

## Summary of Covered Services ~ 2012

Please refer to the Evidence of Coverage booklet for exact terms and conditions

Category Description	Blue Shield Access + HMO & Blue Shield Net Value HMO	PERS Choice & Select PPO		PERS Care PPO	
		Contracting Provider	Non-Contracting Provider	Contracting Provider	Non Contracting Provider
Calendar Year Deductible	None	Member: \$500 / Family: \$1,000		Member: \$500 / Family: \$1,000	
Maximum Annual Co-Payment	Member: \$1,500 Family: \$3,000	Member: \$3,000 Family: \$6,000	None	Member: \$2,000 Family: \$4,000	None
Lifetime Maximum Benefit	None	None		None	
Ambulance	No Charge	20%	20%	20%	20%
Chiropractic/Acupuncture	Not Covered – Discounts Available	20%	40%	10%	40%
Diagnostic X-ray/Lab	No Charge (Outpatient Services)	20%	40%	10%	40%
Durable Medical Equipment	No Charge	20%	40%	10%	40%
Emergency Services	\$50/visit. Waived if hospitalized.	20% See EOC	20% See EOC	10% See EOC	10% See EOC
Hearing Aid Exam	No Charge	20%	40%	10%	40%
Hearing Aid (up to two)	\$1,000 maximum benefit every 36 months.	20% One hearing device every 36 months.		10% One hearing device every 36 months.	
Hospital (Inpatient & Outpatient)	No Charge	PERS Choice: 20% PERS Select: 20% or 30% (Depending on hospital)	40%	10%	40% (\$250 deductible)
Home Health Services (Custodial care not covered)	No Charge	20%	40%	10%	40%
Hospice	No Charge	20% See EOC	20%	10% See EOC	10%
Infertility Testing & Treatment	50% of covered charges. See EOC.	This benefit is not available		This benefit is not available	
Mental Health					
Inpatient	No Charge	20%	40%	10%	40%
Outpatient:	\$15/visit. See EOC.	\$20	40%	\$20	40%
Physician Services					
Office Visits/Urgent Care	\$15/visit	\$20/visit	40%	\$20/visit	40%
Allergy Testing/Treatment	No Charge	20%	40%	10%	40%
Hearing Exam/Screening	No Charge	20%	40%	10%	40%
Immunization/Inoculation	No Charge	No Charge	40%	No Charge	40%
Annual Well-Woman Exam	No Charge	No Charge	40%	No Charge	40%
Periodic Health Exam	No Charge	No Charge	40%	No Charge	40%
Well Baby Care	No Charge	No Charge	40%	No Charge	40%
Surgery/Anesthesia	No Charge	20%	40%	10%	40%
Speech /Physical Therapy					
Inpatient	No Charge	No charge	No charge	No charge	No charge
Outpatient	\$15/visit	20%	40%	20%	20%
Skilled Nursing Facility Care	No Charge – up to 100 days per calendar year	First 10 days: 20% Next 90 days: 30%	40% 40%	First 10 days: 10% Next 170 days: 20%	40% 40%
Substance Abuse					
Inpatient	No Charge	20%	40%	10%	40%
Outpatient	\$15/visit	\$20	40%	\$20	40%
Prescription Drugs	\$1,000 Maximum co-payment per person (excludes non-preferred brands)				
Retail pharmacy:	(Up to a 30 day supply, limited to 2 months)	(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	\$20 per prescription	\$20 per prescription		\$20 per prescription	
Non-Formulary	\$50 per prescription	\$50 per prescription		\$50 per prescription	
Mail Order Prescriptions:	(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	\$40 per prescription	\$40 per prescription		\$40 per prescription	
Non-Formulary	\$100 per prescription	\$100 per prescription		\$100 per prescription	