County of Mendocino - Plan Comparison	Retiree Plan		Active Plan II		Premier 1000		Premier 1500		Premier 5000	
	In-Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits
General Plan Information										
Annual Deductible/Individual	$100	$100	$500	$500	$1,000	$1,000	$1,500	$1,500	$5,000	$5,000
Annual Deductible/Family	$200	$200	$1,500	$1,500	$2,000	$2,000	$3,000	$3,000	$10,000	$10,000
Coinsurance	80%	60%	80%	60%	75%	50%	75%	50%	75%	50%
Office Visit/Exam	80%	60%	80%	60%	$30 copay	50%	$30 copay	50%	$30 copay	50%
Outpatient Specialist Visit	80%	60%	80%	60%	$50 copay	50%	$50 copay	50%	$50 copay	50%
Annual Out-of-Pocket Limit/Individual	$1,100	$3,100	$4,000	$4,000	$4,500*	$7,500*	$4,500*	$7,500*	$4,500*	$7,500*
Annual Out-of-Pocket Limit/Family	$2,200	$6,200	$8,000	$8,000	$9,000*	$15,000*	$9,000*	$15,000*	$9,000*	$15,000*
Deductible Included in Out-of-Pocket Limits	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Lifetime Plan Maximum	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$7,000,000	$7,000,000	$7,000,000	$7,000,000	$7,000,000	$7,000,000
Outpatient Services										
Preventive Services										
Well-Child Care	80%	60%	100%	60%	$30 copay**	50%	$30 copay**	50%	$30 copay**	50%
Immunizations	80%	60%	100%	60%	$30 copay**	50%	$30 copay**	50%	$30 copay**	50%
Well Woman Exams	80%	60%	100%	60%	$30 copay**	50%	$30 copay**	50%	$30 copay**	50%
Mammograms	80%	60%	100%	60%	$30 copay**	50%	$30 copay**	50%	$30 copay**	50%
Adult Periodic Exams with Preventive Tests	80%	60%	100%	60%	$30 copay**	50%	$30 copay**	50%	$30 copay**	50%
Diagnostic X-Ray and Lab Tests for routine exam	80%	60%	80%	60%	75%	50%	75%	50%	75%	50%
Diagnostic X-Ray and Lab Tests	80%	60%	80%	60%	75%	50%	75%	50%	75%	50%
Maternity Care										
Pregnancy and Maternity Care (Pre-Natal Care)	80%	60%	80%	60%	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Inpatient Hospital Services										
Inpatient Hospitalization	80%	60%	80%	60%	75%	50%	75%	50%	75%	50%
Pre-Authorization of Services Required	Yes, $200 deductible for non-precertification	Yes, $200 deductible for non-precertification	Yes, $200 deductible for non-precertification	Yes, $200 deductible for non-precertification	Yes	Yes	Yes	Yes	Yes	Yes
Semi-Private Room & Board; Incl. Services/Supplies	80%	60%	80%	60%	75%	50%	75%	50%	75%	50%
Surgical Services - Outpatient Facility Charge	80%	60%	80%	60%	75%	50%	75%	50%	75%	50%
Emergency Services - Emergency Room	$50 copay, then 80%	$50 copay, then 60%	$50 copay, then 80%	$50 copay, then 60%	75%	75%	75%	75%	75%	75%
Copay/Deductible Waived if Admitted	No	No	Yes	Yes	No	No	No	No	No	No
Urgent Care - Urgent Care Facility	80%	60%	80%	60%	75%	50%	75%	50%	75%	50%
Mental Health Benefits										
Inpatient Care	80% $175/day max	60% $175/day max	80%	60%	75%	50%	75%	50%	75%	50%
Outpatient Care	80% 25 visit max	60% 25 visit max	80%	60%	75%	50%	75%	50%	75%	50%
Alcohol & Substance Abuse										
Inpatient Hospitalization	80%	60%	80% coinsurance, $16,000 combined per calendar year		75%	50%	75%	50%	75%	50%
Inpatient Detoxification Services					75%	50%	75%	50%	75%	50%
Outpatient Services					75%	50%	75%	50%	75%	50%
Prescription Drug Benefits										
Generic	20%	20%	$10 or 10% copay	$10 or 10% copay	$15 copay	Not covered	$15 copay	Not covered	$15 copay	Not covered
Brand (Formulary/Preferred)	20%	20%	$20 or 20% copay	$20 or 20% copay	$40 copay***	Not covered	$40 copay***	Not covered	$40 copay***	Not covered
Brand (Non-Formulary/Non-preferred)			$30 or 30% copay	$30 or 30% copay	$60 copay***	Not covered	$60 copay***	Not covered	$60 copay***	Not covered
Number of Days Supply	30 days	30 days	30 days	30 days	30 days	N/A	30 days	N/A	30 days	N/A
Mail Order										
Generic	20%	20%	$20 copay	$20 copay	$30 copay	Not covered	$30 copay	Not covered	$30 copay	Not covered
Brand (Formulary/Preferred)	20%	20%	$40 copay	$40 copay	$80 copay***	Not covered	$80 copay***	Not covered	$80 copay***	Not covered
Brand (Non-Formulary/Non-preferred)			$60 copay	$60 copay	$120 copay***	Not covered	$120 copay***	Not covered	$120 copay***	Not covered
Number of Days Supply for Mail Order	90 days	90 days	90 days	90 days	90 days	N/A	90 days	N/A	90 days	N/A
Other Services and Supplies										
Durable Medical Equipment & Prosthetic Devices	80%	60%	80%	60%	75%	50%	75%	50%	75%	50%
Home Health Care	80%	60%	80%	60%	75%	50%	75%	50%	75%	50%
Skilled Nursing or Extended Care Facility	80%	60%	80%	60%	75%	50%	75%	50%	75%	50%
Hospice Care	100% $3000 Lifetime Max	100% $3000 Lifetime Max	80%	60%	75%	50%	75%	50%	75%	50%
Chiropractic Services	80% $2000 Calendar Year Max	60% $2000 Calendar Year Max	80%	60%	75%	50%	75%	50%	75%	50%
Acupuncture	80% $250 Calendar Year Max	60% $250 Calendar Year Max	80%	60%	75%	50%	75%	50%	75%	50%
Outpatient Rehabilitative Therapy Services										
Physical	80% $2500 Calendar Year Max	60% $2500 Calendar Year Max	80%	60%	75%	50%	75%	50%	75%	50%
Occupational	80%	60%	80%	60%	75%	50%	75%	50%	75%	50%
Speech	80% $2500 Calendar Year Max	60% $2500 Calendar Year Max	80%	60%	75%	50%	75%	50%	75%	50%

* - In addition to deductible

** - For members covered more than 6 months, deductible is waived. Otherwise $25 or $75 copay and deductible waived for basic or premium screening (for ages 7 and older)

*** - $500 annual prescription drug deductible per member applies before copay amount listed