Merced County Medical Plan Comparison Chart - Active Employees

Plan Information and Network	Anthem 500 Low Cost Plan - EPO	Anthem 1500 Traditional Plan - EPO	Anthem HDHP Plan with H.S.A		Anthem HDHP Plan without H.S.A	
	In-Network	In-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible	$500 single $1,000 family	$1,500 single $3,000 family	$1,650 single $3,900 family	$2,600 single $7,800 family	$1,650 single	$2,600 single
Annual Out-of-Pocket Max	$3,000 single $6,000 family	$5,000 single $10,000 family	$4,000 single $8,000 family	$8,000 single $16,000 family	$4,000 single	$8,000 single
Office Visits & Professional Services						
Visits in an Office						
Primary Care (PCP)	$20 copay per visit, deductible does not apply	$45 copay per visit, deductible does not apply	$25 copay per visit after deductible is met	30% coinsurance after deductible is met	$25 copay per visit after deductible is met	30% coinsurance after deductible is met
Specialist Care	$20 copay per visit, deductible does not apply	$45 copay per visit, deductible does not apply	$25 copay per visit after deductible is met	30% coinsurance after deductible is met	$25 copay per visit after deductible is met	30% coinsurance after deductible is met
Preventive Care	No Charge	No Charge	No Charge	Not covered	No Charge	Not covered
Other Practitioner Visits						
Routine Maternity Care (Prenatal & Postnatal)	$20 copay per visit, deductible does not apply	$45 copay per visit, deductible does not apply	$25 copay per visit after deductible is met	30% coinsurance after deductible is met	$25 copay per visit after deductible is met	30% coinsurance after deductible is met
Retail Health Clinic	$20 copay per visit, deductible does not apply	$45 copay per visit, deductible does not apply	$25 copay per visit after deductible is met	30% coinsurance after deductible is met	$25 copay per visit after deductible is met	30% coinsurance after deductible is met
Chiropractic Care	$20 copay per visit, deductible does not apply (24 visits per benefit period)	$20 copay per visit, deductible does not apply (24 visits per benefit period)	10% coinsurance after deductible is met (30 visits per benefit period)	30% coinsurance after deductible is met (30 visits per benefit period)	10% coinsurance after deductible is met (30 visits per benefit period)	30% coinsurance after deductible is met (30 visits per benefit period)
Acupuncture	No Charge (12 visits per benefit period)	No Charge (12 visits per benefit period)	10% coinsurance after deductible is met (20 visits per benefit period)	30% coinsurance after deductible is met (20 visits per benefit period)	10% coinsurance after deductible is met (20 visits per benefit period)	30% coinsurance after deductible is met (20 visits per benefit period)
Virtual Care (Telemedicine / Telehealth Visits)						
Virtual Visits (With Doctors who also provide services in person)	$20 copay per visit, deductible does not apply	$45 copay per visit, deductible does not apply	$25 copay per visit after deductible is met	30% coinsurance after deductible is met	$25 copay per visit after deductible is met	30% coinsurance after deductible is met
LiveHealth Online	No Charge	No Charge	Primary Care: $59 copay before deductible, then No Charge after deductible is met Specialist: $25 copay after deductible is met		Primary Care: $59 copay before deductible, then No Charge after deductible is met Specialist: $25 copay after deductible is met	
Lab and X-Ray	$20 copay per visit, deductible does not apply	No Charge	$25 copay per visit after deductible is met	30% coinsurance after deductible is met	$25 copay per visit after deductible is met	30% coinsurance after deductible is met
Imaging (CT/PET/MRI)	10% coinsurance after the deductible is met	No Charge	10% coinsurance after deductible is met	30% coinsurance after deductible is met	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Inpatient, Outpatient, and Emergency Care						
Hospitalization (Including Maternity, Mental Health and Substance Use Disorder)						
Facility Fees	No Charge	$250 copay per admission after deductible is met	$250 copay per day after deductible is met (up to 3 day maximum)	30% coinsurance after deductible is met ($600 max limit per day for non-emergency Inpatient admissions)	$250 copay per day after deductible is met (up to 3 day maximum)	30% coinsurance after deductible is met ($600 max limit per day for non-emergency Inpatient admissions)
Doctor and Other Services	No Charge	No Charge after the deductible is met	10% coinsurance after deductible is met	30% coinsurance after deductible is met	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Surgery						
Facility Fees	No Charge	$100 copay per admission after deductible is met	$250 copay per admission after deductible is met	30% coinsurance after deductible is met	$250 copay per admission after deductible is met	30% coinsurance after deductible is met
Doctor and Other Services	No Charge	No Charge after the deductible is met	10% coinsurance after deductible is met	30% coinsurance after deductible is met	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Urgent Care	$20 copay per visit, deductible does not apply	$45 copay per visit, deductible does not apply	10% coinsurance after deductible is met	30% coinsurance after deductible is met	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Emergency Care						
Emergency Room Facility Services	$100 copay per visit after deductible is met (copay waived if admitted)	$100 copay then No Charge after deductible is met (copay waived if admitted)	10% coinsurance after deductible is met		10% coinsurance after deductible is met	
Emergency Room Doctor and Other Services	No Charge	No Charge after the deductible is met	10% coinsurance after deductible is met		10% coinsurance after deductible is met	
Ambulance	10% coinsurance after the deductible is met	No Charge after the deductible is met	10% coinsurance after deductible is met		10% coinsurance after deductible is met	
Outpatient Mental Health and Substance Use Disorder						
Doctor Office Visit	$20 copay per visit, deductible does not aply	$45 copay per visit, deductible does not apply	$25 copay per visit after deductible is met	30% coinsurance after deductible is met	$25 copay per visit after deductible is met	30% coinsurance after deductible is met
Facility Visit	10% coinsurance after the deductible is met	No Charge after the deductible is met	10% coinsurance after deductible is met		10% coinsurance after deductible is met	
Facility Doctor Services	10% coinsurance after the deductible is met	No Charge after the deductible is met	10% coinsurance after deductible is met		10% coinsurance after deductible is met	
Home Health Care	10% coinsurance after the deductible is met (100 visits per benefit period)	No Charge after the deductible is met (100 visits per benefit period)	10% coinsurance after deductible is met (100 visits per benefit period)	30% coinsurance after deductible is met (100 visits per benefit period)	10% coinsurance after deductible is met (100 visits per benefit period)	30% coinsurance after deductible is met (100 visits per benefit period)
Rehabilitation Services	10% coinsurance after the deductible is met	$45 copay per visit, deductible does not apply	10% coinsurance after deductible is met	30% coinsurance after deductible is met	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Skilled Nursing Care (Facility)	10% coinsurance after the deductible is met (100 days per benefit period)	No Charge after the deductible is met (100 days per benefit period)	10% coinsurance after deductible is met (100 days per benefit period)	30% coinsurance after deductible is met (100 days per benefit period)	10% coinsurance after deductible is met (100 days per benefit period)	30% coinsurance after deductible is met (100 days per benefit period)
Durable Medical Equipment	50% coinsurance after the deductible is met	No Charge after deductible is met	50% coinsurance after deductible is met		50% coinsurance after deductible is met	
Hospice Services	No Charge	No Charge after deductible is met	10% coinsurance after deductible is met	30% coinsurance after deductible is met	10% coinsurance after deductible is met	30% coinsurance after deductible is met
Pharmacy						
Pharmacy Network/PBA	**Express Scripts**	**Express Scripts**	**Anthem**		**Anthem**	
Prescription Drug Deductible	None	None	Combined with In-Network	Combined with Non-Network	Combined with In-Network	Combined with Non-Network
Annual Out-of-Pocket Limit	$3,600 single $7,200 family	$1,500 single $4,500 family	Combined with In-Network	Combined with Non-Network	Combined with In-Network	Combined with Non-Network
Pharmacy: Preventive Generic/Preferred Brand	N/A	N/A	No Charge (retail and mail order)	30% coinsurance after deductible is met (retail) Not covered (mail order)	No Charge (retail and mail order)	30% coinsurance after deductible is met (retail) Not covered (mail order)
Pharmacy: Generic	$10 copay (retail) $15 copay (mail order)	$20 copay (retail) $30 copay (mail order)	$15 copay after deductible (retail) $30 copay after deductible (mail order)	30% coinsurance after deductible is met (retail) Not covered (mail order)	$15 copay after deductible (retail) $30 copay after deductible (mail order)	30% coinsurance after deductible is met (retail) Not covered (mail order)
Pharmacy: Preferred Brand	$20 copay (retail) $30 (mail order)	$40 copay (retail) $50 copay (mail order)	$25 copay after deductible (retail) $50 copay after deductible (mail order)	30% coinsurance after deductible is met (retail) Not covered (mail order)	$25 copay after deductible (retail) $50 copay after deductible (mail order)	30% coinsurance after deductible is met (retail) Not covered (mail order)
Pharmacy: Non-preferrred brand	$30 copay (retail) $45 copay (mail order	$60 copay (retail) $70 copay (mail order)	$35 copay after deductible (retail) $70 copay after deductible (mail order)	30% coinsurance after deductible is met (retail) Not covered (mail order)	$35 copay after deductible (retail) $70 copay after deductible (mail order)	30% coinsurance after deductible is met (retail) Not covered (mail order)

Note: This chart is for illustrative purposes only. A comprehensive coverage listing can be found in the Summary of Benefits and Coverages (SBCs) and/or certificate booklets.