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 IBEW in addition to the existing plan options.

KAISER PERMANENTE®

tomer Name:
stomer 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
essional Services (Plan Provider office visits)	**You Pay**
t primary and specialty care consultations and exams	$40 per visit (Deductible doesn't apply)
outine 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 *EOC*	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**
ulance Services	$150 per trip after Deductible

continues

continued

Prescription Drug Coverage	You Pay
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)
Durable Medical Equipment	**You Pay**
Most covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines	20% Coinsurance (Deductible doesn't apply)
Mental Health Services	**You Pay**
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)
Chemical Dependency Services	**You Pay**
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)
Home Health Services	**You Pay**
Home health care (up to 100 visits per calendar year)	No charge (Deductible doesn't apply)
Other	**You Pay**
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