



FRESNO COUNTY ECONOMIC OPPORTUNITIES COMMISSION

MEDICAL BENEFITS – PLAN BENEFIT SUMMARY

A. GENERAL FEATURES	
Calendar Year Deductible	\$ 250 per employee; \$ 500 per family Applies to all Covered Expense unless otherwise indicated below or within the Plan
Out of Pocket Maximum	\$ 3,000 per employee; \$ 6,000 per family
Annual Plan Maximum	\$ 750,000 per individual
Percentage Payable	<u>With Authorization:</u> Participating Provider: 80% of Covered Expense Non-Participating Provider: 60% of Covered Expense <u>Without Authorization:</u> Participating Provider: 60% of Covered Expense Non-Participating Provider: 50% of Covered Expense
Participating Primary Care Providers (PCP)	This would encompass General & Family Practice, OB/GYN, Internist, & Pediatrician
Maternity Coverage	Participant or Spouse
Pre-Existing Conditions	6 months prior to coverage. Waived after 12 months continuous coverage under Plan (with the exception of dependent children 19 years and under) .
B. PAID HOSPITAL EXPENSES	
Inpatient Care / Outpatient Care: (Includes Room & Board, Ancillary Charges, Intensive Care)	<u>With Authorization:</u> Participating Provider: 80% of Covered Expense Non-Participating Provider: 60% of Covered Expense <u>Without Authorization:</u> Participating Provider: 60% of Covered Expense Non-Participating Provider: 50% of Covered Expense
Outpatient Care - Emergency Room	Participating Provider: 80% of Covered Expense after \$100 Copayment Non-Participating Provider: 60% of Covered Expense after \$100 Copayment
Outpatient Care - Urgent Care Centers	Participating Provider: 80% of Covered Expense after \$25 Copayment Non-Participating Provider: 60% of Covered Expense after \$25 Copayment
Surgicenters	<u>With Authorization:</u> Participating Provider: 80% of Covered Expense Non-Participating Provider: 60% of Covered Expense <u>Without Authorization:</u> Participating Provider: 60% of Covered Expense Non-Participating Provider: 50% of Covered Expense
Preadmission Testing	Participating Provider: 80% of Covered Expense Non-Participating Provider: 60% of Covered Expense
C. PROFESSIONAL SERVICES	
Surgeon	Participating Provider: 80% of Covered Expense Non-Participating Provider: 60% of Covered Expense
Assistant Surgeon	25% of Surgeons allowed, payable at 80% of Covered Expense
Anesthesia	Participating Provider: 80% of Covered Expense Non-Participating Provider: 60% of Covered Expense
Doctor Hospital Visit	Participating Provider: 80% of Covered Expense Non-Participating Provider: 60% of Covered Expense
Doctor Visit (Office/Home) Primary Care & Specialist – when Referred by your PCP	Participating Provider: \$15 co-pay, then 100% of Covered Expense. Includes office visit & exam. No Deductible applies. Non-Participating Provider: 80% of Covered Expense, after Deductible has been met.
D. OTHER COVERED EXPENSES	
Diagnostic X-Ray & Lab - MRI's & CAT Scans must be pre-authorized or benefits reduce to 50%	Participating Provider: 80% of Covered Expense Non-Participating Provider: 60% of Covered Expense
Skilled Nursing	100% of Covered Expense for first 10 days and 80% thereafter to a maximum of 60 days per Calendar Year. The Deductible does not apply to this benefit.
Acupuncture	Participating Provider: 80% of Covered Expense Non-Participating Provider: 60% of Covered Expense Limited to a maximum of \$500 per Calendar Year.
Ambulance	80% of Covered Expense
Durable Medical Equipment	80% of Covered Expense
Hearing Aids	50% of Covered Expense up to \$1500. Benefit limited to every 3 years
Weight Management	80% to a lifetime maximum of \$25,000 after a mandatory evaluation period. Benefit limited to approved centers of excellence.



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Physical Therapy	80% of Covered Expense
Chiropractic Care Preferred Chiropractors of Calif (PCC) (559) 228-3215 Under age 15 – Must have MD referral	Maximum of 10 visits per month up to 24 visits per Calendar Year; X-rays are limited to \$100 per Calendar Year for all chiropractic care. <u>Participating PCC Provider:</u> \$15 co-pay, then 100% of Covered Expense up to a maximum of \$30 per visit. No Deductible applies. <u>Non-Participating PCC Provider:</u> 80% of Covered Expense up to a maximum of \$30 per visit, after the Deductible has been met.
Home Health Care	100% of Covered Expense for first 15 visits and 80% thereafter. Deductible does not apply to this benefit. A visit is equal to 4 hours or less of service.
Mental & Nervous Conditions: - Inpatient - Outpatient	Participating Provider: 80% of Covered Expense; Pre Certification is Required. Non-Participating Provider: 60% of Covered Expense; Pre Certification is Required. Participating Provider: \$15 co-pay, then 100% of Covered Expense with a referral by your PCP. Non-Participating Provider: 80% of Covered Expense with a referral by your PCP, after Deductible has been met.
Substance Abuse: -Inpatient -Outpatient	Participating Provider: 80% of Covered Expense; Pre Certification is Required. Non-Participating Provider: 60% of Covered Expense; Pre Certification is Required. Participating Provider: \$15 co-pay, then 100% of Covered Expense with a referral by your PCP. Non-Participating Provider: 80% of Covered Expense with a referral by your PCP, after Deductible has been met.
Smoking Cessation	Participating Provider: 80% of Covered Expense Non-Participating Provider: 60% of Covered Expense Limited to a maximum of \$750 per Calendar Year. Cessation drugs are payable under the outpatient prescription drug services.
Supplemental Accident	\$300 per Accident. Expenses must be incurred within 90 days from the Accident
Well Child Care (up to 18 Years of age)	Routine Physical Exams and Immunizations: Participating Provider: 100% of Covered Expense. No Deductible applies. Non-Participating Provider: 80% of Covered Expense, after Deductible has been met. Diagnostic X-Ray & Lab: Participating Provider: 100% of Covered Expense. No Deductible applies. Non-Participating Provider: 80% of Covered Expense, after Deductible has been met.
Adult Preventive Care (18 Years of age and over)	Routine Physical Exams and Immunizations: Participating Provider: 100% of Covered Expense. No Deductible once per Calendar Year. Benefits based on Gender and age. Non-Participating Provider: 80% of Covered Expense, after Deductible has been met Diagnostic X-Ray & Lab: 100% Covered Expense. No Deductible applies. Benefits based on Gender and Age. Non-Participating Provider: 80% of Covered Expense, after Deductible has been met
E. UTILIZATION MANAGEMENT - PRE-CERTIFICATION	
Inpatient Admissions (800) 274-7767	Requires pre-admission review of at least 3 working days for non-emergency Hospital admissions. Within 48 hours of admission for all other admissions. Failure to obtain approval results in benefits reducing to 60% for a Participating Provider and to 50% for a Non-Participating Provider. Refer to Plan for additional information.
Outpatient Surgery (800) 274-7767	Requires prior authorization or benefits are reduced to 60% for a Participating Provider and to 50% for a Non-Participating Provider. Refer to Plan for additional information.
Outpatient Diagnostic Imaging (800) 777-9428	Requires prior authorization for all MRI's & CAT Scans or benefits are reduced to 50% of Covered Expense.



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OUTPATIENT PRESCRIPTION DRUG SERVICES:

Prescription Drugs - Participating Pharmacy Only through Caremark (888) 665-6759	<u>Participating Pharmacy (30 day supply)</u>	<u>Mail Order (90 day supply)</u>
	Preferred Generic drugs: \$ 5.00	\$ 5.00
	Preferred Name Brand: 20% (\$20 min. - \$35 max.)	20% (\$30 min. - \$45 max.)
	Non Preferred drugs: 20% (\$35 min. - \$60 max.)	20% (\$45 min. - \$70 max.)
Mandatory Mail Order Prescription Program	Requires all participants to utilize Mail Order or a CVS pharmacy for maintenance medications and receive a 90 day supply at the mail order co-pay	

DENTAL PLAN BENEFITS:

	Participating Provider*and Non-Participating Provider
Deductible – Applies to all Covered Expense except Class I services	\$ 25 per Individual; \$ 75 per Family
Plan Maximum:	\$1,500 per Calendar Year
Class I Services: Diagnostic & Preventive	Payable at 80% of Covered Expense – No Deductible Applies
Class II Services: Basic & Restorative	Payable at 80% of Covered Expense
Class III Services: Major (crown, bridgework, dentures, etc.)	Payable at 50% of Covered Expense

* When Using an Interplan DENTINEX Participating Provider for services, you will not be subject to balance billing for charges over Usual, Customary and Reasonable.

Orthodontia Services	Participating Provider*and Non-Participating Provider
Lifetime Deductible:	\$50 per person
Percentage Payable:	50% of Covered Expense
Lifetime Maximum Benefit:	\$1,500 per person

* When Using an Interplan DENTINEX Participating Provider for services, you will not be subject to balance billing for charges over Usual, Customary and Reasonable.

VISION CARE PLAN BENEFITS:

A. PARTICIPATING PROVIDER BENEFITS	Participant Pays
Comprehensive Exam – every 12 months	\$ 25 per employee or dependent
Regular Lenses & Standard Frames – every 12 months	\$ 25 per employee or dependent
Contact Lenses – Medically Necessary	\$ 25 per employee or dependent
Contact Lenses – Cosmetic	Plan allows \$125 towards the cost in lieu of other benefits (lenses & frames).
Tinting and Invisiline	Plan allows standard tinting and Invisiline lenses
B. NON-PARTICIPATING PROVIDER BENEFITS:	Plan Pays up to
Vision Examination	\$ 40
Single Vision Lenses	\$ 30
Bifocal Lenses	\$ 50
Trifocal Lenses	\$ 65
Lenticular Lenses	\$ 125
Frames	\$ 45
Tint	\$ 5
Contact Lenses – Medically Necessary	\$ 250
Contact Lenses – Cosmetic	\$ 125