

CPWEA
Health Benefits Summary 2011 Plan Year

	Kaiser HMO \$15 / \$0 Kaiser Hospitals	Blue Shield HMO \$15 / \$0 Community Hospitals	Blue Shield PPO 90/70% / \$0 St. Agnes & Community	Blue Shield PPO 80/60% / \$500 St. Agnes & Community	Blue Shield HDHP 3000 / 6000 St. Agnes & Community
<i>NOTE: The Annual Medical Deductible must be paid first, except where noted as 'waived', before medical insurance benefits are received from the health plan.</i>					
Annual Deductible	None	None	\$0 preferred / \$500 non-preferred	\$500 preferred & non-preferred	\$3000/\$6000
Maximum out of Pocket (OOP) (annually, per individual/family)	\$1500/\$3000	\$1000/\$2000	\$2000/\$6000	\$3000/\$6000	\$3000/\$6000
Provider Network	Permanent	Sante	Blue Shield Preferred	Blue Shield Preferred	Blue Shield Preferred
Maximum Lifetime Benefits (per individual)	unlimited	unlimited	unlimited	unlimited	unlimited
Hospitalization - inpatient	\$0	\$0	10%	\$250 + 20%	No Charge
Hospital - outpatient	\$15	No Charge	10%	\$125 + 20%	No Charge
Office Visits - Primary Care Physician	\$15	\$15	\$10 (deductible waived)	\$35 (deductible waived)	No Charge
Office Visits - Specialist	\$15 (referral required)	\$15 w/ referral \$30 w/o referral	\$10 (deductible waived)	\$35 (deductible waived)	No Charge
Laboratory & X-ray	0 to \$10	No Charge	\$10	\$35	No Charge
Allergy Testing/Treatment	\$15 Testing/\$5 Treatment (serum included)	\$15	10%	20%	No Charge
Hearing Exam/Screening	No Charge	\$0	\$0	\$0	No Charge
Immunization/Inoculation	No Charge	\$0	No Charge	No Charge	No Charge
Annual GYN Exam	No Charge	\$0	No Charge	No Charge	No Charge
Annual Physical Exam	No Charge	\$0	No Charge	No Charge	No Charge
Well Baby Care	No Charge	\$0	No Charge	No Charge	No Charge
Inpatient Hospital Doctor Visits	No Charge	\$0	10%	20%	No Charge
Surgery/Anesthesia	No Charge	\$0	10%	20%	No Charge
Vision Exam (Refraction Adult & Child)	No Charge	\$0 (screening for children only)	Not Covered	Not Covered	No Charge
Diagnostic X-ray & Labs (DXL)	\$10	\$0	10%	20%	No Charge
Durable Medical Equipment (DME)	20% Includes diabetic testing supplies	20%	10%	20%	No Charge up to \$2,000 per year
Covered Prescription Drugs (up to 1 mo supply)	\$10 for generic \$30 for brand	\$10 generic \$15 formulary brand-name (Home self injection 20% \$100 max)	\$5 generic \$10 formulary brand-name \$25 non-formulary (injectable drugs 30% up to \$150)	\$10 generic \$20 formulary brand-name \$35 non-formulary	No Charge
Covered Prescription Drugs Mail Order (up to 3 mos. supply)	\$20 for generic \$60 for brand name up to 100 day supply	\$20 generic \$30 formulary brand-name	\$10 generic \$20 formulary brand-name \$50 non-formulary	\$20 generic \$40 formulary brand-name \$70 non-formulary	No Charge
Infertility	50%	\$15 for counseling, 50% for treatment	Not Covered	Not Covered	No Charge
Ambulance	\$100	\$100	10%	20%	No Charge
Emergency Room	\$100	\$100	10%	20%	No Charge
Mental Health - inpatient	\$0 up to 30 days per year	\$0	10%	\$250 per admission plus 20%	No Charge
Mental Health - outpatient	\$15	\$15	\$10	\$35	No Charge
Substance Abuse - inpatient	\$0 (Detox Only)	\$0	10% (rehab included)	20% (rehab included)	No Charge
Substance Abuse - outpatient	\$5 group visit, \$15 individual visit	\$15	\$10	\$35	No Charge
Home Health Services	No Charge	\$15	10%	20%	No Charge
Physical, Occupational, & Speech Therapy	\$15	\$15	\$10	\$35	No Charge
Skilled Nursing Facility (SNF)	\$0, up to 100 days per benefit period	\$0 up to 100 day max	10%	20%	No Charge
Hospice	No Charge	No Charge	10%	20%	No Charge
Acupuncture	Not Covered	Not Covered	\$25/visit, up to 20 per year	Not Covered	Not Covered
Chiropractic	\$15/visit, up to 20 per year	\$10/visit	\$25/visit, up to 12 per year	\$25/visit, up to 12 per year	No Charge
Blood & Blood Products	No Charge	\$0	\$10	\$20	\$0
Audiology Exam	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Hearing Aid	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Employee Assistance Plan	3, individual or family visits, per 6 months. Psychological & Emotional, Marital Relationship, Parental Guidance, Substance Abuse, Work Performance, Legal & Financial referral. No co-pay.				
Dental Plan Co-payment	20% of UCR, plus balance over UCR allowance for all covered services except implants				
Dental Plan Maximum Benefit	\$2,000 per person, per Calendar Year for covered services				
Vision Plan Co-payment	\$25 for exam and/or for eyewear + balance over materials allowance				
Allowable Frequency of use	12 months each, for exams, lenses and frames or contacts in lieu of lenses and frames				
Frame Allowance	\$80				
Contact lens Allowance	\$150 toward total cost per year or \$250 per year if medically necessary				
Life Insurance	\$25,000 per employee, \$10,000 legal spouse (except if employed by City of Clovis) \$10,000 each child age 6-months to 19-years, then to age 25 if full-time student				
Voluntary Life Insurance Paid 100% by employee.	\$10,000 to \$500,000 for employee or spouse (50% of EE), subject to Evidence of Insurability. \$2,000 for each child, available only if parent insured. Paid by employee through payroll deduction.				

CPWEA Employee Cost Per Month - 2011 Plan Year

Coverage Type	Kaiser HMO \$15 / \$0	Blue Shield HMO \$15 / \$0	Blue Shield PPO 90% / \$0	Blue Shield PPO 80% / \$500	Blue Shield HDHP 3000/6000
Total Health Coverage					
Employee Only	\$13.02	\$69.18	\$434.04	\$100.01	\$0.00
Employee Plus Child(ren)	\$50.02	\$151.11	\$607.83	\$208.42	\$0.00
Employee & Spouse	\$63.80	\$181.75	\$947.85	\$246.41	\$0.00
Employee, Spouse & Child(ren) - Family	\$105.37	\$273.87	\$1,368.44	\$366.29	\$0.00
					Health Savings Account Inc.
Employee Only					\$30.00
Employee Plus Child(ren)					\$60.00
Employee & Spouse					\$70.00
Employee, Spouse & Child(ren) - Family					\$100.00
					CPWEA rates include the deferred compensation monthly discount of: \$34.11
WAIVER	Employees electing no City of Clovis health coverage of any type (Life and EAP will continue at no cost) for themselves or any family member will receive a monthly health premium rebate for this plan year of: \$400				