

County of Marin

**Blue Cross Renewal and CalPERS Look-alike Option
2011 Plan year**

Medical Benefits	Blue Cross Prudent Buyer Classic Current		Blue Cross Prudent Buyer Plus Current		Blue Cross PERSChoice Look-alike Proposed	
	Network	Non-Network	Network	Non-Network	Network	Non-Network
Calendar Year Deductible Individual / Family	\$100 / Member		\$100 / Member		\$500 / \$1,000	
Annual Out-of-Pocket Maximum Individual / Family	\$1,000/ Member	\$3,000 / Member	\$1,000/Member	\$3,000/Member	\$3,000 / \$6,000	None
Hospital						
Inpatient Services	10%	\$250 ded. + 10% (limited to \$540/day)	10%	\$250 ded. + 10%	20%	40%
Outpatient Surgery	10%	10%	10%	10%	20%	40%
Physician Services						
Physician Office Visit	10%	10%	10%	10%	\$20/visit	40%
Periodic Health Exam / Preventive Care	\$25 / visit	Not Covered	\$25/visit	Not Covered	No Charge	40%
Well Baby Care	10%	10%	10%	10%	No Charge	40%
Adult Immunization / Inoculation	\$25/visit	Not Covered	\$25/visit	Not Covered	No Charge	40%
Diagnostic X-Ray and Lab	10%	10%	10%	10%	20%	40%
Durable Medical Equipment	10%	10%	10%	10%	20%	40%
Ambulance Service	10%	10%	10%	10%	20%	20%
Emergency	10%	10%	10%	10%	\$50 ded. + 20% (deductible waived if admitted)	\$50 ded. + 20% (deductible waived if admitted)
Mental Health						
Inpatient	10%	10%	10%	10%	20%	40%
Outpatient	10%	10%	10%	10%	20%	40%
Substance Abuse						
Inpatient	10%	10%	10%	10%	20%	40%
Outpatient	10%	10%	10%	10%	20%	40%
Home Health Services	10%	10%	10%	10%	20%	40%
	(Limited 60 visits/cal. year)		(Limited 60 visits/cal. year)		(Up to \$6,000/cal. year)	
Skilled Nursing Facility	10%	10%	10%	10%	1-10 Days: 20%	40%
	(Up to 100 days/cal. year)		(Up to 100 days/cal. year)		11-100 Days: 30%	
					(Up to 100 days/cal. year)	
Occupational Therapy	10%	10%	10%	10%	20%	20%
					(Up to \$3,500/cal. yr combined w/Phys Therapy)	
Physical Therapy	10%	10%	10%	10%	20%	40%
					(Up to \$3,500/cal. yr combined w/Occu Therapy)	
Speech Therapy	10%	10%	10%	10%	20%	40%
					(\$5,000 Lifetime Max.)	
Hospice Care	10%	10%	10%	10%	20%	20%
					(\$10,000 Lifetime Max.)	
Acupuncture	Not covered		Not covered		20%	40%
					(15 visits/cal. year combined w/ Chiro)	
Chiropractic	10%	10%	10%	10%	20%	40%
					(15 visits/cal. year combined w/ Acupuncture)	
Prescription Drugs	Generic / Brand / Non-Formulary		Generic / Brand / Non-Formulary		Generic / Brand / Non-Formulary	
Retail (30-day supply)	\$5 / \$10 / \$20	\$5 / \$10 / \$20 + 50% of the remaining drug covered expense + costs in excess of the max allowed amt	\$5 / \$10 / \$20	\$5 / \$10 / \$20 + 50% of the remaining drug covered exp + costs in excess of the max allowed amt	\$5 / \$15 / \$30	
Mail Order (90-day supply)	\$10 / \$20 / \$30	Not Covered	\$10 / \$20 / \$30	Not Covered	\$10 / \$25 / \$45	

Note: This summary is for informational purpose only. It does not amend, extend, or alter the current policy in any way. In the event information in this summary differs from the Plan Document, the Plan Document will prevail.

LEGEND

Bold Green = Better Benefit **Bold Red = Lesser Benefit**