This document is a comparative summary of benefits only. It is not intended to interpret or replace contract language.
Where discrepancies occur, the benefits outlined in the plan document will prevail.

REMIF 2023 HEALTH PLANS

CITY OF ROHNERT PARK - Effective 7-1-23

REMIF

Benefits	EPO 250 In Network Only	EPO 500 In Network Only	PPO 500 In Network	PPO 500 Out of Network	HSA 1500 In Network	HSA 1500 Out of Network	PPO BlueCard 250 (Only For Out of State Retirees) In Network	PPO BlueCard 250 (Only For Out of State Retirees) Out of Network
Plan Year Deductible	$250 Single $500 Two Party $750 Family	$500 Single $1,000 Two Party $1,500 Family	$500 Single $1,000 Two Party $1,500 Family	$1,000 Single $2,000 Two Party $3,000 Family	$1,500 Single $3,000 Family of 2 or more		$250 Single $500 Two Party $750 Family	$250 Single $500 Two Party $750 Family
Plan Year Out of Pocket Max (OOP) [1]	**Total Out of Pocket Maximums** $5,000 Single $10,000 Two Party $13,200 Family			**Total Out of Pocket Max:** $10,000 Single $20,000 Two Party $30,000 Family	$7,500 Single $15,000 Family of 2 or more **(OOP maximum for Medical/Rx are combined)**		**Total Out of Pocket Max:** $5,000 Single $10,000 Two Party $13,200 Family	**Total Out of Pocket Max:** $6,000 Single $12,000 Two Party $18,000 Family
	Separate Medical and Rx OOP maximums accumulate per person up to the family maximum						***Separate Medical and Rx OOP maximums accumulate per person up to the family maximum***	
	Single = $3,400 Medical; $1,600 Rx			**Single = $8,400 Medical; $1,600 Rx**			**Single = $3,400 Medical; $1,600 Rx**	**Single = $4,400 Med; $1,600 Rx**
Family Definition (For deductible and out of pocket maximum)	Single = Employee Only Two Party = Employee + 1 dependent Family = Employee + 2 or more dependents				Single = Employee Only Family = Employee + 1 or more dependents		Single = Employee Only Two Party = Employee + 1 dependent Family = Employee + 2 or more dependents	
Coinsurance (Percentage plan pays after deductible)	100% after deductible	90% after deductible	80% after deductible	70% after deductible	90% after deductible	70% after deductible	100% after deductible	70% after deductible
	Benefits below are what the MEMBER PAYS <u>after</u> deductible unless noted				**Benefits below apply <u>AFTER</u> deductible has been met**		**Benefits below are what the MEMBER PAYS after deductible unless noted**	
Preventive Care	$0 Copay Deductible Waived	$0 Copay Deductible Waived	$0 Copay Deductible Waived	30%	$0 Copay Deductible Waived	30%	$0 Copay Deductible Waived	30%
Physician Visits								
Primary Care	$25 Copay Deductible Waived	$30 Copay Deductible Waived	$30 Copay Deductible Waived	$50 Copay Deductible Waived	10%	30%	$25 Copay Deductible Waived	30%
Specialists	$35 Copay Deductible Waived	$40 Copay Deductible Waived	$40 Copay Deductible Waived	$60 Copay Deductible Waived	10%	30%	$35 Copay Deductible Waived	30%
LiveHealth Online	$10 copay; Deductible Waived	$10 copay; Deductible Waived	$10 copay; Deductible Waived	n/a	10% after deductible	n/a	$10 copay; Deductible Waived	n/a
Diagnostic Lab & X-Ray	$10 copay after deductible	10%	20%	30%	10%	30%	$10 copay after deductible	30%
Advanced Imaging (CT, MRI, etc.) (Subject to utilization review)	$50 copay after deductible	10%	20%	30% (benefit limited to $800/procedure)	10%	30% (benefit limited to $800/procedure)	$50 copay after deductible	30% (benefit limited to $800/procedure)
Emergency Care	$150 Copay Waived if Admitted	10% after $150 Copay Waived if Admitted	20% after $150 Copay Waived if Admitted		10% after deductible		$150 Copay Waived if Admitted	
Hearing Aids	0% after ded.; Max. of $2,500 per ear, every 3 years	10% after ded.; Max. of $2,500 per ear, every 3 years	20% after ded.; Max. of $2,500 per ear, every 3 years		10% after ded.; Max. of $2,500 per ear, every 3 years		0% after ded.; Max. of $2,500 per ear every 3 years	
Rx Benefits Retail: 30 day supply Retail Maintenance and Mail Order: 90 day supply	Not subject to deductible	Not subject to deductible	Not subject to deductible	Not subject to deductible	**Copays apply <u>AFTER</u> deductible has been met**		Not subject to deductible	Not subject to deductible
Tier 1 - Generic	$10 Copay Retail $15 Copay Mail Order	$15 Copay Retail $23 Copay Mail Order	$15 Copay Retail $23 Copay Mail Order	Member pays applicable copay plus all charges in excess of allowable charge	$10 Copay Retail $20 Copay Mail Order	Member pays applicable copay plus all charges in excess of allowable charge	$10 Copay Retail $15 Copay Mail Order	Member pays applicable copay plus all charges in excess of allowable charge
Tier 2 - Preferred Brand	$25 Copay Retail $38 Copay Mail Order	$35 Copay Retail $53 Copay Mail Order	$35 Copay Retail $53 Copay Mail Order		$25 Copay Retail $50 Copay Mail Order		$25 Copay Retail $38 Copay Mail Order	
Tier 3 - Non-Preferred Brand	$50 Copay Retail $75 Copay Mail Order	$50 Copay Retail $75 Copay Mail Order	$50 Copay Retail $75 Copay Mail Order		$50 Copay Retail $100 Copay Mail Order		$50 Copay Retail $75 Copay Mail Order	
Tier 4 - Specialty	$150 Copay	$150 Copay	$150 Copay		20% of maximum allowed amount		$150 Copay	
Specialty (30 day supply)	Must obtain from Specialty Pharmacy. Member pays applicable cost for tier	Must obtain from Specialty Pharmacy. Member pays applicable cost for tier	Must obtain from Specialty Pharmacy. Member pays applicable cost for tier	Not Covered	Must obtain from Specialty Pharmacy. Member pays applicable cost for tier	Not Covered	Must obtain from Specialty Pharmacy. Member pays applicable cost for tier	Not Covered

(1) The Out of Pocket Maximums for Rx and Medical accumulate separately on a per person basis on all plans EXCEPT the HSA 1500. The combined out of pocket maximum will not exceed the total OOP maximum shown for all plans EXCEPT the PPO 500. On the PPO 500, the out of network Rx out of pocket maximum is unlimited.