COUNTY OF MARIN - 2019 Medical RFP

Medicare Retirees

Note: This is only a summary of benefits. For a detailed description of benefits, exclusions, and limitations, please refer to the plan's Evidence of Coverage.

Benefit	Current		Proposed	
	Anthem PPO		UHC	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Medicare Coordination	Medicare Supplement		Medicare Replacement	
Plan Year Deductible*				
Individual	$500		N/A	
Family	$1,000		N/A	
Plan Year Out-of-Pocket Maximum				
Individual	$3,000	$15,000	$1,500 per Medicare member (Medical only)	
Family	$6,000	$45,000		
Professional Services				
Office Visits				
Primary Care Provider	$20 (deductible waived)	40%	$5 Copay	$5 Copay
Specialist	$20 (deductible waived)	40%	$5 Copay	$5 Copay
Preventive Care	No charge (deductible waived)	40%	No Charge	No Charge
Diagnostic X-ray and Lab	20%	40%	$5 Copay	$5 Copay
Imaging (MRI, CT/PET scans)	20%	40%	$5 Copay	$5 Copay
Outpatient Therapy (Speech, Physical, etc.)	20%	40%	$5 Copay	$5 Copay
Acupuncture	20% (12 visits per year w/ Medical Necessity)	40%	$5 Copay (30 visits per year)	$5 Copay
Chiropractic Services	20% (No visit limit w/ Medical Necessity)	40%	$5 Copay (30 visits per year)	$5 Copay
Hospital and Facility Services				
Inpatient Hospital and Physician Services	20%	40%	No Charge	No Charge
Outpatient Surgery	20%	40%	$5 Copay	$5 Copay
Skilled Nursing Facility	20% (100 days per benefit period)	40%	No Charge (100 days per benefit period)	No Charge
Mental Health and Substance Abuse				
Inpatient Facility	20%	40%	No Charge	No Charge
Outpatient Visit	$20 (deductible waived)	40%	$5 Copay	$5 Copay
Emergency Care				
Emergency Room	$50/visit (waived if admitted) + 20%		$75 Copay (waived if admitted)	$75 Copay (waived if admitted)
Ambulance	20%		No Charge	No Charge
Home Health Care	20% (100 visits per benefit period)	40%	No Charge (No visit limit)	No Charge
Hospice Care	20%		No Charge	No Charge
Durable Medical Equipment (DME)	20%	40%	20%	20%
Hearing Aids	One hearing aid every 3 years (per ear)		Covered in Full up to $2,000 Annual Allowance (combined)	
Prescription Drugs	(deductible waived)			
Retail	30-day supply		30-day supply***	
Generic	$5	$5**	Generic	$5
Brand (Formulary)	$15	$15**	Preferred Brand	$20
Brand (Non-Formulary)	$30	$30**	Non-Preferred Brand	$50
Specialty Drugs	$30	$30**	Specialty	$50
Mail Order	90-day supply		90-day supply***	
Generic	$10	N/A	Generic	$10
Brand (Formulary)	$25	N/A	Preferred Brand	$40
Brand (Non-Formulary)	$45	N/A	Non-Preferred Brand	$100
Specialty Drugs	N/A	N/A	Specialty	$100

*All benefits are after deductible unless otherwise noted.

**For out-of-network pharmacies, members pays the above copay plus 50% of the remaining prescription drug maximum allowed amount and costs in excess of the prescription drug maximum allowed amount up to $250 per prescription.

***Only available in-network except in case of emergency.