

**Stanislaus County
Anthem Medical Benefits
HDHP Option – January 1, 2016**

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** in your Summary Plan Description (SPD).

Plan Features	In-Network Benefits (Anthem Network)	Out-of-Network Benefits
Deductible per Calendar Year	\$1,300 Individual coverage \$2,600 Family coverage <hr/> Deductible must be met before any payment will be made or Copays will apply. Once the family Deductible has been met by any number of individuals, the Deductible is met for all.	
Network Copayment	\$20 per Physician office visit "Per visit" means per Provider per day. Copays apply after any applicable Deductibles.	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.	The Plan pays 70% of the allowable Network fee for most covered services and supplies. See individual service type for details.
Medical Out-of-Pocket (OOP) Limit Including Deductible, Medical and Prescription Drug Copays, per Calendar Year	\$3,000 Individual coverage \$6,000 Family coverage	\$5,000 Individual coverage \$10,000 Family coverage
<hr/> Out-of-Pocket limit does not apply to: 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.		

Plan Features	In-Network Benefits (Anthem Network)	Out-of-Network Benefits
Cost Management Services Program/Pre-notification	<p>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.</p> <p><u>Pre-certification is required for the following services:</u></p> <ul style="list-style-type: none"> 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 after Deductible is met	70% of Allowed Charges after Deductible
	 Benefit is limited to the treatment of nausea or chronic pain. Does not apply to Out-of-Pocket Maximum.	
Allergy Injections	\$10 Copay after Deductible is met Copay is waived if the injection is part of an office visit.	70% of Allowed Charges after Deductible
Allergy Serum	\$10 Copay after Deductible is met	70% of Allowed Charges after Deductible
Allergy Testing	\$20 Copay after Deductible is met	70% of Allowed Charges after Deductible
Ambulance	\$50 Copay after Deductible is met	90% of Allowed Charges after Deductible
	Professional and volunteer ambulance, train, and air ambulance are covered.	
Ambulatory Surgical Center, Freestanding	\$100 Copay after Deductible is met	70% of Allowed Charges after Deductible
Anesthesia	100% of Allowed Charges after Deductible	70% of Allowed Charges after Deductible
	Coverage is also available for administration of anesthesia for non-surgical procedures when found Medically Necessary according to Plan provisions.	
Biofeedback	\$20 Copay after Deductible is met	70% of Allowed Charges after Deductible
	 Biofeedback will only be approved for Medical and Mental Health services.	
Blood and Blood Product Services	100% of Allowed Charges after Deductible	70% of Allowed Charges after Deductible
Cardiac Rehabilitation		
• Freestanding Facility	\$20 Copay after Deductible is met	70% of Allowed Charges after Deductible
• Outpatient Hospital	\$20 Copay after Deductible is met	70% of Allowed Charges after Deductible
• Physician Office	\$20 Copay after Deductible is met	70% of Allowed Charges after Deductible
Chemotherapy		
• Freestanding Facility	100% of Allowed Charges after Deductible	70% of Allowed Charges after Deductible
• Outpatient Hospital	100% of Allowed Charges after Deductible	70% of Allowed Charges after Deductible
• Physician Office	100% of Allowed Charges after Deductible	70% of Allowed Charges after Deductible
Chiropractic Care	\$15 Copay after Deductible is met Does not apply to Out-of-Pocket Maximum.	70% of Allowed Charges after Deductible
	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 after Deductible is met	70% of Allowed Charges after Deductible
• Outpatient/Office	\$20 Copay after Deductible is met	70% of Allowed Charges after Deductible
• Second Surgical, Voluntary	\$20 Copay after Deductible is met	70% of Allowed Charges after Deductible
Contact Lenses/Eyeglasses Following Intraocular/Cataract Surgery	100% of Allowed Charges after Deductible	70% of Allowed Charges after Deductible
Dental Care, Limited		
• Inpatient Hospital	\$200 Copay after Deductible is met	70% of Allowed Charges after Deductible
• Inpatient Surgery	100% of Allowed Charges after Deductible	70% of Allowed Charges after Deductible
• Office Visit	\$20 Copay after Deductible is met	70% of Allowed Charges after Deductible
• Outpatient Surgery	\$100 Copay after Deductible is met	70% of Allowed Charges after Deductible
	 For dental injury to sound natural teeth. Coverage of general anesthesia and associated charges for specific persons (under age 7, developmentally disabled, health compromised) conditions directly affecting the upper or lower jawbone or associated bone joints.	
Diabetic Education	100% of Allowed Charges	70% of Allowed Charges after Deductible
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		
• HIV/AIDS testing	\$10 Copay after Deductible is met	70% of Allowed Charges after Deductible
• Genetic Testing	\$10 Copay after Deductible is met	70% of Allowed Charges after Deductible
• Independent/Free-standing Laboratory	\$10 Copay after Deductible is met	70% of Allowed Charges after Deductible
• Laboratory	\$10 Copay after Deductible is met	70% of Allowed Charges after Deductible
• Machine Testing	\$10 Copay after Deductible is met	70% of Allowed Charges after Deductible

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Service Type	In-Network Benefits (Anthem Network)	Out-of-Network Benefits
• Outpatient Hospital	\$10 Copay after Deductible is met	70% of Allowed Charges after Deductible
• Professional Interpretation	100% of Allowed Charges after Deductible	70% of Allowed Charges after Deductible
• X-ray	\$10 Copay after Deductible is met	70% of Allowed Charges after Deductible
• PET/MRA/MRS/CAT scans	\$25 Copay after Deductible is met	70% of Allowed Charges after Deductible
	 Please refer to the Cost Management Section for procedures that require precertification. Excludes services covered under the Preventive Care provisions of the Plan. Out-of-Network services limited to \$800 per procedure.	
Dialysis		
• Freestanding Facility	\$20 Copay after Deductible is met	70% of Allowed Charges after Deductible
• Outpatient Hospital	\$20 Copay after Deductible is met	70% of Allowed Charges after Deductible
• Physician Office	\$20 Copay after Deductible is met	70% of Allowed Charges after Deductible
Dietary Counseling for Renal Disease	\$15 Copay after Deductible is met	70% of Allowed Charges after Deductible
Durable Medical Equipment	\$20 Copay after Deductible is met	80% of Allowed Charges after Deductible
• Oxygen	\$20 Copay after Deductible is met	80% of Allowed Charges after Deductible
	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	70% of Allowed Charges after Deductible
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. Medically Necessary Foot Orthotics are covered.	
Hearing Aid Services	100% of Allowed Charges after Deductible	70% of Allowed Charges after Deductible
	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	70% of Allowed Charges after Deductible
	Limited to 100 visits per Covered Person per Calendar Year and 3 visits per Covered Person per day. <u>One HHC visit equals:</u>	
	<ul style="list-style-type: none"> • 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.	

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Hospice Care	100% of Allowed Charges after Deductible	70% of Allowed Charges after Deductible
	Bereavement counseling is covered for covered family members. Respite care limited to five consecutive days per approved admission.	
Hospital Facility		
• Inpatient Hospital	\$150 Copay after Deductible is met	70% of Allowed Charges after Deductible
	 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 after Deductible is met	70% of Allowed Charges after Deductible
	Clinic room only; related services are allowed per service type (examples include but are not limited to X-ray and diagnostic testing). See Diagnostic Testing	
• Diagnostic Testing	See Diagnostic Testing	See Diagnostic Testing
• Emergency Room for Emergency Condition and Related Charges	\$75 Copay after Deductible is met	90% 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 after Deductible is met	90% of Allowed Charges after Deductible
• Outpatient Surgical Center	\$100 Copay after Deductible is met	70% of Allowed Charges after Deductible
• Other Outpatient Hospital Services and Supplies	100% of Allowed Charges after Deductible	70% of Allowed Charges after Deductible
Impotency Devices	40% of Allowed Charges after Deductible	70% of Allowed Charges after Deductible
	 Impotency surgery.	
Infertility Services	Not covered	Not covered
In-Hospital/Facility Physician's Care	100% of Allowed Charges after Deductible	70% of Allowed Charges after Deductible
	Coverage is only provided for visits for days approved for a covered inpatient stay.	
IV (Infusion) Therapy	\$10 Copay after Deductible is met	70% of Allowed Charges after Deductible
Massage Therapy	Not covered	Not covered

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Service Type	In-Network Benefits (Anthem Network)	Out-of-Network Benefits
Maternity Care		
<ul style="list-style-type: none"> • Inpatient Hospital 	\$150 Copay after Deductible is met  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.	70% of Allowed Charges after Deductible
<ul style="list-style-type: none"> • Physician Charges 		
<ul style="list-style-type: none"> • Delivery 	100% of Allowed Charges after Deductible	70% of Allowed Charges after Deductible
<ul style="list-style-type: none"> • Initial Diagnostic Office Visit 	\$20 Copay after Deductible is met	70% of Allowed Charges after Deductible
<ul style="list-style-type: none"> • Routine Prenatal Care and One Postpartum Care Visit, as mandated by ACA 	100% of Allowed Charges Deductibles and Copays apply for all non-routine prenatal visits and testing.	70% of Allowed Charges after Deductible
Medical/Surgical Supplies	\$20 Copay after Deductible is met	70% of Allowed Charges after Deductible
Mental Disorder Treatment		
<ul style="list-style-type: none"> • Inpatient 		
<ul style="list-style-type: none"> • General Hospital or Private Proprietary Psychiatric Facility 	\$150 Copay after Deductible is met	70% of Allowed Charges after Deductible
<ul style="list-style-type: none"> • Partial Hospitalization or Intensive Outpatient 	100% of Allowed Charges after Deductible	70% of Allowed Charges after Deductible
<ul style="list-style-type: none"> •  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. 		
<ul style="list-style-type: none"> • Inpatient, Physician Charge 	100% of Allowed Charges after Deductible	70% of Allowed Charges after Deductible
<ul style="list-style-type: none"> • Outpatient/Office 	Individual Therapy: \$20 Copay after Deductible is met Group Therapy: \$10 Copay after Deductible is met	70% of Allowed Charges after Deductible
<ul style="list-style-type: none"> • Psychological Testing 	\$20 Copay after Deductible is met 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.	70% of Allowed Charges after Deductible

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Newborn Care		
• Circumcision	100% of Allowed Charges	70% of Allowed Charges after Deductible
• Hospital	100% of Allowed Charges	70% of Allowed Charges after Deductible
• Physician	100% of Allowed Charges	70% of Allowed Charges after Deductible
	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 after Deductible is met 	70% of Allowed Charges after Deductible
• Outpatient	Not covered	Not covered
Obesity Treatment, Morbid		
• Inpatient Hospital	\$200 Copay after Deductible is met	Not covered
• Inpatient Surgery	100% of Allowed Charges after Deductible	
• Office Visit	\$20 Copay after Deductible is met	
• Outpatient Surgery	\$125 Copay after Deductible is met	
• Transportation	Maximum of \$130 each round-trip. (Maximum of 2 trips)	
• 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.	
	 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 after Deductible is met	70% of Allowed Charges after Deductible
• Outpatient Hospital	\$20 Copay after Deductible is met	70% of Allowed Charges after Deductible
• Physician Office	\$20 Copay after Deductible is met	70% of Allowed Charges after Deductible
	Maintenance Care is not covered.	
Orthotics	100% of Allowed Charges after Deductible	70% of Allowed Charges after Deductible
Physical Rehabilitation Facility, Inpatient	See Skilled Nursing Facility	See Skilled Nursing Facility

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Service Type	In-Network Benefits (Anthem Network)	Out-of-Network Benefits
Physical Therapy		
• Freestanding Facility	\$20 Copay after Deductible is met	70% of Allowed Charges after Deductible
• Outpatient Hospital	\$20 Copay after Deductible is met	70% of Allowed Charges after Deductible
• Physician Office	\$20 Copay after Deductible is met	70% of Allowed Charges after Deductible
	Maintenance Care is not covered.	
Physician Care		
• Emergency Room	100% of Allowed Charges after Deductible	70% of Allowed Charges after Deductible
• Emergency Condition and Related Charges	100% of Allowed Charges after Deductible	70% of Allowed Charges after Deductible
• Non-Emergency Condition and Related Charges	100% of Allowed Charges after Deductible	70% of Allowed Charges after Deductible
• Home Visit	100% of Allowed Charges after Deductible	70% of Allowed Charges after Deductible
• Office, Clinic or Elsewhere	\$20 Copay after Deductible is met	70% of Allowed Charges after Deductible
	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	See Urgent Care Facility
Preadmission Testing	100% of Allowed Charges after Deductible	70% of Allowed Charges after Deductible
	Must be: <ul style="list-style-type: none"> 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	70% of Allowed Charges after Deductible
	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
<ul style="list-style-type: none"> • Nutritional Counseling (for adults with risk factors and for adults and children with obesity) 	100% of Allowed Charges	70% of Allowed Charges after Deductible
	Limited to four wellness visits per Covered Person per Calendar Year.	
<ul style="list-style-type: none"> • Prostate-Specific Antigen (PSA) and/or Digital Rectal Examination 	100% of Allowed Charges	70% of Allowed Charges after Deductible
	Limit – One per year from age 50 (from age 40 for men at high risk) combined In- and Out-of-Network.	
<ul style="list-style-type: none"> • Routine Adult Physical (over age 18) 	100% of Allowed Charges	70% of Allowed Charges after Deductible
	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).	
<ul style="list-style-type: none"> • Routine Child Care (up to age 19) 	100% of Allowed Charges	70% of Allowed Charges after Deductible
	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.	
<ul style="list-style-type: none"> • Routine Vision Care – Exam Only (including refraction) 	\$10 Copay after Deductible is met	70% of Allowed Charges after Deductible
<ul style="list-style-type: none"> • Tobacco Cessation Counseling 	100% of Allowed Charges	70% of Allowed Charges after Deductible
	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	70% of Allowed Charges after Deductible
Pulmonary Rehabilitation		
<ul style="list-style-type: none"> • Freestanding Facility 	\$20 Copay after Deductible is met	70% of Allowed Charges after Deductible
<ul style="list-style-type: none"> • Outpatient Hospital 	\$20 Copay after Deductible is met	70% of Allowed Charges after Deductible
<ul style="list-style-type: none"> • Physician Office 	\$20 Copay after Deductible is met	70% of Allowed Charges after Deductible
	Related testing procedures will be considered separately as diagnostic testing. Related Physician exams and evaluations will be considered separately as Physician visits.	
PURA (Psoralen & Ultraviolet Radiation Light Therapy)	\$20 Copay after Deductible is met	70% of Allowed Charges after Deductible
Radiation Therapy		
<ul style="list-style-type: none"> • Freestanding Facility 	100% of Allowed Charges after Deductible	70% of Allowed Charges after Deductible

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Service Type	In-Network Benefits (Anthem Network)	Out-of-Network Benefits
<ul style="list-style-type: none"> • Outpatient Hospital 	100% of Allowed Charges after Deductible	70% of Allowed Charges after Deductible
<ul style="list-style-type: none"> • Physician Office 	100% of Allowed Charges after Deductible	70% of Allowed Charges after Deductible
Refractive Surgery	Not covered	Not covered
Respiratory/Inhalation Therapy		
<ul style="list-style-type: none"> • Freestanding Facility 	\$20 Copay after Deductible is met	70% of Allowed Charges after Deductible
<ul style="list-style-type: none"> • Outpatient Hospital 	\$20 Copay after Deductible is met	70% of Allowed Charges after Deductible
<ul style="list-style-type: none"> • Physician Office 	\$20 Copay after Deductible is met	70% of Allowed Charges after Deductible
Skilled Nursing Facility (SNF), Inpatient	\$200 Copay after Deductible is met	70% of Allowed Charges after Deductible
	 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.	
<ul style="list-style-type: none"> • 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		
<ul style="list-style-type: none"> • Freestanding Facility 	\$20 Copay after Deductible is met	70% of Allowed Charges after Deductible
<ul style="list-style-type: none"> • Outpatient Hospital 	\$20 Copay after Deductible is met	70% of Allowed Charges after Deductible
<ul style="list-style-type: none"> • Physician Office 	\$20 Copay after Deductible is met	70% of Allowed Charges after Deductible
Substance Use Disorder Treatment		
<ul style="list-style-type: none"> • Detoxification 	See type of service rendered	See type of service rendered
<ul style="list-style-type: none"> • Inpatient Facility 		
<ul style="list-style-type: none"> • General Hospital or Certified Alcohol/ Substance Use Disorder Facility Program 	\$150 Copay after Deductible is met	70% of Allowed Charges after Deductible
<ul style="list-style-type: none"> • Partial Hospitalization/ Intensive Outpatient 	\$5 Copay per day after Deductible is met	70% of Allowed Charges after Deductible

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Service Type	In-Network Benefits (Anthem Network)	Out-of-Network Benefits
<ul style="list-style-type: none"> • Transitional Residential Facility 	\$50 Copay after Deductible is met	70% of Allowed Charges after Deductible
	 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.	
<ul style="list-style-type: none"> • Inpatient Physician 	100% of Allowed Charges after Deductible	70% of Allowed Charges after Deductible
<ul style="list-style-type: none"> • Outpatient/Office 	Individual Therapy: \$20 Copay after Deductible is met Group Therapy: \$5 Copay after Deductible is met	70% of Allowed Charges after Deductible
Surgical Charge Benefit <ul style="list-style-type: none"> • Assistant Surgeon 	100% of Allowed Charges after Deductible	70% of Allowed Charges after Deductible
<ul style="list-style-type: none"> • Surgeon • Inpatient 	100% of Allowed Charges after Deductible	70% of Allowed Charges after Deductible
<ul style="list-style-type: none"> • Office 	\$20 Copay after Deductible is met	70% of Allowed Charges after Deductible
<ul style="list-style-type: none"> • Outpatient 	100% of Allowed Charges after Deductible	70% of Allowed Charges after Deductible
 Please refer to the Cost Management Section for procedures that require precertification.		
Therapeutic Injections	\$10 Copay after Deductible is met	70% of Allowed Charges after Deductible
TMJ <ul style="list-style-type: none"> • Inpatient Surgery 	\$200 Copay after Deductible is met	70% of Allowed Charges after Deductible
<ul style="list-style-type: none"> • Office Visit 	\$20 Copay after Deductible is met	70% of Allowed Charges after Deductible
<ul style="list-style-type: none"> • Outpatient Surgery 	\$100 Copay after Deductible is met	70% of Allowed Charges after Deductible
 Benefits are not available for services that are dental in nature.		

 = If this Plan is primary, benefits with this symbol require precertification. Call the POMCO Benefit Management Department at 1.844.344.8045. See the section entitled Cost Management Services for details. If you have any questions regarding claim status or benefits; please feel free to email: medicalbenefitshelp@pomco.com.

Service Type	In-Network Benefits (Anthem Network)	Out-of-Network Benefits
Transplants <ul style="list-style-type: none"> • Inpatient Hospital • Inpatient Surgery • Office Visit • Outpatient Surgery • Transplant Travel Benefit 	\$200 Copay after Deductible is met 100% of Allowed Charges after Deductible \$20 Copay after Deductible is met \$100 Copay after Deductible is met 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 after Deductible is met 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.	70% of Allowed Charges after Deductible
Vision Therapy	Not covered	Not covered
Voluntary or Elective Abortion <ul style="list-style-type: none"> • Inpatient Hospital • Inpatient Surgery • Office Visit • Outpatient Surgery 	\$200 Copay after Deductible is met 100% of Allowed Charges after Deductible \$20 Copay after Deductible is met \$100 Copay after Deductible is met	70% of Allowed Charges after Deductible 70% of Allowed Charges after Deductible 70% of Allowed Charges after Deductible 70% of Allowed Charges after Deductible
		
Voluntary or Elective Sterilization (Female)	100% of Allowed Charges Includes all related services such as anesthesia and facility charges.	70% of Allowed Charges after Deductible
Voluntary or Elective Sterilization (Male)	Per service type rendered	70% of Allowed Charges after Deductible
Wigs	80% of Allowed Charges after Deductible For charges associated with the initial purchase of a wig for cancer patients.	70% of Allowed Charges after Deductible

PRESCRIPTION DRUG BENEFITS

<p>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.</p>						
<p>Any one retail Pharmacy prescription or refill is limited to a 100-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.</p>						
Covered Drugs and Supplies		Network and Out-of-Network				
Prescription Drug Benefit (CVS Health)		<p>Note: You must pay applicable Deductible and Copayments. The Plan pays the balance of Allowable Fees.</p>				
		<p>Subject to Deductible, then Copayments per retail and mail order prescription:</p>				
		Network				Out-of-Network
		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	\$10 plus 50% of the remaining maximum allowed amount and cost in excess of the maximum allowed amount.
Preferred Brand Name Drug	\$25	\$50	\$75	\$25	\$50	\$30 plus 50% of the remaining maximum allowed amount and cost in excess of the maximum allowed amount.
Non-Preferred Brand Name Drug *Only covered if determined to be medically necessary through clinical review.	\$25	\$50	\$75	\$25	\$50	Does not apply
Prescription Drug Out-of-Pocket Limit		<p>Combined with Medical Out-of-Pocket Limit</p> <p>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.</p>				
		<p>Benefit includes coverage for:</p> <ul style="list-style-type: none"> 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) 				

By signing this document, the Plan agrees that all prior documents outstanding at this time are approved and incorporated herein.

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

By Paul Soehr
Stanislaus County

Date 2/4/2016