G.P.O. HMO				
	PERS Kaiser Permanente		SISC-KP $15, Rx 5-20 (30day)	
Benefit	**Network**	**NonNetwork**	**Network**	**NonNetwork**
Annual Deductible	Individual $0	N/A	Individual $0	N/A
	Family $0	N/A	Family $0	N/A
Coinsurance	100%	0%	100%	0%
Office Visit Exam	$15 copay	Not Covered	$15 copay	Not Covered
Annual Out-of-Pocket Limit (OOP)	$1,500 Member; $3,000 Family: RX $6,650 member; $13,300 Family	Unlimited	$1,500 Member; $3,000 Family	Unlimited
Deductible included in OOP Limit	Yes	N/A	Yes	N/A
Lifetime Plan Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Preventive Services				
Well-Child Care (through age 6)	100%	Not Covered	Covered 100%	Not Covered
Routine Physical Exam/immunizations (age 7+)	100%	Not Covered	Covered 100%	Not Covered
Immunizations through age 6	100%	Not Covered	Covered 100%	Not Covered
Well Woman Exams	100%	Not Covered	Covered 100%	Not Covered
Mammograms	100%	Not Covered	Covered 100%	Not Covered
Adult Periodic Exams w/ Preventive Tests	100%	Not Covered	Covered 100%	Not Covered
Diagnostic X-Ray and Lab Tests	100%	Not Covered	Covered 100%	Not Covered
Pregnancy and Maternity Pre-Natal Care	100%	Not Covered	Covered 100%	Not Covered
Inpatient Hospital	100%	Not Covered	Covered 100%	Not Covered
Pre-Authorization of Services Required	Yes	N/A	Yes	N/A
Semi-Private Room and Board, Services and Supplies	100%	Not Covered	Covered 100%	Not Covered
Out-Patient Facility Charge (Ambulatory Surgical Centers)	$15 copay	Not Covered	$15 copay	Not Covered
Emergency Room	$50 copay (waived if admitted)	Covered as In-Network	$100 copay (waived if admitted)	Covered as In-Networ
Ambulance (Air and Ground)	100%	Covered as In-Network	$50 per trip	Covered as In-Networ
Prescription Drugs				
Deductible	$0	N/A	$0	N/A
At Retail:				
- Generic copay	$5/30 days, $10/90 days	Not Covered	$5/30 days	Not Covered
- Brand copay (P=Preferred; F=Formulary)	P $20/30, $40/90 days; NonP $50/30, $100/90 days	Not Covered	$20/30 days	Not Covered
Number of days supply	30/90	N/A	30/90	N/A
From Mail Order				
- Generic copay	$10 copay	Not Covered	$10 copay up to 100-day	Not Covered
- Brand copay (P=Preferred; F=Formulary)	P $40; NonP $100	Not Covered	$40 copay up to 100-day	Not Covered
Number of days supply	90 days	N/A	100 days	N/A
Specialty Pharmacy 30 day supply	As above	Not Covered	As above	Not Covered

G.P.O. HMO				
	PERS Kaiser Permanente		SISC-KP $15, Rx 5-20 (30day)	
Benefit	**Network**	**NonNetwork**	**Network**	**NonNetwork**
Other Services				
DME and Prosthetics (limits apply)	100%	Not Covered	Covered 100%	Not Covered
Home Health Care	100%	Not Covered	Covered 100%	Not Covered
Skilled Nursing or Extended Care Facility (100 days/year)	100%	Not Covered	Covered 100%	Not Covered
Hospice Care	100%	Not Covered	Covered 100%	Not Covered
Chiropractic Services	$15 copay/visit, 20 visits	Not Covered	built in rider $10 copay/visit, 30 visits total combined with Acu	Not Covered
Acupuncture	$15 copay/visit, 20 visits	Not Covered	built in rider $10 copay/visit, 30 visits total combined with Chiro	Not Covered
Infertility Diagnosis	50% of Covered Charges	Not Covered	Covered 100%	Not Covered
Infertility Treatment	50% of Covered Charges	Not Covered	$15 per visit/procedure	Not Covered
Rehabilitation Services - Physical, Occupational, Speech	$15 copay per visit	Not Covered	$15 copay per visit	Not Covered
Inpatient Mental/Nervous & Substance Abuse	100%	Not Covered	Covered 100%	Not Covered
Outpatient Mental/Nervous & Substance Abuse	$15 copay	Not Covered	$15 copay	Not Covered
			The EOC will supersede information provided in this summary if different.	