County of Mendocino - Plan Comparison	Retiree Plan		Active Plan II		HSA1250/90/70		HSA2500/100/70		HSA3000/80/60		HSA1250/80/60	
	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	In-Network Benefits	Out-of-Network Benefits
General Plan Information												
Annual Deductible/Individual	$100	$100	$500	$500	$1,250	$1,250	$2,500	$2,500	$3,000	$3,000	$1,250	$1,250
Annual Deductible/Family	$200	$200	$1,500	$1,500	$2,500	$2,500	$5,000	$5,000	$6,000	$6,000	$2,500	$2,500
Coinsurance	80%	60%	80%	60%	90%	70%	100%	70%	80%	60%	80%	60%
Office Visit/Exam	80%	60%	80%	60%	90%	70%	100%	70%	80%	60%	80%	60%
Outpatient Specialist Visit	80%	60%	80%	60%	90%	70%	100%	70%	80%	60%	80%	60%
Annual Out-of-Pocket Limit/Individual	$1,100	$3,100	$4,000	$4,000	$2,500	$5,000	$3,500	$5,000	$5,000	$10,000	$2,500	$5,000
Annual Out-of-Pocket Limit/Family	$2,200	$6,200	$8,000	$8,000	$5,000	$10,000	$7,000	$10,000	$10,000	$20,000	$5,000	$10,000
Deductible Included in Out-of-Pocket Limits	Yes	Yes	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	$5,000,000	$5,000,000	$5,000,000	$5,000,000	$5,000,000	$5,000,000	$5,000,000	$5,000,000
Outpatient Services												
Preventive Services												
Well-Child Care	80%	60%	100%	60%	100%	70%	100%	70%	100%	60%	100%	60%
Immunizations	80%	60%	100%	60%	100%	70%	100%	70%	100%	60%	100%	60%
Well Woman Exams	80%	60%	100%	60%	100%	70%	100%	70%	100%	60%	100%	60%
Mammograms	80%	60%	100%	60%	100%	70%	100%	70%	100%	60%	100%	60%
Adult Periodic Exams with Preventive Tests	80%	60%	100%	60%	100%	70%	100%	70%	100%	60%	100%	60%
Diagnostic X-Ray and Lab Tests for routine exam	80%	60%	80%	60%	100%	70%	100%	70%	100%	60%	100%	60%
Diagnostic X-Ray and Lab Tests	80%	60%	80%	60%	90%	70%	100%	70%	80%	60%	80%	60%
Maternity Care												
Pregnancy and Maternity Care (Pre-Natal Care)	80%	60%	80%	60%	90%	70%	100%	70%	80%	60%	80%	60%
Inpatient Hospital Services												
Inpatient Hospitalization	80%	60%	80%	60%	90%	70%	100%	70%	80%	60%	80%	60%
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	90%	70%	100%	70%	80%	60%	80%	60%
Semi-Private Room & Board; Incl. Services/Supplies	80%	60%	80%	60%	90%	70%	100%	70%	80%	60%	80%	60%
Surgical Services - Outpatient Facility Charge	80%	60%	80%	60%	90%	70%	100%	70%	80%	60%	80%	60%
Emergency Services - Emergency Room	$50 copay, then 80%	$50 copay, then 60%	$50 copay, then 80%	$50 copay, then 60%	90%	70%	100%	70%	80%	60%	80%	60%
Copay/Deductible Waived if Admitted	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Urgent Care - Urgent Care Facility	80%	60%	80%	60%	90%	70%	100%	70%	80%	60%	80%	60%
Mental Health Benefits									80%	60%		
Inpatient Care	80% $175/day max	60% $175/day max	80%	60%	90%	70%	100%	70%	80%	60%	80%	60%
Outpatient Care	80% 25 visit max	60% 25 visit max	80%	60%	90%	70%	100%	70%	80%	60%	80%	60%
Alcohol & Substance Abuse									80%	60%		
Inpatient Hospitalization			80% coinsurance, $16,000 combined per calendar year		90%	70%	100%	70%	80%	60%	80%	60%
Inpatient Detoxification Services	80%	60%			90%	70%	100%	70%	80%	60%	80%	60%
Outpatient Services					90%	70%	100%	70%	80%	60%	80%	60%
Prescription Drug Benefits												
Generic	20%	20%	$10 or 10% copay	$10 or 10% copay	$10 copay	$10 copay	$10 copay	$10 copay	$10 copay	$10 copay	$10 copay	$10 copay
Brand (Formulary/Preferred)	20%	20%	$20 or 20% copay	$20 or 20% copay	$30 copay	$30 copay	$30 copay	$30 copay	$30 copay	$30 copay	$30 copay	$30 copay
Brand (Non-Formulary/Non-preferred)			$30 or 30% copay	$30 or 30% copay	$50 copay	$50 copay	$50 copay	$50 copay	$50 copay	$50 copay	$50 copay	$50 copay
Number of Days Supply	30 days	30 days	30 days	30 days	30 days	30 days	30 days	30 days	30 days	30 days	30 days	30 days
Mail Order												
Generic	20%	20%	$20 copay	$20 copay	$10 copay	$10 copay	$10 copay	$10 copay	$10 copay	$10 copay	$10 copay	$10 copay
Brand (Formulary/Preferred)	20%	20%	$40 copay	$40 copay	$60 copay	$60 copay	$60 copay	$60 copay	$60 copay	$60 copay	$60 copay	$60 copay
Brand (Non-Formulary/Non-preferred)			$60 copay	$60 copay	$100 copay	$100 copay	$100 copay	$100 copay	$100 copay	$100 copay	$100 copay	$100 copay
Number of Days Supply for Mail Order	90 days	90 days	90 days	90 days	90 days	90 days	90 days	90 days	90 days	90 days	90 days	90 days
Other Services and Supplies												
Durable Medical Equipment & Prosthetic Devices	80%	60%	80%	60%	90%	70%	100%	70%	80%	60%	80%	60%
Home Health Care	80%	60%	80%	60%	90%	70%	100%	70%	80%	60%	80%	60%
Skilled Nursing or Extended Care Facility	80%	60%	80%	60%	90%	70%	100%	70%	80%	60%	80%	60%
Hospice Care	100% $3000 Lifetime Max	100% $3000 Lifetime Max	80%	60%	90%	70%	100%	70%	80%	60%	80%	60%
Chiropractic Services	80% $2000 Calendar Year Max	60% $2000 Calendar Year Max	80%	60%	90%	70%	100%	70%	80%	60%	80%	60%
Acupuncture	80% $250 Calendar Year Max	60% $250 Calendar Year Max	80%	60%	90%	70%	100%	70%	80%	60%	80%	60%
Outpatient Rehabilitative Therapy Services												
Physical	80% $2500 Calendar Year Max	60% $2500 Calendar Year Max	80%	60%	90%	70%	100%	70%	80%	60%	80%	60%
Occupational	80%	60%	80%	60%	90%	70%	100%	70%	80%	60%	80%	60%
Speech	80% $2500 Calendar Year Max	60% $2500 Calendar Year Max	80%	60%	90%	70%	100%	70%	80%	60%	80%	60%

Note: HSA plans require deductible be met prior to benefits being paid for prescription drugs and medical coverage (with the exception of outlined preventive services).