

**Clovis Professional Technical Association  
Health Benefits Summary 2011 Plan Year**

	<b>Kaiser HMO \$15 / \$0 Kaiser Hospitals</b>	<b>Blue Shield HMO \$15 / \$0 Community Hospitals</b>	<b>Blue Shield PPO 90/70% / \$0 St. Agnes &amp; Community</b>	<b>Blue Shield PPO 80/60% / \$500 St. Agnes &amp; Community</b>	<b>Blue Shield HDHP 3000 / 6000 St. Agnes &amp; Community</b>
<small>NOTE: The Annual Medical Deductible must be paid first, except where noted as "waived", before medical insurance benefits are received from the health plan.</small>					
<b>Annual Deductible</b>	None	None	0 preferred / \$500 non-preferred	\$500 preferred & non-preferred	\$3000/\$6000
<b>Maximum out of Pocket (OOP) (annually, per individual/family)</b>	\$1500/\$3000	\$1000/\$2000	\$2000/\$6000	\$3000/\$6000	\$3000/\$6000
<b>Provider Network</b>	Permanent	Sante	Blue Shield Preferred	Blue Shield Preferred	Blue Shield Preferred
<b>Maximum Lifetime Benefits (per individual)</b>	unlimited	unlimited	unlimited	unlimited	unlimited
<b>Hospitalization - inpatient</b>	\$0	\$0	10%	\$250 + 20%	No Charge
<b>Hospital - outpatient</b>	\$15	No Charge	10%	\$125 + 20%	No Charge
<b>Office Visits - Primary Care Physician</b>	\$15	\$15	\$10 (deductible waived)	\$35 (deductible waived)	No Charge
<b>Office Visits-Specialist</b>	\$15 (referral required)	\$15 w/ referral \$20 w/o referral	\$10 (deductible waived)	\$35 (deductible waived)	No Charge
<b>Laboratory &amp; X-ray</b>	0 to \$10	No Charge	\$10	\$35	No Charge
<b>Allergy Testing/Treatment</b>	\$15 Testing/\$5 Treatment (serum included)	\$15	10%	20%	No Charge
<b>Hearing Exam/Screening</b>	No Charge	\$0	\$0	\$0	No Charge
<b>Immunization/Inoculation</b>	No Charge	\$0	No Charge	No Charge	No Charge
<b>Annual GYN Exam</b>	No Charge	\$0	No Charge	No Charge	No Charge
<b>Annual Physical Exam</b>	No Charge	\$0	No Charge	No Charge	No Charge
<b>Well Baby Care</b>	No Charge	\$0	No Charge	No Charge	No Charge
<b>Inpatient Hospital Doctor Visits</b>	No Charge	\$0	10%	20%	No Charge
<b>Surgery/Anesthesia</b>	No Charge	\$0	10%	20%	No Charge
<b>Vision Exam (Refraction-Adult &amp; Child)</b>	No Charge	\$0 (screening for children only)	Not Covered	Not Covered	No Charge
<b>Diagnostic X-ray &amp; Labs (DXL)</b>	\$10	\$0	10%	20%	No Charge
<b>Durable Medical Equipment (DME)</b>	20% includes diabetic testing supplies	20%	10%	20%	No Charge up to \$2,000 per year
<b>Covered Prescription Drugs (up to 1 mo supply)</b>	\$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
<b>Covered Prescription Drugs Mail Order (up to 3 mos. supply)</b>	\$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
<b>Infertility</b>	50%	for counseling, 50% for treat	Not Covered	Not Covered	No Charge
<b>Ambulance</b>	\$100	\$100	10%	20%	No Charge
<b>Emergency Room</b>	\$100	\$100	10%	20%	No Charge
<b>Mental Health - inpatient</b>	\$0 up to 30 days per year	\$0	10%	\$250 per admission plus 20%	No Charge
<b>Mental Health - outpatient</b>	\$15	\$15	\$10	\$35	No Charge
<b>Substance Abuse - inpatient</b>	\$0 (Detox Only)	\$0	10% (rehab included)	20% (rehab included)	No Charge
<b>Substance Abuse - outpatient</b>	\$5 group visit, \$15 individual visit	\$15	\$10	\$35	No Charge
<b>Home Health Services Physical, Occupational, &amp; Speech Therapy</b>	No Charge	\$15	10%	20%	No Charge
<b>Skilled Nursing Facility (SNF)</b>	\$0, up to 100 days per benefit period	\$0 up to 100 day max	10%	20%	No Charge
<b>Hospice</b>	No Charge	No Charge	10%	20%	No Charge
<b>Acupuncture</b>	Not Covered	Not Covered	\$25/visit, up to 20 per year	Not Covered	Not Covered
<b>Chiropractic</b>	\$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
<b>Blood &amp; Blood Products</b>	No Charge	\$0	\$10	\$20	\$0
<b>Audiology Exam</b>	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
<b>Hearing Aid</b>	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
<b>Employee Assistance Plan</b>	3 visits, individual or family, per 6 months. Psychological & Emotional, Marital Relationship, Parental Guidance, Substance Abuse, Work Performance, Legal & Financial referral. No co-pay.				
<b>Dental Plan Co-payment</b>	20% of UCR, plus balance over UCR allowance for all covered services except implants				
<b>Dental Plan Maximum Benefit</b>	\$2,000 per person, per Calendar Year for covered services				
<b>Vision Plan Co-payment</b>	\$25 for exam and/or for eyewear + balance over materials allowance				
<b>Allowable Frequency of use</b>	12 months each, for exam, lenses and frames or contacts in lieu of lenses and frames				
<b>Frame Allowance</b>	\$80				
<b>Contact lens Allowance</b>	\$150 toward total cost per year or \$250 per year if medically necessary.				
<b>Life Insurance</b>	\$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				
<b>Voluntary Life Insurance</b>	\$10,000 to \$500,000 for employee or spouse (50% of EE), subject to Evidence of Insurability.				
<b>Paid 100% by employee.</b>	\$2,000 for each child, available only if parent insured. Paid by employee through payroll deduction.				
<b>CPTA Employee Cost Per Month - 2011 Plan Year</b>					
<b>Coverage Type</b>	<b>Kaiser HMO \$15 / \$0</b>	<b>Blue Shield HMO \$15 / \$0</b>	<b>Blue Shield PPO 90% / \$0</b>	<b>Blue Shield PPO 80% / \$500</b>	<b>Blue Shield HDHP 3000/6000</b>
<b>Total Health Coverage</b>					
<b>Employee Only</b>	\$4.32	\$60.48	\$425.34	\$91.31	\$0.00
<b>Employee Plus Child(ren)</b>	\$41.32	\$142.41	\$799.13	\$199.72	\$0.00
<b>Employee &amp; Spouse</b>	\$53.10	\$173.05	\$939.15	\$237.71	\$0.00
<b>Employee, Spouse &amp; Child(ren)</b>	\$96.67	\$265.17	\$1,359.74	\$357.59	\$0.00
					<b>Health Savings Account Inc.</b>
<b>Employee Only</b>					\$30.00
<b>Employee Plus Child(ren)</b>					\$60.00
<b>Employee &amp; Spouse</b>					\$76.00
<b>Employee, Spouse &amp; Child(ren)</b>					\$100.00
					<b>CPTA rates include the deferred compensation monthly discount of:</b>
					<b>\$42.81</b>
<b>WAIVER</b>	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				