

COUNTY MEDICAL PLANS COMPARISON CHART

These benefit summaries only highlight your benefits. They are not Summary Plan Descriptions (SPDs). If any discrepancy exists between these benefit summaries and the official plan documents, the official plan documents will prevail.

	Exclusive Care EPO	Kaiser HMO	Blue Shield HMO	Blue Shield Preferred Care PPO	
	Network Only	Network Only	Network Only	In-Network	Out-of-Network²
Choice of physician	Any Exclusive Care network physician	Any Kaiser physician and/or facility	Any BSC HMO network physician	Any BSC PPO network physician	Any licensed physician and/or facility
Deductible	None	None	None	Individual: \$500 combined; Individual +1: \$1,000; Family: \$1,000 combined in- and out-of-network	
Calendar year out-of-pocket maximum	\$3,000/person	\$1,500/person \$3,000/family	\$800/person \$1,600/2-party \$2,400/family	\$3,000/person \$6,000/family	
Lifetime maximum	\$1,000,000/person	None	None	\$6,000,000/person	
Pre-existing condition limitation	Fully covered	Fully covered	Fully covered	Not covered for 6 months unless you provide proof of previous coverage	
Office Visit Benefits					
Diagnostic X-ray & lab	100%	100%	100%	80% after deductible	60% after deductible
Physician hospital visits	100% after \$5 copay at physician clinics	\$15 copay per admission	\$15 copay per admission	\$20 copay/visit	60% after deductible
Immunizations	100% after \$5 copay for office visit	100%	100% after \$15 copay	No charge	60% after deductible ⁴
Maternity care	100% after \$5 copay	100% after \$15 copay	No charge	80% after deductible	60% after deductible ⁴
Periodic health evaluations/physicals	100% after \$5 copay	100% after \$15 copay	100% after \$15 copay for referred visits	\$20 copay/visit ³	60% after deductible ⁴
Physician office visits	100% after \$5 copay	100% after \$15 copay	100% after \$15 copay; 100% after \$30 copay for self-referred visits	\$20 copay/visit ³	60% after deductible ⁴
Vision exams	Not covered	100% after \$15 copay	100% after \$15 copay	\$20 copay/visit ³	60% after deductible ⁴
Well baby care	100% after \$5 copay	100% after \$15 copay	100% after \$15 copay	\$20 copay/visit ³	60% after deductible ⁴
Well woman care	100% after \$5 copay	100% after \$15 copay	100% after \$15 copay	\$20 copay/visit ³	60% after deductible ⁴

^{1, 2, 3, 4, 5, 6} Refer to the box below for footnote references.



PLEASE USE THE FOLLOWING REFERENCES WITH COUNTY MEDICAL PLANS COMPARISON CHART

1. Severe mental health conditions are covered the same as any other illness. Benefits for physician visits or hospital care include the diagnosis and medically necessary treatment of the following conditions: anorexia nervosa, bipolar disorder, bulimia nervosa, major depressive disorder, obsessive-compulsive disorder, panic disorder, pervasive developmental disorder or autism, schizoaffective disorder, schizophrenia.
2. You will pay any amount charged by an out-of-network provider that is in excess of the Blue Shield's allowable amount.
3. Benefits are not subject to deductible.
4. Deductibles and copayments do not accrue to out-of-pocket maximum.
5. Outpatient mental health and substance abuse visits accrue to a combined 30-visit maximum per calendar year.
6. Outpatient treatment for severe and non-severe mental health conditions is limited to a combined in-network and out-of-network benefit maximum of 20 visits per calendar year.

Please refer to the individual medical plan booklets for detailed lists of covered expenses, and exclusions and limitations. Medical plan booklets are available from your Department Representative, at a Benefits Fair or by contacting the Benefits Information Line at (951) 955-4981.

COUNTY MEDICAL PLANS COMPARISON CHART (CONTINUED)					
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	Exclusive Care EPO	Kaiser HMO	Blue Shield HMO	Blue Shield Preferred Care PPO	
	Network Only	Network Only	Network Only	In-Network	Out-of-Network ²
Prescription Drugs					
Network retail pharmacies (30- to 34-day supply)	Generic: \$5 copay Preferred brand: \$15 copay Nonpreferred brand: \$25 copay	Generic: \$10 copay (up to 100-day supply) Brand formulary: \$25 copay (up to 100-day supply)	Generic: \$10 copay Preferred brand: \$25 copay Nonpreferred brand: \$50 copay	Generic: \$5 copay Preferred brand: \$15 copay Nonpreferred brand: \$30 copay	Generic: \$5 copay Preferred brand: \$15 copay Nonpreferred brand: \$30 copay
Network mail order (90-day supply)	Generic: \$10 copay Preferred brand: \$30 copay Nonpreferred brand: \$50 copay	Generic: \$10 copay (up to 100-day supply) Brand formulary: \$25 copay (up to 100-day supply)	Generic: \$20 copay Preferred brand: \$50 copay Nonpreferred brand: \$100 copay	Generic: \$10 copay Preferred brand: \$30 copay Nonpreferred brand: \$60 copay	Generic: \$10 copay Preferred brand: \$30 copay Nonpreferred brand: \$60 copay
Hospital and Emergency Room Benefits					
Ambulance (medically necessary)	100%	100%	100%	80% after deductible	80% after deductible
Ambulatory surgical center	100%	100% after \$15 copay	100%	80% after deductible	60% after deductible ⁴
Physician hospital visits	100% after \$5 copay	100% after \$100 copay per admit	100%	\$20 copay/visit	60% after deductible ⁴
Inpatient hospital	100% at network facility; \$250 per day for emergency services at non-network facility	\$100 copay per admit	\$100 copay per admit	80% after deductible	60% after deductible ⁴
Outpatient hospital	100%	100%; \$15 copay/procedure for outpatient surgery	100%	80% after deductible	60% after deductible up to \$600/day ⁴
Hospital emergency room	100% after \$50 copay at network facility; 100% after \$250 copay at non-network facility (waived if admitted)	100% after \$50 copay; waived if admitted	100% after \$50 copay; waived if admitted	\$50 copay/visit ^{3,4}	
Urgent care	100% after \$20 copay at network facility; 100% after \$50 copay at non-network facility	100% after \$15 copay	100% after \$35 copay; waived if admitted	80% after deductible	60% after deductible ⁴
Severe Mental Health Treatment					
Inpatient benefit	100%; unlimited admissions	\$100 per admit; unlimited visits	\$100 per admit; unlimited visits	80% after deductible	60% after deductible ⁴
Outpatient benefit	\$10 copay/visit for visits 1-10; \$25 copay for visits 11-30	\$15 copay; private visit; \$5 copay/group visit (unlimited visits)	100% after \$15 copay ⁵	\$20 copay/visit ^{3,6}	60% after deductible ^{4,6}
Non-Severe Mental Health Treatment					
Inpatient benefit	100%; unlimited admissions	\$100 copay per admit; up to 30 days/cal. year	Not covered	Not covered	Not covered
Outpatient private	\$10 copay/visit for visits 1-10; \$25 copay for visits 11-30	\$15 copay (unlimited visits)	100% after \$15 copay ⁵	80% after deductible ^{4,6}	60% after deductible ^{4,6}
Outpatient group		\$7 copay (unlimited visits)	100% after \$15 copay (counts as 1/2 private visit toward the combined 30 visit max) ⁵		

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COUNTY MEDICAL PLANS COMPARISON CHART (CONTINUED)					
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	Exclusive Care EPO	Kaiser HMO	Blue Shield HMO	Blue Shield Preferred Care PPO	
	Network Only	Network Only	Network Only	In-Network	Out-of-Network ²
Substance Abuse					
Inpatient program	100%; up to 90 days/lifetime max.	Residential program: \$100 copay; up to 30 days/cal. year; transitional residential recovery centers: \$100 copay; up to 60 days/cal. year or 120 in 5-year period	\$100 per admission; up to 30 days/cal. year	Not covered	Not covered
Inpatient detoxification	100% as medically necessary for 3-5 days; limit one episode/lifetime	\$100 copay per day, as medically necessary (detox. only)	\$100 copay	80% after deductible	60% after deductible ⁴
Outpatient hospital services	\$5 copay for visits 1-10; \$15 copay for visits 11-30		100% after \$15 copay; 100% after \$30 copay for self-referred visits ⁵	Not covered	Not covered
Outpatient office visit	\$5 copay for visits 1-10; \$15 copay for visits 11-30	\$15 copay/private; \$5 copay/group visit; unlimited visits	\$15 copay; up to 30 visits/cal. year ⁵	80% after deductible; 24 visits per calendar year combined in- and out-of-network ⁴	60% after deductible; 24 visits per calendar year combined in- and out-of-network ⁴
Other Benefits					
Allergy testing & treatment	100% after \$5 copay	100% after \$15 copay; \$3/injection	100% after \$15 copay	\$20 copay/visit	60% after deductible
Chiropractic	100% after \$5 copay; up to 20 visits/cal. year	100% after \$15 copay/visit; up to 20 visits/cal. year	100% after \$15 copay/visit; up to 20 visits/cal. year	80% after deductible; 12 visits per calendar year combined in- and out-of-network	60% after deductible; 12 visits per calendar year combined in- and out-of-network
Durable medical equipment	100%	100%	100%	80% after deductible; up to combined max of \$3,000/cal. year	60% after deductible; up to combined max of \$3,000/cal. year
Family planning - Elective pregnancy termination	100% after \$50 copay for 1st trimester; \$100 for 2nd trimester; 3rd trimester not covered unless life threatening	100% after \$15 copay	\$100/elective abortion, tubal ligation; \$75/vasectomy	Elective abortion, tubal ligation, vasectomy = 80% after deductible	Not covered
- Infertility services	50% copay of \$10,000 lifetime max	50% of costs	Infertility – 50% of allowed charges	Infertility services not covered	
- Tubal ligation	100%	100% after \$15 copay			
- Vasectomy	100%	100% after \$15 copay			
Home health care	100%	100%	100% after \$15 copay	80% after deductible	60% after deductible
Hospice – routine home and inpatient respite care	100%	100%	100%	No charge	No charge with prior authorization
Hospice – 24 hour continuous home care and general inpatient care	100%	100%	100%	80% after deductible	80% after deductible with prior authorization
Physical therapy	100% up to 30 visits/disability (within 90 day period)	100% after \$15 copay	100% after \$15 copay	\$20 copay/visit ³	60% after deductible
Skilled nursing facility	100%; up to 100 days/disability	100% up to 100 days per cal. year	\$100 copay; up to 100 days/cal. year	80% after deductible	60% after deductible ⁴

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