

## 2009 Summary of Covered Services

**This is only a summary of benefits. Please refer to the Evidence of Coverage booklet for the exact terms and conditions of coverage.**

Category Description	Blue Shield Access+/ NetValue HMO Kaiser Permanente HMO	PERS Choice/Select PPO		PERS Care PPO	
		PPO	Non-PPO	PPO	Non-PPO
<b>Calendar Year Deductible</b>	None	Individual: \$500 / Family: \$1,000		Individual: \$500 / Family: \$1,000	
<b>Maximum Annual Co-Payment</b>	Individual: \$1,500 Family: \$3,000	Individual : \$3,000 Family: \$6,000	None	Individual : \$2,000 Family: \$4,000	None
<b>Lifetime Maximum Benefit</b>	None	\$2,000,000 per individual		None	
<b>Ambulance</b>	No Charge	20%	20%	20%	20%
<b>Chiropractic/Acupuncture</b>	\$15/visit (not available with Blue Shield)	20%	40%	10%	40%
<b>Diagnostic X-ray/Lab</b>	No Charge (Outpatient Services)	20%	40%	10%	40%
<b>Durable Medical Equipment</b>	No Charge	20%	40%	10%	40%
<b>Emergency Services</b>	\$50/visit. Waived if hospitalized.	20% (\$50 deductible)	20% (\$50 deductible)	10% (\$50 deductible)	10% (\$50 deductible)
<b>Hearing Aid Exam</b>	No Charge	20%	40%	10%	40%
Hearing Aid (up to two)	\$1,000 maximum benefit every 36 months.	\$1,000 max benefit every 36 months.		\$1,000 max benefit every 36 months.	
<b>Hospital (Inpatient &amp; Outpatient)</b>	No Charge	20%	40%	10%	40%
<b>Home Health Services</b>	No Charge (Custodial care not covered)	20%	40%	10%	40%
<b>Hospice</b>	No Charge	20% See EOC	20%	10% See EOC	10%
<b>Infertility Testing &amp; Treatment</b>	50% of allowed charges. See EOC for details.	This benefit is not available		This benefit is not available	
<b>Mental Health</b>					
Inpatient	No Charge	20%	40%	10%	40%
Outpatient:	\$7-\$20 co-pay. Refer to EOC for details.	20%	40%	10%	40%
<b>Physician Services</b>					
<b>Office Visits</b>	<b>\$15/visit co-pay</b>	<b>\$20 co-pay</b>	<b>40%</b>	<b>\$20 co-pay</b>	<b>40%</b>
Allergy Testing	\$15/visit (none for Blue Shield)	20%	40%	10%	40%
Hearing Exam/Screening	No co-pay for preventative care	20%	40%	10%	40%
Immunization/Inoculation	No co-pay for preventative care	No Charge	40%	No Charge	40%
Annual Well-Woman Exam	No co-pay for preventative care	No Charge	40%	No Charge	40%
Periodic Health Exam	No co-pay for preventative care	No Charge	40%	No Charge	40%
Well Baby Care	No co-pay for preventative care	No Charge	40%	No Charge	40%
Inpatient Hospital Visits	No Charge	20% See EOC	40%	10% See EOC	40%
Surgery/Anesthesia (outpatient)	\$15/visit	20%	40%	10%	40%
<b>Prescription Drugs</b>					
<b>Retail Pharmacy:</b>	(Up to a 30 day supply)	(Up to a 30 day supply, limited to 2 months)		(Up to a 34 day supply, limited to 2 months)	
Generic	\$5 per prescription	\$5 per prescription		\$5 per prescription	
Formulary Brand	\$15 per prescription	\$15 per prescription		\$15 per prescription	
Non-Formulary	\$45 per prescription	\$45 per prescription		\$45 per prescription	
<b>Mail Order Program:</b>	(Up to a 90-day supply)	(Up to a 90-day supply)		(Up to a 90-day supply)	
Generic	\$10 per prescription	\$10 per prescription		\$10 per prescription	
Formulary Brand	\$25 per prescription	\$25 per prescription		\$25 per prescription	
Non-Formulary	\$75 per prescription	\$75 per prescription		\$75 per prescription	
<b>Kaiser Permanente</b>	\$5/generic, \$15/brand name (Provides up to 100-day supply for certain drugs) through either its pharmacies or mail order program.				
<b>Speech /Physical Therapy</b>	No Charge, (\$15/visit if outpatient)	20%	40%	10%	40%
<b>Skilled Nursing Facility Care</b>	No Charge – up to 100 days per calendar year	First 10 days: 20% Next 90 days: 30%	40%	First 10 days: 10% Next 170 days: 20%	40%
<b>Substance Abuse</b>					
Inpatient	No Charge	20%	40%	10%	40%
Outpatient	\$15/visit – up to 20 visits per calendar year.	20%	40%	10%	40%