

CITY OF BAKERSFIELD 2017  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%	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>EMPLOYEES YOU WILL PAY</u>	<u>RETIREES YOU WILL PAY</u>		
Lifetime Maximum	None	None	None	None	None		
					Retirees \$5,000,000		
<b>DEDUCTIBLE</b>				In Network	Out of Network	In Network	Out of Network
Individual	None	\$1,000 Single	None	\$750	\$1,000.00	\$750	\$1,000.00
Two Party	None		None	\$1,500	\$2,000	\$1,500	\$2,000
Family	None	\$2,000 Family	None	\$2,250	\$3,000	\$2,250	\$3,000
Carryover Provision	None		None	None	n/a	None	n/a
<b>OUT-OF-POCKET LIMIT MAXIMUM</b>							
	\$ 1,500 copay max single	\$3,000 copay max single	\$ 3,000 copay max single	In Network Single \$2,000 Out of Network \$7,000	In Network Single \$2,000 Out of Network \$7,000		
	\$ 3,000 copay max family	\$6,000 copay max family	\$ 6,000 copay max family	In Network Family \$6,000 Out of Network \$21,000 All copays apply to the stop loss	In Network Family \$6,000 Out of Network \$21,000 All copays apply to the stop loss		
<b>HOSPITAL</b>							
<b>INPATIENT</b> Room and board and all medically necessary services, including general nursing care services, operating and special room fees, diagnostic x-ray and laboratory services	\$250 Copay per admittance(all care must be referred by Primary Care Provider & authorized by the Medical Group)	30% Coinsurance after Deductible. \$250 Copay per admittance (all care must be referred by Primary Care Provider & authorized by the Medical Group)	\$250 per day Copay (\$750 max) (all care must be referred by Primary Care Provider & authorized by the Medical Group)	\$250 Copay + 10% Per Admission  In Network 10%  Out of Network 50% *  \$600/day. Members are responsible for 50% of this \$600/day, plus all charges in excess of \$600.	\$250 Copay + 10% Per Admission  In Network 10%  Out of Network 50% *  \$600/day. Members are responsible for 50% of this \$600/day, plus all charges in excess of \$600.		
<b>OUTPATIENT</b>							
Physicians, Surgeons & Assistants Anesthesiology, Surgical room fee. Radiation & Chemotherapy treatment, renal dialysis  Outpatient surgical center	\$25 Copay	30% Coinsurance after Deductible Per Procedure	\$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	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		
<b>PHYSICIAN CARE</b>							
<b>Office/Home Visits</b> Includes All Specialists	\$25 Copay	\$30 Copay (Deductible does not apply)	\$20 Copay	In Network 10% (not subject to the Calendar Year medical deductible)	In Network 10% (not subject to the Calendar Year medical deductible)		
<b>Hospital physician</b>	No charge	No charge	No charge	Out of Network 50% (are subject to the Calendar Year medical deductible)	Out of Network 50% (are subject to the Calendar Year medical deductible)		
<b>Visit to a specialist</b>	\$25 Copay	\$30 Copay (Deductible does not apply)	\$20 Copay  Self-referrals higher Copay applies.	In Network 10% (not subject to the Calendar Year medical deductible)	In Network 10% (not subject to the Calendar Year medical deductible)		
<b>Well Child Care Immunization</b>	No charge	No charge (Deductible does not apply)	\$0 Copay	Out of Network 50% (is subject to the Calendar Year medical deductible)	Out of Network 50% (is subject to the Calendar Year medical deductible)		
<b>Preventative Care</b> (Annual physical exam, pap smear, mammogram, prostate exam)	No charge		\$0 Copay	No Charge Non-Network 50% (subject to deductible)	In Network preventative care is \$50, not subject to deductible.  In Network preventative care is \$50, not subject to deductible.  Non-Network 50% (subject to deductible)		
<b>DIAGNOSTIC X-RAY AND LABORATORY</b>							

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Diagnostic X-Ray and Laboratory (DXL) Services	No charge	\$10 per encounter after Deductible  MRI, most CT, & PET scans \$50 per procedure after Deductible	DXL No Charge   \$100/test for CT, MRI, PET	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. Pre- authorization is required.	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. Pre- authorization is required.
<b>PRESCRIPTION DRUGS</b>					
Drugs (approved by the Food and Drug Administration and prescribed by a physician)          <b>Includes preventive flu, pneumonia &amp; shingles vaccines administered by a participating retail pharmacy.</b>	Formulary Brand or Generic \$10/\$20 copay 30 day supply     Limitations contact Member Services  Specialty RX - 20% Coinsurance (not to exceed \$150) for up to a 30-day supply	Generic \$10  Brand \$30 after \$100 drug Deductible up to 100 day supply  Deductible for Certain Drugs \$100 per  Specialty RX - 20% Coinsurance (not to exceed \$150) for up to a 30-day supply	Generic \$10; Brand (Formulary) \$50; 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;	Generic \$10; Brand (Formulary) \$20; Brand (Non-Formulary) \$20;
<b>RX MAIL ORDER PROGRAM</b>					
	\$20/\$40 up to a 100-day supply		<u>Mail Order (90-day Supply)</u>  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)	<u>Mail Order (90-day Supply)</u>  Generic \$20; Brand (Formulary) \$30, Brand (Non-Formulary) \$30, Specialty (up to a 30-day supply) 30% (up to \$200 copay max)	<u>Mail Order (90-day Supply)</u>  Generic \$20; Brand (Formulary) \$30, Brand (Non-Formulary) \$30, Specialty (up to a 30-day supply) 30% (up to \$200 copay max)
<b>EMERGENCY ROOM</b>					
	\$100 Copay (waived if admitted)	30% Coinsurance after Deductible	ER \$100 Copay (waived if admitted)	\$100 Copay + 10% (not subject to the Calendar Year medical deductible)	\$100 Copay + 10% (not subject to the Calendar Year medical deductible)
<b>AMBULANCE</b>					
Ground / Air Ambulance Services (when medically necessary)	\$100 per trip	\$150 per trip after Deductible	\$100 per trip	10% in/out network	10% in/out network
<b>FAMILY PLANNING</b>					
Sterilization	\$25 Copay	50% Coinsurance (Deductible doesn't apply)	\$50 Copay; Vasectomy; Tubal Ligation \$0 Copay	In Network 10%, Tubal ligation No charge, Vasectomy 10% (is subject to the Calendar Year medical deductible)	In Network 10%, Tubal ligation No charge, Vasectomy 10% (is subject to the Calendar Year medical deductible)
Infertility Testing/Treatment	\$25 Copay		50% Copay	Not Covered	Not Covered
Contraceptive Devices/Fitting	No charge	No charge	\$20 Copay	No Charge	10% (Not subject to the Calendar Year medical deductible)
<b>HOME HEALTH SERVICES</b>					
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 Coverage limited to 100 visits per member per calendar year. Non- participating home health care & home infusion are not covered unless pre-authorized, you pay the participating provider Copayment.	In Network 10% Out of Network 50%  Coverage limited to 100 visits per member per calendar year. Non- participating home health care & home infusion are not covered unless pre-authorized, you pay the participating provider Copayment.	In Network 10% Out of Network 50%  Coverage limited to 100 visits per member per calendar year. Non- participating home health care & home infusion are not covered unless pre-authorized, you pay the participating provider Copayment.

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<b>SKILLED NURSING</b>					
Services provided in a licensed skilled nursing facility when medically necessary; custodial care not covered	No charge (up to 100 days per year)	30% Coinsurance after Deductible (up to 100 days per year)	No charge (up to 100 days per year)	In Network 10% free-standing  Out of Network 50% \$600/day. Members are responsible for 50% of this \$600/day, plus all charges in excess of \$600.	In Network 10% free-standing  Out of Network 50% \$600/day. Members are responsible for 50% of this \$600/day, plus all charges in excess of \$600.
<b>THERAPY &amp; PHYSICAL MEDICINE</b>					
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%	In 10%/Out 50%  In 10%/Out 50%
<b>CHIROPRACTIC</b>					
	Not covered	Not covered	\$15 copay 60 Visits combined with acupuncture	In Network 10% per calendar year Out of Network 50%	In Network 10% per calendar year Out of Network 50%
<b>DURABLE MEDICAL EQUIPMENT</b>					
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%	In Network 10%  Out Network 50%
<b>OTHER</b>					
Acupuncture	Not covered	Not covered	\$15 copay, 60 visits combined with Chiropractic	In Network 10%/ Out Network 50% Acupuncture limited to 20 visits per calendar year	In Network 10%/ Out Network 50% Acupuncture limited to 20 visits per calendar year
Unreplaced Blood and Blood Products	No charge	No charge	No charge	10%	10%
Health Education Classes	Offered by Medical Group at little or no cost	Offered by Medical Group at little or no cost	Offered by Medical Group at little or no cost	Not Covered	Not Covered
Diabetes Education Programs	No charge	No charge	\$20	Diabetes self-mgmt. training 10% no ded / 50%	Diabetes self-mgmt. training 10% no ded / 50%
Hospice	No charge	No charge	No charge	In Network No Charge. Out of Network is not covered unless prior authorized. When authorized, copayment/coinsurance calculated at the participating provider level, based upon the agreed rate between BS & agency.	In Network No Charge. Out of Network is not covered unless prior authorized. When authorized, copayment/coinsurance calculated at the participating provider level, based upon the agreed rate between BS & agency.
Organ and Tissue Transplant	No charge	No charge	\$250 per day (\$750 max)		
<b>EYE CARE</b>					
Vision Exam	Exam - \$25 annually at participating providers contact member services	Exam No Charge (Deductible doesn't apply)	Exam - \$20 annual at participating providers contact Medical Provider Network for doctor listing	Eye Exam and Eyewear: Covered by Medical Eye Services (MES) www.mesvision or contact Human Resources for forms & information.	Eye Exam and Eyewear: Covered by Medical Eye Services (MES) www.mesvision or contact Human Resources for forms & information.
Eyewear	Eyewear Covered by Medical Eye Service www.mesvision or contact your Human Resources for forms & information	Eyewear Covered by Medical Eye Service www.mesvision or contact your Human Resources for forms & information	Eye Exam Eyewear Covered by Medical Eye Service Co. www.mesvision or contact your Human Resources for forms & information	Eye exam & Eyewear are not available to Retirees within the Blue Shield PPO Plan.	Eye exam & Eyewear are not available to Retirees within the Blue Shield PPO Plan.
<b>MENTAL HEALTH</b>					

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	\$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 patient physician services. In network: No Charge  Out of Network 50%	In patient physician services. In network: No Charge  Out of Network 50%

**NERVOUS DISORDERS & SUBSTANCE ABUSE**

	Out patient \$25-\$5	Out patient \$30 - \$5	Outpatient (approval req'd) \$20	Routine outpatient mental health & substance use disorder services 10% (not subject to the calendar year medical deductible)	Routine outpatient mental health & substance use disorder services 10%
	Inpatient Rehab: \$250	Inpatient 30% Coinsurance after Deductible	Inpatient - Facility based care (approval req'd) \$250/day, up to a 3 day max.	In Network Inpatient hospital services \$250 per admission + 10% Out of Network 50% up to \$600 per day.	In Network Inpatient hospital services \$250 per admission + 10% Out of Network 50% up to \$600 per day.