



REMIF 2016 HEALTH PLANS

City of St. Helena - Effective 7-1-16

Benefits	EPO 250		EPO 500 (POA ONLY)		PPO BlueCard 250 (Only For Out of State Retirees)	
	In Network Only		In Network Only		In Network	Out of Network
Plan Year Deductible	\$250 Single \$500 Two Party \$750 Family		\$500 Single \$1,000 Two Party \$1,500 Family		\$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: \$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
	<i>Separate Medical and Rx OOP maximums accumulate per person up to the family maximum</i>				<i>Separate Medical and Rx OOP maximums accumulate per person up to the family maximum</i>	
	Single = \$3,400 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 Two Party = Employee + 1 dependent Family = Employee + 2 or more dependents	
Coinsurance (Percentage plan pays after deductible)	100% after deductible		90% after deductible		100% after deductible	70% after deductible
	Benefits below are what the MEMBER PAYS after deductible unless noted				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%
Office Visits - Primary Care	\$25 Copay Deductible Waived		\$30 Copay Deductible Waived		\$25 Copay Deductible Waived	30%
Office Visits - Specialists	\$35 Copay Deductible Waived		\$40 Copay Deductible Waived		\$35 Copay Deductible Waived	30%
Diagnostic Lab & X-Ray	\$10 copay after deductible		10%		\$10 copay after deductible	30%
Advanced Imaging (CT, MRI, etc.) (Subject to utilization review)	\$50 copay after deductible		10%		\$50 copay after deductible	30% (benefit limited to \$800/procedure)
Emergency Care	\$150 Copay Waived if Admitted		10% after \$150 Copay Waived if Admitted		\$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		0% after ded.; Max. of \$2,500 per ear every 3 years	
Rx Benefits Retail: 30 day supply Mail Order: 90 day supply	Not subject to deductible		Not subject to deductible		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		\$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		\$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	
Tier 4 - Specialty	\$150 Copay		\$150 Copay		\$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
"DAW" (Dispense as written)	Not Included		Not Included		Not Included	Not Included

(1) The Out of Pocket Maximums for Rx and Medical accumulate separately on a per person basis on all plans EXCEPT the HSA 1300. The combined out of pocket maximum will not exceed the total OOP maximum shown.