

CITY OF BAKERSFIELD 2016 Employees & Retirees Medical Benefits	Kaiser Permanente	Kaiser High Deductible	Blue Shield HMO Access+ & TRIO Plans <u>Not Available to Retirees</u>	Blue Shield PPO In Network (PPO) 10% Out of Network 50%
	<u>YOU WILL PAY</u>	<u>YOU WILL PAY</u>	<u>YOU WILL PAY</u>	<u>YOU WILL PAY</u>
Lifetime Maximum	None	None	None	None Retirees \$5,000,000
Deductible				
Individual	None	\$1,000 Single	None	In-Network \$750.00
Two Party	None		None	\$1,500.00
Family	None	\$2,000 Family	None	\$2,250.00
Carryover Provision	None		None	None Out-of-Network \$1,000.00 \$2,000.00 \$3,000.00
Out-of-Pocket Limit Maximum	\$ 1,500 copay max single	\$3,000 copay max single	\$ 6,000 copay max single	In Network Single \$2,000 Out of Network \$7,000 In Network Family \$6,000 Out of Network \$21,000 All copays apply to the stop loss
	\$ 3,000 copay max family	\$6,000 copay max family		
Hospital	\$250 Copay Per admittance	30% Coinsurance after Deductible	\$250 per day Copay (\$750 max)	\$250 Copay + 10% Per Admission In Network 10%
INPATIENT Room and board and all medically necessary services, including general nursing care services, operating and special room fees, diagnostic x-ray and laboratory services	(all care must be referred by Primary Care Provider & authorized by the Medical Group)	(all care must be referred by Primary Care Provider & authorized by the Medical Group)	(all care must be referred by Primary Care Provider & authorized by the Medical Group)	Out of Network 50% * \$600/day. Members are responsible for 50% of this \$600/day, plus all charges in excess of \$600.
OUTPATIENT Physicians, Surgeons & Assistants Anesthesiology, Surgical room fee. Radiation & Chemotherapy treatment, renal dialysis Outpatient surgical center	\$25 Copay	30% Coinsurance after Deductible	\$125 Outpatient Surgery Only Outpatient Radiation, Chemotherapy, or Radiation \$40 per visit/admit (all care must be referred by Primary Care Physician & authorized by the Medical Group)	In Network 10% Out of Network 50% * \$350/day. Members are responsible for 50% of this \$350/day, plus all charges in excess of \$350 \$350/day. Members are responsible for 50% of this \$350/day, plus all charges in excess of \$350
Physician Care				
Office/Home Visits Includes All Specialists	\$25 Copay	\$30 Copay (Deductible does not apply)	\$20 Copay	In Network 10% (not subject to the Calendar Year medical deductible) Out of Network 50% (not subject to the Calendar Year medical
Hospital physician	No charge		No charge	
Visit to a specialist			\$40 Copay Self-referrals higher copy applies.	In Network 10% (not subject to the Calendar Year medical deductible) Out of Network 50% (not subject to the Calendar Year medical deductible

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Physician Care - continued	No charge	No charge (Deductible does not apply)	\$0 Copay	No Charge
Well Child Care Immunization	No charge		\$0 Copay	
Preventative Care (Annual physical exam, pap smear, mammogram, prostate exam)	No charge		\$0 Copay	Non-Network 50% (subject to deductible)
Diagnostic X-Ray & Laboratory		\$10 per encounter after Deductible	DXL Charge	In Network 10%
Diagnostic X-Ray and Laboratory Services	No charge	MRI, most CT, & PET scans \$50 per procedure after Deductible	\$100/test for CT, MRI, PET	Out of Network 50% \$350/day. Members are responsible for 50% of this \$350/day, plus all charges in excess of \$350. Pre-authorization is required
Prescription Drugs	Formulary Brand or Generic \$10/\$20 copay	Generic \$10	Generic \$10; Brand (Formulary) \$25; Brand (Non-Formulary) \$45; Only Mail Order for Specialty (up to a 30-day supply) 20% (Up to \$200 copayment maximum per prescription)	Generic \$10; Brand (Formulary) \$20; Brand (Non-Formulary) \$20;
Drugs (approved by the Food and Drug Administration and prescribed by a physician)	30 day supply	Brand \$30 after \$100 drug Deductible up to 100 day supply	Mail Order (90-day Supply)	Mail Order (90-day Supply)
Includes preventive flu, pneumonia & shingles vaccines administered by a participating retail pharmacy.	Limitations contact Member Services		Generic \$10; Brand (Formulary) \$10; Brand (Non-Formulary) \$90; Only Mail Order for Specialty (up to a 30-day supply) 20% (up to \$200 copay max)	Generic \$20; Brand (Formulary) \$30; Brand (Non-Formulary) \$30; Specialty (up to a 30-day supply) 30% (up to \$200 copay max)
Mail Order Program	\$20/\$40 up to a 100-day supply	Deductible for Certain Drugs \$100 per member		
Emergency Room				\$100 Copay + 10% (not subject to the Calendar Year medical deductible)
	\$100 Copay (waived if admitted)	30% Coinsurance after Deductible	ER \$100 Copay (waived if admitted)	
Ambulance				
Ground / Air Ambulance Services (when medically necessary)	\$100 per trip	\$150 per trip after Deductible	\$100 per trip	10% in/out network
Family Planning			\$50 Copay: Vasectomy	In Network 10%, Tubal ligation 10%, Vasectomy 10% (Not subject to the Calendar Year medical deductible)
Sterilization	\$25 Copay	50% Coinsurance (Deductible doesn't apply)	Tubal Ligation \$0 Copay	
Infertility Testing/Treatment	\$20 Copay		50% Copay	Not Covered
Contraceptive Devices/Fitting	No charge		\$20 Copay	10% (Not subject to the Calendar Year medical deductible)

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Home Health Services Medically necessary services obtained through a licensed Home Health Agency; (custodial care not covered)	No charge	Up to 100 visits No Charge (Deductible doesn't apply)	\$20 Copay (Limit; 100 visits/year)	In Network 10% Out of Network 50% (Limit; 100 visits/year)
Skilled Nursing Services provided in a licensed skilled nursing facility when medically necessary; custodial care not covered	No charge (up to 100 days/year)	30% Coinsurance after Deductible (up to 100 days/year)	No charge (up to 100 days/year)	In/Out Network 10% free-standing In/Out Network 50% at hospital
Therapy & Physical Medicine Speech therapy following injury or surgery	Outpatient: \$25 Copay	\$30 per visit after Deductible	\$20 Copay Referral from Primary Care Physician required (No max based on medical necessity.)	In 10%/Out 50% In 10%/Out 50%
Chiropractic	Not covered	Not covered	\$15 copay 60 Visits combined with acupuncture	In Network 10% calendar year
Durable Medical Equipment i.e.... Hearing aids, wheelchairs, nebulizers, crutches, pumps (Hearing aids limit 36 months)	20% Based on Formulary List	20% Coinsurance (Deductible doesn't apply)	50% Hearing Aids Not Covered	In Network 10% Out Network 50%
Other Acupuncture Unreplaced Blood and Blood Products Health Education Classes Diabetes Education Programs Hospice Organ and Tissue Transplant	Not covered No charge Offered by Medical Group at little or no cost No charge No charge No charge	Not covered No charge Offered by Medical Group at little or no cost No charge No charge	\$15 copay 60 visits combined with Chiropractic No charge Offered by Medical Group at little or no cost \$20 No charge \$250 per day (\$750 max)	In Network 10%/ Out Network 50% Acupuncture limited to 20 visits per calendar year 10% Not covered Diabetes self-mgmt. training 10% no ded / 50% In Network No Charge / Out Network 50%
Eye Care	Exam - \$25 annually at participating provider contact member services Eyewear Covered by Medical Eye Service www.mesvision or contact your Benefits office for forms & information	Exam No Charge (Deductible doesn't apply) Eyewear Covered by Medical Eye Service www.mesvision or contact your Benefits office for forms & information	Eye Exam Eyewear Covered by Medical Eye Service Co. www.mesvision or contact your Benefits office for forms & information	<i>This benefit is not available to Retirees</i> Eye Exam and Eyewear Covered by Medical Eye Service www.mesvision or contact your Benefits office for forms & information

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Mental Health	\$25 Copay - \$12 group visit	\$30 individual visit - \$15 group visit (Deductible doesn't apply)	Inpatient - Facility based care (approval req'd) \$250/day, up to a 3 day max.	In Network Inpt \$250+10%+ded / Out Network 50% up to \$600 per day Outpt 10% / 50% Outpt visits 10% no ded
Nervous Disorders & Substance Abuse	Out patient \$25-\$5 Impatient Rehab: \$250	Inpatient 30% Coinsurance after Deductible Out patient \$30 - \$5	Outpatient (approval req'd) \$20	Inpt \$250+10%+ded / 50% up to \$600 per day Outpt 10% / 50% Outpt visits 10% no ded