PERSONNEL SERVICES
EMPLOYEE BENEFITS

ACTIVE EMPLOYEES

HEALTH BENEFITS

- ANTHEM BLUE CROSS **HMO**
- ANTHEM BLUE CROSS **PPO**
- ANTHEM BLUE CROSS **HDPPO**
- KAISER **HMO**

SUPPLEMENTAL BENEFITS

- PRESCRIPTION COVERAGE
- VISION COVERAGE
- DENTAL PLANS
- MENTAL HEALTH

PLAN YEAR 2012

MEDICAL • PRESCRIPTIONS • VISION • DENTAL • MENTAL HEALTH • FLEXIBLE BENEFITS

MEDICAL PLANS COUNTY OF FRESNO HEALTH CARE BENEFITS COMPARISON - ACTIVE EMPLOYEES

The County of Fresno 2012 contribution rates are $208.06 per pay period and an additional $95.00 per pay period for employee plus children or spouse OR $100 for employee plus family. Employees who select a health plan with a premium less than the County contribution will not receive the excess contribution. Please note the employee costs listed on this chart do not apply to part-time employees. The following information summarizes certain key features of the health plans. It is provided for your convenience in comparing plans only. In all cases, official documents legally govern each plan's operations and benefits. Employees must meet all the eligibility requirements of the selected plan regarding service area limitations. All benefits are covered as stated only so long as plan requirements for prior authorization, primary care physician referrals and/or bona fide emergency or medical necessity are met. All benefits with a notation, "limit _days," indicate the maximum covered per calendar year.

RATES PLAN YEAR 12/12/11 to 12/9/12

BI-WEEKLY PREMIUMS

	PLAN 1				PLAN 2			
Medical	ANTHEM BLUE CROSS **HMO**				ANTHEM BLUE CROSS **PPO**			
Prescription	Catalyst **RX**				Catalyst **RX**			
Vision	MES **Vision**				MES **Vision**			
Mental Health	Avante **Mental Health**				Avante **Mental Health**			
Dental Plans	Delta Dental **DPPO**	or	MetLife **DHMO**		Delta Dental **DPPO**	or	MetLife **DHMO**	
	TOTAL PREMIUM	EMPLOYEE COST	TOTAL PREMIUM	EMPLOYEE COST	TOTAL PREMIUM	EMPLOYEE COST	TOTAL PREMIUM	EMPLOYEE COST
Employee Only	$280.29	$72.23	$265.91	$57.85	$387.32	$179.26	$372.94	$164.88
Employee + Child(ren)	$432.83	$129.77	$418.07	$115.01	$721.39	$418.33	$706.63	$403.57
Employee + Spouse	$489.41	$186.35	$469.10	$166.04	$796.53	$493.47	$776.22	$473.16
Employee + Family	$642.75	$334.69	$620.35	$312.29	$1,095.94	$787.88	$1,073.54	$765.48

	PLAN 3				PLAN 4			
Medical	ANTHEM BLUE CROSS **HDPPO**				KAISER			
Prescription	Anthem Blue Cross **RX**				Kaiser **RX**			
Vision	MES **Vision**				Kaiser **Vision**			
Mental Health	Anthem Blue Cross **Mental Health**				Kaiser **Mental Health**			
Dental Plans	Delta Dental **DPPO**	or	MetLife **DHMO**		Delta Dental **DPPO**	or	MetLife **DHMO**	
	TOTAL PREMIUM	EMPLOYEE COST	TOTAL PREMIUM	EMPLOYEE COST	TOTAL PREMIUM	EMPLOYEE COST	TOTAL PREMIUM	EMPLOYEE COST
Employee Only	$224.68	$16.62	$210.30	$2.24	$406.49	$198.43	$392.11	$184.05
Employee + Child(ren)	$411.67	$108.61	$396.91	$93.85	$619.77	$316.71	$605.01	$301.95
Employee + Spouse	$458.99	$155.93	$438.68	$135.62	$737.19	$434.13	$716.88	$413.82
Employee + Family	$623.40	$315.34	$601.00	$292.94	$944.22	$636.16	$921.82	$613.76

Anthem HMO

BENEFITS PLAN YEAR 12/12/11 to 12/9/12

BI-WEEKLY PREMIUMS	Delta Dental DPPO			MetLife Dental DHMO	
	TOTAL PREMIUM	EMPLOYEE COST		TOTAL PREMIUM	EMPLOYEE COST
Employee Only	$280.29	$72.23	or	$265.91	$57.85
Employee + Child(ren)	$432.83	$129.77		$418.07	$115.01
Employee + Spouse	$489.41	$186.35		$469.10	$166.04
Employee + Family	$642.75	$334.69		$620.35	$312.29

PHYSICIAN SELECTION *(Service areas are defined in each plan's benefit summary)*	Employees and dependents must live or work within an **Anthem Blue Cross** service area and receive care from Plan providers. Employees and dependents must select a primary care physician. Each family member may select a different primary care physician.
PHYSICIAN SERVICES	
Office Visits	$15 per visit.
Hospital Care	$0 co-pay.
Home Visits	$15 per visit *(as medically necessary)*.
PREVENTIVE SERVICES Routine Physicals - Pediatric and Adult/ Laboratory/ Immunizations/Well Baby Care *(Newborn to 2)*/ Annual Breast and Pelvic	$0 co-pay.
HOSPITAL SERVICES	Area Hospitals including Community Medical Center of Fresno, Clovis Community Hospital, Children's Hospital Central California. * Not all hospitals are listed. Please visit the Anthem Blue Cross website for a complete listing at www.anthem.com/ca.
EMERGENCY SERVICES *(When medically necessary)*	Worldwide coverage: Services which are immediately required to treat a sudden, serious and unexpected illness or injury, including services to alleviate severe pain associated with a sudden, serious and unexpected illness or injury.
Ambulance	$0 co-pay.
EMERGENCY ROOM Accident or Illness	$100 per visit, waived if admitted.
INPATIENT SERVICES Inpatient Services, Semiprivate Room, ICU	$0 co-pay.
OUTPATIENT SERVICES Surgery/X-RAY/Lab Tests	$0 co-pay.
SKILLED NURSING FACILITY Freestanding SNF/Hospital SNF Unit	$0 co-pay.

OTHER BENEFITS	
Home Health Care	$15 per visit.
Home Hospice Care	$0 co-pay.
DURABLE MEDICAL EQUIPMENT	$0 co-pay. Includes hearing aid every 3 years.
PROSTHETIC MEDICAL DEVICES	$0 co-pay.
MATERNITY Hospital/ Physician In-Hospital/ Newborn Nursery Care/ Prenatal Care	$0 co-pay.
FAMILY PLANNING	$15 co-pay per visit – no charge for family planning counseling.
STERILIZATIONS	$15 co-pay.
ABORTION	
Elective	$100 co-pay.
INFERTILITY SERVICES	
Diagnosis for Infertility	$15 co-pay.
PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY/ REHABILITATIVE SERVICES Outpatient Services	$15 co-pay. – Limited to a 60 day period of care after illness or injury; Additional visits may be approved if medically necessary.
ALLERGY TESTING/ TREATMENT	$0 co-pay. Serum included in office visit.
HEARING TEST	$0 co-pay.
HEARING AID	Refer to Durable Medical Equipment.
INITIAL EVALUATION	$15 co-pay.
SPEECH AND HEARING DISORDERS	$15 co-pay.
HEALTH EDUCATION	$0 co-pay.
CHIROPRACTIC CARE	$10 per visit, "limit 40 visits" per year.
ACUPUNCTURE	$15 co-pay.
ANNUAL CO-PAYMENT LIMIT	$1,000 per person or $2,000 per family per calendar year.

This chart is only a summary of benefits. Please see the Evidence of Coverage, the Disclosure Form and the Group Health Services Contract for the exact terms and conditions of coverage.

Anthem HMO

BENEFITS PLAN YEAR 12/12/11 to 12/9/12

MENTAL HEALTH SERVICES/CHEMICAL DEPENDENCY	Benefits provided by **Avante Behavioral Health**.
Inpatient	Unlimited Inpatient days per year, plan pays 100% of contracted rate.
Outpatient	$15 co-pay per visit. Unlimited Inpatient days per year, plan pays 100% of contracted rate.
PRESCRIPTION DRUGS	
Administered in Hospital or Dr. Office	No charge.
Outpatient Prescriptions	Prescription drugs provided by **Catalyst Rx** at the following co-pay levels: $10 co-pay *(Generic)*; $20 co-pay *(Preferred)*; $35 co-pay *(Non-preferred)* 30-day supply when member utilizes a Participating Pharmacy. Mail order 90-day supply for 2 co-pays.
Dental RX	If prescribed by plan physician *(not dentist)*, same benefit level as "Outpatient Prescriptions".
RX Contraceptives	Same as Outpatient RX Contraceptive diaphragms are limited to one per year and are subject to the brand name co-pay.

VISION BENEFITS	Benefits provided by **Medical Eye Services**.
Co-payments	$5.00 per covered person annually.
Examinations	**Every 12 Months.** *In Network:* Complete eye exam 100%. *Out of Network:* Maximum payable of $40.
Eyeglass Lenses	**Every 12 Months.** *In Network:* Covers standard lenses at 100%. Progessive lenses and polycarbonate lens coverage up to $89.50. Additional allowances applied to some lens upgrades. *Out of Network:* Payable based on reimbursement benefit schedule.
Eyeglass Frames	**Every 24 Months.** *In Network:* Allowance $150 + 20% discount of the amount over $150 on higher priced frames at participating discount provider locations. *Out of Network:* Maximum reimbursement of $75.
Elective Contact Lenses	**Every 12 Months in lieu of eyeglasses.** *In Network:* $130 maximum. *Out of Network:* $130 maximum.
Medically Necessary Contact Lenses	**Every 12 Months.** *In Network:* Paid in full. *Out of Network:* $250 maximum. Must be pre-authorized by MES Vision.
Laser Eye Surgery	15% discount through **TLC Vision** network: www.tlcvision.com.
Lens Customization/ Additional Benefits	Members responsible for optional upgrades such as lens tints and coatings. Some discounts may apply.

This chart is only a summary of benefits. Please see the Evidence of Coverage, the Disclosure Form and the Group Health Services Contract for the exact terms and conditions of coverage.

Active - 2012

Anthem PPO

BENEFITS PLAN YEAR 12/12/11 to 12/9/12

Plan Year Deductible: $250 Individual

BI-WEEKLY PREMIUMS

	Delta Dental **DPPO**			MetLife Dental **DHMO**	
	TOTAL PREMIUM	EMPLOYEE COST		TOTAL PREMIUM	EMPLOYEE COST
Employee Only	$387.32	$179.26	or	$372.94	$164.88
Employee + Child(ren)	$721.39	$418.33		$706.63	$403.57
Employee + Spouse	$796.53	$493.47		$776.22	$473.16
Employee + Family	$1,095.94	$787.88		$1,073.54	$765.48

PHYSICIAN SELECTION *(Service areas are defined in each plan's benefit summary)*	Members can access care from either Preferred Providers or Non-preferred Providers. If a member uses a Non-preferred Provider they are responsible for the full billed amount. ABC only pays 50% up to the allowed amount.
PHYSICIAN SERVICES	
Office Visits	$20 per visit *(deductible waived)*. Non-PPO 50% after deductible.
Hospital Care	$0 co-pay/Non-PPO $500/admission *(waived for emergency admission)*.
Home Visits	$20 per visit *(deductible waived for routine physical exam)*. Non-PPO 50% after deductible.
PREVENTIVE SERVICES	
Routine Physicals - Pediatric and Adult	$0 co-pay/Non-PPO 50% up to a maximum of $20 per visit.
Laboratory	$0 co-pay/Non-PPO 50% after deductible.
Immunizations	$0 co-pay/Non-PPO 50% up to a maximum of $12 per immunization.
Annual Breast and Pelvic	$0 co-pay/Non-PPO 50% deductible waived.
HOSPITAL SERVICES	Area Hospitals including Saint Agnes, Community Medical Center of Fresno, Clovis Community Hospital, Children's Hospital Central California. * Not all hospitals are listed. Please visit the Anthem Blue Cross website for a complete listing at www.anthem.com/ca.
EMERGENCY SERVICES *(When medically necessary)*	Worldwide coverage: Emergency service for sudden, serious, and unexpected acute illness, injury, or condition which the member reasonably believes could permanently endanger health if medical treatment is not received immediately.
Ambulance	$0 co-pay.
EMERGENCY ROOM Accident or Illness	$0 co-pay. $100 deductible *(waived for emergency admission)*.
INPATIENT SERVICES Semiprivate Room, ICU	$0 co-pay/Non-PPO 50% after deductible. $500 deductible per admission for Non-PPO only *(waived for emergency admission)*.
Bariatric Surgery *(Preauthorization Required)*	$0 co-pay.
OUTPATIENT SERVICES Surgery/X-RAY/Lab Tests	$0 co-pay/Non-PPO 50% after deductible.
SKILLED NURSING FACILITY	Limited to 100 days per calendar year.
Freestanding SNF/ Hospital SNF Unit	$0 co-pay/Non-PPO 50% after deductible.
OTHER BENEFITS Routine Home Care and Home Health Care	$0 co-pay/Non-PPO 50% after deductible. – Limited to 100 visits per calendar year.
Inpatient Respite Care/ Home Hospice Care	$0 co-pay.
DURABLE MEDICAL EQUIPMENT	$0 co-pay/Non-PPO 50% after deductible.
Prosthetic Medical Devices	$0 co-pay/Non-PPO 50% after deductible.
MATERNITY Hospital/ Physician In-Hospital/ Newborn Nursery Care	$0 co-pay/Non-preferred Provider 50% after deductible.
Prenatal Care	$20 per visit/Non-preferred Provider 50% after deductible.
FAMILY PLANNING/ STERILIZATIONS/ ABORTION Therapeutic/Elective	$0 co-pay/Non-preferred Provider 50% after deductible.
INFERTILITY SERVICES Diagnosis for Infertility	$0 co-pay/Non-preferred Provider 50% after deductible.
Treatment of Infertility	Not covered.
CHIROPRACTIC, PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY/ REHABILITATIVE SERVICES Outpatient Services	$0 co-pay/Non-PPO 50% after deductible. – Limited to $25 per visit for Non-PPO. Chiropractic care, physical, occupational and rehabilitative therapies are limited to a combined maximum of 24 visits per calendar year. Additional visits may be approved, if medically necessary.
ALLERGY TESTING AND TREATMENT	$0 co-pay/Non-PPO 50% after deductible.

This chart is only a summary of benefits. Please see the Evidence of Coverage, the Disclosure Form and the Group Health Services Contract for the exact terms and conditions of coverage.

Anthem PPO

Plan Year Deductible: $250 Individual/ $500 Family (Preferred/Non-preferred)

BENEFITS PLAN YEAR 12/12/11 to 12/9/12

HEARING TEST	Routine hearing tests are not covered *(medically necessary hearing tests are covered).*
HEARING AID	$0 co-pay/Non-PPO 50% after deductible. For all providers, one aid per ear every 36 months. Combined with durable medical equipment.
INITIAL EVALUATION SPEECH & HEARING DISORDERS	$0 co-pay/Non-PPO 50% after deductible.
HEALTH EDUCATION/ DIABETES CARE	$20 per visit *(deductible waived)*/Non-PPO 50% after deductible.
ACUPUNCTURE	$0 co-pay/Non-PPO 50% after deductible. $30 per visit for Non-PPO. – Limited to 12 visits per calendar year.
ANNUAL OUT OF POCKET MAXIMUM	$3,000 per individual/$5,000 per family *(PPO).* $10,000 per individual/$15,000 per family *(Non-PPO).*
MENTAL HEALTH SERVICES/CHEMICAL DEPENDENCY	Benefits provided by **Avante Behavioral Health**.
Inpatient	Unlimited Inpatient days per year. Covered at 100% of the contracted rate.
Outpatient	Unlimited visits per year. Co-pay at $20 per visit.
PRESCRIPTION DRUGS	
Administered in Hospital or Dr. Office	$0 co-pay.
Outpatient Prescriptions	Benefits provided by **Catalyst Rx** at the following co-pay levels: $10 co-pay *(Generic)*; $20 co-pay *(Preferred)*; $35 co-pay *(Non-preferred)* 30-day supply when member utilizes a Participating Pharmacy. Mail order 90-day supply for 2 co-pays. $20 Generic, $40 preferred brand, $70 non-preferred brand.
Dental RX	Same as Outpatient.

AVANTE BEHAVIORAL HEALTH · Catalyst Rx · MES Vision · DELTA DENTAL · MetLife

VISION BENEFITS	Benefits provided by **Medical Eye Services**.
Co-payments	$5.00 per covered person annually.
Examinations	**Every 12 Months.** *In Network:* Complete eye exam 100%. *Out of Network:* Maximum payable of $40.
Eyeglass Lenses	**Every 12 Months.** *In Network:* Covers standard lenses at 100%. Progessive lenses and polycarbonate lens coverage up to $89.50. Additional allowances applied to some lens upgrades. *Out of Network:* Payable based on reimbursement benefit schedule.
Eyeglass Frames	**Every 24 Months.** *In Network:* Allowance $150 + 20% discount of the amount over $150 on higher priced frames at participating discount provider locations. *Out of Network:* Maximum reimbursement of $75.
Elective Contact Lenses	**Every 12 Months in lieu of eyeglasses.** *In Network:* $130 maximum. *Out of Network:* $130 maximum.
Medically Necessary Contact Lenses	**Every 12 Months.** *In Network:* Paid in full. *Out of Network:* $250 maximum. Must be pre-authorized by MES Vision.
Laser Eye Surgery	15% discount through **TLC Vision** network: www.tlcvision.com.
Lens Customization/ Additional Benefits	Members responsible for optional upgrades such as lens tints and coatings. Some discounts may apply.

This chart is only a summary of benefits. Please see the Evidence of Coverage, the Disclosure Form and the Group Health Services Contract for the exact terms and conditions of coverage.

Anthem HDPPO

BI-WEEKLY PREMIUMS

	Delta Dental DPPO			MetLife Dental DHMO	
	TOTAL PREMIUM	EMPLOYEE COST		TOTAL PREMIUM	EMPLOYEE COST
Employee Only	$224.68	$16.62	or	$210.30	$2.24
Employee + Child(ren)	$411.67	$108.61		$396.91	$93.85
Employee + Spouse	$458.99	$155.93		$438.68	$135.62
Employee + Family	$623.40	$315.34		$601.00	$292.94

BENEFITS PLAN YEAR 12/12/11 to 12/9/12

Calendar Year Deductible: $3,000 Individual/$6,000 Family (In Network Provider)

PROVIDERS	In Network	Out of Network
PHYSICIAN SELECTION *(Service areas are defined in each plan's benefit summary)*	Covered out-of-state services *(Benefits provided through the BlueCard® Program)* Benefits provided through the BlueCard® Program, for out-of-state emergency and non-emergency care, are provided at the preferred level of the local Blue Plan allowable amount when you use a Blue Cross/Blue Shield provider. $0 co-pay after deductible.	50%
PHYSICIAN SERVICES Office Visits/Hospital Care/Home Visits	$0 co-pay.	50% after deductible.
PREVENTIVE SERVICES Routine Physicals - Pediatric and Adult/ Laboratory/ Immunizations/ Annual Breast and Pelvic	Preventive care *(not subject to the calendar year deductible).* $0 co-pay.	50%
HOSPITAL SERVICES	Area Hospitals including Saint Agnes, Community Medical Center of Fresno, Clovis Community Hospital, Children's Hospital Central California. * Not all hospitals are listed. Please visit the Anthem Blue Cross website for a complete listing at www.anthem.com/ca.	
EMERGENCY SERVICES *(When medically necessary)*	Emergency health coverage. $0 co-pay after deductible.	
Ambulance	$0 co-pay after deductible.	
EMERGENCY ROOM Accident or Illness	$0 co-pay after deductible.	
INPATIENT SERVICES Semiprivate Room, ICU	$0 co-pay after deductible.	50% after deductible.
Bariatric Surgery	$0 co-pay.	Not covered.
OUTPATIENT SERVICES Surgery/X-RAY/ Lab Tests	$0 co-pay after deductible.	50% after deductible.
SKILLED NURSING FACILITY	$0 co-pay. 50% after deductible. Benefits are limited to 100 days per calendar year for all providers.	

PROVIDERS	In Network	Out of Network
OTHER BENEFITS Routine Home Care and Home Health Care	$0 co-pay. 50% after deductible. Services limited to 100 visits per calendar year for all providers.	
Inpatient Respite Care/ Home Hospice Care	$0 co-pay.	50%
DURABLE MEDICAL EQUIPMENT Prosthetic Medical Devices	$0 co-pay after deductible.	50% after deductible.
MATERNITY Hospital/ Physician In-Hospital/ Newborn Nursery Care/ Prenatal Care	$0 co-pay after deductible.	50% after deductible.
FAMILY PLANNING/ STERILIZATIONS/ ABORTION Therapeutic/Elective	$0 co-pay.	50%
INFERTILITY SERVICES Diagnosis for Infertility	$0 co-pay/Non-preferred Provider 50% after deductible.	
Treatment of Infertility	Not covered.	
PHYSICAL, OCCUPATIONAL AND REHABILITATIVE SERVICES Outpatient Services	$0 co-pay.	50% after deductible. Up to $25 per visit. Limited to 24 visits per calendar year for all providers. Additional visits can be approved, if medically necessary.
SPEECH THERAPY	$0 co-pay.	50% after deductible.
ALLERGY TESTING AND TREATMENT	$0 co-pay.	50% after deductible.
HEARING TEST	$0 co-pay.	50% after deductible.
HEARING AID	One aid per ear every 36 months	
HEALTH EDUCATION	Self-management training and education *(if billed by your provider, you will also be responsible for the office visit co-pay).* No charge after deductible.	50% after deductible.
DIABETES CARE	Equipment, devices and supplies $0 co-pay after deductible.	50% after deductible.

This chart is only a summary of benefits. Please see the Evidence of Coverage, the Disclosure Form and the Group Health Services Contract for the exact terms and conditions of coverage.

Active - 2012

Anthem HDPPO

BENEFITS PLAN YEAR 12/12/11 to 12/9/12

PLAN 3 CONTINUED

Plan Year Out of Pocket Maximum
In-Network Provider: $3,000 Individual/$6,000 Family
Out of Network Provider: $5,000 Individual/$10,000 Family

MES Vision DELTA DENTAL MetLife

PROVIDERS	In Network	Out of Network
CHIROPRACTIC CARE	Chiropractic services provided by a chiropractor *(up to 24 visits per calendar year, combined with physical therapy, occupational therapy and rehabilitative services).* No co-pay after deductible.	50% after deductible.
ACUPUNCTURE	$0 co-pay. Limited to $30 per visit and 12 visits per calendar year for all providers.	50%
ANNUAL OUT OF POCKET MAXIMUM	Individual Coverage $3,000 Family Coverage $6,000	Individual Coverage $5,000 Family Coverage $10,000
MENTAL HEALTH SERVICES	Benefits provided by **Anthem Blue Cross**.	
Inpatient/Outpatient	$0 co-pay after deductible.	50% after deductible.
PRESCRIPTION DRUGS	Benefits provided by **Anthem Blue Cross (Express Scripts)**. *(Subject to deductible)* Retail pharmacy mail service *(claim form needed).*	
Administered in Hospital or Dr. Office/Outpatient Prescriptions/Dental RX	$0 co-pay.	50%

VISION BENEFITS	
Benefits provided by **Medical Eye Services**.	
Co-payments	$5.00 per covered person annually.
Examinations	**Every 12 Months.** *In Network:* Complete eye exam 100%. *Out of Network:* Maximum payable of $40.
Eyeglass Lenses	**Every 12 Months.** *In Network:* Covers standard lenses at 100%. Progessive lenses and polycarbonate lens coverage up to $89.50. Additional allowances applied to some lens upgrades. *Out of Network:* Payable based on reimbursement benefit schedule.
Eyeglass Frames	**Every 24 Months.** *In Network:* Allowance $150 + 20% discount of the amount over $150 on higher priced frames at participating discount provider locations. *Out of Network:* Maximum reimbursement of $75.
Elective Contact Lenses	**Every 12 Months in lieu of eyeglasses.** *In Network:* $130 maximum. *Out of Network:* $130 maximum.
Medically Necessary Contact Lenses	**Every 12 Months.** *In Network:* Paid in full. *Out of Network:* $250 maximum. Must be pre-authorized by MES Vision.
Laser Eye Surgery	15% discount through **TLC Vision** network: www.tlcvision.com.
Lens Customization/ Additional Benefits	Members responsible for optional upgrades such as lens tints and coatings. Some discounts may apply.

This chart is only a summary of benefits. Please see the Evidence of Coverage, the Disclosure Form and the Group Health Services Contract for the exact terms and conditions of coverage.

KAISER PERMANENTE $15

BENEFITS PLAN YEAR 12/12/11 to 12/9/12

BI-WEEKLY PREMIUMS

	Delta Dental DPPO			MetLife Dental DHMO	
	TOTAL PREMIUM	EMPLOYEE COST		TOTAL PREMIUM	EMPLOYEE COST
Employee Only	$406.49	$198.43		$392.11	$184.05
Employee + Child(ren)	$619.77	$316.71	or	$605.01	$301.95
Employee + Spouse	$737.19	$434.13		$716.88	$413.82
Employee + Family	$944.22	$636.16		$921.82	$613.76

PHYSICIAN SELECTION *(Service areas are defined in each plan's benefit summary)*	Primary care and specialty physician services must be obtained at **Kaiser Permanente** medical offices by teams of physicians affiliated with the Plan. You are encouraged to choose a personal physician from the staff for you and your family members. Referral to community specialists may be provided when Specialty care services are unavailable at Kaiser Permanente facilities.
PHYSICIAN SERVICES	
Office Visits	$15 per provider visit.
Hospital Care	No charge for Inpatient care.
Home Visits	No charge.
PREVENTIVE SERVICES	
Routine Physicals	No charge.
Pediatric and Adult/ Laboratory/Immunizations	No charge.
Well Baby Care *(Newborn to 2)*	No charge.
Annual Breast and Pelvic	No charge.
HOSPITAL SERVICES	Services available at **Kaiser Permanente** facilities.
EMERGENCY SERVICES *(When medically necessary)*	Worldwide coverage: Emergency service received within the service area from providers not contracting with health plan are limited to emergencies which might result in death, serious disability or significant jeopardy to the member's condition. Emergency services are provided outside the service area for members becoming ill or injured while outside the service area.
Ambulance	Ambulance: $50 per trip.
EMERGENCY ROOM	
Accident or Illness	$100 per visit, waived if admitted.
INPATIENT SERVICES	No charge at participating hospitals. Referral by a Plan physician required for all non-emergency hospital services.
Inpatient Services, Semiprivate Room, ICU	
OUTPATIENT SERVICES	
Surgery	$15 per procedure.
X-RAY/Lab Tests	No charge.

SKILLED NURSING FACILITY	
Freestanding SNF/ Hospital SNF Unit	No charge. "Limit 100 days" per benefit period.
OTHER BENEFITS	No charge if prescribed by a Plan physician. Paid in full up to 180 days per lifetime.
Routine Home Care and Inpatient Respite Care/ Home Health Care/Home Hospice Care	
DURABLE MEDICAL EQUIPMENT	20% co-insurance.
PROSTHETIC MEDICAL DEVICES	20% co-insurance.
MATERNITY	
Hospital/ Physician In-Hospital/ Newborn Nursery Care	No charge.
Prenatal Care	No charge.
FAMILY PLANNING/ STERILIZATIONS	$15 per visit.
ABORTION	
Therapeutic/Elective	$15 per visit.
INFERTILITY SERVICES	
Diagnosis for Infertility	Office visits: $15 per visit.
Treatment of Infertility	Outpatient surgery: $15 per procedure. Outpatient lab tests and special procedures: No charge. Hospital inpatient care: No charge.
PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY	$15 per visit. Occupational and speech therapy.
REHABILITATIVE SERVICES	
Outpatient Services	
ALLERGY TESTING	$15 per visit.
TREATMENT	$3 per injection.
HEARING TEST	No charge.
HEARING AID	Hearing aid(s) benefit of $1,000 allowance per device, one device per ear, two devices every 36 months.
SPEECH & HEARING DISORDERS/INITIAL EVALUATION	$15 per visit.

This chart is only a summary of benefits. Please see the Evidence of Coverage, the Disclosure Form and the Group Health Services Contract for the exact terms and conditions of coverage.

KAISER PERMANENTE HMO

BENEFITS PLAN YEAR 12/12/11 to 12/9/12

DELTA DENTAL MetLife

HEALTH EDUCATION	Most classes relating to specific medical conditions are $15 per visit. Classes relating to general health are provided at a reasonable rate.
CHIROPRACTIC CARE	$10 co-pay, "limit 30 visits" per calendar year. Services must be rendered by an American Specialty Health Plan Provider.
ACUPUNCTURE	Not covered.
ANNUAL CO-PAYMENT LIMIT	$1,500 for one member. $3,000 for the Subscriber and all his or her dependents.
CLAIM FORMS	May be required for out-of-area emergency service.
COORDINATION OF BENEFITS	None.
MENTAL HEALTH SERVICES/CHEMICAL DEPENDENCY	Benefits provided by **Kaiser Permanente**.
Inpatient	Referral by a Plan physician required for all non-emergency admissions.
Outpatient	$15 for an individual visit and $7 for a group visit. $5 for chemical dependency group visit.
PRESCRIPTION DRUGS Administered in Hospital or Dr. Office	Benefits provided by **Kaiser Permanente**. No charge.
Outpatient Prescriptions	$10 co-pay *(Generic)*; $20 co-pay *(Brand)*, per 30-day supply. Mail orders: 100-day supply for two co-pays.
Dental RX/RX Contraceptives	Same as Outpatient.
VISION BENEFITS	
Co-payments	$15 per visit.
Examinations	No charge.
Eyeglasses Lenses/ Eyeglass Frames/Contact Lenses *(Medically Necessary/Elective)*	$175 allowance toward the purchase of covered lenses, frames and/or cosmetic contact lenses, every 24 months.
Lens Customization/ Additional Benefits	Members responsible for non-basic lens options *(tinting, scratch coating, photo-chromic lenses, etc.)*. 25% discount on second pair if purchased within one year.

BENEFITS	DELTA DENTAL DPPO Plan	MetLife DHMO Plan
SUMMARY	Plan will pay a portion of the bill after deductible is met. The Plan's portion for covered basic and preventive services is 100% of the covered dental expense. All covered major services and some basic services are paid at 50% of the covered dental expense. Dental implants and composite fillings may be covered.	Members receive benefits from one of the participating dentists in the network. The plan covers most preventive diagnostic, restorative and other basic procedures at NO CHARGE. Major procedures may require fixed co-pays.
DENTIST SELECTION	All covered persons may select a dentist without restriction. If a participating dentist is selected, the member may have a reduction in out-of-pocket costs.	Members must select a dentist from the list of Plan approved dentists.
DEDUCTIBLE	Basic and Major Services: $50 per person, $150 per family per calendar year. No deductible for Preventive/Diagnostic services from a PPO dentist, and Orthodontic services.	No deductible.
MAXIMUM BENEFITS Predetermination of Benefits	$2,500 per person per year. *(Maximum Waived for Diagnostic, Orthodontia & Preventive Services)*	No annual maximum.
EMERGENCY SERVICES	Covered the same as routine services.	Palliative treatment of pain only.
CLAIM FORMS	Participating dentists will submit claim forms for you.	No claim forms are necessary except for out-of the-area emergencies.
COORDINATION OF BENEFITS	The plan will coordinate with other coverages if the person is qualified in more than one plan.	The plan will coordinate with other coverages if the person is qualified in more than one plan for specialty claims only.
SERVICE AREA	No service limitations in California.	No service limitations in California.
	Preferred Provider Dentist / **Non-preferred Provider Dentist**	
BENEFIT PROVISIONS **BASIC/PREVENTIVE SERVICES**		
Diagnostic Services Examinations, X-rays, Check-ups	0% (*Deductible Waived)* / 10%	No charge *(except for resin/composite fillings on posterior teeth; the co-pays for these procedures range from $85-$140).* The no charge is for amalgam for all teeth and resin/composite for anterior teeth.
Preventive Services/Cleanings & Fluoride Treatment	0% **(Deductible Waived)* / 10% **Extra visit for pregnancy.*	No charge.

BENEFITS	DELTA DENTAL DPPO Plan		MetLife DHMO Plan
	Preferred Provider Dentist	Non-preferred Provider Dentist	
Restorative Services/Fillings, Pulp Capping	10%	10%	Members receive benefits from one of the participating dentists in the network. The plan covers most preventive diagnostic, restorative and other basic procedures at NO CHARGE.
OTHER SERVICES - Endodontics *(minor)*/**Treatment of Gums** *(minor)*/**Teeth Bleaching** *(DHMO Only)*	50%	50%	No charge, except for teeth bleaching.
MAJOR SERVICES - Oral Surgery Impactions/Root Canals/ Apicoectomy/Periodontal Surgery/Crowns/Bridges/ Dentures/Other Prosthetics/ Simple Extractions/Implants *(DPPO Only)*	50%	50%	Most services do not require a co-pay. Co-pay may be required for an upgrade from a base metal to a precious metal.
OTHER BENEFITS - Orthodontia* *(Teeth Straightening - Adults and Children)*	Adult member *(age 20 and over)* $1,880 co-pay per case. Child member *(through age 19)* $1,660 co-pay per case. One case per lifetime. Maximum of 24 months of active orthodontic treatment.		Adult member *(age 20 and over)* $1,400 co-pay per case. Child member *(through age 19)* $1,300 co-pay per case.
EXCLUSIONS/LIMITATIONS	More than two cleanings per calendar year; Lost/stolen appliances; Cosmetic dentistry; Charges in excess of customary for Nonparticipating dentists; Hospital expenses; Prescription drugs; Replacement of prosthetics within 5 years of placement; Unnecessary/Experimental procedures; Treatment to alter vertical dimension; TMJ treatment; Other exclusions/limitations as provided in policy.		Lost/stolen appliances; Cosmetic dentistry *(except those noted within the schedule of benefits)*; Hospital expenses; Replacement of repairable dentures; Orthognatic surgery; Implants; Experimental/unnecessary procedures; Treatment to alter vertical dimension; TMJ treatment; Other exclusions/limitations as provided in policy.

ADDITIONAL RESOURCES FOR ACTIVE EMPLOYEES

www.co.fresno.ca.us/openenrollment

MEDICAL

Anthem Blue Cross HMO Group Number: 275341H001 / Phone: (800) 888-8288
Anthem Blue Cross PPO Group Number: 275341M450 / Phone: (800) 888-8288
Anthem Blue Cross HDPPO Group Number: 275341M650 / Phone: (866) 207-9878
Kaiser HMO / Phone: (800) 464-4000

24/7 Nurseline for PPO, HMO / (800) 977-0027
24/7 Nurseline for HDPPO / (866) 800-8780

DENTAL

Delta Dental DPPO Group Number: 5879 / Phone: (800) 765-6003
MetLife Dental DHMO / Phone: (800) 880-1800

VISION – MEDICAL EYE SERVICES

Group Number: 23004 / Phone: (800) 877-6372

PRESCRIPTIONS – CATALYST RX

Phone: (800) 207-2568

MENTAL HEALTH – AVANTE

Phone: (559) 261-9060

FLEX SPENDING ACCOUNTS – ALL VALLEY ADMINISTRATORS

Phone: (559) 447-1600

PERSONNEL SERVICES
EMPLOYEE BENEFITS

OPEN ENROLLMENT OFFICE

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