

MEDICAL PLANS FOR RETIREES AND DEPENDENTS WHO ARE MEDICARE-ELIGIBLE		
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 Medicare Coordination Plan	
	Tier 1: Exclusive Care Network	Tier 2: Any Provider Who Accepts Medicare Assignment
BENEFIT PROVISIONS		
Coordination with Medicare	Medicare will pay benefits first; the plan will then pay the benefits shown below when you go to a Tier 1 provider who accepts Medicare assignment	Medicare will pay benefits first; the plan will then pay the benefits shown below when you go to a provider who accepts Medicare assignment (based on Medicare reimbursement fees)
Choice of physician	Any Exclusive Care contracted provider	Any provider who accepts Medicare assignment
Deductible	\$250/person; \$750/family	\$500/person; \$1,500/family
Out-of-pocket maximum ³	\$1,500/person; \$4,500/family	\$2,500/person; \$7,500/family
Lifetime maximum benefit	Unlimited	
Pre-existing condition limitation	Fully covered (provided it is a covered benefit)	Fully covered (provided it is a covered benefit)
OFFICE VISIT BENEFITS		
Physician office visits	100% after \$10 copay ²	100% after \$25 copay ²
Diagnostic X-ray and lab	90% after deductible	80% after deductible
Immunizations	100% after \$10 copay ²	100% after \$25 copay ²
Maternity care	90% after deductible	80% after deductible
Periodic health evaluations/physicals	100% after \$10 copay ²	100% after \$25 copay ²
Vision exams	100% after \$10 copay ²	100% after \$25 copay ²
Well-baby care	100% after \$10 copay ²	100% after \$25 copay ²
Well-woman care	100% after \$10 copay ²	100% after \$25 copay ²
PRESCRIPTION DRUGS⁵		
Network retail pharmacies (30- to 34-day supply)	Generic drugs: 100% after \$15 copay; brand formulary: 100% after \$25 copay; brand nonformulary: 100% after \$40 copay; significant or new therapeutic class drugs: 50%	
Network mail order (90-day supply)	Generic drugs: 100% after \$30 copay; brand formulary: 100% after \$50 copay; brand nonformulary: 100% after \$80 copay; mail order is MANDATORY for maintenance medications after a 30-day trial	
HOSPITAL AND EMERGENCY ROOM SERVICES		
Ambulance (medically necessary)	90% after deductible	80% after deductible
Ambulatory surgical center	90% after deductible	80% after deductible
Physician hospital visits	100% after \$10 copay ²	100% after \$25 copay ²
Inpatient hospital care	90% after deductible ⁶	80% after deductible ⁶
Outpatient hospital care	90% after deductible	80% after deductible
Hospital emergency room	90% after a \$50 copay ²	80% after \$100 copay ²
Urgent care	100% after \$20 copay ²	100% after \$50 copay ²
MENTAL HEALTH TREATMENT		
Inpatient care	90% after deductible	80% after deductible
Outpatient care	\$20 copay ² , up to 30 visits per calendar year	Not covered
SUBSTANCE ABUSE TREATMENT		
Inpatient program	90% after deductible	80% after deductible
Inpatient detoxification	90% after deductible	80% after deductible
Outpatient hospital services	100% after \$20 copay/visit ² , up to 30 visits per calendar year	
Outpatient office visits	100% after \$20 copay/visit ² , up to 30 visits per calendar year	
OTHER BENEFITS		
Allergy testing and treatment	90% after deductible	80% after deductible
Chiropractic	Not covered	Not covered
Durable medical equipment	90% after deductible, up to combined max of \$1,000/calendar year	80% after deductible, up to combined max of \$1,000/calendar year
Family planning - Elective pregnancy termination - Infertility services - Tubal ligation - Vasectomy	90% after deductible Not covered 90% after deductible 90% after deductible	Not covered
Home health care	90% after deductible, up to combined max of 26 days/calendar year	80% after deductible, up to combined max of 26 days/calendar year
Hospice (routine home and inpatient respite care)	90% after deductible	80% after deductible
Hospice (24-hour continuous home care and general inpatient care)	90% after deductible	80% after deductible
Physical therapy	90% after deductible	80% after deductible
Skilled nursing facility	90% after deductible, up to combined max of 100 days/calendar year	80% after deductible, up to combined max of 100 days/calendar year

Refer to footnotes on page 27.

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	Health Net HMO Coordination of Benefits Plan	Health Net PPO Coordination of Benefits Plan		Health Net Flex Indemnity Medicare
	Network Only	PPO Network	Out-of-Network ¹	
BENEFIT PROVISIONS				
Coordination with Medicare	The plan pays all Medicare deductibles. Providers first submit claims to Medicare and then submit claims to the plan for the remainder of the Medicare allowed amount. The provider can charge you the office visit copayment. You must use providers in the Health Net HMO network who accept Medicare assignment.	The plan pays all Medicare deductibles. Providers first submit claims to Medicare and then submit claims to the plan for the remainder of the Medicare allowed amount. As long as you use providers in the Health Net PPO network who accept Medicare assignment, you will have no out-of-pocket costs for benefits covered by Medicare. If you use providers outside the Health Net PPO network, you may have out-of-pocket costs.		Medicare will pay benefits first. The plan will then pay the benefits shown below when you go to a provider who accepts Medicare assignment (based on Medicare reimbursement fees).
Choice of physician	All care must be coordinated by your PCP	Any PPO network provider	Any provider who accepts Medicare assignment	Any licensed physician who accepts Medicare
Deductible	None	\$500/person		None
Out-of-pocket maximum ³	\$1,500/person; \$3,000/family	\$1,000/family		None
Lifetime maximum benefit	Unlimited	Unlimited		Unlimited
Pre-existing condition limitation	Fully covered	6-month waiting period applies for adults		Fully covered
OFFICE VISIT BENEFITS				
Physician office visits	100% after \$15 copay	100% after \$20 copay ²	40% after deductible	Covered in full
Diagnostic X-ray and lab	100%	20% after deductible	40% after deductible	Covered in full
Immunizations	100%	100%	40% after deductible	Covered in full (immunizations for foreign travel or occupational purpose not covered)
Periodic health evaluations/physicals	100%	100%	40% after deductible	Covered in full
Vision exams (preventive)	100%	100% after \$20 copay ²	100% after deductible	Covered in full
Vision exams (refractive) - Children - Adults	100% 100%	100% after \$20 copay 100% after \$20 copay	Not covered 40% after deductible	Covered in full
Well-woman care	100%	100%	100% after deductible	Covered in full
PRESCRIPTION DRUGS⁵				
Network retail pharmacies (30- to 34-day supply)	Generic: 100% after \$10 copay Brand ⁶ formulary: 100% after \$25 copay. Brand ⁶ nonformulary: 100% after \$50 copay Injectables: \$50 copay ² Specialty drugs: \$50 copay ²	Generic: \$5 copay ² Preferred brand: \$15 copay ² Nonpreferred brand: \$45 copay ² Injectables: \$45 copay ² Specialty drugs: \$45 copay ²	Generic: \$5 copay Preferred brand: \$15 copay Nonpreferred brand: \$45 copay plus 50% of average wholesale price. Injectables: \$45 copay Specialty drugs: \$45 copay	Generic: \$5 copay ² Preferred brand: \$15 copay ² Nonpreferred brand: \$45 copay ² Injectables: \$45 copay ² Specialty drugs: \$45 copay ²
Network mail order (90-day supply)	Generic: 100% after \$20 copay Brand formulary: 100% after \$50 copay. Brand nonformulary: 100% after \$100 copay Injectables: \$100 copay ² Specialty drugs: \$100 copay ²	Generic: \$10 copay ² Preferred brand: \$25 copay ² Nonpreferred brand: \$75 copay ² Injectables: \$75 copay ² Specialty drugs: \$75 copay ²	Not covered	Generic: \$10 copay ² Preferred brand: \$25 copay ² Nonpreferred brand: \$75 copay ² Injectables: \$75 copay ² Specialty drugs: \$75 copay ²
HOSPITAL AND EMERGENCY ROOM SERVICES				
Ambulance (medically necessary)	100%	20% after deductible	40% after deductible	Covered in full
Physician hospital visits	100%	20% after deductible	40% after deductible	Covered in full
Inpatient hospital care	100% after \$100 copay per admission	20% after deductible	40% after deductible; benefits limited to \$600 per day	Days 1-60: Plan pays initial Part A annual Medicare deductible Days 61-90: Plan pays Medicare coinsurance Day 91 and after: While using 60 lifetime reserve days, plan pays Medicare coinsurance. After 60 Medicare lifetime reserve days are used, plan pays 90% of Medicare-eligible expenses for 365 lifetime additional days.
Outpatient surgery	100%	20% after deductible	40% after deductible	Covered in full
Hospital emergency room	100% after \$100 copay; waived if admitted	20% after deductible; a separate \$50 deductible applies if not admitted	40% after deductible; a separate \$50 deductible applies if not admitted	Covered in full
Urgent care	\$35 copay	20% after deductible; a separate \$20 deductible applies if not admitted	40% after deductible; a separate \$20 deductible applies if not admitted	Covered in full

Refer to footnotes on page 27.

COUNTY'S INTRANET SITE: [HTTP://INTRANET.CO.RIVERSIDE.CA.US](http://intranet.co.riverside.ca.us)

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	Health Net HMO Coordination of Benefits Plan	Health Net PPO Coordination of Benefits Plan		Health Net Flex Indemnity Medicare
	Network Only	PPO Network	Out-of-Network ¹	
MENTAL HEALTH TREATMENT				
Inpatient benefit	\$100 copay per admission (unlimited admissions)	20% after deductible	40% after deductible; benefits limited to \$600 per day	Days 1–60: Plan pays initial Part A annual Medicare deductible Days 61–90: Plan pays Medicare coinsurance Day 91 and after: While using 60 lifetime reserve days, plan pays Medicare coinsurance. After 60 Medicare lifetime reserve days are used, plan pays 90% of Medicare-eligible expenses for 365 lifetime additional days
Outpatient benefit	\$15 copay/visit (unlimited visits)	100% after \$20 copay ²	40% after deductible	Covered in full
SUBSTANCE ABUSE TREATMENT				
Inpatient detoxification	\$100 copay per admission (unlimited admissions)	20% after deductible	40% after deductible; benefits limited to \$600 per day	Days 1–60: Plan pays initial Part A annual Medicare deductible Days 61–90: Plan pays Medicare coinsurance Day 91 and after: While using 60 lifetime reserve days, plan pays Medicare coinsurance. After 60 Medicare lifetime reserve days are used, plan pays 90% of Medicare-eligible expenses for 365 lifetime additional days
Outpatient detoxification	\$15 copay/visit (unlimited visits)	100% after \$20 copay ²	40% after deductible	Covered in full
OTHER BENEFITS				
Allergy testing and treatment	100% after \$15 copay	100% after \$20 copay ²	40% after deductible	Covered in full
Chiropractic	Not covered	20% after deductible	40% after deductible	Covered in full
Durable medical equipment	50%, up to a maximum benefit of \$2,000/calendar year	20% after deductible <i>Benefits limited to \$6,000 per calendar year</i>	40% after deductible	Covered in full
Home health care	100% after \$15 copay, up to 100 visits per calendar year	20% after deductible <i>Benefits limited to \$110 per day</i>	40% after deductible	Covered in full <i>(Limited to part-time intermittent skilled nursing care, up to 8 hours each day for a maximum of 21 days; physical therapy; or speech therapy. Medicare covers services for home health care at no charge to the member.)</i>
Hospice (routine home and inpatient respite care)	100%	20% after deductible <i>Inpatient respite care is limited to a maximum of 5 consecutive days</i>	40% after deductible	Covered by Medicare
Hospice (24-hour continuous home care and general inpatient care)	100%	20% after deductible	40% after deductible	Covered by Medicare
Rehabilitative therapy services (includes outpatient physical, speech, occupational, respiratory, and cardiac therapy)	100%	20% after deductible <i>Benefits limited to \$5,000 per calendar year</i>	40% after deductible	Covered in full
Skilled nursing facility	100% after \$100 copay, up to 100 days/calendar year	20% after deductible	40% after deductible; benefits limited to \$250 per day	Days 1–20: No benefits Days 21–100: Plan pays Medicare coinsurance Days 101–365: Plan pays 80% of Medicare-eligible expenses, up to an additional 265 days each benefit period

Refer to footnotes below.

Please use the following Footnote References for the county medical plans comparison charts on the previous pages.

1. You will pay any amount charged by an out-of-network provider that is in excess of the plan's fee schedules.
2. Benefits are not subject to deductible.
3. Copayments do not count toward the out-of-pocket maximum.
4. Infertility benefit is limited to physician services and diagnostic testing only.
6. If you have a prescription filled with a brand-name drug when a generic equivalent is available, you will pay the copayment PLUS the cost difference between that drug and the generic (unless your physician indicates that the brand-name drug must be dispensed as written). Some medications require prior authorization from Health Net.

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	Kaiser Senior Advantage HMO	Health Net Seniority Plus HMO	SCAN HMO
	Network Only	Network Only	Network Only
BENEFIT PROVISIONS			
Coordination with Medicare	This plan requires you to assign your Medicare benefits to Kaiser Permanente. This means that you can only receive benefits within the Kaiser network of providers.	This plan requires you to assign your Medicare benefits to Health Net. This means that you can only receive benefits within the Health Net network of providers.	This plan requires you to assign your Medicare benefits to SCAN. This means that you can only receive benefits within the SCAN network of providers.
Choice of physician	Any Kaiser provider and/or facility	All care must be coordinated by your PCP	Any SCAN provider
Deductible	None	None	None
Out-of-pocket maximum ³	\$1,500/person \$3,000/family	\$3,400/person	\$6,700
Lifetime maximum benefit	Unlimited	Unlimited	Unlimited
Pre-existing condition limitation	Fully covered	Fully covered	Fully covered (provided it is a covered benefit)
OFFICE VISIT BENEFITS			
Physician office visits	100% after \$10 copay	100% after \$10 copay	100% after \$15 copay
Diagnostic X-ray and lab	100%	100%	100%
Immunizations	100%	100% (you pay 20% coinsurance for foreign travel immunizations)	100%
Maternity care	100% after \$10 copay	N/A	N/A
Periodic health evaluations/physicals	100% after \$10 copay	100%	100% after \$15 copay
Vision exams	100% after \$10 copay	100% after \$10 copay	100% after \$15 copay for exams to diagnose and treat diseases and conditions of the eye
Well-baby care	100% after \$10 copay	N/A	N/A
Well-woman care	100% after \$10 copay	100%	100% after \$15 copay
PRESCRIPTION DRUGS⁴			
Network retail pharmacies (30- to 34-day supply)	Generic: 100% after \$5 copay Brand formulary: 100% after \$15 copay	Generic: 100% after \$10 copay Brand formulary: 100% after \$20 copay ⁶ Brand nonformulary: 100% after \$40 copay ⁶ Injectables: \$40 copay ² Specialty drugs: \$40 copay ²	Generic: 100% after \$10 copay Brand: 100% after \$20 copay Additional brand: 100% after \$20 copay Specialty drugs: 100% after \$40 copay
Network mail order (90-day supply)	Generic: 100% after \$5 copay Brand formulary: 100% after \$15 copay	Generic: 100% after \$20 copay Brand formulary: 100% after \$40 copay ⁶ Brand nonformulary: 100% after \$80 copay ⁶ Injectables: \$80 copay ² Specialty drugs: \$80 copay ²	Generic: 100% after \$20 copay Brand: 100% after \$40 copay Additional brand: 100% after \$40 copay
HOSPITAL AND EMERGENCY ROOM SERVICES			
Ambulance (medically necessary)	100%	100%	100%
Ambulatory surgical center	100% after \$10 copay per procedure	100%	100%
Physician hospital visits	100%	100%	100%
Inpatient hospital care	100%	100%	100% after \$100 copay
Outpatient hospital care	100%	100%	100%
Hospital emergency room	100% after \$10 copay; waived if admitted	100% after \$50 copay; waived if admitted	100% after \$50 copay; waived if admitted
Urgent care	100% after \$10 copay	100% after \$50 copay	100% after \$25 copay

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	Kaiser Senior Advantage HMO	Health Net Seniority Plus HMO	SCAN HMO
	Network Only	Network Only	Network Only
MENTAL HEALTH TREATMENT			
Inpatient benefit	100%; unlimited admissions	100%	100% after \$100 copay per admission
Outpatient benefit	Individual visits: 100% after \$10 copay Group visits: 100% after \$5 copay	100% after \$10 copay	100% after \$15 copay
SUBSTANCE ABUSE TREATMENT			
Inpatient detoxification	100%	100%	100% after \$100 copay per admission
Outpatient detoxification	Individual visits: 100% after \$10 copay Group visits: 100% after \$5 copay	100% after \$10 copay	100% after \$15 copay
OTHER BENEFITS			
Allergy testing and treatment	100% after \$10 copay/visit for testing; 100% after \$3 copay/visit for injections	100%	100%
Chiropractic	100% after \$15 copay/visit; up to 20 visits per calendar year	100% after \$10 copay for services provided by American Specialty Health providers; up to 20 visits/calendar year	100% after \$15 copay; up to 20 self-referred visits
Durable medical equipment	100%	100%	100%
Family planning - Elective pregnancy termination - Infertility services - Tubal ligation - Vasectomy	100% after \$10 copay 100% after \$10 copay [†] 100% after \$10 copay 100% after \$10 copay	N/A	N/A
Home health care	100%	100%	100%
Hospice (routine home and inpatient respite care)	100%	Not covered; hospice services administered only through Medicare	100%
Hospice (24-hour continuous home care and general inpatient care)			100%
Physical therapy	100% after \$10 copay	100% after \$10 copay; limited to treatment for conditions that should significantly improve through relatively reasonable therapy	100% after \$15 copay
Skilled nursing facility	100%; up to 100 days/calendar year	100%; up to 150 days per benefit period (spell of illness) in a Medicare-certified bed A benefit period begins when a member receives skilled nursing services and ends when the member has not received inpatient care (in a hospital or skilled nursing facility) for 60 consecutive days	100%; up to 100 days for each benefit period

Refer to footnotes on page 27.

Please refer to the individual medical plan booklets for detailed lists of covered expenses and for exclusions and limitations. If there are any discrepancies between these booklets and the official plan documents, the official plan documents will prevail. Medical plan booklets are available by contacting the Benefits Information Line at (951) 955-4981. For information about CalPERS medical plans, refer to your CalPERS enrollment materials.

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Exclusive Care Select Medicare Supplement Plan	
BENEFIT PROVISIONS	WHAT THE PLAN PAYS
Coordination with Medicare	This plan supplements your Medicare coverage. After Medicare pays benefits, the plan is billed. Between this plan and Medicare, you will be covered for 100% of all Medicare-approved amounts when you receive services from a provider who accepts Medicare assignment. If you go to a provider who does not accept Medicare assignment, the plan will pay only up to 20% of the Medicare-approved amount, and you will have to pay the balance (in addition to plan copayments, deductibles, and coinsurance).
Choices of physician	You can go to any provider you choose, but your out-of-pocket expenses will be lower when you go to a provider who accepts Medicare assignment.
Deductible	Plan pays your Medicare Part A deductible. You are responsible for your Part B deductible before the plan pays for covered services.
Out-of-pocket maximum	N/A
Lifetime maximum benefit	Unlimited
OFFICE VISIT BENEFITS	
Physician office visits	Plan pays 20% coinsurance (Medicare pays 80%), after member fulfills annual Medicare Part B deductible.
Annual health evaluations/physicals	Plan pays 100%, up to the Medicare-approved amount after you pay the Part B deductible.
Diagnostic X-ray and lab	Plan pays 20% coinsurance (Medicare pays 80%), after member fulfills annual Medicare Part B deductible.
PRESCRIPTION DRUGS ⁵	
Participating retail pharmacies, including Exclusive Care's Rubidoux Pharmacy (30- to 34-day supply)	Generic drugs: 100% after \$15 copay Brand formulary: 100% after \$25 copay Brand nonformulary: 100% after \$40 copay Significant or new therapeutic class drugs: 50%
Exclusive Care Rubidoux mail order (up to 90-day supply)	Generic drugs: 100% after \$30 copay Brand formulary: 100% after \$50 copay Brand nonformulary: 100% after \$80 copay Mail order is MANDATORY for maintenance medications after a 30-day trial
HOSPITAL AND EMERGENCY ROOM SERVICES	
Inpatient hospital care	Days 1–60: Plan pays initial Part A annual Medicare deductible Days 61–90: Plan pays additional Medicare daily copay amount Day 91 and after: <ul style="list-style-type: none"> • While using 60 lifetime reserve days, plan pays additional day deductible • After 60 Medicare lifetime reserve days are used, plan pays 100% of Medicare-eligible expenses for 365 lifetime additional days Benefits limited to 365 days/lifetime maximum
Hospital emergency room	Plan pays Medicare-required copay amount, after member fulfills annual Medicare Part B deductible.
Skilled nursing facility	Days 1–20: Plan pays initial Part A annual Medicare deductible Days 21–100: Plan pays Medicare daily copay Day 101 and beyond: Not covered
OTHER SERVICES	
Physical therapy	Plan pays 20% coinsurance (Medicare pays 80%), after member fulfills annual Medicare Part B deductible.
Hearing exams and aids	Plan pays the amounts listed below, up to a combined benefit of \$1,000 every 60 months: <ul style="list-style-type: none"> • Hearing exams: Plan pays the difference (if any) between the amount charged by your provider and the Medicare-approved amount • Hearing aids: Plan pays up to \$1,000
Durable medical equipment	Plan pays 20% coinsurance (Medicare pays 80%), after member fulfills annual Medicare Part B deductible, up to \$1,000 per calendar.

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