

**Transit Employees Bargaining Unit
Health Benefits Summary 2011 Plan Year**

	Kaiser HMO \$15 / \$0 Kaiser Hospitals	Blue Shield HMO \$15 / \$0 Community Hospitals	Blue Shield PPO 90/70% / \$0 St. Agnes & Community	Blue Shield PPO 80/60% / \$500 St. Agnes & Community	Blue Shield HDHP 3000 / 6000 St. Agnes & Community
<i>NOTE: The Annual Medical Deductible must be paid first, except where noted as "waived", before medical insurance benefits are received from the health plan.</i>					
Annual Deductible	None	None	Preferred / \$500 non-preferred	\$500 preferred & non-preferred	\$3000/\$6000
Maximum out of Pocket (OOP) (annually, per individual/family)	\$1500/\$3000	\$1000/\$2000	\$2000/\$6000	\$3000/\$6000	\$3000/\$6000
Provider Network	Permanent	Same	Blue Shield Preferred	Blue Shield Preferred	Blue Shield Preferred
Maximum Lifetime Benefits (per individual)	unlimited	unlimited	unlimited	unlimited	unlimited
Hospitalization - inpatient	\$0	\$0	10%	\$250 + 20%	No Charge
Hospital - outpatient	\$15	No Charge	10%	\$125 + 20%	No Charge
Office Visits - Primary Care Physician	\$15	\$15	(deductible waived) \$10	(deductible waived) \$35	No Charge
Office Visits-Specialist	\$15 (referral required)	\$15 w/ referral \$30 w/o referral	\$10 (deductible waived)	\$35 (deductible waived)	No Charge
Laboratory & X-ray	0 to \$10	No Charge	\$10	\$35	No Charge
Allergy Testing/Treatment	\$15 Testing/\$5 Treatment (serum included)	\$15	10%	20%	No Charge
Hearing Exam/Screening	No Charge	\$0	\$0	\$0	No Charge
Immunization/Inoculation	No Charge	\$0	No Charge	No Charge	No Charge
Annual GYN Exam	No Charge	\$0	No Charge	No Charge	No Charge
Annual Physical Exam	No Charge	\$0	No Charge	No Charge	No Charge
Well Baby Care	No Charge	\$0	No Charge	No Charge	No Charge
Inpatient Hospital Doctor Visits	No Charge	\$0	10%	20%	No Charge
Surgery/Anesthesia	No Charge	\$0	10%	20%	No Charge
Vision Exam (Refraction-Adult & Child)	No Charge	\$0 (screening for children only)	Not Covered	Not Covered	No Charge
Diagnostic X-ray & Labs (DXL)	\$10	\$0	10%	20%	No Charge
Durable Medical Equipment (DME)	20% includes diabetic testing supplies	20%	10%	20%	No Charge up to \$2,000 per year
Covered Prescription Drugs (up to 1 mo supply)	\$10 for generic \$30 for brand	\$10 generic \$15 formulary brand-name (Home self injection 20% \$100 max)	\$5 generic \$10 formulary brand-name \$25 non-formulary (Injectible drugs 30% up to \$150)	\$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 \$30 formulary brand-name	\$10 generic \$20 formulary brand-name \$50 non-formulary	\$20 generic \$40 formulary brand-name \$70 non-formulary	No Charge
Infertility	50%	for counseling, 50% for treatm	Not Covered	Not Covered	No Charge
Ambulance	\$100	\$100	10%	20%	No Charge
Emergency Room	\$100	\$100	10%	20%	No Charge
Mental Health - inpatient	\$0 up to 30 days per year	\$0	10%	\$250 per admission plus 20%	No Charge
Mental Health - outpatient	\$15	\$15	\$10	\$35	No Charge
Substance Abuse - inpatient	\$0 (Detox Only)	\$0	10% (rehab included)	20% (rehab included)	No Charge
Substance Abuse - outpatient	\$5 group visit, \$15 individual visit	\$15	\$10	\$35	No Charge
Home Health Services	No Charge	\$15	10%	20%	No Charge
Physical, Occupational, & Speech Therapy	\$15	\$15	\$10	\$35	No Charge
Skilled Nursing Facility (SNF)	\$0, up to 100 days per benefit period	\$0 up to 100 day max	10%	20%	No Charge
Hospice	No Charge	No Charge	10%	20%	No Charge
Acupuncture	Not Covered	Not Covered	\$25/visit, up to 20 per year	Not Covered	Not Covered
Chiropractic	\$15/visit, up to 20 per year	\$10/visit	\$25/visit, up to 12 per year	\$25/visit, up to 12 per year	No Charge
Blood & Blood Products	No Charge	\$0	\$10	\$20	\$0
Audiology Exam	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Hearing Aid	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Employee Assistance Plan	3 visits, individual or family, 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				
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	\$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.				

Transit Employee Cost Per Month - 2011 Plan Year

Coverage Type	Kaiser HMO \$15 / \$0	Blue Shield HMO \$15 / \$0	Blue Shield PPO 90% / \$0	Blue Shield PPO 80% / \$500	Blue Shield HDHP 3000/6000
Total Health Coverage					
Employee Only	\$0.00	\$42.71	\$407.57	\$73.54	\$0.00
Employee Plus Child(ren)	\$23.54	\$124.63	\$781.35	\$181.94	\$0.00
Employee & Spouse	\$37.33	\$155.28	\$921.38	\$219.94	\$0.00
Employee, Spouse & Child(ren)	\$78.90	\$247.40	\$1,341.97	\$339.82	\$0.00
					Health Savings Account Inc.
Employee Only					\$30.00
Employee Plus Child(ren)					\$60.00
Employee & Spouse					\$70.00
Employee, Spouse & Child(ren)					\$100.00
					Transit rates include the deferred compensation monthly discount of:
					\$60.58
WAIVER	Employees electing no City of Clovis health coverage of any type (Life and EAP will continue at no cost) for themselves or any family member will receive a monthly health premium rebate for this plan year of \$400				