

**Stanislaus County
Stanislaus County Partners In Health 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 (Stanislaus County Partners in Health Network) | Out-of-Network Benefits |
|------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
| Deductible per Calendar Year | \$1,300 Individual coverage \$2,600 Family coverage 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. | Does not apply |
| 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. | Does not apply |
| Medical Out-of-Pocket (OOP) Limit Including Deductible, Medical and Prescription Drug Copays, per Calendar Year | \$3,000 Individual coverage \$6,000 Family coverage 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. | Does not apply |

| Plan Features | In-Network Benefits (Stanislaus County Partners In Health 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 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"> 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 | |

|  = If this Plan is primary, benefits with this symbol require precertification. Call HealthCare Strategies at 1.855.279.1545. 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 (Stanislaus County Partners in Health Network) | Out-of-Network Benefits |
| Acupuncture | \$20 Copay after Deductible is met 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 after Deductible is met Copay is waived if the injection is part of an office visit. | Not covered |
| Allergy Serum | \$10 Copay after Deductible is met | Not covered |
| Allergy Testing | \$20 Copay after Deductible is met | Not covered |
| Ambulance | \$50 Copay after Deductible is met Professional and volunteer ambulance, train, and air ambulance are covered. | \$50 Copay after Deductible is met |
| Ambulatory Surgical Center, Freestanding | \$100 Copay after Deductible is met | Not covered |
| Anesthesia | 100% 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. | Not covered |
| Biofeedback | \$20 Copay after Deductible is met  Biofeedback will only be approved for Medical and Mental Health services. | Not covered |
| Blood and Blood Product Services | 100% of Allowed Charges after Deductible | Not covered |
| Cardiac Rehabilitation | | |
| • Freestanding Facility | \$20 Copay after Deductible is met | Not covered |
| • Outpatient Hospital | \$20 Copay after Deductible is met | Not covered |
| • Physician Office | \$20 Copay after Deductible is met | 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 after Deductible is met 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 after Deductible. Maintenance Care is not covered. | Not covered |
| 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 | Not covered |
| • Outpatient/Office | \$20 Copay after Deductible is met | Not covered |

 = If this Plan is primary, benefits with this symbol require precertification. Call HealthCare Strategies at 1.855.279.1545. 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 (Stanislaus County Partners in Health Network) | Out-of-Network Benefits |
|------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
| • Second Surgical, Voluntary | \$20 Copay after Deductible is met | Not covered |
| Contact Lenses/Eyeglasses Following Intraocular/Cataract Surgery | 100% of Allowed Charges after Deductible | Not covered |
| Dental Care, Limited | | |
| • Inpatient Hospital | \$200 Copay after Deductible is met | Not covered |
| • Inpatient Surgery | 100% of Allowed Charges after Deductible | Not covered |
| • Office Visit | \$20 Copay after Deductible is met | Not covered |
| • Outpatient Surgery | \$100 Copay after Deductible is met | Not covered |
| |  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 | 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 | | |
| • HIV/AIDS testing | \$10 Copay after Deductible is met | Not covered |
| • Genetic Testing | \$10 Copay after Deductible is met | Not covered |
| • Independent/Free-standing Laboratory | \$10 Copay after Deductible is met | Not covered |
| • Laboratory | \$10 Copay after Deductible is met | Not covered |
| • Machine Testing | \$10 Copay after Deductible is met | Not covered |
| • Outpatient Hospital | \$10 Copay after Deductible is met | Not covered |
| • Professional Interpretation | 100% of Allowed Charges after Deductible | Not covered |
| • X-ray | \$10 Copay after Deductible is met | Not covered |
| • PET/MRA/MRS/CAT scans | \$25 Copay after Deductible is met | 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 after Deductible is met | Not covered |
| • Outpatient Hospital | \$20 Copay after Deductible is met | Not covered |
| • Physician Office | \$20 Copay after Deductible is met | Not covered |
| Dietary Counseling for Renal Disease | \$15 Copay after Deductible is met | Not covered |
| Durable Medical Equipment | | |
| • Oxygen | \$20 Copay after Deductible is met | Not covered |
| | Excludes services covered under the Preventive Care provision of the Plan. | |

 = If this Plan is primary, benefits with this symbol require precertification. Call HealthCare Strategies at 1.855.279.1545. 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 (Stanislaus County Partners in Health Network) | Out-of-Network Benefits |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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. Medically Necessary Foot Orthotics are covered. | |
| 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> <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. |
| 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. |
| Hospital Facility <ul style="list-style-type: none"> • Inpatient Hospital • Outpatient Hospital • Clinic • Diagnostic Testing • Emergency Room for Emergency Condition and Related Charges • Emergency Room for non-Emergency Condition and Related Charges • Outpatient Surgical Center • Other Outpatient Hospital Services and Supplies | \$150 Copay after Deductible is met | 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. | |
| | \$20 Copay after Deductible is met | Not covered |
| | 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 | Not covered |
| | \$75 Copay after Deductible is met | \$75 Copay after Deductible is met |
| Benefit Copayment is waived if the Covered Person is admitted as an inpatient into the treating Hospital directly from the emergency room. | | |
| \$75 Copay after Deductible is met | Not covered | |
| \$100 Copay after Deductible is met | Not covered | |
| 100% of Allowed Charges after Deductible | Not covered | |
| Impotency Devices | 40% of Allowed Charges after Deductible  Impotency surgery. | |

 = If this Plan is primary, benefits with this symbol require precertification. Call HealthCare Strategies at 1.855.279.1545. 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 (Stanislaus County Partners in Health Network) | Out-of-Network Benefits |
|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
| Infertility Services | Not covered | Not covered |
| In-Hospital/Facility Physician's Care | 100% of Allowed Charges after Deductible Coverage is only provided for visits for days approved for a covered inpatient stay. | Not covered |
| IV (Infusion) Therapy | \$10 Copay after Deductible is met | Not covered |
| Massage Therapy | Not covered | Not covered |
| 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. | Not covered |
| <ul style="list-style-type: none"> • Physician Charges | | |
| <ul style="list-style-type: none"> • Delivery | 100% of Allowed Charges after Deductible | Not covered |
| <ul style="list-style-type: none"> • Initial Diagnostic Office Visit | \$20 Copay after Deductible is met | Not covered |
| <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. | Not covered |
| Medical/Surgical Supplies | \$20 Copay after Deductible is met | Not covered |
| 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 | Not covered |
| <ul style="list-style-type: none"> • Partial Hospitalization or Intensive Outpatient | 100% 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. | Not covered |
| <ul style="list-style-type: none"> • Inpatient, Physician Charge | 100% of Allowed Charges after Deductible | Not covered |

 = If this Plan is primary, benefits with this symbol require precertification. Call HealthCare Strategies at 1.855.279.1545. 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 (Stanislaus County Partners in Health Network) | Out-of-Network Benefits |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
| <ul style="list-style-type: none"> • Outpatient/Office | Individual Therapy: \$20 Copay after Deductible is met Group Therapy: \$10 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. | Not covered |
| <ul style="list-style-type: none"> • Psychological Testing | \$20 Copay after Deductible is met | Not covered |
| Newborn Care | | |
| <ul style="list-style-type: none"> • Circumcision | 100% of Allowed Charges | Not covered |
| <ul style="list-style-type: none"> • Hospital | 100% of Allowed Charges | Not covered |
| <ul style="list-style-type: none"> • 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 | | |
| <ul style="list-style-type: none"> • Inpatient | \$150 Copay after Deductible is met | Not covered |
|  | | |
| <ul style="list-style-type: none"> • Outpatient | Not covered | Not covered |
| Obesity Treatment, Morbid | | |
| <ul style="list-style-type: none"> • Inpatient Hospital | \$200 Copay after Deductible is met | Not covered |
| <ul style="list-style-type: none"> • Inpatient Surgery | 100% of Allowed Charges after Deductible | |
| <ul style="list-style-type: none"> • Office Visit | \$20 Copay after Deductible is met | |
| <ul style="list-style-type: none"> • Outpatient Surgery | \$125 Copay after Deductible is met | |
| <ul style="list-style-type: none"> • Transportation | Maximum of \$130 each round-trip. (Maximum of 2 trips) | |
| <ul style="list-style-type: none"> • 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 | | |
| <ul style="list-style-type: none"> • Freestanding Facility | \$20 Copay after Deductible is met | Not covered |
| <ul style="list-style-type: none"> • Outpatient Hospital | \$20 Copay after Deductible is met | Not covered |

 = If this Plan is primary, benefits with this symbol require precertification. Call HealthCare Strategies at 1.855.279.1545. 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 (Stanislaus County Partners in Health Network) | Out-of-Network Benefits |
|---------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
| • Physician Office | \$20 Copay after Deductible is met Maintenance Care is not covered. | Not covered |
| Orthotics | 100% of Allowed Charges after Deductible | Not covered |
| Physical Rehabilitation Facility, Inpatient | See skilled Nursing Facility | Not covered |
| Physical Therapy | | |
| • Freestanding Facility | \$20 Copay after Deductible is met | Not covered |
| • Outpatient Hospital | \$20 Copay after Deductible is met | Not covered |
| • Physician Office | \$20 Copay after Deductible is met | 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 after Deductible is met | 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: <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 | 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. | |

 = If this Plan is primary, benefits with this symbol require precertification. Call HealthCare Strategies at 1.855.279.1545. 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 (Stanislaus County Partners in Health 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 |
| • Prostate-Specific Antigen (PSA) and/or Digital Rectal Examination | Limited to four wellness visits per Covered Person per Calendar Year. 100% of Allowed Charges | Not covered |
| • Routine Adult Physical (over age 18) | Limit – One per year from age 50 (from age 40 for men at high risk) combined In- and Out-of-Network. 100% of Allowed Charges | Not covered |
| • Routine Child Care (up to age 19) | 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). 100% of Allowed Charges | Not covered |
| • Routine Vision Care – Exam Only (including refraction) | 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. \$10 Copay after Deductible is met | Not covered |
| • Tobacco Cessation Counseling | 100% of Allowed Charges | Not covered |
| Prosthetics | Limited to two attempts per Calendar Year. Each attempt includes a maximum of four intermediate or intensive sessions. 100% of Allowed Charges after Deductible | Not covered |
| Pulmonary Rehabilitation | | |
| • Freestanding Facility | \$20 Copay after Deductible is met | Not covered |
| • Outpatient Hospital | \$20 Copay after Deductible is met | Not covered |
| • Physician Office | \$20 Copay after Deductible is met | 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 after Deductible is met | 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 |

 = If this Plan is primary, benefits with this symbol require precertification. Call HealthCare Strategies at 1.855.279.1545. 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 (Stanislaus County Partners in Health Network) | Out-of-Network Benefits |
|----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
| Respiratory/Inhalation Therapy | | |
| • Freestanding Facility | \$20 Copay after Deductible is met | Not covered |
| • Outpatient Hospital | \$20 Copay after Deductible is met | Not covered |
| • Physician Office | \$20 Copay after Deductible is met | Not covered |
| Skilled Nursing Facility (SNF), Inpatient | \$200 Copay after Deductible is met | 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 after Deductible is met | Not covered |
| • Outpatient Hospital | \$20 Copay after Deductible is met | Not covered |
| • Physician Office | \$20 Copay after Deductible is met | 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 after Deductible is met | Not covered |
| • Partial Hospitalization/ Intensive Outpatient | \$5 Copay per day after Deductible is met | Not covered |
| • Transitional Residential Facility | \$50 Copay after Deductible is met | 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 |
| • Outpatient/Office | Individual Therapy: \$20 Copay after Deductible is met Group Therapy: \$5 Copay after Deductible is met | 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 after Deductible is met | Not covered |

 = If this Plan is primary, benefits with this symbol require precertification. Call HealthCare Strategies at 1.855.279.1545. 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 (Stanislaus County Partners in Health Network) | Out-of-Network Benefits |
|-----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
| • Outpatient | 100% of Allowed Charges after Deductible  Please refer to the Cost Management Section for procedures that require precertification. | Not covered |
| Therapeutic Injections | \$10 Copay after Deductible is met | Not covered |
| TMJ | | |
| • Inpatient Surgery | \$200 Copay after Deductible is met | Not covered |
| • Office Visit | \$20 Copay after Deductible is met | Not covered |
| • Outpatient Surgery | \$100 Copay after Deductible is met | Not covered |
| |  Benefits are not available for services that are dental in nature. | |
| Transplants | | |
| • 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 | \$100 Copay after Deductible is met | |
| • 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.  | |
| Urgent Care Facility | \$20 Copay after Deductible is met | 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 |
| Voluntary or Elective Abortion | | |
| • Inpatient Hospital | \$200 Copay after Deductible is met | Not covered |
| • Inpatient Surgery | 100% of Allowed Charges after Deductible | Not covered |
| • Office Visit | \$20 Copay after Deductible is met | Not covered |
| • Outpatient Surgery | \$100 Copay after Deductible is met | 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 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.

| Covered Drugs and Supplies | Network Only | | | | |
|------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|-----------------------------|-----------------------------|---------------------------------|
| Prescription Drug Benefit (CVS Health) | <p><i>Note: You must pay applicable Deductible and Copayments. The Plan pays the balance of Allowable Fees.</i></p> <p>Subject to Deductible, then Copayments per retail and mail order prescription:</p> | | | | |
| | 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 *Only covered if determined to be medically necessary through clinical review. | \$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) | | | | |

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 Soehn
Stanislaus County

Date 2/4/2016