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 Permanente HMO	UHC SignatureValue Alliance HMO
	Network Only	Network Only	Network Only
Choice of physician	Any Exclusive Care network physician	Any Kaiser Permanente physician and/or facility	All care must be coordinated by your Alliance network PCP
Deductible	None	None	None
Calendar year out-of-pocket maximum	$1,500/person $3,000/family	$1,500/person $3,000/family	$1,500/person $3,000/family
Lifetime maximum benefit	Unlimited	Unlimited	Unlimited
Pre-existing condition limitation	Fully covered	Fully covered	Fully covered
Office Visit Benefits			
Diagnostic X-ray and lab	100%	100%	100%
Immunizations	100%	100%	100%
Maternity care	100%	100%	100%
Periodic health evaluations/ physicals	100%	100%	100%
Physician office visits	100% after $15 copayment	100% after $15 copayment	100% after $15 copayment
Vision exams	100% for screening and refraction	100% after $15 copayment	100% for screening; $15 copayment for refraction
Well-baby care	100%	100%	100%
Well-woman care	100%	100%	100%
Prescription Drugs			
Network retail pharmacies (30- to 34-day supply)	Generic: $10 copayment Preferred brand: $25 copayment Nonpreferred brand: $50 copayment	Generic: $10 copayment (up to 30-day supply) Brand formulary: $25 copayment (up to 30-day supply)	Generic: $10 copayment Preferred brand: $25 copayment Nonpreferred brand: $50 copayment
Network mail order (90-day supply)	Generic: $20 copayment Preferred brand: $50 copayment Nonpreferred brand: $100 copayment **Mail order is MANDATORY for maintenance medications after a 30-day trial.**	Generic: $20 copayment (up to 100-day supply) Brand formulary: $50 copayment (up to 100-day supply)	Generic: $20 copayment Preferred brand: $50 copayment Nonpreferred brand: $100 copayment
Hospital and Emergency Room Benefits			
Ambulance (medically necessary)	100%	100%	100%
Ambulatory surgical center	100%	100% after $15 copayment	100%
Physician hospital visits	100% after $15 copayment	100% after $100 copayment per admission	100%
Inpatient hospital	$100 copayment per admission	$100 copayment per admission	$100 copayment per admission
Outpatient hospital	100%	100%; $15 copayment / procedure for outpatient surgery	100%
Emergency room services	100% after $100 copayment at a network facility	100% after $100 copayment; waived if admitted	100% after $100 copayment; waived if admitted
Urgent care	100% after $20 copayment at network facility; 100% after $50 copayment at non-network facility	100% after $15 copayment	100% after $35 copayment; waived if admitted

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 EPO	Kaiser Permanente HMO	UHC SignatureValue Alliance HMO
	Network Only	Network Only	Network Only
Mental Health Treatment			
Inpatient Benefit	$100 copayment per admission	100%; unlimited admissions	$100 copayment per admission (unlimited admissions)
Outpatient Benefit	$15 copayment/visit (unlimited visits)	$15 copayment/private visit; $7 copayment/group visit (unlimited visits)	$15 copayment/visit (unlimited visits)
Substance Abuse Treatment			
Inpatient Detoxification	$100 copayment per admission	$100 copayment per day, as medically necessary (detox only)	$100 copayment per admission (unlimited admissions)
Outpatient Detoxification	$15 copayment/visit (unlimited visits)	$15 copayment/private visit; $5 copayment/group visit (unlimited visits)	$15 copayment/private visit; (unlimited visits)
Other Benefits			
Allergy testing and treatment	100% after $15 copayment	100% after $15 copayment; $3/injection	100% after $15 copayment
Chiropractic	100% after $15 copayment; up to 12 visits/calendar year	100% after $15 copayment/ visit; up to 20 visits/calendar year	100% after $15 copayment for chiropractic and acupuncture; up to 20 visits combined annual maximum
Durable medical equipment	50%	100%	100%
Family planning			
- Elective pregnancy termination	100% after $50 copayment for 1st trimester; $100 for 2nd trimester; 3rd trimester not covered unless life-threatening	100% after $15 copayment	100% after $125 copayment for 1st trimester; $200 for 2nd trimester; 3rd trimester (after 20 wks) not covered unless life threatening
- Infertility services	50% of costs, up to a lifetime maximum benefit of $10,000	50% of costs	50% of cost copayment
- Tubal ligation	100%	100%	100%
- Vasectomy	100%	100% after $15 copayment	$50 copayment
Home health care	100%	100%, up to 100 visits/ calendar year	100% after $15 copayment; up to 100 visits/calendar year
Hospice – routine home and inpatient respite care	100%	100%	100%
Hospice – 24-hour continuous home care and general inpatient care	100%	100%	100% (prognosis of life expectancy of one year or less)
Physical therapy	$15 copayment/visit; up to 30 visits/disability (within 90-day period)	100% after $15 copayment	100% after $15 copayment
Skilled nursing facility	100%; up to 100 days/ disability	100% up to 100 days/calendar year	$100 copayment; up to 100 days/benefit period

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.

	UHC Select Plus PPO	
	PPO Network	**Out-of-Network**
Choice of physician	Any network provider	Any licensed provider
Annual Deductible	$500/person $1,000/family	
Calendar year out-of-pocket maximum	$3,000/person $6,000/family	
Lifetime maximum benefit	Unlimited	
Office Visit Benefits		
Physician office visits	100% after $20 copayment	40% after deductible has been met
Diagnostic X-ray and lab	100%; deductible does not apply	40% after deductible has been met
Adult preventive care (includes mammography, Pap smear, sigmoidoscopy, and prostate exam)	100%	100%; copayments and deductibles do not apply
Well-baby care	100%	40% after deductible
Well-woman care	100%	40% after deductible
Vision exams	100% after $20 copayment	40% after deductible
Prescription Drugs		
Network retail pharmacies (up to a 31-day supply)	Generic: $5 copayment Preferred brand: $15 copayment Nonpreferred brand: $45 copayment	Generic: $5 copayment Preferred brand: $15 copayment Nonpreferred brand: $45 copayment
Network mail order (up to a 90-day supply)	Generic: $10 copayment Preferred brand: $30 copayment Nonpreferred brand: $90 copayment	Not covered
Hospital and Emergency Room Services		
Inpatient hospital services	20% after deductible	40% after deductible
Physician hospital visits	20% after deductible	40% after deductible
Ambulatory surgical center	20% after deductible	40% after deductible
Ambulance (medically necessary)	20% after deductible	20% after deductible
Hospital emergency room	$50 copayment waived if admitted	$50 copayment waived if admitted
Urgent care facility	100% after $20 copayment/visit	40% after deductible
Mental Health Treatment		
Inpatient services	20% after deductible	40% after deductible
Outpatient services	100% after $20 copayment	40% after deductible
Substance Abuse Treatment		
Inpatient program	20% after deductible	40% after deductible
Outpatient office visits	100% after $20 copayment	40% after deductible
Other Benefits		
Chiropractic	100% after $20 copayment/visit; benefits limited to 24 visits per calendar year	40% after deductible
Durable medical equipment	20% after deductible	40% after deductible
Family planning	20% after deductible	40% after deductible
Home health care	20% after deductible	40% after deductible
	Benefits limited to 100 visits per year	
Hospice services	20% after deductible	40% after deductible
Infertility services	20% after deductible	40% after deductible
	Benefits subject to a separate $500 lifetime deductible and a lifetime maximum benefit of $2,000; GIFT, ZIFT, in vitro fertilization, intrafallopian transfers, and artificial insemination not covered	
Rehabilitation therapy (includes outpatient physical, speech, occupational, respiratory, and cardiac therapy)	100% after you pay $20 copayment per visit	40% after deductible
Skilled nursing facility	20% after deductible	40% after deductible
	Benefits limited to 60 days per year	