

**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.