

**Stanislaus County  
Stanislaus County Partners in Health Medical Benefits  
EPO 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 (Stanislaus County Partners in Health Network)	Out-of-Network Benefits
<b>Deductible per Calendar Year</b>	Does not apply	Does not apply
<b>Network Copayment</b>	\$20 per Physician office visit  "Per visit" means per Provider per day.	Does not apply
<b>Percentage Coinsurance</b>	The Plan pays 100% of the allowable Network fee for most covered services and supplies.  See individual service type for details.	Does not apply
<b>Medical Out-of-Pocket (OOP) Limit Including Medical and Prescription Drug Copays, per Calendar Year</b>	\$1,500 per person \$3,000 per family  <b>Out-of-Pocket limit does not apply to:</b> 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

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<b>Cost Management Services Program/Pre-notification</b>	<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 HealthCare Strategies toll-free at 1.855.279.1545. 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"> <li>Acupuncture</li> <li>Biofeedback</li> <li>Genetic Testing</li> <li>Hospitalizations</li> <li>Impotence surgery</li> <li>Morbid obesity services</li> <li>MRA (magnetic resonance angiography)</li> <li>MRI (magnetic resonance imaging)</li> <li>MRS (magnetic resonance spectroscopy)</li> <li>Nuclear Cardiac Imaging</li> <li>PET/CAT scans</li> <li>Private duty nursing</li> <li>Skilled Nursing Facility stays</li> <li>Sleep disorder studies</li> <li>Substance Use Disorder/Mental Disorder inpatient admissions</li> <li>Transplants, including but not limited to organ and stem cell transplants</li> </ul>	

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

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<b>Consultation</b> <ul style="list-style-type: none"> <li>• Inpatient Consultation</li> <li>• Outpatient/Office</li> <li>• Second Surgical, Voluntary</li> </ul>	\$20 Copay, then 100% of Allowed Charges \$20 Copay, then 100% of Allowed Charges \$20 Copay, then 100% of Allowed Charges	Not covered Not covered Not covered
<b>Contact Lenses/Eyeglasses Following Intraocular/Cataract Surgery</b>	100% of Allowed Charges	Not covered
<b>Dental Care, Limited</b> <ul style="list-style-type: none"> <li>• Inpatient Hospital</li> <li>• Inpatient Surgery</li> <li>• Office Visit</li> <li>• Outpatient Surgery</li> </ul>	\$200 Copay, then 100% of Allowed Charges 100% of Allowed Charges \$20 Copay, then 100% of Allowed Charges \$100 Copay, then 100% of Allowed Charges  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.	Not covered Not covered Not covered Not covered
<b>Diabetic Education</b>	100% of Allowed Charges	Not covered
<b>Diabetic Supplies/Equipment</b>	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.	
<b>Diagnostic Testing</b> <ul style="list-style-type: none"> <li>• HIV/AIDS testing</li> <li>• Genetic Testing</li> <li>• Independent/Free-standing Laboratory</li> <li>• Laboratory</li> <li>• Machine Testing</li> <li>• Outpatient Hospital</li> <li>• Professional Interpretation</li> <li>• X-ray</li> <li>• PET/MRA/MRS/CAT scans</li> </ul>	\$10 Copay, then 100% of Allowed Charges \$10 Copay, then 100% of Allowed Charges 100% of Allowed Charges \$10 Copay, then 100% of Allowed Charges \$25 Copay, then 100% of Allowed Charges	Not covered Not covered Not covered Not covered Not covered Not covered Not covered 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.		
<b>Dialysis</b> <ul style="list-style-type: none"> <li>• Freestanding Facility</li> <li>• Outpatient Hospital</li> <li>• Physician Office</li> </ul>	\$20 Copay, then 100% of Allowed Charges \$20 Copay, then 100% of Allowed Charges \$20 Copay, then 100% of Allowed Charges	Not covered Not covered Not covered
<b>Dietary Counseling for Renal Disease</b>	\$15 Copay, then 100% of Allowed Charges	Not covered

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Durable Medical Equipment • Oxygen	\$20 Copay, then 100% of Allowed Charges	Not covered
	\$20 Copay, then 100% of Allowed Charges	Not covered
	Excludes services covered under the Preventive Care provision of the Plan.	
Food Products (Aminoacidopathies Formula, Nutritional Supplements and Modified Solid Food Products)	100% of Allowed Charges	Not covered
Foot Care and Podiatry Services	Per service type rendered. Routine foot care is not covered. <b>Exception:</b> 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	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	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> <ul style="list-style-type: none"> <li>• Up to four hours of home health aid care; or</li> <li>• Each visit by other covered members of the HHC team.</li> </ul> Services must be in lieu of Hospitalization or inpatient SNF care.	
Hospice Care	100% of Allowed Charges	Not covered
	Bereavement counseling is covered for covered family members. Respite care limited to five consecutive days per approved admission.	
Hospital Facility • Inpatient Hospital	\$150 Copay, then 100% of Allowed Charges	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	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	\$75 Copay, then 100% of Allowed Charges
	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	Not covered

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• Outpatient Surgical Center	\$100 Copay, then 100% of Allowed Charges	Not covered
• Other Outpatient Hospital Services and Supplies	100% of Allowed Charges	Not covered
<b>Impotency Treatment</b>	40% of Allowed Charges  Impotency surgery.	Not covered
<b>Infertility Services</b>	Not covered	Not covered
<b>In-Hospital/Facility Physician's Care</b>	100% of Allowed Charges  Coverage is only provided for visits for days approved for a covered inpatient stay.	Not covered
<b>IV (Infusion) Therapy</b>	\$10 Copay, then 100% of Allowed Charges	Not covered
<b>Massage Therapy</b>	Not covered	Not covered
<b>Maternity Care</b>		
• Inpatient Hospital	\$150 Copay, then 100% of Allowed Charges  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.	Not covered
• <b>Physician Charges</b>		
• <b>Delivery</b>	100% of Allowed Charges	Not covered
• <b>Initial Diagnostic Office Visit</b>	\$20 Copay, then 100% of Allowed Charges	Not covered
• <b>Routine Prenatal Care and One Postpartum Care Visit, as mandated by ACA</b>	100% of Allowed Charges  Deductibles and Copays apply for all non-routine prenatal visits and testing.	Not covered
<b>Medical/Surgical Supplies</b>	\$20 Copay, then 100% of Allowed Charges	Not covered
<b>Mental Disorder Treatment</b>		
• <b>Inpatient</b>		
• General Hospital or Private Proprietary Psychiatric Facility	\$150 Copay, then 100% of Allowed Charges	Not covered
• Partial Hospitalization or Intensive Outpatient	100% of Allowed Charges   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.	Not covered
• <b>Inpatient, Physician Charge</b>	100% of Allowed Charges	Not covered

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<ul style="list-style-type: none"> <li>• <b>Outpatient/Office</b></li> </ul>	Individual Therapy: \$20 Copay, then 100% of Allowed Charges Group Therapy: \$10 Copay, then 100% of Allowed Charges  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.	Not covered
<ul style="list-style-type: none"> <li>• <b>Psychological Testing</b></li> </ul>	\$20 Copay, then 100% of Allowed Charges	Not covered
<b>Newborn Care</b>		
<ul style="list-style-type: none"> <li>• <b>Circumcision</b></li> </ul>	100% of Allowed Charges	Not covered
<ul style="list-style-type: none"> <li>• <b>Hospital</b></li> </ul>	100% of Allowed Charges	Not covered
<ul style="list-style-type: none"> <li>• <b>Physician</b></li> </ul>	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. 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.	
<b>Nursing, Private Duty</b>		
<ul style="list-style-type: none"> <li>• <b>Inpatient</b></li> </ul>	\$150 Copay, then 100% of Allowed Charges	Not covered
		
<ul style="list-style-type: none"> <li>• <b>Outpatient</b></li> </ul>	Not covered	Not covered
<b>Obesity Treatment, Morbid</b>		
<ul style="list-style-type: none"> <li>• <b>Inpatient Hospital</b></li> </ul>	\$200 Copay, then 100% of Allowed Charges	Not covered
<ul style="list-style-type: none"> <li>• <b>Inpatient Surgery</b></li> </ul>	100% of Allowed Charges	
<ul style="list-style-type: none"> <li>• <b>Office Visit</b></li> </ul>	\$20 Copay, then 100% of Allowed Charges	
<ul style="list-style-type: none"> <li>• <b>Outpatient Surgery</b></li> </ul>	\$125 Copay, then 100% of Allowed Charges	
<ul style="list-style-type: none"> <li>• <b>Transportation</b></li> </ul>	Maximum of \$130 each round-trip. (Maximum of 2 trips)	
<ul style="list-style-type: none"> <li>• <b>Travel and Lodging</b></li> </ul>	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.	

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<b>Occupational Therapy</b> <ul style="list-style-type: none"> <li>• <b>Freestanding Facility</b></li> <li>• <b>Outpatient Hospital</b></li> <li>• <b>Physician Office</b></li> </ul>	\$20 Copay, then 100% of Allowed Charges \$20 Copay, then 100% of Allowed Charges \$20 Copay, then 100% of Allowed Charges Maintenance Care is not covered.	Not covered Not covered Not covered
<b>Orthotics</b>	100% of Allowed Charges	Not covered
<b>Physical Rehabilitation Facility, Inpatient</b>	See Skilled Nursing Facility	Not covered
<b>Physical Therapy</b> <ul style="list-style-type: none"> <li>• <b>Freestanding Facility</b></li> <li>• <b>Outpatient Hospital</b></li> <li>• <b>Physician Office</b></li> </ul>	\$20 Copay, then 100% of Allowed Charges \$20 Copay, then 100% of Allowed Charges \$20 Copay, then 100% of Allowed Charges Maintenance Care is not covered.	Not covered Not covered Not covered
<b>Physician Care</b> <ul style="list-style-type: none"> <li>• <b>Emergency Room</b> <ul style="list-style-type: none"> <li>• Emergency Condition and Related Charges</li> <li>• Non-Emergency Condition and Related Charges</li> </ul> </li> <li>• <b>Home Visit</b></li> <li>• <b>Office, Clinic or Elsewhere</b></li> </ul>	100% of Allowed Charges 100% of Allowed Charges 100% of Allowed Charges \$20 Copay, then 100% of Allowed Charges	Not covered Not covered Not covered Not covered
<ul style="list-style-type: none"> <li>• <b>Urgent Care (Physician Charges)</b></li> </ul>	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. See Urgent Care Facility	Not covered
<b>Preadmission Testing</b>	100% of Allowed Charges Must be: <ul style="list-style-type: none"> <li>○ Performed on an outpatient basis within 7 days before a scheduled Hospital confinement;</li> <li>○ Your Physician ordered the tests; and</li> <li>○ Physically present at the Hospital for the tests.</li> </ul> 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.	Not covered
<b>Prescription Drugs with COB</b>	Not covered	Not covered

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<b>Preventive Care (Includes all Ancillary Charges)</b>	Please see <a href="http://www.HealthCare.gov/center/regulations/prevention.html">www.HealthCare.gov/center/regulations/prevention.html</a> for complete listing and frequencies, unless listed below.	
• <b>Contraceptive Management</b>	100% of Allowed Charges	Not covered
• <b>Nutritional Counseling (for adults with risk factors and for adults and children with obesity)</b>	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.	
• <b>Prostate-Specific Antigen (PSA) and/or Digital Rectal Examination</b>	100% of Allowed Charges	Not covered
• <b>Routine Adult Physical (over age 18)</b>	Limited to four wellness visits per Covered Person per Calendar Year.	
• <b>Routine Child Care (up to age 19)</b>	100% of Allowed Charges	Not covered
• <b>Routine Vision Care-Exam only (Including refraction)</b>	Limit – One per year from age 50 (from age 40 for men at high risk) combined In- and Out-of-Network.	
• <b>Tobacco Cessation Counseling</b>	100% of Allowed Charges	Not covered
• <b>Routine Vision Care-Exam only (Including refraction)</b>	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).	
• <b>Routine Vision Care-Exam only (Including refraction)</b>	\$10 Copay, then 100% of Allowed Charges	Not covered
• <b>Tobacco Cessation Counseling</b>	100% of Allowed Charges	Not covered
<b>Prosthetics</b>	Limited to two attempts per Calendar Year. Each attempt includes a maximum of four intermediate or intensive sessions.	
<b>Pulmonary Rehabilitation</b>	100% of Allowed Charges	Not covered
• <b>Freestanding Facility</b>	\$20 Copay, then 100% of Allowed Charges	Not covered
• <b>Outpatient Hospital</b>	\$20 Copay, then 100% of Allowed Charges	Not covered
• <b>Physician Office</b>	\$20 Copay, then 100% of Allowed Charges	Not covered
	Related testing procedures will be considered separately as diagnostic testing. Related Physician exams and evaluations will be considered separately as Physician visits.	

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<b>PUVA (Psoralen &amp; Ultraviolet Radiation Light Therapy)</b>	\$20 Copay, then 100% of Allowed Charges	Not covered
<b>Radiation Therapy</b>		
• <b>Freestanding Facility</b>	100% of Allowed Charges	Not covered
• <b>Outpatient Hospital</b>	100% of Allowed Charges	Not covered
• <b>Physician Office</b>	100% of Allowed Charges	Not covered
<b>Refractive Surgery</b>	Not covered	Not covered
<b>Respiratory/Inhalation Therapy</b>		
• <b>Freestanding Facility</b>	\$20 Copay, then 100% of Allowed Charges	Not covered
• <b>Outpatient Hospital</b>	\$20 Copay, then 100% of Allowed Charges	Not covered
• <b>Physician Office</b>	\$20 Copay, then 100% of Allowed Charges	Not covered
<b>Skilled Nursing Facility (SNF), Inpatient</b>	\$200 Copay, then 100% of Allowed Charges	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.	
• <b>Outpatient Services</b>	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.	
<b>Speech Therapy</b>		
• <b>Freestanding Facility</b>	\$20 Copay, then 100% of Allowed Charges	Not covered
• <b>Outpatient Hospital</b>	\$20 Copay, then 100% of Allowed Charges	Not covered
• <b>Physician Office</b>	\$20 Copay, then 100% of Allowed Charges	Not covered
<b>Substance Use Disorder Treatment</b>		
• <b>Detoxification</b>	See type of service rendered	Not covered
• <b>Inpatient Facility</b>		
• General Hospital or Certified Alcohol/ Substance Use Disorder Facility Program	\$150 Copay, then 100% of Allowed Charges	Not covered
• Partial Hospitalization/ Intensive Outpatient	\$5 Copay per day, then 100% of Allowed Charges	Not covered
• Transitional Residential Facility	\$50 Copay, then 100% of Allowed Charges	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.	
• <b>Inpatient Physician</b>	100% of Allowed Charges	Not covered

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<ul style="list-style-type: none"> <li>• Outpatient/Office</li> </ul>	Individual Therapy: \$20 Copay, then 100% of Allowed Charges Group Therapy: \$5 Copay, then 100% of Allowed Charges	Not covered
<b>Surgical Charge Benefit</b> <ul style="list-style-type: none"> <li>• Assistant Surgeon</li> <li>• Surgeon               <ul style="list-style-type: none"> <li>• Inpatient</li> <li>• Office</li> <li>• Outpatient</li> </ul> </li> </ul>	100% of Allowed Charges  100% of Allowed Charges \$20 Copay, then 100% of Allowed Charges 100% of Allowed Charges   Please refer to the Cost Management Section for procedures that require precertification.	Not covered  Not covered Not covered Not covered
<b>Therapeutic Injections</b>	\$10 Copay, then 100% of Allowed Charges	Not covered
<b>TMJ</b> <ul style="list-style-type: none"> <li>• Inpatient Surgery</li> <li>• Office Visit</li> <li>• Outpatient Surgery</li> </ul>	\$200 Copay, then 100% of Allowed Charges \$20 Copay, then 100% of Allowed Charges \$100 Copay, then 100% of Allowed Charges   Benefits are not available for services that are dental in nature.	Not covered Not covered Not covered
<b>Transplants</b> <ul style="list-style-type: none"> <li>• Inpatient Hospital</li> <li>• Inpatient Surgery</li> <li>• Office Visit</li> <li>• Outpatient Surgery</li> <li>• Transplant Travel Benefit</li> </ul>	\$200 Copay, then 100% of Allowed Charges 100% of Allowed Charges \$20 Copay, then 100% of Allowed Charges \$100 Copay, then 100% of Allowed Charges  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
<b>Urgent Care Facility</b>	\$20 Copay, then 100% of Allowed Charges  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.	Not covered
<b>Vision Therapy</b>	Not covered	Not covered
<b>Voluntary or Elective Abortion</b> <ul style="list-style-type: none"> <li>• Inpatient Hospital</li> <li>• Inpatient Surgery</li> <li>• Office Visit</li> </ul>	\$200 Copay, then 100% of Allowed Charges 100% of Allowed Charges \$20 Copay, then 100% of Allowed Charges	Not covered Not covered Not covered

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• Outpatient Surgery	\$100 Copay, then 100% of Allowed Charges 	Not covered
Voluntary or Elective Sterilization (Female)	100% of Allowed Charges	Not covered
Voluntary or Elective Sterilization (Male)	Includes all related services such as anesthesia and facility charges. Per service type rendered	Not covered
Wigs	100% of Allowed Charges For charges associated with the initial purchase of a wig for cancer patients.	Not covered

**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>					
<b>Covered Drugs and Supplies</b>	<b>Network Only</b>				
<b>Prescription Drug Benefit (CVS Health)</b>	<p><i>Note: You must pay applicable Copayments. The Plan pays the balance of Allowable Fees.</i></p> <p>Copayments per retail and mail order prescription:</p>				
	<b>Retail (30 days)</b>	<b>Retail (31-60 days)</b>	<b>Retail (61-100 days)</b>	<b>Mail Order (30 days)</b>	<b>Mail Order (31-100 days)</b>
	Generic Drugs	\$10	\$20	\$30	\$10
	Preferred Brand Name Drug	\$25	\$50	\$75	\$25
	Non-Preferred Brand Name Drug *Only covered if determined to be medically necessary through clinical review.	\$25	\$50	\$75	\$25
<b>Prescription Drug Out-of-Pocket Limit</b>	<p>Copayments apply to the 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"> <li>Oral contraceptives</li> <li>Growth Hormone</li> <li>Minoxidil/Rogaine (medically necessary)</li> <li>Retin A (medically necessary)</li> <li>Smoking Cessation</li> <li>Viagra (50% of Allowed Charges, limited to 8 doses within 30-day period)</li> </ul>				

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

By Paul Loch  
Stanislaus County

Date 2/4/2016