PERSONNEL SERVICES
EMPLOYEE BENEFITS

RETIREES

HEALTH BENEFITS

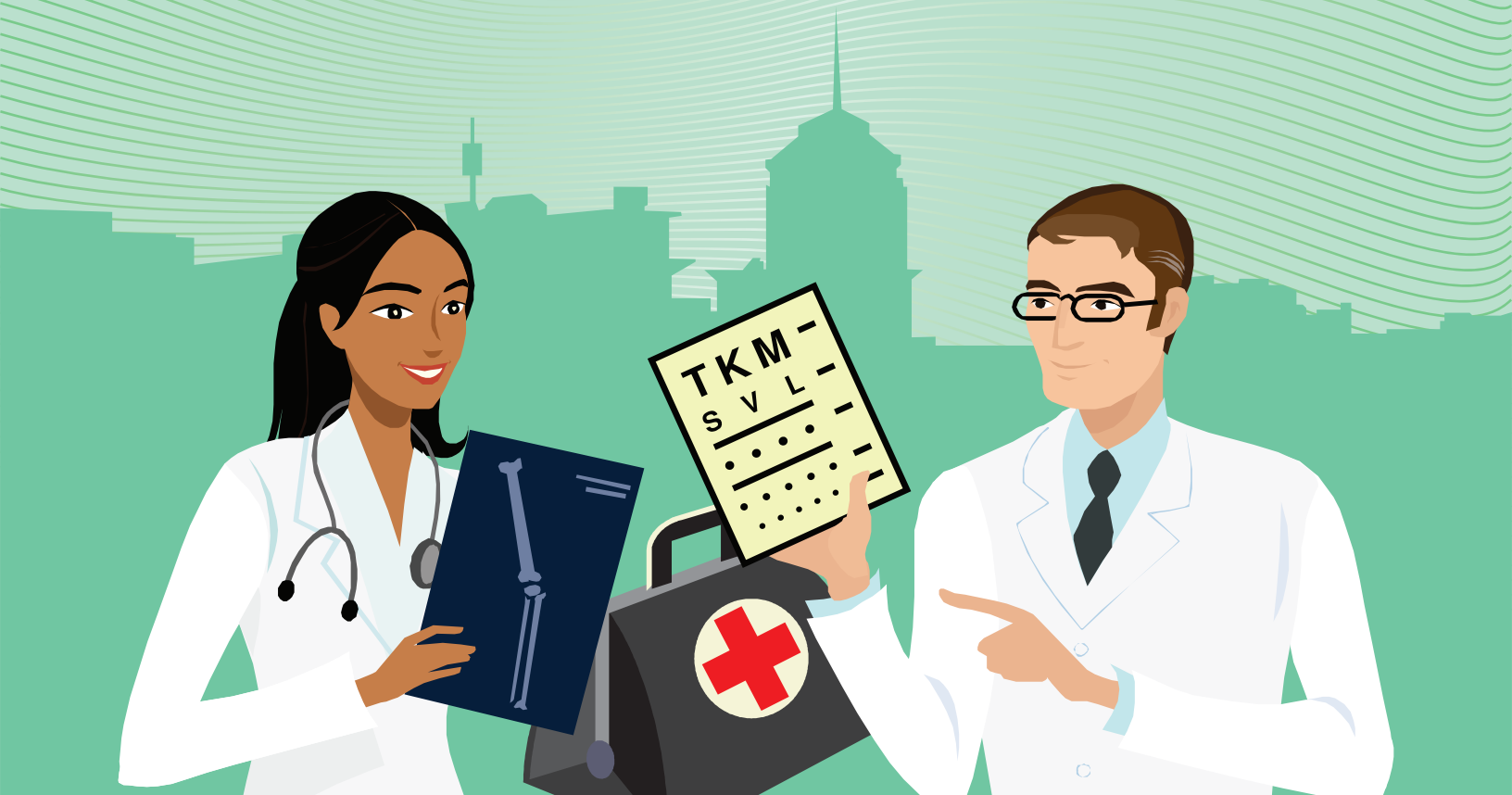
- ANTHEM BLUE CROSS **HDPPO**
- KAISER **HMO**
- THE HARTFORD **GROUP MEDICARE RETIREE PLAN**
- KAISER **SENIOR ADVANTAGE - HIGH**
- KAISER **SENIOR ADVANTAGE - LOW**

SUPPLEMENTAL BENEFITS

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

PLAN YEAR 2012

MEDICAL • PRESCRIPTIONS • VISION • DENTAL • MENTAL HEALTH



MEDICAL PLANS COUNTY OF FRESNO HEALTH CARE BENEFITS COMPARISON - RETIREES

This information summarizes certain key features of the health/dental plans. It is provided for your convenience in comparing plans only. In all cases, **official documents legally govern the plans' operations and benefits**. Retirees must meet 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 referral and/or bona fide emergency or medical necessity are met. All benefits with a notation,"limit_____days" indicate the maximum covered per calendar or contract year. Please contact Employee Benefits at (559) 600-1810 for eligibility and premium payment information. Those enrolling into a Medicare Plan must be eligible for Medicare Parts A + B to qualify for coordination of Benefits with the health plan.

RATES PLAN YEAR 1/1/12 to 12/31/12

MONTHLY PREMIUMS

NON-MEDICARE RETIREES (UNDER AGE 65)	PLAN 1		PLAN 2	
Medical	ANTHEM BLUE CROSS **HDPPO**		KAISER **HMO**	
Prescription	Anthem Blue Cross **RX**		Kaiser **RX**	
Vision	Anthem Blue Cross **Mental Health**		Kaiser **Mental Health**	
Mental Health	MES **Vision**		Kaiser **Vision**	
Dental Plans	Delta **Dental DPPO**	MetLife **Dental DHMO**	Delta **Dental DPPO**	MetLife **Dental DHMO**
Retiree Only	$656.31	$625.16	$1,537.70	$1,506.55
Retiree + Child(ren)	$1,015.07	$983.10	$2,354.45	$2,322.48
Retiree + Spouse	$1,147.95	$1,103.94	$2,805.51	$2,761.50
Retiree + Spouse and Child(ren)	$1,508.49	$1,459.96	$3,595.64	$3,547.11
Medicare & Non Medicare	$1,182.23	$1,138.22	*	*

MEDICARE RETIREES (AGE 65 AND OVER)	PLAN 3		PLAN 4		PLAN 5	
Medical	HARTFORD / **BENISTAR**		KAISER **SENIOR ADVANTAGE - HIGH**		KAISER **SENIOR ADVANTAGE - LOW**	
Prescription	Express Scripts **RX**		Kaiser **RX**		Kaiser **RX**	
Vision	Avante **Mental Health**		Kaiser **Mental Health**		Kaiser **Mental Health**	
Mental Health	MES **Vision**		Kaiser **Vision**		Kaiser **Vision**	
Dental Plans	Delta **Dental DPPO**	MetLife **Dental DHMO**	Delta **Dental DPPO**	MetLife **Dental DHMO**	Delta **Dental DPPO**	MetLife **Dental DHMO**
Retiree Only	$547.38	$516.23	$370.57	$339.42	$339.34	$308.19
Retiree + Spouse	$1056.80	$1,012.79	$706.09	$662.08	$643.63	$599.62

* Not all Retiree Rate categories are included in this comparison sheet. Please contact Fresno County Employee Benefits at (559) 600-1810 if your situation is not identified.

Anthem HDPPO

See Rate Chart for Current Pricing
See Supplemental Charts for Additional Benefits

BENEFITS PLAN YEAR 1/1/12 to 12/31/12

Calendar-year Deductible: Individual $1,500/Family $3,000

PROVIDERS	In Network	Out of Network
PHYSICIAN SELECTION *(Service areas are defined in each plan's benefit summary)*	20%	40%
	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.	
PHYSICIAN SERVICES Office Visits/Hospital Care/Home Visits	20% after deductible.	40% after deductible.
PREVENTIVE SERVICES	Preventive care *(not subject to the calendar year deductible).*	
Routine Physicals - Pediatric and Adult/ Laboratory/ Immunizations/ Annual Breast and Pelvic	$0 co-pay.	40% after deductible.
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)*	20%	20%
Ambulance	20%	20%
EMERGENCY ROOM Accident or Illness	20% after deductible.	20% after deductible.
INPATIENT SERVICES		
Semiprivate Room, ICU	20% after deductible.	40% after deductible.
Bariatric Surgery	20%	Not covered.
OUTPATIENT SERVICES Surgery/X-RAY/ Lab Tests	20% after deductible.	40% after deductible.

PROVIDERS	In Network	Out of Network
SKILLED NURSING FACILITY	Limited to 100 days per calendar year.	
Freestanding SNF/ Hospital SNF Unit	20% after deductible.	40% after deductible.
OTHER BENEFITS	Limited to 100 days per calendar year.	
Home Health Care/ Hospice Care/Inpatient Respite Care	20% after deductible.	40% after deductible.
DURABLE MEDICAL EQUIPMENT	20% after deductible.	40% after deductible.
Prosthetic Medical Devices	Not limited to maximum.	
CHIROPRACTIC, PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY	Limited to 24 visits per calendar year. 20% after deductible.	40% after deductible.
REHABILITATIVE SERVICES		
Outpatient Services	20% after deductible.	40% after deductible.
ALLERGY TESTING AND TREATMENT	20% after deductible.	40% after deductible.
HEARING TEST/ HEARING AID	20% after deductible. * 1 aid per ear every 36 months.	40% after deductible.
INITIAL EVALUATION SPEECH AND HEARING DISORDERS	20% after deductible.	40% after deductible.
HEALTH EDUCATION	20% after deductible. Self-management training and education *(if billed by your provider, you will also be responsible for the office visit co-payment).*	40% after deductible.
DIABETES CARE	20% after deductible. Equipment, devices and supplies.	40% after deductible.
ACUPUNCTURE	20% after deductible. Limited to 12 visits per calendar year. Out of Network $30 maximum per visit.	40% 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 HDPPO

MES Vision DELTA DENTAL MetLife

BENEFITS PLAN YEAR 1/1/12 to 12/31/12

PROVIDERS	In Network	Out of Network
ANNUAL OUT OF POCKET MAXIMUM		
Individual	$3,000	$10,000
Family	$5,000	$15,000
PRESCRIPTION DRUGS Administered in Hospital or Dr. Office/Outpatient Prescriptions/Dental RX	Benefits provided by **Anthem B.C.** 20% after deductible. *(Subject to deductible.)*	40% after deductible.
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.	
Eyeglasses Lenses	**Every 12 Months.** *In Network:* Covers standard lenses at 100%. Progressive 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.	
Contact Lenses - Elective Contact Lenses	**Every 12 Months in lieu of eyeglasses.** *In Network:* $130 maximum. *Out of Network:* $130 maximum.	
Medically Necessary 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.	
MENTAL HEALTH SERVICES	Benefits provided by **Anthem B.C.**	
Inpatient	20% after deductible.	40% after deductible.
Outpatient	20% after deductible. Prior authorization required after twelfth visit.	40% 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.

KAISER PERMANENTE HMO

See Rate Chart for Current Pricing
See Supplemental Charts for Additional Benefits

BENEFITS PLAN YEAR 1/1/12 to 12/31/12

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 - Pediatric and Adult	No charge.
Laboratory/ Immunizations	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	$50 per trip.
EMERGENCY ROOM Accident or Illness	$100 per visit, waived if admitted.
INPATIENT SERVICES Semiprivate Room, ICU/ Bariatric Surgery *(Preauthorization Required)*	No charge at participating hospitals. Referral by a Plan physician required for all non-emergency hospital services.
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	
Routine Home Care/ Inpatient Respite Care	No charge if prescribed by a Plan physician.
Home Health Care/Home Hospice Care	3 visits per day. 100 visits per year.
DURABLE MEDICAL EQUIPMENT Prosthetic Medical Devices	20% co-insurance. External prosthetic and orthotic devices.
PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY	$15 per visit. Occupational and speech therapy.
REHABILITATIVE SERVICES Outpatient Services	
ALLERGY TESTING AND TREATMENT	$15 per visit. $3 per injection.
HEARING TEST	No charge.
HEARING AID	$1,000 per aid every 36 months.
INITIAL EVALUATION SPEECH AND HEARING DISORDERS	$15 per visit.
HEALTH EDUCATION/ DIABETES CARE	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.

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

DELTA DENTAL MetLife

BENEFITS PLAN YEAR 1/1/12 to 12/31/12

COORDINATION OF BENEFITS	Required.
PRESCRIPTION DRUGS	
Administered in Hospital or Dr. Office	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	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.
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.

THE HARTFORD
GROUP MEDICARE RETIREE PLAN

See Rate Chart for Current Pricing
See Supplemental Charts for Additional Benefits

Disclaimer: The benefits described are for illustrative purposes only and are not binding.

BENEFITS PLAN YEAR 1/1/12 to 12/31/12

$0 Deductible

PHYSICIAN SELECTION *(Service areas are defined in each plan's benefit summary)*	The Hartford Product does not contract with providers. A member may receive health care services from any licensed provider as long as that provider participates in Original Medicare and is willing to accept the terms and conditions of the Hartford Medicare Supplement plan.
PHYSICIAN SERVICES	
Office Visit	$0 co-pay.
Specialist	$0 co-pay.
Urgent Care	$0 co-pay for each Medicare-covered visit.
PREVENTIVE SERVICES	
Routine Physicals - Adult	$0 co-pay.
Laboratory	$0 co-pay.
Immunizations	$0 co-pay *(Influenza, Pneumonia and Hepatitis B).*
Annual Breast and Pelvic	Pelvic & Pap – $0 co-pay. Mammogram – $0 co-pay.
HOSPITAL SERVICES	For Medicare-covered hospital stays: $0 co-pay per admission.
EMERGENCY SERVICES *(When medically necessary)*	This coverage is worldwide and is limited to what is allowed under the Medicare fee schedule for the services performed/received in the United States. Coverage is also available for Emergency or urgent care services while traveling outside the United States during a temporary absence of less than 6 months. Please see EOC for full listing of coverage.
Ambulance	$0 co-pay for Medicare-covered ambulance services.
EMERGENCY ROOM Accident or Illness	$0 co-pay for each Medicare-covered emergency room visit. Emergency co-pay is waived if the member is admitted to the hospital within 72 hours for the same condition.
INPATIENT SERVICES Semiprivate Room, ICU	For Medicare-covered hospital stays: $0 co-pay per admission.

OUTPATIENT SERVICES	
Surgery	$0 co-pay for each Outpatient Hospital Facility or Ambulatory Surgical Center visit for surgery.
X-RAY/Lab Tests	$0 co-pay for each Medicare-covered x-ray visit. $0 co-pay for Medicare-covered clinical/diagnostic lab test.
SKILLED NURSING FACILITY Freestanding SNF/ Hospital SNF Unit	For Medicare-covered SNF stays: $0 co-pay per admission.
OTHER BENEFITS	
Home Health Care	$0 co-pay for Medicare covered home health visits.
Home Hospice Care	$0 co-pay.
DURABLE MEDICAL EQUIPMENT	0% co-insurance on all Medicare-covered DME and related supplies.
Prosthetic Medical Devices	0% co-insurance on all Medicare covered Prosthetic and related supplies.
PHYSICAL AND OCCUPATIONAL THERAPY, CARDIAC AND PULMONARY REHABILITATION AND SPEECH/LANGUAGE THERAPY	$0 co-pay per visit for Medicare-covered outpatient rehabilitation services.
ALLERGY TESTING AND TREATMENT	$0 co-pay.
HEARING TEST	Not covered.
HEARING AID	Not covered.
INITIAL EVALUATION SPEECH & HEARING DISORDERS	$0 co-pay.
CHIROPRACTIC CARE	$0 co-pay for each Medicare-covered visit.
ACUPUNCTURE	Not covered.
ANNUAL CO-PAYMENT LIMIT	Not applicable.
CLAIM FORMS	Not applicable.
COORDINATION OF BENEFITS	Medicare is primary payer. The Hartford is secondary.

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.

See Rate Chart for Current Pricing
See Supplemental Charts for Additional Benefits

THE HARTFORD
GROUP MEDICARE RETIREE PLAN

MES Vision | AVANTE BEHAVIORAL HEALTH | DELTA DENTAL | MetLife

BENEFITS PLAN YEAR 1/1/12 to 12/31/12

VISION BENEFITS	Benefits provided by the **MES.**
Co-payments Examinations	$5 per visit.
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. Benefits provided by **Medical Eye Services**.
Lens Customization/ Additional Benefits	Tinting, scratch coating, photo chromic lenses etc. Members responsible for non-basic lens options. 25% discount on second pair if purchased within one year.
PRESCRIPTION DRUGS	Benefits provided by **Express Scripts.**
Preferred Generic Retail	$0 co-pay.
Generic Retail	$10 co-pay.
Preferred Brand and Specialty Retail	$20 co-pay.
Non-preferred Brand Retail	$30 co-pay.
MENTAL HEALTH SERVICES	Benefits provided by the **Hartford and Avante**.
Inpatient	For Medicare-covered Hospital Stays: $0 co-pay per admission.
	$0 co-pay for each Medicare-covered individual or group therapy visit.
Outpatient	Additional services provided by **Avante**.

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KAISER PERMANENTE

SENIOR ADVANTAGE - HIGH

See Rate Chart for Current Pricing
See Supplemental Charts for Additional Benefits

BENEFITS PLAN YEAR 1/1/12 to 12/31/12

PHYSICIAN SELECTION *(Service areas are defined in each plan's benefit summary)*	Subscriber must have Medicare Parts A and B + D and live within the Kaiser Service Area. Physician's services are provided at Kaiser Permanente Medical Offices by teams of physicians affiliated with the Plan. You may choose a personal physician from the staff for you and your family members.
PHYSICIAN SERVICES	
Office Visits	$15 per visit.
Hospital Care	No charge.
Home Visits	No charge when authorized by Plan physician.
PREVENTIVE SERVICES	
Routine Physicals - Pediatric and Adult	$0 per visit.
Laboratory	No charge.
Immunizations/ Annual Breast and Pelvic	$0 per visit.
HOSPITAL SERVICES	Hospital services are provided at Kaiser Foundation Hospitals or at other hospitals contracting with the Plan.
EMERGENCY SERVICES *(When medically necessary)*	Emergency services are provided at $50 per visit; waived if admitted. Must be medically necessary and authorized by Plan physician. Worldwide coverage for unforeseen illness or injury.
Ambulance	Provided at $100 co-pay when medically necessary or authorized by Plan Physician.
EMERGENCY ROOM Accident or Illness	$50 per visit, waived if admitted.
INPATIENT SERVICES Semiprivate Room, ICU	No charge.
OUTPATIENT SERVICES	
Surgery	$50 per procedure.
X-RAY/Lab Tests	No charge.
SKILLED NURSING FACILITY Freestanding SNF/ Hospital SNF Unit	No charge. Up to 100 days per benefit period. Each benefit period begins on the first day of acute stay or SNF stay and ends on the 61st day after discharge. A new benefit period then begins. Covered in Medicare-certified facility only by referral from Plan Physician.

OTHER BENEFITS Routine Home Care and Inpatient Respite Care/Home Health Care/Home Hospice Care	Part time, intermittent care provided at no charge.
DURABLE MEDICAL EQUIPMENT	20% co-insurance.
Prosthetic Medical Devices	20% co-insurance.
PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY	$15 per visit. Inpatient provided at no charge.
REHABILITATIVE SERVICES	
Outpatient Services	$15 per visit.
ALLERGY TESTING AND TREATMENT	$15 per visit. $3 per injection.
HEARING TEST	$0 per visit.
HEARING AID	$1,000 allowance per device, one device per ear, two devices every 36 months.
HEALTH EDUCATION/ DIABETES CARE	A variety of health education classes are available.
CHIROPRACTIC CARE	$10 co-pay, limit "30 visits" per calendar year. Services must be rendered by an American Specialty Health Plan provider.
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	Not applicable.

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

SENIOR ADVANTAGE - HIGH

See Rate Chart for Current Pricing
See Supplemental Charts for Additional Benefits

DELTA DENTAL MetLife

BENEFITS PLAN YEAR 1/1/12 to 12/31/12

PRESCRIPTION DRUGS	
Administered in Hospital or Dr. Office	No charge.
Outpatient Prescriptions	Generic: $5 for up to 100-day supply. Brand: $20 for up to 100-day supply.
VISION BENEFITS	
Co-payments Examinations	$0 per visit.
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.
MENTAL HEALTH SERVICES	
Inpatient	Referral by a Plan physician required for all non-emergency hospital admissions.
Outpatient	$15 per visit; unlimited visits. No limit for parity diagnosis *(severe mental illness)*.

KAISER PERMANENTE

SENIOR ADVANTAGE - LOW

See Rate Chart for Current Pricing
See Supplemental Charts for Additional Benefits

BENEFITS PLAN YEAR 1/1/12 to 12/31/12

PHYSICIAN SELECTION *(Service areas are defined in each plan's benefit summary)*	Subscriber must have Medicare Parts A and B + D and live within the Kaiser Service Area. Physician's services are provided at Kaiser Permanente Medical Offices by teams of physicians affiliated with the Plan. You may choose a personal physician from the staff for you and your family members.
PHYSICIAN SERVICES	
Office Visits	$15 per visit.
Hospital Care	No charge.
Home Visits	No charge when authorized by Plan physician.
PREVENTIVE SERVICES	
Routine Physicals - Pediatric and Adult	$0 per visit.
Laboratory	No charge.
Immunizations/ Annual Breast and Pelvic	$0 per visit.
HOSPITAL SERVICES	Hospital services are provided at Kaiser Foundation Hospitals or at other hospitals contracting with the Plan.
EMERGENCY SERVICES *(When medically necessary)*	Emergency services are provided at $50 per visit; waived if admitted. Must be medically necessary and authorized by Plan physician. Worldwide coverage for unforeseen illness or injury.
Ambulance	$100 co-pay when medically necessary or authorized by Plan Physician.
EMERGENCY ROOM Accident or Illness	$50 per visit, waived if admitted.
INPATIENT SERVICES Semiprivate Room, ICU	No charge.
OUTPATIENT SERVICES	
Surgery	$50 per procedure.
X-RAY/Lab Tests	No charge.
SKILLED NURSING FACILITY Freestanding SNF/ Hospital SNF Unit	No charge. Up to 100 days per benefit period. Each benefit period begins on the first day of acute stay or SNF stay and ends on the 61st day after discharge. A new benefit period then begins. Covered in Medicare-certified facility only by referral from Plan Physician.
OTHER BENEFITS Routine Home Care and Inpatient Respite Care/Home Health Care/Home Hospice Care	Part time, intermittent care provided at no charge.
DURABLE MEDICAL EQUIPMENT	20% co-insurance.
Prosthetic Medical Devices	20% co-insurance.
PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY	$15 per visit. Inpatient provided at no charge.
REHABILITATIVE SERVICES	
Outpatient Services	$15 per visit.
ALLERGY TESTING AND TREATMENT	$15 per visit. $3 per injection.
HEARING TEST	$0 per visit.
HEARING AID	$1,000 allowance per device, one device per ear, two devices every 36 months.
HEALTH EDUCATION/ DIABETES CARE	A variety of health education classes are available.
CHIROPRACTIC CARE	$10 co-pay, limit "30 visits" per calendar year. Services must be rendered by an American Specialty Health Plan provider.
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	Not applicable.

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

SENIOR ADVANTAGE - LOW

See Rate Chart for Current Pricing
See Supplemental Charts for Additional Benefits

DELTA DENTAL MetLife

BENEFITS PLAN YEAR 1/1/12 to 12/31/12

PRESCRIPTION DRUGS	
Administered in Hospital or Dr. Office	No charge.
Outpatient	Generic: $10 for up to 30-day supply. Brand: $25 for up to 30-day supply.
Prescriptions	Generic: $20 for up to 100-day mail order supply. Brand: $50 for up to 100-day mail order supply.
VISION BENEFITS	
Co-payments Examinations	$0 per visit.
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.
MENTAL HEALTH SERVICES	
Inpatient	Referral by a Plan physician required for all non-emergency hospital admissions.
Outpatient	$15 per visit; unlimited visits. No limit for parity diagnosis.

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 RETIREES

www.co.fresno.ca.us/openenrollment

MEDICAL

Anthem Blue Cross HDPPO ($1,500) / Phone: (866) 207-9878
Kaiser HMO Pre-65 / Phone: (800) 464-4000
The Hartford / Benistar / Phone: (800) 236-4782
Kaiser Senior Advantage (High and Low) / Phone: (800) 443-0815
24/7 Nurseline for HDPPO / Phone: (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

MENTAL HEALTH – AVANTE

Phone: (559) 261-9060

PERSONNEL SERVICES
EMPLOYEE BENEFITS

OPEN ENROLLMENT OFFICE

2220 Tulare Street, 14th Floor
Fresno, California 93721
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