

City of St. Helena
Human Resources
1480 Main Street
St. Helena, CA 94574

POA Anthem Health Plan Changes for 2016/17



MAY 3 2016

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Health Plan Changing Effective July 1, 2016

Amend the Anthem Health Plan Offering to Higher Deductible Tier for Plan Year 2016/17 per Article 21.1.C.

The City has received the Anthem premium plans renewals for Plan Year 2016/17. The City currently offers the EPO 250 plan through the REMIF Self-Funded Plan.

The chart below shows the current plan premiums for Plan Year 2015/16, plan premiums for Plan Year 2016/17 that go in effect July 1, 2016, and the percent change.

Participation	Premium 2015/16	Premium 2016/17	Percent Change
Employee Only	\$659	\$721	8.60%
Employee + 1	\$1,383	\$1,511	8.47%
Employee + Family	\$1,975	\$2,158	8.48%

As shown in the chart, the health insurance premiums have increased 8.52 percent from the previous year. Due to the increased cost for this plan, the City is amending the Anthem health plan offering to include the next higher deductible tier to offset costs per the Memorandum of Understanding between St. Helena Police Officer's Foundation and the City of St. Helena for the period July 1, 2014 - June 20, 2017, Article 21.1.C.

In the event City's health insurance premiums increase more than five percent (5%) on July 1 of any given year, the City can amend the health plan to the next higher deductible tier to offset cost. In the event the health insurance premiums increase more than fifteen percent (15) after deductibles have been amended, the members agree to split the cost increase 75%/25%, with the members paying 25%.

The next higher deductible plan offering is the EPO 500. POA members who are currently on the EPO 250 will be automatically enrolled in the REMIF Self-Funded EPO 500 unless during the open enrollment period the employee chooses to participate in the Kaiser plan.

Prior to open enrollment period, Human Resources will be available by appointment to review the options available. The City will assist employees in understanding their options, but will not advise employees on which options to choose.

Information regarding the health plan offerings are included in the attachments and are as follows:

- Attachment 1. Plan Year 2015/16 REMIF Self-Funded EPO 250
- Attachment 2. Plan Year 2016/17 REMIF Self-Funded Health Plans
- Attachment 3. REMIF Plan Year 2015/16 vs. Plan Year 2016/17 Comparison
- Attachment 4. Plan Year 2015/16 Kaiser Group Plan Offering
- Attachment 5. Plan Year 2016/17 Kaiser Group Plan Offering

Attachment 1
EPO 250
Plan Year 2015/16
(Current)

**Redwood Empire Municipal Insurance Fund
EPO 250**

Coverage Period: Begins on or after July 1, 2015 Attachment 1

Summary of Benefits and Coverage:
What this plan Covers & What it Costs

Coverage for:
Individual + Spouse + Children

Plan Type:
EPO

 This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at https://www.healthcomp.com or by calling 1(800) 442-7247.		
Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$250 per person / \$750 family Doesn't apply to: urgent care, organ transplant travel meals and lodging, office visits, second surgical opinions, preventive services, mental health in an office setting, substance abuse in an office setting, hospice care, bariatric travel expenses and diabetes education.	You must pay all costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1 st). See the Common Medical Events section for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the Common Medical Events section for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. Medical: \$3,400 per person; \$6,800 two party; \$10,000 family Prescription Drug: \$1,600 per person; \$3,200 family	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, utilization management program penalties, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The Common Medical Events section describes <i>specific</i> coverage limits, such as limits on the number of office visits.
Does this plan use a <u>network of providers</u> ?	Yes. See www.healthcomp.com or call 1(800) 442-7247 for a list of <u>network providers</u> .	If you use a <u>network</u> doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your <u>network</u> doctor or hospital may use a non-network <u>provider</u> for some services. Plans use the term <u>network, preferred,</u> or participating for <u>providers</u> in their <u>network</u> . See the Common Medical Events section for how this plan pays different kinds of <u>providers</u> .

Questions: Call 1 (800) 442-7247 or visit us at www.healthcomp.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1 (800) 442-7247 to request a copy.

**Redwood Empire Municipal Insurance Fund
EPO 250**

Coverage Period: Begins on or after July 1, 2015

Summary of Benefits and Coverage:
What this plan Covers & What it Costs

Coverage for:
Individual + Spouse + Children

Plan Type:
EPO

Important Questions	Answers	Why this Matters:
Do I need a referral to see a <u>specialist</u> ?	No. You don't need a referral to see a <u>specialist</u> .	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed in the Excluded Services and Other Covered Services section. See your policy or plan document for additional information about <u>excluded services</u> .



- Copayments are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- Coinsurance is your share of the cost of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount of an overnight hospital stay is \$1,000, your coinsurance payment of 20% would be \$200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If a non-network provider charges more than the allowed amount you may have to pay the difference. For example, if a non-network hospital charges \$1,500 for an overnight stay and the allowed amount is \$1,000, you may have to pay the \$500 difference. (This is called balance billing.)
- This plan may encourage you to use network providers by charging you lower deductibles, copayments and coinsurance amounts.

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What this plan Covers & What it Costs

Coverage for:
Individual + Spouse + Children

Plan Type:
EPO

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider *	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 copay/visit	Not covered	Copay applies to office visit charges only. Additional services billed at the time of the visit may be subject to deductible and applicable coinsurance.
	Specialist visit	\$25 copay/visit	Not covered	Copay applies to office visit charges only. Additional services billed at the time of the visit may be subject to deductible and applicable coinsurance.
	Other practitioner office visit	Acupuncture or Chiropractic care: No charge	Acupuncture or Chiropractic care: Not covered	Acupuncture: 12 visits per plan year. Chiropractic care: 24 visits per plan year combined with occupational therapy and physical therapy.
	Preventive care/screening/immunization	No charge	Not covered	As defined by the Patient Protection Affordable Care Act.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	None.
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Subject to utilization review.

* Coinsurance amounts apply to Recognized Charges only for non-network [providers](#). Actual charges may vary by [provider](#).

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Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider *	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.envisiorx.com	Tier 1 – Typically Generic	Retail: \$10 Mail order: \$15	Retail: \$10 plus all charges in excess of allowable charge Mail order: Not covered	Retail is limited to a 30 day supply. Mail order is limited to a 90 day supply and must be obtained through Orchard Pharmaceutical Services.
	Tier 2 - Preferred Brand Name Drugs	Retail: \$25 Mail order: \$38	Retail: \$25 plus all charges in excess of allowable charge Mail order: Not covered	Retail is limited to a 30 day supply. Mail order is limited to a 90 day supply and must be obtained through Orchard Pharmaceutical Services.
	Tier 3 - Non- Preferred Brand Name Drugs	Retail: \$25 Mail order: \$38	Retail: \$25 plus all charges in excess of allowable charge Mail order: Not covered	Retail is limited to a 30 day supply. Mail order is limited to a 90 day supply and must be obtained through Orchard Pharmaceutical Services.
	Tier 4 – Typically Specialty Drugs (includes self-administered injectable drugs, except insulin)	Mail order: \$25	Not covered	Must be obtained through Orchard Specialty Mail Order. Limited to a 30 day supply.

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Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider *	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	Certain surgeries are subject to utilization review.
	Physician/surgeon fees	No charge	Not covered	None.
If you need immediate medical attention	Emergency room services	\$100 copay/visit	\$100 copay/visit	Copay waived if admitted. This is for the hospital facility charge only. The emergency room physician may be separate.
	Emergency medical transportation	No charge	No charge	Non-Network Providers may balance bill for charges over the Plan's recognized charge.
	Urgent care	\$25 copay/visit	\$25 copay/visit	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Subject to utilization review for inpatient services and certain outpatient services; waived for emergency admissions.
	Physician/surgeon fee	No charge	Not covered	None.

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What this plan Covers & What it Costs

Coverage for:
Individual + Spouse + Children

Plan Type:
EPO

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider *	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Office setting: \$25 copay/visit Outpatient: No charge	Not covered	None.
	Mental/Behavioral health inpatient services	No charge	Not covered	Subject to utilization review for inpatient services and certain outpatient services; waived for emergency admissions.
	Substance use disorder outpatient services	Office setting: \$25 copay/visit Outpatient: No charge	Not covered	None.
	Substance use disorder inpatient services	No charge	Not covered	Subject to utilization review for inpatient services and certain outpatient services; waived for emergency admissions.
If you are pregnant	Prenatal and postnatal care	Prenatal visit: No charge Postnatal visit: \$25 copay/visit	Not covered	None.
	Delivery and all inpatient services	No charge	Not covered	None.

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Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider *	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Subject to utilization review. Coverage is limited to a total of 100 visits/plan year (one visit by a home health aide equals four hours or less).
	Rehabilitation services	No charge	Not covered	24 visits combined for chiropractic care, physical therapy and occupational therapy. Additional visits allowed for physical and occupational therapies if medically necessary.
	Habilitation services	No charge	Not covered	All rehabilitation and habilitation visits count toward your rehabilitation visit limit where applicable.
	Skilled nursing care	No charge	Not covered	Subject to utilization review. Coverage is limited to a combined total of 100 days per plan year.
	Durable medical equipment	No charge	Not covered	May be subject to utilization review.
	Hospice service	No charge	Not covered	None.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	Must enroll in separate vision plan for vision benefits.
	Glasses	Not covered	Not covered	Must enroll in separate vision plan for vision benefits.
	Dental check-up	Not covered	Not covered	Must enroll in separate dental plan for dental benefits.

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Excluded services & Other Covered Services:

Services your Plan Does Not Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
<ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult) • Infertility treatment 	<ul style="list-style-type: none"> • Long-term care • Non-emergency care when traveling outside the U.S. • Private-duty nursing 	<ul style="list-style-type: none"> • Routine eye care (Adult) • Routine foot care • Weight loss programs
Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
<ul style="list-style-type: none"> • Acupuncture • Bariatric surgery 	<ul style="list-style-type: none"> • Chiropractic care • Hearing aids 	

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Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at (800) 442-7247. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1 (877) 267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: HealthComp Administrators at 1(800) 442-7247.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-442-7247.

-----*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*-----

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

	<p>This is not a cost estimator.</p>
<p>Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.</p>	
<p>See the next page for important information about these examples.</p>	

Having a baby (normal delivery)		Managing type 2 diabetes (routine maintenance of a well-controlled condition)	
<ul style="list-style-type: none"> ▪ Amount owed to providers: \$7,540 ▪ Plan pays \$7,245 ▪ Patient pays \$295 		<ul style="list-style-type: none"> ▪ Amount owed to providers: \$5,400 ▪ Plan pays \$4,885 ▪ Patient pays \$515 	
Sample care costs:		Sample care costs:	
Hospital charges (mother)	\$2,700	Prescriptions	\$2,900
Routine Obstetric care	\$2,100	Medical Equipment and Supplies	\$1,300
Hospital Charges (baby)	\$900	Office Visits and Procedures	\$700
Anesthesia	\$900	Education	\$300
Laboratory tests	\$500	Laboratory tests	\$100
Prescriptions	\$200	Vaccines, other preventive	\$100
Radiology	\$200	Total	\$5,400
Vaccines, other preventive	\$40		
Total	\$7,540	Patient Pays:	
		Deductibles	\$250
Patient Pays:		Copays	\$185
Deductible	\$250	Coinsurance	\$0
Copays	\$45	Limits or exclusions	\$80
Coinsurance	\$0	Total	\$515
Limits or exclusions	\$0		
Total	\$295		

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Redwood Empire Municipal Insurance Fund EPO 250

Summary of Benefits and Coverage:
What this plan Covers & What it Costs

Coverage Period: Begins on or after July 1, 2015

Coverage for:
Individual + Spouse + Children

Plan Type:
EPO

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include [premiums](#).
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an exclusion.
- All services and treatment started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from [network providers](#). If the patient had received care from non-network [providers](#), costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the coverage helps you see how [deductibles](#), [copayments](#), and [coinsurance](#) can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

***No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

***No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your [providers](#) charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓Yes. An important cost is the [premium](#) you pay. Generally, the lower your [premium](#), the more you'll pay in out-of-pocket costs, such as [copayments](#), [deductibles](#), and [coinsurance](#). You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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Attachment 2
Plan Year 2016/17 REMIF
SELF-FUNDED HEALTH PLANS

This document is a comparative summary of benefits only. It is not intended to interpret or replace contract language. Where discrepancies occur, the benefits outlined in the plan document will prevail.



REMIF 2016 HEALTH PLANS

- Effective 7-1-16

Benefits	EPO 250		EPO 500		PPO 500		HSA 1300		PPO BlueCard 250 (Only For Out of State Retirees)		
	In Network Only		In Network Only		In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	
Plan Year Deductible	\$250 Single \$500 Two Party \$750 Family		\$500 Single \$1,000 Two Party \$1,500 Family		\$500 Single \$1,000 Two Party \$1,500 Family	\$1,000 Single \$2,000 Two Party \$3,000 Family	\$1,300 Single \$2,600 Family of 2 or more		\$250 Single \$500 Two Party \$750 Family	\$250 Single \$500 Two Party \$750 Family	
Plan Year Out of Pocket Max (OOP) ⁽¹⁾	Total Out of Pocket Maximums \$5,000 Single \$10,000 Two Party \$13,200 Family <i>Separate Medical and Rx OOP maximums accumulate per person up to the family maximum</i> Single = \$3,400 Medical; \$1,600 Rx					Total Out of Pocket Max: \$10,000 Single \$20,000 Two Party \$30,000 Family		Total Out of Pocket Max: \$5,000 Single \$10,000 Two Party \$13,200 Family (OOP maximum for Medical/Rx are combined)		Total Out of Pocket Max: \$6,000 Single \$12,000 Two Party \$18,000 Family <i>Separate Medical and Rx OOP maximums accumulate per person up to the family maximum</i> Single = \$3,400 Medical; \$1,600 Rx Single = \$4,400 Med; \$1,600 Rx	
Family Definition (for deductible and out of pocket maximum)	Single = Employee Only Two Party = Employee + 1 dependent Family = Employee + 2 or more dependents										
Coinurance (Percentage plan pays after deductible)	100% after deductible	90% after deductible	80% after deductible	70% after deductible	90% after deductible	70% after deductible	100% after deductible	70% after deductible	100% after deductible	70% after deductible	
Benefits below are what the MEMBER PAYS after deductible unless noted											
Preventive Care	\$0 Copay Deductible Waived	\$0 Copay Deductible Waived	\$0 Copay Deductible Waived	30%	\$0 Copay Deductible Waived	30%	\$0 Copay Deductible Waived	30%	\$0 Copay Deductible Waived	30%	
Office Visits - Primary Care	\$25 Copay Deductible Waived	\$30 Copay Deductible Waived	\$30 Copay Deductible Waived	\$50 Copay Deductible Waived	\$25 Copay Deductible Waived	30%	\$25 Copay Deductible Waived	30%	\$25 Copay Deductible Waived	30%	
Office Visits - Specialists	\$35 Copay Deductible Waived	\$40 Copay Deductible Waived	\$40 Copay Deductible Waived	\$60 Copay Deductible Waived	\$35 Copay Deductible Waived	30%	\$35 Copay Deductible Waived	30%	\$35 Copay Deductible Waived	30%	
Diagnostic Lab & X-Ray	\$10 copay after deductible	10%	20%	30%	\$10 copay after deductible	10%	\$10 copay after deductible	30%	\$10 copay after deductible	30%	
Advanced Imaging (CT, MRI, etc.) (Subject to utilization review)	\$50 copay after deductible	10%	20%	30% (benefit limited to \$800/procedure)	\$50 copay after deductible	10%	\$50 copay after deductible	30% (benefit limited to \$800/procedure)	\$50 copay after deductible	30% (benefit limited to \$800/procedure)	
Emergency Care	\$150 Copay Waived if Admitted	10% after \$150 Copay Waived if Admitted	20% after \$150 Copay Waived if Admitted		10% after deductible		\$150 Copay Waived if Admitted		0% after ded.; Max. of \$2,500 per ear, every 3 years		
Hearing Aids	0% after ded.; Max. of \$2,500 per ear, every 3 years	10% after ded.; Max. of \$2,500 per ear, every 3 years	20% after ded.; Max. of \$2,500 per ear, every 3 years		10% after ded.; Max. of \$2,500 per ear, every 3 years		0% after ded.; Max. of \$2,500 per ear every 3 years		0% after ded.; Max. of \$2,500 per ear every 3 years		
Rx Benefits Retail: 30 day supply Mail Order: 90 day supply	Not subject to deductible	Not subject to deductible	Not subject to deductible	Not subject to deductible	Copays apply AFTER deductible has been met				Not subject to deductible	Not subject to deductible	
Tier 1 - Generic	\$10 Copay Retail \$15 Copay Mail Order	\$15 Copay Retail \$23 Copay Mail Order	\$15 Copay Retail \$23 Copay Mail Order	Member pays applicable copay plus all charges in excess of allowable charge	\$10 Copay Retail \$20 Copay Mail Order	Member pays applicable copay plus all charges in excess of allowable charge	\$10 Copay Retail \$15 Copay Mail Order	Member pays applicable copay plus all charges in excess of allowable charge	\$10 Copay Retail \$15 Copay Mail Order	Member pays applicable copay plus all charges in excess of allowable charge	
Tier 2 - Preferred Brand	\$25 Copay Retail \$38 Copay Mail Order	\$35 Copay Retail \$53 Copay Mail Order	\$35 Copay Retail \$53 Copay Mail Order	Member pays applicable copay plus all charges in excess of allowable charge	\$25 Copay Retail \$50 Copay Mail Order	Member pays applicable copay plus all charges in excess of allowable charge	\$25 Copay Retail \$38 Copay Mail Order	Member pays applicable copay plus all charges in excess of allowable charge	\$25 Copay Retail \$38 Copay Mail Order	Member pays applicable copay plus all charges in excess of allowable charge	
Tier 3 - Non-Preferred Brand	\$50 Copay Retail \$75 Copay Mail Order	\$50 Copay Retail \$75 Copay Mail Order	\$50 Copay Retail \$75 Copay Mail Order	Member pays applicable copay plus all charges in excess of allowable charge	\$50 Copay Retail \$100 Copay Mail Order	Member pays applicable copay plus all charges in excess of allowable charge	\$50 Copay Retail \$75 Copay Mail Order	Member pays applicable copay plus all charges in excess of allowable charge	\$50 Copay Retail \$75 Copay Mail Order	Member pays applicable copay plus all charges in excess of allowable charge	
Tier 4 - Specialty	\$150 Copay	\$150 Copay	\$150 Copay	Member pays applicable copay plus all charges in excess of allowable charge	20% of maximum allowed amount	Member pays applicable copay plus all charges in excess of allowable charge	\$150 Copay	Member pays applicable copay plus all charges in excess of allowable charge	\$150 Copay	Member pays applicable copay plus all charges in excess of allowable charge	
Specialty (30 day supply)	Must obtain from Specialty Pharmacy. Member pays applicable cost for tier	Must obtain from Specialty Pharmacy. Member pays applicable cost for tier	Must obtain from Specialty Pharmacy. Member pays applicable cost for tier	Not Covered	Must obtain from Specialty Pharmacy. Member pays applicable cost for tier	Not Covered	Must obtain from Specialty Pharmacy. Member pays applicable cost for tier	Not Covered	Must obtain from Specialty Pharmacy. Member pays applicable cost for tier	Not Covered	
"DAW" (Dispense as written)	Not Included	Not Included	Not Included	Not Included	Not Included	Not Included	Not Included	Not Included	Not Included	Not Included	

(1) The Out of Pocket Maximums for Rx and Medical accumulate separately on a per person basis on all plans EXCEPT the HSA 1300. The combined out of pocket maximum will not exceed the total OOP maximum shown.

Attachment 3
Plan Year 2015/16 vs.
Plan Year 2016/17
Comparison

RX and All Medical Changes

EPO 250 & BlueCard

Alternative Medical Benefits	Current Benefit	Alternative Medical Benefit
Office Visits	\$25 PCP or Specialist	\$25 PCP and \$35 Specialist
ER Visit	\$100 Copay	\$150 Copay
Lab & X-Ray	0 % after deductible	\$10 Copay after deductible
Advanced Imaging	0% after deductible	\$50 Copay after deductible
Hearing Aids (EPO 250)	0% after deductible	0% after deductible ~ up to maximum benefit of \$2,500 per ear every three years ~ Expand access to allow members to obtain hearing aids from non-participating plan vendors
Hearing Aids (BlueCard)	0% after deductible in network 30% after deductible out of network	Same coinsurance amounts with added limitation: ~ up to maximum benefit of \$2,500 per ear every three years
Rx Copays		
Tier 1 (Generic)	\$10	\$10
Tier 2 (Preferred Brand)	\$25	\$25
Tier 3 (Non-Preferred Brand)	\$25	\$50
Tier 4 (Specialty)	\$25	\$150
DAW (Dispense as Written)	Allows DAW from physician	Will require authorization based on medical necessity for brand drugs if generic is available

EPO 500 & PPO 500

Alternative Medical Benefits	Current Benefit	Alternative Medical Benefit
Office Visits (In Network)	\$30 PCP or Specialist	\$30 PCP and \$40 Specialist
Office Visits (Out of Network) (Out of network applies to PPO Only)	\$50 PCP or Specialist, deductible waived.	\$50 PCP and \$60 Specialist, deductible applies to out of network office visits
ER Visit	\$100 Copay	\$150 Copay
Hearing Aids (EPO 500)	0% after deductible	0% after deductible ~ up to maximum benefit of \$2,500 per ear every three years ~ Expand access to allow members to obtain hearing aids from non-participating plan vendors
Hearing Aids (PPO 500)	20% after deductible in network 30% after deductible out of network	Same coinsurance amounts with added limitation: ~ up to maximum benefit of \$2,500 per ear every three years
Rx Copays		
Tier 1 (Generic)	\$15	\$15
Tier 2 (Preferred Brand)	\$30	\$35
Tier 3 (Non-Preferred Brand)	\$30	\$50
Tier 4 (Specialty)	\$40	\$150

**Attachment 4
Kaiser Group Plan
Plan Year 2015/16
(Current)**

The following provides the current benefit summary for the Plan Year 2015/16 large group plan.

32904 CITY OF ST. HELENA

Principal Benefits for Kaiser Permanente Traditional Plan (7/1/15–6/30/16)

The services described below are covered only if all of 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

Accumulation Period

The Accumulation Period for this plan is 1/1/15 through 12/31/15 (calendar year).

Out-of-Pocket Maximum

For services subject to the maximum, you will not pay any more Cost Share during the calendar year if the Copayments and Coinsurance you pay for those services add up to one of the following 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

Plan Deductible

None

Lifetime Maximum

None

Professional Services (Plan Provider office visits)

You Pay

- Most Primary Care Visits for evaluations and treatment \$20 per visit
- Most Specialty Care Visits for consultations, evaluations, and treatment \$20 per visit
- Routine physical maintenance exams, including well-woman exams No charge
- Well-child preventive exams (through age 23 months) No charge
- Family planning counseling and consultations No charge
- Scheduled prenatal care exams No charge
- Routine eye exams with a Plan Optometrist for Members under age 19 No charge
- Routine eye exams with a Plan Optometrist for Members age 19 and older No charge
- Hearing exams No charge
- Urgent care consultations, evaluations, and treatment \$20 per visit
- Most physical, occupational, and speech therapy \$20 per visit

Outpatient Services

You Pay

- Outpatient surgery and certain other outpatient procedures \$20 per procedure
- Allergy injections (including allergy serum) \$3 per visit
- Most immunizations (including the vaccine) No charge
- Most X-rays and laboratory tests No charge
- Covered individual health education counseling No charge

Covered health education programs	No charge
Hospitalization Services	You Pay
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	No charge
Emergency Health Coverage	You Pay
Emergency Department visits	\$50 per visit
Note: This Cost Share does not apply if admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Share).	
Ambulance Services	You Pay
Ambulance Services	\$50 per trip
Prescription Drug Coverage	You Pay
Covered outpatient items in accord with our drug formulary guidelines at a Plan Pharmacy or through our mail-order service:	
Most generic items	\$10 for up to a 100-day supply
Most brand-name items	\$20 for up to a 100-day supply
Durable Medical Equipment (DME)	You Pay
DME items that are essential health benefits in accord with our DME formulary guidelines	20% Coinsurance
DME items that are not essential health benefits in accord with our DME formulary guidelines	20% Coinsurance
Mental Health Services	You Pay
Inpatient psychiatric hospitalization	No charge
Individual outpatient mental health evaluation and treatment	\$20 per visit
Group outpatient mental health treatment	\$10 per visit
Chemical Dependency Services	You Pay
Inpatient detoxification	No charge
Individual outpatient chemical dependency evaluation and treatment	\$20 per visit
Group outpatient chemical dependency treatment	\$5 per visit
Home Health Services	You Pay
Home health care (up to 100 visits per calendar year)	No charge
Other	You Pay
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Ostomy and urological supplies	No charge
Prosthetic and orthotic devices that are essential health benefits	No charge
Prosthetic and orthotic devices that are not essential health benefits	No charge
Hospice care	No charge

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

**Attachment 5
Kaiser Group Plan
Plan Year 2016/17**

32904 CITY OF ST. HELENA

**Principal Benefits for
Kaiser Permanente Traditional Plan (7/1/16–6/30/17)**

The Services described below are covered only if all of 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

Accumulation Period

The Accumulation Period for this plan is 1/1/16 through 12/31/16 (calendar year).

Plan Out-of-Pocket Maximum

For Services subject to the maximum, you will not pay any more Cost Share for the rest of the calendar year if the Copayments and Coinsurance you pay for those Services add up to one of the following 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

Plan Deductible

None

Professional Services (Plan Provider office visits)

You Pay

- Most Primary Care Visits and most Non-Physician Specialist Visits \$20 per visit
- Most Physician Specialist Visits \$20 per visit
- Routine physical maintenance exams, including well-woman exams No charge
- Well-child preventive exams (through age 23 months) No charge
- Family planning counseling and consultations No charge
- Scheduled prenatal care exams No charge
- Routine eye exams with a Plan Optometrist No charge
- Hearing exams No charge
- Urgent care consultations, evaluations, and treatment \$20 per visit
- Most physical, occupational, and speech therapy \$20 per visit

Outpatient Services

You Pay

- Outpatient surgery and certain other outpatient procedures \$20 per procedure
- Allergy injections (including allergy serum) \$3 per visit
- Most immunizations (including the vaccine) No charge
- Most X-rays and laboratory tests No charge
- Covered individual health education counseling No charge
- Covered health education programs No charge

Hospitalization Services

You Pay

- Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs No charge

Emergency Health Coverage	You Pay
Emergency Department visits.....	\$50 per visit
Note: This Cost Share does not apply if admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Share).	
Ambulance Services	You Pay
Ambulance Services	\$50 per trip
Prescription Drug Coverage	You Pay
Covered outpatient items in accord with our drug formulary guidelines at a Plan Pharmacy or through our mail-order service:	
Most generic items	\$10 for up to a 100-day supply
Most brand-name items.....	\$20 for up to a 100-day supply
Most specialty items at a Plan Pharmacy.....	20% Coinsurance (not to exceed \$150) for up to a 30-day supply
Durable Medical Equipment (DME)	You Pay
DME items in accord with our DME formulary guidelines	20% Coinsurance
Mental Health Services	You Pay
Inpatient psychiatric hospitalization	No charge
Individual outpatient mental health evaluation and treatment	\$20 per visit
Group outpatient mental health treatment.....	\$10 per visit
Chemical Dependency Services	You Pay
Inpatient detoxification	No charge
Individual outpatient chemical dependency evaluation and treatment	\$20 per visit
Group outpatient chemical dependency treatment	\$5 per visit
Home Health Services	You Pay
Home health care (up to 100 visits per calendar year)	No charge
Other	You Pay
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Prosthetic and orthotic devices	No charge
Hospice care	No charge

For answers on benefit questions, verification of coverage, new member assistance, ID card replacement and to request a copy of your Evidence of Coverage, please contact our Member Services Call Center during the following business hours:

Monday to Friday – 7:00AM to 7:00PM
Saturday & Sunday – 7:00AM to 3:00PM

English – 800.464.4000
Spanish – 800.788.0616
Chinese dialects – 800.757.7585
Senior Advantage and Medicare members – 800.443.0815