

Benefit Summary
San Juan County Employees HSA



Effective Date 1/1/2012 **Health Plan Options** **Ref** RQ-51164

This is a brief summary of benefits. THIS IS NOT A CONTRACT OR CERTIFICATE OF COVERAGE. All benefit descriptions, including alternative care, are for medically necessary services. The Member will be charged the lesser of the cost share for the covered service or the actual charge for that service. For full coverage provisions, including limitations, please refer to your certificate of coverage.

In accordance with the Patient Protection and Affordable Care Act of 2010,

- The lifetime maximum on the dollar value of covered essential health benefits no longer applies. Members whose coverage ended by reason of reaching a lifetime limit under this plan are eligible to enroll in this plan, and
- Dependent children who are under the age of twenty-six (26) are eligible to enroll in this plan.

Benefits	Inside Network	Outside Network
Plan deductible	Individual deductible: \$1,500 per calendar year Family deductible: \$3,000 per calendar year	Shared with in-network
Individual deductible carryover	4th quarter carryover does not apply	4th quarter carryover does not apply
Plan coinsurance	Plan pays 90%, you pay 10%	Plan pays 80%, you pay 20% of the Usual, Customary and Reasonable (UCR) charges.
Out-of-pocket limit	Individual out-of-pocket limit: \$5,100 Family out-of-pocket limit: \$10,200 Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: All cost shares for covered services	Out-of-pocket limit is shared with in-network Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: All cost shares for covered services
Pre-existing condition (PEC) waiting period	No PEC	Same as in-network
Lifetime maximum	Unlimited	Same as in-network maximum
Outpatient services (Office visits)	\$15 copay, deductible and coinsurance apply	\$15 copay, deductible and coinsurance apply
Hospital services	Inpatient services: Deductible and coinsurance apply Outpatient surgery: \$15 copay, deductible and coinsurance apply	Inpatient services: Deductible and coinsurance apply Outpatient surgery: \$15 copay, deductible and coinsurance apply
Prescription drugs (some injectable drugs may be covered under Outpatient services)	Formulary generic/formulary brand \$15/\$30 copay per 30 day supply, deductible applies	Formulary generic/formulary brand \$30/\$60 copay per 30 day supply, deductible applies
Prescription mail order	3 x prescription cost share per 90 day supply	Not covered
Acupuncture	Covered up to 8 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by the plan \$15 copay, deductible and coinsurance apply	\$15 copay, deductible and coinsurance apply
Ambulance services	Deductible and coinsurance	Deductible and coinsurance apply
Chemical dependency	Inpatient: Deductible and coinsurance apply Outpatient: \$15 copay, deductible and coinsurance apply	Inpatient: Deductible and coinsurance apply Outpatient: \$15 copay, deductible and coinsurance apply
Devices, equipment and supplies		
<ul style="list-style-type: none"> • Durable medical equipment • Orthopedic appliances • Post-mastectomy bras limited to two (2) every six (6) months 	Covered at 50%, deductible applies	Covered at 50%, deductible applies,
<ul style="list-style-type: none"> • Ostomy supplies • Prosthetic devices 	Covered at 50%, deductible applies	Covered at 50%, deductible applies,

Diabetic supplies	Insulin, needles, syringes and lancets-see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies-see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits.	Insulin, needles, syringes and lancets-see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies-see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits.
Diagnostic lab and X-ray services	Inpatient: Covered under Hospital services Outpatient: Deductible and coinsurance apply High end radiology imaging services such as CT, MR and PET must be determined Medically Necessary and require prior authorization except when associated with Emergency care or inpatient services.	Inpatient: Covered under Hospital services Outpatient: Deductible and coinsurance apply High end radiology imaging services such as CT, MR and PET must be determined Medically Necessary and require prior authorization except when associated with Emergency care or inpatient services.
Emergency services (copay waived if admitted)	\$0 copay Deductible and coinsurance apply	\$0 copay In-network deductible and coinsurance apply
Hearing exams (routine)	\$15 copay, deductible and coinsurance apply	\$15 copay, deductible and coinsurance apply
Hearing hardware	Not covered	Not covered
Home health services	No visit limit, deductible and coinsurance apply	No visit limit Deductible and coinsurance apply
Hospice services	Deductible and coinsurance apply	Deductible and coinsurance apply
Infertility services	Not covered	Not covered
Manipulative therapy	Unlimited visits without prior authorization \$15 copay, deductible and coinsurance apply	Unlimited visits \$15 copay, deductible and coinsurance apply
Massage services	See Rehabilitation services	See Rehabilitation services
Maternity services	Inpatient: Deductible and coinsurance apply Outpatient: \$15 copay, deductible and coinsurance apply. Routine care not subject to outpatient services copay.	Inpatient: Deductible and coinsurance apply Outpatient: \$15 copay; deductible and coinsurance apply. Routine care not subject to outpatient services copay.
Mental Health	Inpatient: Deductible and coinsurance apply Outpatient: \$15 copay, deductible and coinsurance apply	Inpatient: Deductible and coinsurance apply Outpatient: \$15 copay, deductible and coinsurance apply
Naturopathy	Covered up to 3 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by plan \$15 copay, deductible and coinsurance apply	\$15 copay, deductible and coinsurance apply
Newborn Services	Initial hospital stay: See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care. Any applicable cost share for newborn services is separate from that of the mother.	Initial hospital stay: See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care. Any applicable cost share for newborn services is separate from that of the mother.
Obesity-related surgery (bariatric)	Not covered	Not covered
Organ transplants Donor search & harvest applies to lifetime max	Unlimited, no waiting period Inpatient: Deductible and coinsurance apply Outpatient: \$15 copay, deductible and coinsurance apply	Shared with in-network Inpatient: Deductible and coinsurance apply Outpatient: \$15 copay, deductible and coinsurance apply
Preventive care Well-care physicals, immunizations, Pap smear exams, mammograms	Covered in full	\$300 per person; \$600 per family per calendar year Coinsurance applies Routine mammograms: Deductible and coinsurance apply
Rehabilitation services (Occupational, speech, physical including services for neurodevelopmentally disabled children age six and under) Rehabilitation visits are a total of combined therapy visits per calendar year	Inpatient: 60 days per calendar year Deductible and coinsurance apply Outpatient: 60 visits per calendar year \$15 copay, deductible and coinsurance apply	Inpatient: Day limits shared with in-network Deductible and coinsurance apply Outpatient: Visit limits shared with in-network \$15 copay, deductible and coinsurance apply
Skilled nursing facility	Up to 60 days per calendar year, deductible and coinsurance apply	Day limits shared with in-network benefit, deductible and coinsurance apply
Sterilization (vasectomy, tubal ligation)	Inpatient: Deductible and coinsurance apply Outpatient: \$15 copay, deductible and coinsurance apply	Inpatient: Deductible and coinsurance apply Outpatient: \$15 copay, deductible and coinsurance apply
Temporomandibular Joint (TMJ) services	\$1,000 per calendar year; \$5,000 lifetime max Inpatient: Deductible and coinsurance apply Outpatient: \$15 copay, deductible and coinsurance apply	Shared with in-network Inpatient: Deductible and coinsurance apply Outpatient: \$15 copay, deductible and coinsurance apply
Tobacco cessation counseling	Quit for Life Program - covered in full	Applicable cost shares apply

Routine vision care (1 visit every 12 months)	\$15 copay, deductible and coinsurance apply	Not covered
Optical hardware Lenses, including contact lenses and frames	Not covered	Not covered

Coverage provided by Group Health Options, Inc.

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