

**2017 MEDICAL PLANS COMPARISON
HIGH OPTION - A ACTIVE EMPLOYEES**

Benefit	Indemnity*	Blue Shield California (BSC)	Kaiser High
Calendar Year Deductible	\$100/person; \$200/family	None	None
Calendar Year and lifetime Maximums	Unlimited	Unlimited	Unlimited
Ambulance	PPO - 20%; OON - 20% UCR	No charge	No charge
Annual Co-pay limit			
Individual	\$500 - PPO; OON - None	\$600/person; \$1,200/two-party	\$1,500
Family	None	\$1,800	\$3,000
Durable Medical Equipment	PPO - 20%; OON - 20% UCR	No charge	No charge
Emergency Services	20%** of allowable services over \$500	No copay	No copay
Home Health Care	20%; 30 visits/CY	\$3 copay, 100 visit/CY	No charge
Hospital			
Inpatient	PPO - No charge; OON - 20% UCR	No charge	No charge
Outpatient	PPO - No charge; OON - 20% UCR	No charge	No charge
Mental Health and Substance Use***			
Inpatient	Provided by MHN; PPO - No charge; OON - 20% UCR. Alternate levels of treatment covered.	Provided by MHN: No charge; no maximum based on medical necessity;	No charge
Outpatient	Provided by MHN: \$0 copay individual; \$5 copay group.	Provided by MHN: \$3 copay	No charge
Outpatient Diagnostic-X-ray and Laboratory	PPO - No charge; OON - 20% of UCR	No charge	No charge
Physical exam	PPO- no charge; OON no charge 1st \$500, balance 20%; frequency - AMA guidelines	\$3 copay/well woman - no charge	No charge
Physician Services -			
Office/Home visit	PPO - No charge; OON - 20% UCR	\$3 copay - routine; A+Specialist - \$20	No charge
Well child care	PPO - no charge; OON no charge 1st \$200 balance 20%	No charge	No charge
Physical therapy	13 visits	\$3 per visit	
Prescription Drugs	Sav RX plan; Retail (30 days) and Mail Order (60 days) \$2 copay	Retail: \$2 copay Mail - \$2 copay	Retail (100 day supply): No copay
Skilled Nursing Facility	No charge up to maximum Plan payment of \$20/day	No charge; 100 days per CY	No charge; 100 days/benefit period
Vision (through VSP)	\$5 copay/exam and materials 12-12-24	\$3 copay/exam and materials 12-12-24	\$5 copay/exam and materials 12-12-24
Wellness Benefit****	PPO - no charge; OON - no charge 1st \$500 adults,\$200 children; balance 20%	No copay	No copay

*Charges in excess of UCR are paid by the participant in addition to normal co-insurance for out-of-network (OON) providers and services.

**Deductible waived only for emergency accident admits under indemnity medical plan.

***MHN Authorization is required for inpatient PPO; no pre-treatment required if emergency inpatient but must notify MHN within 24 hrs. of admit.

Alternate levels of care includes Day Treatment, Partial hospitalization and intensive outpatient care.

****Includes: OB/GYN, Pap smear, Mammogram, routine Lab, immunizations, hearing, colonoscopy, bone density

Note: This is only a summary of your benefits; Refer to EOC or disclosure form for HMO benefit details, and exclusions and limitations.