

## **FRESNO METROPOLITAN FLOOD CONTROL DISTRICT MEDICAL INSURANCE PLANS**

The Fresno Metropolitan Flood Control District offers three medical plans:

- 1) Blue Cross Prudent Buyer Classic – PPO**
- 2) Blue Cross California Care – HMO**
- 3) Kaiser Permanente**

Insurance coverage begins the first of the month following your date of hire. The District pays 100% of the employee cost and 60% of the dependent cost. The following is a summary of benefits only. Please contact the District for further information.

### **BLUE CROSS PLANS SUMMARY OF BENEFITS**

Description	Blue Cross Calif. Care - HMO	Blue Cross Prudent Buyer – PPO	
		<u>PPO Physician</u>	<u>Non-PPO</u>
<b>Deductibles</b> (per calendar yr)	None	\$200/Member	\$600/Family
<b><u>Hospital:</u></b>			
Inpatient	-0-	100%	100%
Outpatient	-0-	100%	100%
<b><u>Physician Care:</u></b>			
Office Visits	\$10/visit	\$15/visit	80%
Hospital/Skilled Nursing Facility	-0-	80%	80%
Well-Woman / Child Exams	\$10/visit	\$15/visit	80%
<b>Surgical Services</b>	-0-	80%	80%
<b>Diagnostic X-Ray/Lab</b>	-0-	80%	80%
<b>Durable Medical Equipment</b>	\$2,000 annual maximum	80%	80%
<b><u>Maternity:</u></b>			
Pre & Post-natal Care Office Visits	\$10/visit	\$15/visit	80%
Hospitalization & Nursery Care	-0-	100%	100%
<b><u>Family Planning:</u></b>			
Sterilization	\$50 vasectomy \$150 tubal ligation	80%	80%
Infertility Testing/Treatment	50% service & facility fees	Limited Coverage	
<b><u>Additional Benefits:</u></b>			
Ambulance	-0-	80%	80%
Emergency Room Services	\$50 (waived if hospitalized)	\$50 (waived if hospitalized)	
Home Health Services	-0- (limit 2 visits/day)	100%	100%
Skilled Nursing Care	-0- (100 days/calendar yr)	100%	100%
Outpatient Speech, Physical, and Occupational Therapy	-0- (60 days each injury)	80%	80%

**BLUE CROSS PLANS SUMMARY OF BENEFITS**

Description	Blue Cross Calif. Care - HMO	Blue Cross Prudent Buyer – PPO	
		PPO Physician	Non-PPO
<b>Chiropractic</b> (30 visits maximum per year)	\$10/visit	80%	80%
<b>Hospice</b>	-0-	100%	100%
<b><u>Mental/Nervous Disorders &amp; Chemical Dependency:</u></b>			
Inpatient PPO:		70% with \$300 Deductible	50% with \$600 Ded
Inpatient Physician Services PPO:		100%	100%
Inpatient HMO (Detoxification only)	-0-		
Outpatient:	\$20/visit	80%-100%	50%
<b>Maximum Co-payments per Calendar Year:</b>	\$500 per member \$1,500 per family		
<b>Maximum Stop Loss per Calendar Year:</b> - Major Medical Only (Benefits paid under Mental Health and Basic not included)		\$4,000	\$8,000
<b>Lifetime Maximum Benefits:</b>	Not Applicable	\$2,000,000 per Member	
<b><u>Outpatient Prescription Drugs - Retail 30-day Supply:</u></b>			
Generic	\$ 5.00	\$ 5.00	
Brand - single source (no generic available)	\$15.00	\$15.00	
Brand – multi source (generic is available)	\$25.00	\$25.00	
Non-formulary	\$35.00	\$35.00	
Biotechnological Drugs Co-payment (Maximum out-of-pocket \$100 per prescription)	20%	20%	
<b><u>Outpatient Prescription Drugs – Mail Order 90-day Supply:</u></b>			
Generic	\$10.00	\$10.00	
Brand - single source (no generic available)	\$30.00	\$30.00	
Brand – multi source (generic is available)	\$50.00	\$50.00	
Non-formulary	\$70.00	\$70.00	
Biotechnological Drugs Co-payment (Maximum out-of-pocket \$200 per prescription)	20%	20%	
<b>Retail &amp; Mail Order Calendar Year Maximum Out-of-Pocket</b>	\$2,000	\$2,000	

**KAISER PERMANENTE SUMMARY OF BENEFITS**

<b>Description</b>	<b>You Pay</b>
<b><u>Hospital Inpatient Care</u></b> – Room and board, surgery, anesthesia, X-rays, lab tests, and medications	No charge
<b><u>Outpatient Care</u></b> – Primary and specialty care visits for internal medicine, family practice, pediatrics, and gynecology (includes routine and urgent care appointments) Well-child preventive care visits (23 months or younger) Scheduled prenatal care and first postpartum visit Eye exams to provide a prescription for eyeglasses Hearing exams Outpatient surgery Allergy injection visits Immunizations X-rays and lab tests Physical, occupational, and speech therapy visits Health education for specific conditions: Individual visits Group visits Emergency Department visits (waived if admitted directly to the hospital)	\$5 per visit \$5 per visit \$5 per visit \$5 per visit \$5 per visit \$5 per procedure \$3 per visit No charge No charge No charge \$5 per visit No charge \$50
<b><u>Infertility Services</u></b> – Covered services related to the diagnosis and treatment of infertility	50% Coinsurance
<b><u>Mental Health Services</u></b> – Inpatient psychiatric care (up to 30 days per calendar year) Outpatient visits: Individual therapy visits Group therapy visits	No charge \$5 per visit \$2 per visit
<b><u>Chemical Dependency Services</u></b> – Inpatient detoxification Outpatient individual therapy visits Outpatient group therapy visits Transitional residential recovery services (up to 60 days per calendar year)	No charge \$5 per visit \$2 per visit \$2 per visit
<b><u>Additional Benefits</u></b> – Durable medical equipment in accord with KP formulary External sexual dysfunction devices in accord with our formulary External prosthetic and orthotic devices Skilled nursing facility care (up to 100 days per benefit period) Home health care Hospice care Ambulance Services	20% Coinsurance 50% Coinsurance 20% Coinsurance No charge No charge No charge \$50 per trip
<b><u>Outpatient Prescription Drugs</u></b> – Covered items in accord with KP formulary when obtained at Plan pharmacies Drugs for the treatment of infertility and sexual dysfunction disorders	\$5 –100 day supply 50% Coinsurance 100-day supply