Cessation Viagra (50% of Allowed Charges, limited to 8 doses within 30-day period)				

IN WITNESS WHEREOF, this instrument is executed for Stanislaus County on or as of the day and year first below written.

By _____
Stanislaus County

Date_____