

<b>COUNTY MEDICAL PLANS COMPARISON CHART</b>			
<b>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.</b>			
	<b>Exclusive Care EPO</b>	<b>Kaiser HMO</b>	<b>Blue Shield Access+ HMO</b>
	<b>Network Only</b>	<b>Network Only</b>	<b>Network Only</b>
Choice of physician	Any Exclusive Care network physician	Any Kaiser physician and/or facility	Any Blue Shield HMO network physician
Deductible	None	None	None
Calendar year out-of-pocket maximum	\$3,000/person	\$1,500/person \$3,000/family	\$1,500/person \$3,000/family
Lifetime maximum	\$1,000,000/person	None	None
Pre-existing condition limitation	Fully covered	Fully covered	Fully covered
<b>Office Visit Benefits</b>			
Diagnostic X-ray & lab	100%	100%	100%
Physician hospital visits	100% after \$5 copay at physician clinics	\$15 copay per admission	\$15 copay per admission
Immunizations	100% after \$5 copay for office visit	100%	100% after \$15 copay
Maternity care	100% after \$5 copay	100% after \$15 copay	100%
Periodic health evaluations/physicals	100% after \$5 copay	100% after \$15 copay	100%
Physician office visits	100% after \$5 copay	100% after \$15 copay	100% after \$15 copay; 100% after \$30 copay for self-referred specialist visits
Vision exams	Not covered	100% after \$15 copay	100% after \$15 copay; covered in full up to age 18
Well-baby care	100% after \$5 copay	100% after \$15 copay	100% after \$15 copay
Well-woman care	100% after \$5 copay	100% after \$15 copay	100% after \$15 copay



**PLEASE USE THE FOLLOWING REFERENCES WITH THE EXCLUSIVE CARE SELECT PLAN CHART ON PAGE 17**

1. You will pay any amount charged by an out-of-network provider that is in excess of Blue Shield's allowable amount.
2. Benefits are not subject to deductible.
3. Deductibles and copayments do not count toward out-of-pocket maximum.
4. The plan uses Centers of Excellence for certain procedures, such as specialty surgery and transplants, and for orthopedic, cardiac, and oncology treatment. Centers of Excellence are designated by the plan and are characterized by exemplary results in the area of specialty.

**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 Access+ HMO
	Network Only	Network Only	Network Only
<b>Prescription Drugs</b>			
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
Network mail order (90-day supply)	Generic: \$10 copay Preferred brand: \$30 copay Nonpreferred brand: \$50 copay / <b>Mail-order is MANDATORY for maintenance medications after a 30-day trial</b>	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
<b>Hospital and Emergency Room Benefits</b>			
Ambulance (medically necessary)	100%	100%	100%
Ambulatory surgical center	100%	100% after \$15 copay	100%
Physician hospital visits	100% after \$5 copay	100% after \$100 copay per admission	100%
Inpatient hospital	100% at network facility; \$250 per day for emergency services at non-network facility	\$100 copay per admission	\$100 copay per admission
Outpatient hospital	100%	100%; \$15 copay/procedure for outpatient surgery	100%
Emergency room services	100% after \$100 copay at network facility; 100% after \$250 copay at non-network facility (waived if admitted)	100% after \$50 copay; waived if admitted	100% after \$100 copay; waived if admitted
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
<b>Mental Health Treatment</b>			
Inpatient Benefit	100%; unlimited admissions	100%; unlimited admissions	\$100 copay per admission (unlimited admissions)
Outpatient Benefit	\$5 copay/visit (unlimited visits)	\$15 copay/private visit; \$7 copay/group visit (unlimited visits)	\$15 copay/visit (unlimited visits)
<b>Substance Abuse Treatment</b>			
Inpatient Detoxification	100%; unlimited admissions	\$100 copay per day, as medically necessary (detox only)	\$100 copay per admission (unlimited admissions)
Outpatient Detoxification	\$5 copay/visit (unlimited visits)	\$15 copay/private visit; \$7 copay/group visit (unlimited visits)	\$15 copay/visit (unlimited visits)

**COUNTY MEDICAL PLANS COMPARISON CHART (CONTINUED)**

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	Exclusive Care EPO	Kaiser HMO	Blue Shield Access+ HMO
	Network Only	Network Only	Network Only
<b>Other Benefits</b>			
Allergy testing & treatment	100% after \$5 copay	100% after \$15 copay; \$3/injection	100% after \$15 copay
Chiropractic	100% after \$5 copay; up to 12 visits/calendar year	100% after \$15 copay/visit; up to 20 visits/calendar year	Not covered (discounts of 25% or more available through Blue Shield's Alternative Care Discounts program)
Durable medical equipment	50%, up to a maximum benefit of \$2,000/calendar year	100%	50%, up to a maximum benefit of \$2,000/calendar 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 copay
- Infertility services	50% of costs, up to a lifetime maximum benefit of \$5,000	50% of costs	50% of allowed charges
- Tubal ligation	100%	100% after \$15 copay	\$100 copay
- Vasectomy	100%	100% after \$15 copay	\$75 copay
Home health care	100%	100%	100% after \$15 copay
Hospice – routine home and inpatient respite care	100%	100%	100%
Hospice – 24 hour continuous home care and general inpatient care	100%	100%	100%
Physical therapy	100% up to 30 visits/disability (within 90-day period)	100% after \$15 copay	100% after \$15 copay
Skilled nursing facility	100%; up to 100 days/disability	100% up to 100 days/calendar year	\$100 copay; up to 100 days/calendar year

**COUNTY MEDICAL PLANS COMPARISON CHART (CONTINUED)**

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 Select POS		
	Tier 1 Exclusive Care Network	Tier 2 National Network	Tier 3 Out-of-Network
Choice of Physician	Any Exclusive Care contracted provider	Any network provider	Any licensed provider
Calendar Year Deductible	\$250/person \$750/family	\$500/person \$1,500/family	\$1,000/person \$3,000/family
Calendar Year Out-of-Pocket Maximum	\$1,500/person \$4,500/family	\$2,500/person \$7,500/family	\$5,000/person \$15,000/family
Lifetime Maximum Benefit	\$1,000,000/person		
Pre-existing Condition Limitation	Fully covered	Fully covered	Fully covered
<b>Office Visit Benefits</b>			
Diagnostic X-ray & Lab	90% after deductible	80% after deductible	60% after deductible <sup>1</sup>
Immunizations	100% after \$10 copay <sup>2</sup>	100% after \$25 copay <sup>2</sup>	Not covered
Maternity Care	90% after deductible	80% after deductible	60% after deductible <sup>1</sup>
Periodic Health Evaluations/Physicals	100% after \$10 copay <sup>2</sup>	100% after \$25 copay <sup>2</sup>	Not covered
Physician Office Visits	Primary care physician: 100% after \$10 copay <sup>2</sup> . Specialist: 100% after \$20 copay <sup>2</sup>	Primary care physician: 100% after \$25 copay <sup>2</sup> . Specialist: 100% after \$50 copay <sup>2</sup>	60% after deductible <sup>1</sup>
Vision Exams	100% after \$10 copay <sup>2</sup>	100% after \$25 copay <sup>2</sup>	Not covered
Well Baby Care	100% after \$10 copay <sup>2</sup>	100% after \$25 copay <sup>2</sup>	Not covered
Well Woman Care	100% after \$10 copay <sup>2</sup>	100% after \$25 copay <sup>2</sup>	Not covered
<b>Prescription Drugs</b>			
Network Retail Pharmacies (30- to 34-day supply)	Generic drugs: 100% after \$15 copay / Preferred brand-name drugs: 100% after \$25 copay Nonpreferred drugs: 100% after \$40 copay / Significant or new therapeutic class drugs: 50%		
Network Mail Order (90-day supply)	Generic drugs: 100% after \$30 copay / Preferred brand-name drugs: 100% after \$50 copay Nonpreferred drugs: 100% after \$80 copay / <b>Mail-order is MANDATORY for maintenance medications after a 30-day trial</b>		
<b>Hospital and Emergency Room Service</b>			
Ambulance (medically necessary)	90% after deductible	80% after deductible	80% after deductible <sup>1</sup>
Ambulatory Surgical Center	90% after deductible <sup>4</sup>	80% after deductible <sup>4</sup>	60% after deductible <sup>4</sup>
Physician Hospital Visits	100% after \$10 copay <sup>2</sup>	100% after \$25 copay <sup>2</sup>	60% after deductible <sup>1</sup>
Inpatient Hospital	90% after deductible <sup>4</sup>	80% after deductible <sup>4</sup>	60% after deductible <sup>4</sup>
Outpatient Hospital	90% after deductible <sup>4</sup>	80% after deductible <sup>4</sup>	60% after deductible <sup>1,4</sup>
Hospital Emergency Room	90% after a \$50 copay <sup>2</sup>	80% after a \$100 copay <sup>2</sup>	80% after a \$100 copay <sup>2</sup>
Urgent Care	100% after \$20 copay/visit <sup>2</sup>	100% after \$50 copay/visit <sup>2</sup>	60% after deductible <sup>1,2</sup>
<b>Mental Health Treatment</b>			
Inpatient Benefit	90% after deductible <sup>3</sup>	80% after deductible <sup>3</sup>	60% after deductible <sup>1,3</sup>
Outpatient Benefit	100% after \$20 copay <sup>3</sup>		60% after deductible <sup>1,3</sup>
<b>Substance Abuse Treatment</b>			
Inpatient Program	90% after deductible <sup>3</sup>	80% after deductible <sup>3</sup>	60% after deductible <sup>1,3</sup>
Inpatient Detoxification	90% after deductible <sup>3</sup>	80% after deductible <sup>3</sup>	60% after deductible <sup>1,3</sup>
Outpatient Office Visits	100% after \$20 copay <sup>3</sup>		60% after deductible <sup>1,3</sup>
<b>Other Benefits</b>			
Allergy Testing & Treatment	90% after deductible	80% after deductible	Not covered
Chiropractic	Not covered	Not covered	Not covered
Durable Medical Equipment	90% after deductible, up to combined max of \$1,000/cal. year	80% after deductible, up to combined max of \$1,000/cal. year	60% after deductible, up to combined max of \$1,000/cal. year
Family Planning - Elective Pregnancy Termination - Infertility Services - Tubal Ligation - Vasectomy	90% after deductible Not covered 90% after deductible 90% after deductible	80% after deductible Not covered 80% after deductible 80% after deductible	Not covered
Home Health Care	90% after deductible, up to combined max of 26 days/cal. year	80% after deductible, up to combined max of 26 days/cal. year	60% after deductible, up to combined max of 26 days/cal. year
Hospice - Routine home and inpatient respite care	90% after deductible	80% after deductible	60% after deductible
Hospice - 24-hour continuous home care and general inpatient care	90% after deductible	80% after deductible	60% after deductible
Physical Therapy	90% after deductible; limited to 20 visits/cal. year	80% after deductible; limited to 20 visits/cal. year	60% after deductible; limited to 20 visits/cal. year
Skilled Nursing Facility	90% after deductible, up to combined max of 100 days/cal. year	80% after deductible, up to combined max of 100 days/cal. year	60% after deductible, up to combined max of 100 days/cal. year

<sup>1,2,3,4</sup> Refer to the box on page 14 for footnote references.