Ukiah Unified Medical Plan Options

	Plan G-1	Plan G-2	Plan K	Plan M
CALENDAR YEAR DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM	Member Pays	Member Pays	Member Pays	Member Pays
Individual/Family Deductibles	$500 / $1.000	$500 / $1,000	$1,000 / $2,000	$3,000 / $6,000
Individual/Family Out-of-Pocket Max (includes deductibles and co-pays)	$2,000 / $4,000	$2,000 / $4,000	$3,000 / $6,000	$4,000 / $8,000
Rx DRUG PLANS - IN NETWORK BENEFIT COMPARISON	*Free Generic Drugs available at Costco for Plan G1 only. Plans G2, K and M have reduced Copays for Generic Prescriptions filled at Costco.*			
Individual / Family: Brand / Specialty Deductible	$0 / $0	$200 / $500	$200 / $500	$200 / $500
Individual / Family: Out of Pocket Maximum	$2,500 / $3,500	$2,500 / $3,500	$2,500 / $3,500	$2,500 / $3,500
Retail 30 Day Supply: Generic / Brand	$9 / $35	$15 / $50	$15 / $50	$15 / $50
Mail 90 Day Supply: Generic / Brand	$0 / $90	$15 / $135	$15 / $135	$15 / $135
Costco Retail 30 Day Supply: Generic / Brand	$0 / $35	$5 / $50	$5 / $50	$5 / $50
Costco Retail 90 Day Supply: Generic / Brand	$0 / $90	$15 / $135	$15 / $135	$15 / $135
2017 – 2018 EMPLOYEE DEDUCTIONS (INCLUDES DENTAL AND VISION)	*Active employees pay "Tenthly" rate with no payment in July or August. Retirees pay a monthly rate.*			
Employee Contribution: Monthly/Tenthly	***$68.00 / $80.00***	***$46.00 / $55.00***	***$38.00 / $45.00***	***$0 / $0***
Child Surcharge (Up to 2): Monthly/Tenthly	***$158.00 / $190.00***			
Spousal Surcharge: Monthly/Tenthly	***$529.00 / $635.00***			
PROFESSIONAL SERVICES - IN NETWORK BENEFIT COMPARISON				
Office Visit co-pay	$30	$30	$30	$40
Urgent Care co-pay	$30	$30	$30	$40
Specialists/Consultants co-pay	$30	$30	$30	$40
Prenatal, postnatal office visit co-pay	$30	$30	$30	$40
Scans: CT, CAT, MRI, PET etc.	20%	20%	20%	20%
Diagnostic X-ray & Laboratory Procedures	20%	20%	20%	20%
Infertility (diagnosis/treatment of causes of infertility)	Not covered	Not covered	Not covered	Not covered
Preventive Care Services (includes physical exams & screenings)	0%, Deductible Waived	0%, Deductible Waived	0%, Deductible Waived	0%, Deductible Waived
HOSPITAL & SKILLED NURSING FACILITY SERVICES - IN NETWORK BENEFIT COMPARISON				
Emergency Room visit co-pay (waived if admitted) * co-pay plus coinsurance	20% $100 co-pay	20% $100 co-pay	20% $100 co-pay	20% $100 co-pay
Inpatient Hospital co-pay (preauthorization required)	20%	20%	20%	20%
Outpatient Hospital co-pay	20%	20%	20%	20%
Surgery, Outpatient (performed in an Ambulatory Surgery Center)	20%	20%	20%	20%
Surgery, Outpatient (performed in a Hospital)	20%	20%	20%	20%
MENTAL HEALTH SERVICES & SUBSTANCE ABUSE TREATMENT - IN NETWORK BENEFIT COMPARISON				
INPATIENT CARE: Facility based care (preauthorization required)	20%	20%	20%	20%
OUTPATIENT CARE: Facility based care (preauthorization required)	Deductible waived office visit co-pay applies	Deductible waived office visit co-pay applies	Deductible waived office visit co-pay applies	Deductible waived office visit co-pay applies
OTHER SERVICES				
Acupuncture - Limits apply	20%	20%	20%	20%
Ambulance (Ground or Air) co-pay plus coinsurance. ****$100 co-pay effective 10/01/17**	20% $100 co-pay	20% $100 co-pay	20% $100 co-pay	20% $100 co-pay
Chiropractic - Limits apply	20%	20%	20%	20%
Durable Medical Equipment (DME)	20%	20%	20%	20%
Physical and Occupational Therapy - Limits apply	20%	20%	20%	20%

This summary only highlights benefits, it is not a Summary of Benefits and Coverage (SBC), Summary Plan Description (SPD) or Evidence of Coverage (EOC). If any discrepancy exists between this summary and the official document(s), the official document(s) will prevail.