

**CPOA  
Health Benefits Summary 2016 Plan Year**

	<b>Kaiser HMO \$15 / \$0 Kaiser Hospitals</b>	<b>Blue Cross HMO \$15 / \$0 Community Hospitals</b>	<b>Blue Cross PPO 80/60% \$500 Deductible St. Agnes &amp; Community</b>	<b>Blue Cross HDHP 100/50% \$3000 / 6000 Deductible St. Agnes &amp; Community</b>
<b>Rates shown are for preferred providers</b>				
<i>NOTE: The Annual Medical Deductible must be paid except where noted as "waived", before medical insurance benefits are received from the health plan.</i>				
Annual Deductible (Individual)	None	None	\$500/\$1000	\$3000/\$6000
Maximum out of Pocket (OOP) (annually, per individual/family)	\$1500/\$3000	\$1000/\$2000	\$3,000/\$6,000-PPO \$10,000/20,000-NonPPO	\$3,000/\$6,000 -PPO \$5,000/\$10,000 - NonPPO
Provider Network	Permanente	Sante	Anthem Blue Cross PPO	Anthem Blue Cross PPO
Maximum Lifetime Benefits (per individual)	unlimited	unlimited	unlimited	unlimited
Hospitalization - inpatient	No Charge	No Charge	\$250 + 20%	No Charge
Hospital - outpatient	\$15	No Charge	20%	No Charge
Office Visits - Primary Care Physician	\$15	\$15	\$35 (deductible waived)	No Charge
Office Visits-Specialist	\$15 (referral required)	\$15	\$35 (deductible waived)	No Charge
<b>Preventative</b>				
Laboratory & X-ray	No Charge	No Charge	No charge, x-ray excluded	No Charge
Allergy Testing/Treatment	\$15 Testing/\$5 Treatment (serum included)	\$15 copay serum & injections	20%	No Charge
Hearing Exam/Screening	No Charge	No Charge	No Charge, Deductible Waived	No Charge, Deductible Waived
Immunization/Inoculation	No Charge	No Charge	No Charge, Deductible Waived	No Charge, Deductible Waived
Well Woman Exam	No Charge	No Charge	No Charge, Deductible Waived	No Charge, Deductible Waived
Annual Physical Exam	No Charge	No Charge	No Charge, Deductible Waived	No Charge, Deductible Waived
Well Baby Care	No Charge	No Charge	No Charge, Deductible Waived	No Charge, Deductible Waived
Inpatient Hospital Doctor Visits	No Charge	No Charge	\$250 + 20%	No Charge
Outpatient Surgery/Anesthesia	No Charge	No Charge	20%	No Charge
Vision Exam (Refraction-Adult & Child)	No Charge	Not Covered	Not Covered	Not Covered
Diagnostic X-ray & Labs (DXL)	\$10	No Charge	No Charge except MRI other scans	No Charge
Durable Medical Equipment (DME)	20% includes diabetic testing supplies	No Charge	20%	No Charge
Covered Prescription Drugs (up to 1 mo supply)	\$10 for generic \$30 for brand	\$10 generic \$20 formulary brand-name \$35 non-formulary	\$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 \$40 formulary brand-name \$60 non-formulary	\$20 generic \$40 formulary brand-name \$60 non-formulary	No Charge
Ambulance	\$100	No Charge	20%	No Charge
Emergency Room	\$100	\$100	20%	No Charge
Mental Health - inpatient	No Charge	No Charge	\$250 per admission plus 20%	No Charge
Mental Health - outpatient	\$15	\$15	\$35	No Charge
Substance Abuse - inpatient	No Charge	No Charge	\$250 per admission plus 20%	No Charge
Substance Abuse - outpatient	\$5 group visit, \$15 individual visit	\$15	\$35	No Charge
Home Health Services	No Charge, 100 visits	\$15, 100 Visits	20% up to 100 per year	No Charge
Physical, Occupational, & Speech Therapy	\$15	\$15/visit - 60 day limit.	\$35	No Charge
Skilled Nursing Facility (SNF)	No Charge up to 100 days	No Charge up to 100 day max	20% up to 100 days	No Charge
Hospice	No Charge	No Charge	No Charge	No Charge
Acupuncture	Not Covered	\$10/visit 40 per year combined	20%, up to 20 per year	No charge up to 12 per year
Chiropractic	\$15/visit, up to 20 per year	\$10/visit 40 per year combined	\$25/visit, up to 12 per year	No Charge up to 24 per year
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. 100% some preventative services if in Network 50% of UCR, plus balance over UCR allowance for implant services			
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 exam, 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.			
<b>CPOA Employee Cost Per Month - 2016 Plan Year</b>				
<b>Coverage Type</b>	<b>Kaiser HMO \$15 / \$0</b>	<b>Blue Shield HMO \$15 / \$0</b>	<b>Blue Shield PPO 80%/60</b>	<b>Blue Shield HDHP 3000/6000</b>
<b>Total Health Coverage</b>				
Employee Only	\$56.74	\$102.81	\$134.17	\$0.00
Employee Plus Child(ren)	\$100.16	\$195.82	\$254.40	\$0.00
Employee & Spouse	\$116.33	\$230.58	\$296.36	\$0.00
Employee, Spouse & Child(ren)	\$165.11	\$335.18	\$429.20	\$0.00
				<b>Health Savings Account Inc.</b>
Employee Only		For the 2016 Plan Year, current employees will be eligible for the incentive at the benefit level at which they were enrolled in the 2015 plan year (EE, ES, EC, EF), regardless of plan. New employees will receive the appropriate level for which they are enrolling.		\$30.00
Employee Plus Child(ren)				\$60.00
Employee & Spouse				\$70.00
Employee, Spouse & Child(ren)				\$100.00
<b>WAIVER</b>	Employees not electing any health coverage for themselves or their families will receive a monthly health rebate of \$400. Life and EAP will continue at no cost.			