

**CITY PROPOSAL – HEALTHCARE COST SHARING**

Proposed Language:

Effective pay date July 1, 2011, the City pays eighty-five percent (85%) of the cost of the lowest priced plan for the employee or the employee and dependent coverage and the employee pays fifteen percent (15%) of the premium for the lowest priced plan. If the employee selects a plan other than the lowest priced plan, the employee pays the difference between the total cost of the selected plan and the City's contribution towards the lowest priced plan.

Effective pay date January 13, 2012, the City pays eight-five percent (85%) of the cost of the lowest priced Non-Deductible HMO plan for the employee or the employee and dependent coverage and the employee pays fifteen percent (15%) of the premium for the lowest priced Non-Deductible HMO plan. If the employee selects a plan other than the lowest priced Non-Deductible HMO plan, the employee pays the difference between the total cost of the selected plan and the City's contribution toward the lowest priced Non-Deductible HMO plan.

Effective January 1, 2012, Kaiser Permanente Deductible HMO Benefit Plan 3800 will be available to employees represented by ABMEI in addition to the existing plan options.



Customer Name:  
Customer ID:

Benefit Plan 3800  
HCR TYPE XD5; \$1500 DED;  
\$40 OUTP; 30% INPT; \$30/\$10RX

**Proposed Benefit Summary**

**Principal Benefits for Kaiser Permanente Deductible HMO Plan (1/1/11—12/31/11)**

The Services described below are covered only if all the following conditions are satisfied:

- The Services are Medically Necessary
- The Services are provided, prescribed, authorized, or directed by a Plan Physician and you receive the Services from Plan Providers inside our Northern California Region Service Area (your Home Region), except where specifically noted to the contrary in the *Evidence of Coverage (EOC)* for authorized referrals, hospice care, Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

**Annual Out-of-Pocket Maximum for Certain Services**

For Services subject to the maximum, you will not pay any more Cost Sharing during a calendar year if the Copayments and Coinsurance you pay for those Services, plus all your Deductible payments, add up to one of the following amounts:

For self-only enrollment (a Family of one Member).....	\$4,000 per calendar year
For any one Member in a Family of two or more Members.....	\$4,000 per calendar year
For an entire Family of two or more Members.....	\$8,000 per calendar year

**Deductible for Certain Services as specified below**

You must pay Charges for Services you receive in a calendar year until you reach one of the following Deductible amounts:

For self-only enrollment (a Family of one Member).....	\$1,500 per calendar year
For any one Member in a Family of two or more Members.....	\$1,500 per calendar year
For an entire Family of two or more Members.....	\$3,000 per calendar year

**Lifetime Maximum**

None

**Professional Services (Plan Provider office visits)**

**You Pay**

At primary and specialty care consultations and exams .....	\$40 per visit (Deductible doesn't apply)
Routine physical maintenance exams .....	No charge (Deductible doesn't apply)
Well-child preventive exams (through age 23 months) .....	No charge (Deductible doesn't apply)
Family planning counseling .....	No charge (Deductible doesn't apply)
Scheduled prenatal care exams and first postpartum follow-up consultation and exam .....	No charge (Deductible doesn't apply)
Eye exams for refraction.....	No charge (Deductible doesn't apply)
Hearing exams .....	No charge (Deductible doesn't apply)
Urgent care consultations and exams .....	\$40 per visit (Deductible doesn't apply)
Physical, occupational, and speech therapy.....	\$40 per visit after Deductible

**Outpatient Services**

**You Pay**

Outpatient surgery and certain other outpatient procedures .....	30% Coinsurance after Deductible
Allergy injections (including allergy serum).....	No charge after Deductible
Most immunizations (including vaccines) .....	No charge (Deductible doesn't apply)
Most X-rays and laboratory tests .....	\$10 per encounter after Deductible
Preventive X-rays, screenings, and laboratory tests as described in the <i>EOC</i> ....	No charge (Deductible doesn't apply)
MRI, most CT, and PET scans.....	\$50 per procedure after Deductible
Health education:	
Covered individual health education counseling and programs .....	No charge (Deductible doesn't apply)
Covered group educational programs .....	No charge (Deductible doesn't apply)

**Hospitalization Services**

**You Pay**

Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs .....	30% Coinsurance after Deductible
--	----------------------------------

**Emergency Health Coverage**

**You Pay**

Emergency Department visits.....	30% Coinsurance after Deductible
----------------------------------	----------------------------------

**Ambulance Services**

**You Pay**

Ambulance Services.....	\$150 per trip after Deductible
-------------------------	---------------------------------

continued

<b>Prescription Drug Coverage</b>	<b>You Pay</b>
Most covered outpatient items in accord with our drug formulary guidelines:	
Generic items from a Plan Pharmacy.....	\$10 for up to a 30-day supply, \$20 for a 31- to 60-day supply, or \$30 for a 61- to 100-day supply (Deductible doesn't apply)
Generic refills from our mail-order service .....	\$10 for up to a 30-day supply or \$20 for a 31- to 100-day supply (Deductible doesn't apply)
Brand-name items from a Plan Pharmacy.....	\$30 for up to a 30-day supply, \$60 for a 31- to 60-day supply, or \$90 for a 61- to 100-day supply (Deductible doesn't apply)
Brand-name refills from our mail-order service .....	\$30 for up to a 30-day supply or \$60 for a 31- to 100-day supply (Deductible doesn't apply)
<b>Durable Medical Equipment</b>	<b>You Pay</b>
Most covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines.....	20% Coinsurance (Deductible doesn't apply)
<b>Mental Health Services</b>	<b>You Pay</b>
Inpatient psychiatric hospitalization and intensive psychiatric treatment programs.....	30% Coinsurance after Deductible
Outpatient mental health evaluation and treatment.....	\$40 per individual visit (Deductible doesn't apply) \$20 per group visit (Deductible doesn't apply)
<b>Chemical Dependency Services</b>	<b>You Pay</b>
Inpatient detoxification.....	30% Coinsurance after Deductible
Individual outpatient chemical dependency consultations and treatment.....	\$40 per visit (Deductible doesn't apply)
Group outpatient chemical dependency treatment.....	\$5 per visit (Deductible doesn't apply)
<b>Home Health Services</b>	<b>You Pay</b>
Home health care (up to 100 visits per calendar year).....	No charge (Deductible doesn't apply)
<b>Other</b>	<b>You Pay</b>
Skilled nursing facility care (up to 100 days per benefit period) .....	30% Coinsurance after Deductible
All covered Services related to infertility treatment.....	50% Coinsurance (Deductible doesn't apply)
Hospice care.....	No charge (Deductible doesn't apply)

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Sharing. For a complete explanation, please refer to the EOC. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

**Proposed monthly dues effective: 1/1/11—12/31/11**

- Subscriber**
- Subscriber & Spouse**
- Subscriber & Child(ren)**
- Subscriber & Family**