

## Bay District Medical Plans

	Enhanced Blue Choice 0317	Blue Options 3900	HSA – Employee Only Blue Options 05192	HSA – EE + Dependents Blue Options 05193
	In-Network	In-Network	In-Network	In-Network
<b>Individual Deductible</b>	\$500	\$2,000 per person	\$2,500	\$5,000
<b>Family Deductible</b>	\$1,500	N/A	N/A	\$5,000
<b>Coinsurance</b>	20%	30%	20%	20%
<b>Individual Out of Pocket</b>	\$2,000	\$6,350	\$5,800	\$6,850
<b>Family Out of Pocket</b>	\$6,000	\$12,700	N/A	\$11,600
<b>Out-Patient Hospital (Surgery)</b>	DED + COINSURANCE	\$300 Copay	DED + COINSURANCE	DED + COINSURANCE
<b>In-Patient Hospital</b>	DED + COINSURANCE	\$1,500 Copay	DED + COINSURANCE	DED + COINSURANCE
<b>Ambulatory Surgical Center</b>	DED + COINSURANCE	DED + COINSURANCE	DED + COINSURANCE	DED + COINSURANCE
<b>Independent Clinical Lab</b>	Coinsurance (20%)	\$0	DEDUCTIBLE	DEDUCTIBLE
<b>Outpatient Diagnostic Testing</b>	DED + COINSURANCE	DED + COINSURANCE	DED + COINSURANCE	DED + COINSURANCE
<b>Advanced Imaging Facility Services</b>	DED + COINSURANCE	\$200 Copay	DED + COINSURANCE	DED + COINSURANCE
<b>Provider Services at Hosp/ER</b>	DED + COINSURANCE	DED + COINSURANCE	DED + COINSURANCE	DED + COINSURANCE
<b>Emergency Room</b>	\$250 Copay + DED + COINSURANCE	\$200 Copay	DED + COINSURANCE	DED + COINSURANCE
<b>Ambulance Ground and Air Travel</b>	DED + COINSURANCE	DED + COINSURANCE	DED + COINSURANCE	DED + COINSURANCE
<b>Urgent Care</b>	\$20 Copay	\$60 Copay	DED + COINSURANCE	DED + COINSURANCE
<b>Office Visit - Family Phys</b>	\$20 Copay	\$35 Copay	DED + COINSURANCE	DED + COINSURANCE
<b>Office Visit - Specialist</b>	\$50 Copay	\$50 Copay	DED + COINSURANCE	DED + COINSURANCE
<b>Adult Wellness Benefit Max</b>	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%
<b>Prescription Drugs</b>	<i>Retail</i>	<i>Retail</i>	<i>Retail</i>	<i>Retail</i>
<b>Generic</b>	\$10 Copay	\$10 Copay	Deductible then \$10 Copay	Deductible then \$10 Copay
<b>Preferred Brand</b>	\$30 Copay	20% for <b>Select Brand</b> or \$50 whichever is greater	Deductible then \$30 Copay	Deductible then \$30 Copay
<b>Non-Preferred Brand</b>	\$50 Copay	Not Covered	Deductible then \$50 Copay	Deductible then \$50 Copay
<b>Mail-Order</b>	\$14/\$28/\$28	\$25/20% or 150 whichever is greater	DED + \$25/\$75/\$125	DED + \$25/\$75/\$125

