Schedule of Benefits

City of Madera

Blue Shield Full PPO Savings Embedded Deductible 5500

7/1/2020

Plan Code: OR.0-0318YLBlueShieldFullPPOSavingsEmbeddedDeductible5500

Your Blue Shield plan has a Deductible of $5,500/$11,000 which will be shared between you and your employer as outlined below. Any remaining balance is the member's responsibility.

Blue Shield's Deductible is shared between the employee and employer	Employee Pays	Employer Pays
This is an Embedded Deductible		
Deductible Per Calendar Year - 2 Times Family	$0	None
Office Visit - Deductible Waived	$10	Employer Pays Balance
Urgent Care Visit - Deductible Waived	$10	Employer Pays Balance
Wellness	$0	Carrier Paid
Lab and X-Ray Co-Pay	0%	100%
Emergency Room	$50	Employer Pays Balance
Inpatient Hospital	$100 per day up to 7 days	Employer Pays Balance
Outpatient Surgery	$100	Employer Pays Balance
Ambulance	$50	Employer Pays Balance
Outpatient Mental and Substance - Deductible Waived	$10	Employer Pays Balance
Acupuncture	$10	Employer Pays Balance
Chiropractic	$10	Employer Pays Balance
Physical and Occupational Therapy	$10	Employer Pays Balance
Durable Medical Equipment	0%	100%
All Other Deductible Services & Supplies	0%	100%
Out of Network	Not Covered	
Prescription Deductible; Tier 2, Tier 3 and Tier 4	$0	None
RX Tier 1 - Deductible Waived	$10	Employer Pays Balance
RX Tier 2	$25	Employer Pays Balance
RX Tier 3	$40	Employer Pays Balance
RX Tier 4	30% up to $500 Max	Employer Pays Balance
Out of Pocket Under the Blue Shield Deductible	**Employee Responsibility**	**Employer Maximum Contribution**
Employee Only through Step One	$0.00	$5,500.00
Employee with Dependents through Step One	$0.00	$11,000.00

Step One*

Your Blue Shield plan has a Co-Insurance max of $1,150/$2,300 after Blue Shield's deductible has been met. The employee must meet this amount before Blue Shield pays 100% and may be shared as outlined below.

Benefits After Blue Shield Deductible	Employee Pays	Employer Pays	Blue Shield Pays
Co Insurance for Most Covered Expenses	Copays	20% up to $150/$300	80%
Co Insurance for Most Covered Expenses - Remaining Out of Pocket	Remaining 20%	0%	80%
Out of Pocket After Blue Shield Deductible	**Employee Responsibility**	**Employer Maximum Contribution**	**Blue Shield Pays**
Employee Only through Step Two	$1,000.00	$150.00	Balance
Employee with Dependents through Step Two	$2,000.00	$300.00	

Step Two*

Employee Maximum Out Of Pocket for Individual/Family	$1,000.00 / $2,000.00

*** Please refer to the Blue Shield Plan document for complete details of covered benefits.**
Your ASi reimbursement plan follows your Blue Shield's benefits.
CA Lic. #0D35033

blue of california

Group Plan
PPO Savings Plan

Summary of Benefits

Full PPO Savings Embedded Deductible 5500

This Summary of Benefits shows the amount you will pay for Covered Services under this Blue Shield of California Plan. It is only a summary and it is included as part of the Evidence of Coverage (EOC).[1] Please read both documents carefully for details.

Medical Provider Network: **Full PPO Network**

This Plan uses a specific network of Health Care Providers, called the Full PPO provider network. Providers in this network are called Participating Providers. You pay less for Covered Services when you use a Participating Provider than when you use a Non-Participating Provider. You can find Participating Providers in this network at blueshieldca.com.

Pharmacy Network: **Rx Ultra**

Drug Formulary: **Plus Formulary**

Calendar Year Deductibles (CYD)[2]

A Calendar Year Deductible (CYD) is the amount a Member pays each Calendar Year before Blue Shield pays for Covered Services under the Plan. Blue Shield pays for some Covered Services before the Calendar Year Deductible is met, as noted in the Benefits chart below.

		When using a Participating[3] or Non-Participating[4] Provider
Calendar Year medical and pharmacy Deductible	*Individual coverage*	$5,500
This Plan combines medical and pharmacy Deductibles into one Calendar Year Deductible	*Family Coverage*	$5,500: individual $11,000: Family

Calendar Year Out-of-Pocket Maximum[5]

An Out-of-Pocket Maximum is the most a Member will pay for Covered Services each Calendar Year. Any exceptions are listed in the Notes section at the end of this Summary of Benefits.

	When using a Participating Provider[3]	When using a Non-Participating Provider[4]
Individual coverage	$6,650	$10,000
Family Coverage	$6,650: individual $13,300: Family	$10,000: individual $20,000: Family

No Annual or Lifetime Dollar Limit

Under this Plan there is no annual or lifetime dollar limit on the amount Blue Shield will pay for Covered Services.

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Preventive Health Services[7]				
Preventive Health Services	$0		Not covered	
California Prenatal Screening Program	$0		$0	
Physician services				
Primary care office visit	20%	✔	50%	✔
Specialist care office visit	20%	✔	50%	✔
Physician home visit	20%	✔	50%	✔
Physician or surgeon services in an outpatient facility	20%	✔	50%	✔
Physician or surgeon services in an inpatient facility	20%	✔	50%	✔
Other professional services				
Other practitioner office visit	20%	✔	50%	✔
Includes nurse practitioners, physician assistants, and therapists.				
Acupuncture services	20%	✔	50%	✔
Up to 20 visits per Member, per Calendar Year.				
Chiropractic services	20%	✔	50%	✔
Up to 20 visits per Member, per Calendar Year.				
Teladoc consultation	$5/consult	✔	Not covered	
Family planning				
• Counseling, consulting, and education	$0		Not covered	
• Injectable contraceptive; diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure.	$0		Not covered	
• Tubal ligation	$0		Not covered	
• Vasectomy	20%	✔	Not covered	
Podiatric services	20%	✔	50%	✔
Pregnancy and maternity care[7]				
Physician office visits: prenatal and postnatal	20%	✔	50%	✔
Physician services for pregnancy termination	20%	✔	50%	✔
Emergency services				
Emergency room services	$150/visit plus 20%	✔	$150/visit plus 20%	✔
If admitted to the Hospital, this payment for emergency room services does not apply. Instead, you pay the Participating Provider payment under Inpatient facility services/ Hospital services and stay.				
Emergency room Physician services	20%	✔	20%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Urgent care center services	20%	✔	50%	✔
Ambulance services *This payment is for emergency or authorized transport.*	20%	✔	20%	✔
Outpatient facility services				
Ambulatory Surgery Center	10%	✔	50% of up to $350/day plus 100% of additional charges	✔
Outpatient Department of a Hospital: surgery	20%	✔	50% of up to $350/day plus 100% of additional charges	✔
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	20%	✔	50% of up to $350/day plus 100% of additional charges	✔
Inpatient facility services				
Hospital services and stay	20%	✔	50% of up to $600/day plus 100% of additional charges	✔
Transplant services *This payment is for all covered transplants except tissue and kidney. For tissue and kidney transplant services, the payment for Inpatient facility services/ Hospital services and stay applies.*				
• Special transplant facility inpatient services	20%	✔	Not covered	
• Physician inpatient services	20%	✔	Not covered	
Bariatric surgery services, designated California counties *This payment is for bariatric surgery services for residents of designated California counties. For bariatric surgery services for residents of non-designated California counties, the payments for Inpatient facility services/ Hospital services and stay and Physician inpatient and surgery services apply for inpatient services; or, if provided on an outpatient basis, the outpatient facility services and Outpatient Physician services payments apply.*				
Inpatient facility services	20%	✔	Not covered	
Outpatient facility services	20%	✔	Not covered	
Physician services	20%	✔	Not covered	

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Diagnostic x-ray, imaging, pathology, and laboratory services				
This payment is for Covered Services that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures, such as CT scans, MRIs, MRAs, and PET scans. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.				
Laboratory services				
Includes diagnostic Papanicolaou (Pap) test.				
• Laboratory center	20%	✔	50%	✔
• Outpatient Department of a Hospital	30%	✔	50% of up to $350/day plus 100% of additional charges	✔
X-ray and imaging services				
Includes diagnostic mammography.				
• Outpatient radiology center	20%	✔	50%	✔
• Outpatient Department of a Hospital	30%	✔	50% of up to $350/day plus 100% of additional charges	✔
Other outpatient diagnostic testing				
Testing to diagnose illness or injury such as vestibular function tests, EKG, ECG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.				
• Office location	20%	✔	50%	✔
• Outpatient Department of a Hospital	30%	✔	50% of up to $350/day plus 100% of additional charges	✔
Radiological and nuclear imaging services				
• Outpatient radiology center	20%	✔	50%	✔
• Outpatient Department of a Hospital	$100/visit plus 20%	✔	50% of up to $350/day plus 100% of additional charges	✔
Rehabilitative and Habilitative Services				
Includes Physical Therapy, Occupational Therapy, Respiratory Therapy, and Speech Therapy services.				
Office location	20%	✔	50%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Outpatient Department of a Hospital	20%	✔	50% of up to $350/day plus 100% of additional charges	✔
Durable medical equipment (DME)				
DME	20%	✔	50%	✔
Breast pump	$0		Not covered	
Orthotic equipment and devices	20%	✔	50%	✔
Prosthetic equipment and devices	20%	✔	50%	✔
Home health care services *Up to 100 visits per Member, per Calendar Year, by a home health care agency. All visits count towards the limit, including visits during any applicable Deductible period. Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist, and medical supplies.*	20%	✔	Not covered	
Home infusion and home injectable therapy services				
Home infusion agency services *Includes home infusion drugs and medical supplies.*	20%	✔	Not covered	
Home visits by an infusion nurse	20%	✔	Not covered	
Hemophilia home infusion services *Includes blood factor products.*	20%	✔	Not covered	
Skilled Nursing Facility (SNF) services *Up to 100 days per Member, per Benefit Period, except when provided as part of a Hospice program. All days count towards the limit, including days during any applicable Deductible period and days in different SNFs during the Calendar Year.*				
Freestanding SNF	20%	✔	20%	✔
Hospital-based SNF	20%	✔	50% of up to $600/day plus 100% of additional charges	✔
Hospice program services *Includes pre-Hospice consultation, routine home care, 24-hour continuous home care, short-term inpatient care for pain and symptom management, and inpatient respite care.*	$0	✔	Not covered	
Other services and supplies				
Diabetes care services • Devices, equipment, and supplies	20%	✔	50%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
• Self-management training	20%	✔	50%	✔
Dialysis services	20%	✔	50% of up to $350/day plus 100% of additional charges	✔
PKU product formulas and Special Food Products	20%	✔	20%	✔
Allergy serum billed separately from an office visit	20%	✔	50%	✔

Mental Health and Substance Use Disorder Benefits	Your payment			
Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Service Administrator (MHSA).	When using a MHSA Participating Provider[3]	CYD[2] applies	When using a MHSA Non-Participating Provider[4]	CYD[2] applies
Outpatient services				
Office visit, including Physician office visit	20%	✔	50%	✔
Other outpatient services, including intensive outpatient care, electroconvulsive therapy, transcranial magnetic stimulation, Behavioral Health Treatment for pervasive developmental disorder or autism in an office setting, home, or other non-institutional facility setting, and office-based opioid treatment	20%	✔	50%	✔
Partial Hospitalization Program	20%	✔	50% of up to $350/day plus 100% of additional charges	✔
Psychological Testing	20%	✔	50%	✔
Inpatient services				
Physician inpatient services	$0	✔	50%	✔
Hospital services	20%	✔	50% of up to $600/day plus 100% of additional charges	✔
Residential Care	20%	✔	50% of up to $600/day plus 100% of additional charges	✔

Prescription Drug Benefits[8,9]	Your payment			
	When using a Participating Pharmacy[3]	CYD[2] applies	When using a Non-Participating Pharmacy[4]	CYD[2] applies
Retail pharmacy prescription Drugs				
Per prescription, up to a 30-day supply.				
Contraceptive Drugs and devices	$0		Applicable Tier 1, Tier 2, or Tier 3 Co-payment	✔
Tier 1 Drugs	$10/prescription	✔	25% plus $10/prescription	✔
Tier 2 Drugs	$25/prescription	✔	25% plus $25/prescription	✔
Tier 3 Drugs	$40/prescription	✔	25% plus $40/prescription	✔
Tier 4 Drugs (excluding Specialty Drugs)	30% up to $200/prescription	✔	30% up to $200/prescription plus 25% of purchase price	✔
Mail service pharmacy prescription Drugs				
Per prescription, up to a 90-day supply.				
Contraceptive Drugs and devices	$0		Not covered	
Tier 1 Drugs	$20/prescription	✔	Not covered	
Tier 2 Drugs	$50/prescription	✔	Not covered	
Tier 3 Drugs	$80/prescription	✔	Not covered	
Tier 4 Drugs (excluding Specialty Drugs)	30% up to $400/prescription	✔	Not covered	
Network Specialty Pharmacy Drugs				
Per prescription, up to a 30-day supply.				
Tier 4 Specialty Drugs	30% up to $200/prescription	✔	Not covered	
Oral Anticancer Drugs	30% up to $200/prescription	✔	Not covered	
Per prescription, up to a 30-day supply.				

Prior Authorization

The following are some frequently-utilized Benefits that require prior authorization:

- Radiological and nuclear imaging services
- Outpatient mental health services, except office visits
- Inpatient facility services
- Hospice program services
- Some prescription Drugs (see blueshieldca.com/pharmacy)

Please review the Evidence of Coverage for more about Benefits that require prior authorization.

Notes

1 Evidence of Coverage (EOC):

The Evidence of Coverage (EOC) describes the Benefits, limitations, and exclusions that apply to coverage under this Plan. Please review the EOC for more details of coverage outlined in this Summary of Benefits. You can request a copy of the EOC at any time.

Capitalized terms are defined in the EOC. Refer to the EOC for an explanation of the terms used in this Summary of Benefits.

2 Calendar Year Deductible (CYD):

Calendar Year Deductible explained. A Deductible is the amount you pay each Calendar Year before Blue Shield pays for Covered Services under the Plan.

If this Plan has any Calendar Year Deductible(s), Covered Services subject to that Deductible are identified with a check mark (✔) in the Benefits chart above.

Covered Services not subject to the Calendar Year combined medical and pharmacy Deductible. Some Covered Services received from Participating Providers are paid by Blue Shield before you meet any Calendar Year combined medical and pharmacy Deductible. These Covered Services do not have a check mark (✔) next to them in the "CYD applies" column in the Benefits chart above.

Family coverage has an individual Deductible within the Family Deductible. This means that the Deductible will be met for an individual with Family coverage who meets the individual Deductible prior to the Family meeting the Family Deductible within a Calendar Year.

3 Using Participating Providers:

Participating Providers have a contract to provide health care services to Members. When you receive Covered Services from a Participating Provider, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.

"Allowable Amount" is defined in the EOC. In addition:

- Coinsurance is calculated from the Allowable Amount or Benefit maximum, whichever is less.

4 Using Non-Participating Providers:

Non-Participating Providers do not have a contract to provide health care services to Members. When you receive Covered Services from a Non-Participating Provider, you are responsible for:

- the Copayment or Coinsurance (once any Calendar Year Deductible has been met), and
- any charges above the Allowable Amount, or
- any charges above the stated dollar amount, which is the Benefit maximum.

"Allowable Amount" is defined in the EOC. In addition:

- Coinsurance is calculated from the Allowable Amount or Benefit maximum, whichever is less.
- Charges above the Allowable Amount or Benefit maximum do not count towards the Out-of-Pocket Maximum, and are your responsibility for payment to the provider. This out-of-pocket expense can be significant.

5 Calendar Year Out-of-Pocket Maximum (OOPM):

Your payment after you reach the Calendar Year OOPM. You will continue to pay all charges above a Benefit maximum.

Essential health benefits count towards the OOPM.

Any Deductibles count towards the OOPM. Any amounts you pay that count towards the medical Calendar Year Deductible also count towards the Calendar Year Out-of-Pocket Maximum.

This Plan has a separate Participating Provider OOPM and Non-Participating Provider OOPM.

Covered Drugs obtained at Non-Participating Pharmacies. Any amounts you pay for Covered Drugs at Non-Participating Pharmacies count towards the Participating Provider OOPM.
Family coverage has an individual OOPM within the Family OOPM. This means that the OOPM will be met for an individual with Family coverage who meets the individual OOPM prior to the Family meeting the Family OOPM within a Calendar Year.

6 Separate Member Payments When Multiple Covered Services are Received:

Each time you receive multiple Covered Services, you might have separate payments (Copayment or Coinsurance) for each service. When this happens, you may be responsible for multiple Copayments or Coinsurance. For example, you may owe an office visit Copayment in addition to an allergy serum Copayment when you visit the doctor for an allergy shot.

7 Preventive Health Services:

If you only receive Preventive Health Services during a Physician office visit, there is no Copayment or Coinsurance for the visit. If you receive both Preventive Health Services and other Covered Services during the Physician office visit, you may have a Copayment or Coinsurance for the visit.

8 Outpatient Prescription Drug Coverage:

Medicare Part D-creditable coverage-

This Plan's prescription drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called creditable coverage). Because this plan's prescription drug coverage is creditable, you do not have to enroll in Medicare Part D while you maintain this coverage; however, you should be aware that if you do not enroll in Medicare Part D within 63 days following termination of this coverage, you could be subject to Medicare Part D premium penalties.

9 Outpatient Prescription Drug Coverage:

Brand Drug coverage when a Generic Drug is available. If you select a Brand Drug when a Generic Drug equivalent is available, you are responsible for the difference between the cost to Blue Shield for the Brand Drug and its Generic Drug equivalent plus the tier 1 Copayment or Coinsurance. This difference in cost will not count towards any Calendar Year pharmacy Deductible, medical Deductible, or the Calendar Year Out-of-Pocket Maximum. If your Physician or Health Care Provider prescribes a Brand Drug and indicates that a Generic Drug equivalent should not be substituted, you pay your applicable tier Copayment or Coinsurance. If your Physician or Health Care Provider does not indicate that a Generic Drug equivalent should not be substituted, you may request a Medical Necessity Review. If approved, the Brand Drug will be covered at the applicable Drug tier Copayment or Coinsurance.

Short-Cycle Specialty Drug program. This program allows initial prescriptions for select Specialty Drugs to be filled for a 15-day supply with your approval. When this occurs, the Copayment or Coinsurance will be pro-rated.

Plans may be modified to ensure compliance with State and Federal requirements.

CITY OF MADERA

Policy #: 010-48070

FUSION combines dental and eye care benefits into one easy-to-administer plan. This plan combines the annual maximum between the dental and vision plans.
For the maximum:

- The member can use up to $1,000 toward any covered dental expense.
- The member can use up to $100 toward any covered eye care expense.
- Total benefits paid between the two coverages will not exceed $1,500.

Dental Plan Benefits *subject to FUSION plan design listed above*

	In-Network	Out-of-Network
Type 1 Preventive No Waiting Period	100%	90%
	• Routine Exam (1 per 6 months) • Bitewing X-rays (1 per 12 months) • Cleaning (1 per 6 months)	• Routine Exam (1 per 6 months) • Bitewing X-rays (1 per 12 months) • Cleaning (1 per 6 months)
Type 2 Basic No Waiting Period	80%	70%
	• Surgical Extractions • Restorative Amalgams • Restorative Composites • Endodontics (nonsurgical) • Periodontics (nonsurgical) • Endodontics (surgical) • Periodontics (surgical) • Simple Extractions	• Surgical Extractions • Restorative Amalgams • Restorative Composites • Endodontics (nonsurgical) • Periodontics (nonsurgical) • Endodontics (surgical) • Periodontics (surgical) • Simple Extractions
Type 3 Major No Waiting Period	50%	50%
	• Crowns (1 in 10 years per tooth) • Prosthodontics (Bridges, Dentures) (1 in 10 years)	• Crowns (1 in 10 years per tooth) • Prosthodontics (Bridges, Dentures) (1 in 10 years)

Deductible

Type 1	$0	$0
Type 2 and 3	$50 per person, per calendar year	$50 per person, per calendar year
Family Maximum	When 3 family members satisfy their Deductible Amounts for this Calendar Year, no additional Deductibles will apply to any family members for the rest of this Calendar Year.	When 3 family members satisfy their Deductible Amounts for this Calendar Year, no additional Deductibles will apply to any family members for the rest of this Calendar Year.

Benefit Year Maximum

Type 1, 2, and 3 (per person, per calendar year)	$1,500	$1,000

Orthodontia Benefits (children under age 19)

No waiting period

Plan Benefit	50%	50%
Lifetime Deductible	$0	$0
Lifetime Maximum (per person)	$1,000	$1,000

Claims Allowance

Type 1, 2 and 3	Discounted Fee	90th U&C

CITY OF MADERA
Policy #: 010-48070

Ameritas
fulfilling life.

Vision Plan Benefits *subject to FUSION plan design listed above*

	Allowances	Frequencies Based on date of service**	
Exam	Subject to Maximum	Exam	None
Lenses (per pair)		Lenses	None
Single	Subject to Maximum	Frames	None
Bifocal	Subject to Maximum		
Trifocal	Subject to Maximum		
Lenticular	Subject to Maximum	Maximum	$100
Progressive	Subject to Maximum	Deductibles (Lifetime deductible)	$0
Contacts			
Elective/Medically Necessary	Subject to Maximum		
Frames	Subject to Maximum		

**Deductible applies to the first service received*
***Please submit claims within 90 days of the date of service so that the plan can consider benefits (subject to State requirements).*

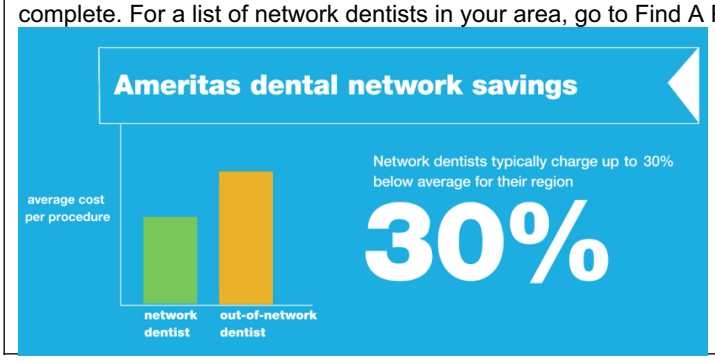
Dental Rewards

Your dental plan includes Dental Rewards as a way to grow your annual maximum benefit. Simply by visiting a dental provider each year and submitting a claim, you can increase your annual maximum benefit over time. After your initial benefit is used, accumulated rewards are there to help pay for more expensive procedures, such as root canals or crowns.

Here's how it works. For each year, you submit at least one dental claim and your total dental benefits paid for the year are at or under $500 you qualify to carry over $250 in rewards to the following year. When your dental visit is to an Ameritas network provider, you earn an extra $100 PPO Bonus. You may accumulate rewards up to the maximum amount of $1000. Please note, if you do not submit a dental claim during the year, no rewards are earned and accumulated rewards are reset to zero. However, you can start qualifying for rewards again the very next year.

Provider Flexibility and Network Savings

Members aren't limited to one particular dentist, or a small group of providers, who may or may not be taking new patients. Each plan member is free to visit any provider they choose, including your current dentist, regardless if they are in- or out-of-network. And family members do not have to see the same dentist. When you visit an in-network dentist there are no claim forms to complete. For a list of network dentists in your area, go to Find A Provider at ameritas.com.



The Ameritas dental network is one of the **5 largest networks** in the nation for access points. Source: NetMinder 2016

Ameritas Network: These plans give you more than 428,000 access points across the nation for dental care.

Late Entrant

We strongly encourage you and/or your dependents to sign up for coverage when you are initially eligible. If you choose to enroll after initially declined, you and/or your eligible dependents will be considered a Late Entrant. Covered expenses will not include and benefits will not be payable in the first 12 months that a person is insured if the person is a Late Entrant; except for evaluations, prophylaxis (cleanings), and fluoride application. After 12 months, you will have access to all of the plan's benefits.

Member Savings

CITY OF MADERA

Policy #: 010-48070

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Prescriptions

Save an average of 40% on generic and brand name prescriptions at over 60,000 pharmacies including CVS, Walgreens, Rite Aid and Walmart. Use your normal health care pharmacy benefit, or the prescription discount, whichever saves you more. This Rx discount is offered at no additional cost, and it is not insurance.

Access your Ameritas Rx savings card:
https://www.ameritas.com/OCM/GetFile?doc=037275

Frames and lenses

Save up to 15% at any Walmart Vision Center:

- top quality frames for the entire family including today's most popular brands
- wide selection of lens options; all lenses come with scratch resistent coating for no additional charge
- safety eyewear

This discount is available to you without any additional cost to your plan premium.

Customer Service

Customer Connections 800-487-5553 www.Ameritas.com
Monday - Thursday 7am-12am CST, Friday 7am-6:30pm CST

This document is a highlight of plan benefits provided by Ameritas Life Insurance Corp. as selected by your employer. It is not a certificate of insurance and does not include exclusions and limitations. For exclusions and limitations, or a complete list of covered procedures, contact your benefits administrator.

SUPERIOR VISION

See yourself healthy.

Vision Plan Benefits for City of Madera

Co-Pays	
Exam	$25
Materials[1]	$0
Contact Lens Fitting (standard & specialty)	$30

Services/Frequency	
Exam	12 months
Frame	24 months
Contact Lens Fitting	12 months
Lenses	12 months
Contact Lenses	12 months

(Based on date of service)

Benefits

	In-Network	Out-of-Network
Exam (Ophthalmologist)	Covered in full	Up to $40 retail
Exam (Optometrist)	Covered in full	Up to $30 retail
Frames	$130 retail allowance	Up to $62 retail
Contact Lens Fitting (standard[2])	Covered in full	Not covered
Contact Lens Fitting (specialty[2])	$50 retail allowance	Not covered
Lenses (standard) per pair		
Single Vision	Covered in full	Up to $32 retail
Bifocal	Covered in full	Up to $42 retail
Trifocal	Covered in full	Up to $58 retail
Progressive lens upgrade	See description[3]	Up to $58 retail
Contact Lenses[4]	$130 retail allowance	Up to $100 retail

Co-pays apply to in-network benefits; co-pays for out-of-network visits are deducted from reimbursements

[1] *Materials co-pay applies to lenses and frames only, not contact lenses*

[2] *See your benefits materials for definitions of standard and specialty contact lens fittings*

[3] *Covered to provider's in-office standard retail lined trifocal amount; member pays difference between progressive and standard retail lined trifocal, plus applicable co-pay*

[4] *Contact lenses are in lieu of eyeglass lenses and frames benefit*

Discount Features

Look for providers in the Provider Directory who accept discounts, as some do not; please verify their services and discounts (range from 10%-30%) prior to service as they vary.

Discounts on Covered Materials

Frames:	20% off amount over allowance
Lens options:	20% off retail
Progressives:	20% off amount over retail lined trifocal lens, including lens options

The following options have out-of-pocket maximums[5] on standard (not premium, brand, or progressive) lenses.

	Maximum Member Out-of-Pocket	
	Single Vision	Bifocal & Trifocal
Scratch coat	$13	$13
Ultraviolet coat	$15	$15
Tints, solid or gradients	$25	$25
Anti-reflective coat	$50	$50
Polycarbonate	$40	20% off retail
High index 1.6	$55	20% off retail
Photochromics	$80	20% off retail

Discounts on Non-Covered Exam and Materials

Exams, frames, and prescription lenses:	30% off retail
Lens options, contacts, other prescription materials:	20% off retail
Disposable contact lenses:	10% off retail

[5] *Discounts and maximums may vary by lens type. Please check with your provider.*

SuperiorVision.com
Customer Service
800.507.3800

Refractive Surgery

Superior Vision has a nationwide network of refractive surgeons and leading LASIK networks who offer members a discount. These discounts range from 15%-50%, and are the best possible discounts available to Superior Vision.

The Plan discount features are not insurance.

All allowances are retail; the member is responsible for paying the provider directly for all non-covered items and/or any amount over the allowances, minus available discounts. These are not covered by the plan.

Discounts are subject to change without notice.

Disclaimer: All final determinations of benefits, administrative duties, and definitions are governed by the Certificate of Insurance for your vision plan. Please check with your Human Resources department if you have any questions.

Enrollment count on 10/23/2020

	EE Only				EE +1				EE + Family			
	Active EE	EDC	Retiree	COBRA	Active EE	EDC	Retiree	COBRA	Active EE	EDC	Retiree	COBRA
Dental	47	2	6	0	35	0	3	0	102	1	0	0
Vision	48	2	6	0	34	0	3	0	102	1	1	0
Medical	47	2	7	0	35	0	3	0	102	1	0	0

Dependent Care FSA	1
Medical FSA	26
Voluntary Life	91
Supplemental Insurance	12

2020-21 Health Benefit Renewal Premiums (Monthly)

	2019-20 Blue Shield PPO w/ ASi			2020-21 Blue Shield PPO w/ ASi		
	EE Only	**EE+1**	**EE+Family**	**EE Only**	**EE+1**	**EE+Family**
Medical						
Blue Shield	609.53	1,117.88	1,707.90	536.52	983.99	1,503.33
ASi	99.58	199.16	199.16	89.69	179.38	179.38
ASi Admin	15.00	15.00	15.00	15.00	15.00	15.00
Teledoc	6.50	6.50	6.50	6.50	6.50	6.50
Broker Fee	6.94	6.94	6.94	6.94	6.94	6.94
Total Medical - Monthly	737.55	1345.48	1935.50	654.65	1191.81	1711.15
Dental - Monthly	27.40	57.44	106.24	27.40	57.44	106.24
Vision - Monthly	6.24	9.69	15.36	6.24	9.69	15.36
Total Monthly Premium	**$771.19**	**$1,412.61**	**$2,057.10**	**$688.29**	**$1,258.94**	**$1,832.75**
City Contribution	**$740.16**	**$1,354.83**	**$1,971.79**	**$688.29**	**$1,258.94**	**$1,832.75**
Employee Contribution	**$31.03**	**$57.78**	**$85.31**	**$0.00**	**$0.00**	**$0.00**

Waiver with proof of other coverage	$330/month
Employer paid life	$0.13/$1000
Employer paid AD&D	$0.035/$1000
Dependent Life	$1.75
LTD	$0.36/$100
Section 125 Plan	$250 annual fee; $6/month per employee enrolled in Medical or Dependent Care FSA
EAP + Wellness	$3.42 PEPM