Medical Plan Highlights
CoreSource Medical PPO Plan
Kaiser Medical HMO Plan

August 1, 2008

	CORESOURCE PPO PLAN		KAISER HMO PLAN
Plan	**Network**	**Non-Network**	**Network**
Calendar Year Deductible: (deductibles cross accumulate)	$100 per person; 3 times individual deductible per family		None
Out of Pocket Maximum:	$300 per person; $900 per family	$1,000 per person; $3,000 per family	$1,500 per person; $3,000 per family
Lifetime Maximum Benefit:	$5,000,000		Unlimited
Pre-Existing Condition Limitation:	6 months if enrolling when first eligible or 18 months if enrolling anytime thereafter. Limitation may be reduced by prior Creditable Coverage.		None
Network:	California residents access Anthem Blue Cross (www.anthem.com/ca); Non-California residents access PHCS (www.phcs.com)	Not applicable	Kaiser Www.kp.org
Physician Office Visits:	$10 copay (deductible waived)	80% of usual and customary fees, after calendar year deductible	$10 copay
Diagnostic Testing, X-Rays and Laboratory:	100% of negotiated rates, after calendar year deductible	80% of usual and customary fees, after calendar year deductible	100%
Inpatient Hospitalization:	100% of negotiated rates, after calendar year deductible	80% of usual and customary fees, after calendar year deductible	100%
Pre-Certification of Inpatient Services:	Required. Penalty is 25% reduction of benefits. Does not apply to maternity or emergency visits.		Required. Penalty is 100% reduction of benefits. Does not apply to maternity or emergency visits.
Emergency Room Visits:	$35 copay (deductible waived). Copay will be waived if admitted to the hospital.		$35 copay. Copay will be waived if admitted to the hospital.
Out of Area Benefits:	If no contracting providers are within 30 miles of your residence, providers are considered in-network. Call CoreSource about water and/or mountain barriers.		Limited to life threatening emergency treatment only.
Vision Plan:	See Spectera brochure for schedule of Network and Non-Network vision benefits		Vision exam covered under medical plan. Materials benefit limited to $175 allowance per 24 month period
Prescription Coverage:	Must use contracting pharmacy vendors ONLY! Retail is covered up to a 30 day supply at a $10 copay for generic prescription or a $15 copay for a brand name prescription. Mail order is covered up to a 90 day supply at a $5 copay for either generic or brand name prescriptions. Retail Pharmacy Note ~ if a brand name drug is prescribed and there is no generic equivalent, then the member will ONLY pay the generic copay.		Retail and mail order is covered up to a 100 day supply at a $10 copay for generic formulary or a $15 copay for a brand name formulary.

Check out your Benefits Information Center (BIC)

To learn more about your benefits, please visit your Benefits Information Center (BIC) website at: www.peralta.pswbenefits.net.