

# 2008 Personal Care PPO

**This is a summary only.**

For complete information on benefits, covered services, exclusions & limitations, refer to the PPO Certificate!

	<b>BASIC</b> >>green application<<		<b>ALTERNATE</b> >>yellow application<<	
	<b>In-Network</b>	<b>Out-of-Network</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Deductible</b>	<b>\$250 Ind. \$500 Fam.</b>	<b>\$500 Ind. \$1000 Fam.</b>	<b>\$500 Ind. \$1000 Fam.</b>	<b>\$1000 Ind. \$2000 Fam.</b>
<b>Out of Pocket Maximum</b>	\$1,500 Ind. \$3,000 Fam.	\$3,000 Ind. \$6,000 Fam.	\$1,500 Ind. \$3,000 Fam.	\$3,000 Ind. \$6,000 Fam.
<b>Lifetime Maximum</b>	5,000,000		5,000,000	
<b>Office Visit</b>	<b>\$20 co-pay</b>	<b>70% *</b>	<b>\$30 co-pay</b>	<b>70% *</b>
<b>X-rays (St.Mary's / Riverside)</b>	100%*	70% *	90%*	70% *
<b>Labs (MedCenter, Riverside or Quest)</b>	100%*	70% *	90%*	70% *
<b>Prescriptions</b>	<b>\$10 /\$20 /\$50</b>		<b>\$25 /\$40 /\$70</b>	
<b>Mail Order RX (90 day supply)</b>	\$30 /\$60 /\$150		\$75 /\$120 /\$210	
<b>Self Administered Injectables</b> <small>(these claims do NOT apply to out of pocket maximum)</small>	25% formulary; 50% non-formulary; \$150 max/script	No Coverage	25% formulary; 50% non-formulary; \$150 max/script	No Coverage
<b>Emergency Room</b>	<b>\$100 co-pay</b> <b>(waived if admitted)</b>	<b>\$100 co-pay</b> <b>(waived if admitted)</b>	<b>\$200 co-pay</b> <b>(waived if admitted)</b>	<b>\$200 co-pay</b> <b>(waived if admitted)</b>
<b>Ambulance</b> <small>(when medically necessary)</small>	90%*	90%*	90%*	90%*
<b>Maternity</b>	90% *	70% *	90% *	70% *
<b>Hospital Inpatient</b>	<b>90% *</b>	<b>70% *</b>	<b>90% *</b>	<b>70% *</b>
<b>Hospital Outpatient</b>	<b>90% *</b>	<b>70% *</b>	<b>90% *</b>	<b>70% *</b>
<b>Vision (Sears or Pearl)</b>	\$30 co-pay (1 exam per year)	No Coverage	\$30 co-pay (1 exam per year)	No Coverage
<b>Chiropractic</b>	90% *	70% *	90% *	70% *
<b>Outpatient Rehabilitation</b> <small>(Physical/Occupational/Speech Therapy)</small>	<b>\$25 co-pay</b>	70%*	<b>\$40 co-pay</b>	70%*
<b>Mental Health / Substance Abuse-Inpatient</b> <small>(see certificate for specifications)</small>	90% *	70% *	90% *	70%/50% *
<b>Mental Health / Substance Abuse-Outpatient</b> <small>(see certificate for specifications)</small>	<b>\$25 co-pay / 90%*</b>	70%*	<b>\$40 co-pay / 90%*</b>	70%/50%*

**\* = after deductible**

**Remember: When using out of network providers you are also responsible for charges over reasonable and customary!**

