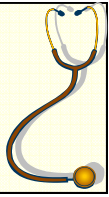


**Medical Plan Highlights  
CoreSource Medical PPO Plan  
Kaiser Medical HMO Plan**



**August 1, 2008**

**CORESOURCE PPO PLAN**

**KAISER HMO PLAN**

Plan	Network	Non-Network	Network
<b>Calendar Year Deductible:</b> <small>(deductibles cross accumulate)</small>	\$100 per person; 3 times individual deductible per family		None
<b>Out of Pocket Maximum:</b>	\$300 per person; \$900 per family	\$1,000 per person; \$3,000 per family	\$1,500 per person; \$3,000 per family
<b>Lifetime Maximum Benefit:</b>	\$5,000,000		Unlimited
<b>Pre-Existing Condition Limitation:</b>	6 months if enrolling when first eligible or 18 months if enrolling anytime thereafter. Limitation may be reduced by prior Creditable Coverage.		None
<b>Network:</b>	California residents access Anthem Blue Cross ( <a href="http://www.anthem.com/ca">www.anthem.com/ca</a> ); Non-California residents access PHCS ( <a href="http://www.phcs.com">www.phcs.com</a> )	Not applicable	Kaiser <a href="http://www.kp.org">www.kp.org</a>
<b>Physician Office Visits:</b>	\$10 copay (deductible waived)	80% of usual and customary fees, after calendar year deductible	\$10 copay
<b>Diagnostic Testing, X-Rays and Laboratory:</b>	100% of negotiated rates, after calendar year deductible	80% of usual and customary fees, after calendar year deductible	100%
<b>Inpatient Hospitalization:</b>	100% of negotiated rates, after calendar year deductible	80% of usual and customary fees, after calendar year deductible	100%
<b>Pre-Certification of Inpatient Services:</b>	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.
<b>Emergency Room Visits:</b>	\$35 copay (deductible waived). Copay will be waived if admitted to the hospital.		\$35 copay. Copay will be waived if admitted to the hospital.
<b>Out of Area Benefits:</b>	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.
<b>Vision Plan:</b>	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
<b>Prescription Coverage:</b>	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](http://www.peralta.pswbenefits.net).