

MEDICAL PLAN COMPARISON CHART

	Kaiser	Blue Shield Signature HMO	
		Tier One	Tier Two
Providers, Deductibles, Maximums, PreExisting Conditions			
Choice of physician and other providers	Kaiser physicians and facilities only	Shield Signature HMO Network (includes Blue Card Program access)	Shield Signature Level II Network (includes providers in Shield PPO Network)
Calendar year Deductible combined PPO/OON	None		None
Hospital or Ambulatory Surgical Center deductible	None		None
Lifetime benefits maximum	None		None
Out-of-Pocket annual maximum	\$1,500 each member \$3,000 family maximum	\$1,500 each member \$3,000 family maximum	Not applicable
Preexisting condition	Fully covered		Fully covered
Office/Outpatient Care			
Office visits	You pay a \$10 copay	You pay a \$10 copay	You pay a \$30 copay
Periodic health exams / annual physicals	No charge	No charge	You pay a \$30 copay
Hearing screenings	No charge	No charge	You pay a \$30 copay
Immunizations	No charge	No charge	You pay a \$30 copay
Family planning Infertility services	You pay 50% excludes GIFT, ZIFT and IVF	You pay 50% excludes GIFT, ZIFT and IVF	Covered under Level 1 Benefit
Tubal ligation	You pay a \$10 copay	No charge	Covered under Level 1 Benefit
Vasectomy	You pay a \$10 copay	You pay a \$10 copay	Covered under Level 1 Benefit
Specialists	You pay a \$10 copay	You pay a \$10 copay	You pay a \$30 copay
Well baby/Well child care	No charge	No charge	You pay a \$30 copay
Well woman exam (annual)	No charge	No charge	You pay a \$30 copay
Emergency Medical Care			
Ambulance	No charge when medically necessary	No charge	No charge if medically necessary
Emergency room	You pay a \$50 copay (waived if admitted)	You pay a \$50 copay (waived if admitted)	Covered under Level 1 Benefit
Urgent care	You pay a \$10 copay		You pay a \$10 copay

Please note: This comparison chart only highlights benefits. The Evidence of Coverage (EOC) and official plan documents contain comprehensive benefit details and govern your rights and benefits under each plan. If any discrepancy exists between this Comparison Chart and the official plan documents, the official plan documents will prevail.

Blue Shield PPO		
	In-Network	Out-of-Network
	Shield PPO Network (includes Blue Card Program access)	(includes Blue Card Program access)
	\$250 per individual \$500 per family	
	None	
	None	
	\$1,500 each member \$3,000 family maximum (Some benefits excluded from the OoP maximum, refer to EOC for details)	\$2,000 each member \$4,000 family maximum (Some benefits excluded from the OoP maximum, refer to EOC for details)
	Fully covered	
	You pay a \$10 copay [CY ded. waived]	You pay 30% after CY deductible
	No charge [CY ded. waived]	You pay 30% after CY deductible
	No charge [CY ded. waived]	You pay 30% after CY deductible
	No charge [CY ded. waived]	You pay 30% after CY deductible
	Not covered	Not covered
	No charge [CY ded. waived]	You pay 50% after CY deductible (A facility charge may also apply)
	You pay 30% after deductible	You pay 50% after deductible
	You pay 20% [CY ded. waived]	You pay 30% after CY deductible
	No charge [CY ded. waived]	You pay 30% after CY deductible
	No charge [CY ded. waived]	You pay 30% after CY deductible
	You pay 20% after CY deductible	You pay 20% after CY deductible
	\$50 per visit + 20% after CY deductible (\$50 waived if admitted) ER Physician Services: You pay 20% after CY deductible	\$50 per visit + 20% after CY deductible (\$50 waived if admitted & treated as in-network benefit) ER Physician Services: You pay 20% after CY deductible
	You pay a \$10 copay [CY ded. waived]	You pay 30% after CY deductible

	Kaiser	Blue Shield Signature HMO	
		Tier One	Tier Two
Diagnostic Services			
Laboratory and Pathology Tests	No charge	No charge	Covered only when performed in physician's office
Diagnostic Tests and X-Ray	No charge	No charge	Covered only when performed in physician's office For CT, MRI, MUGA, PET, and SPECT covered under Level 1 benefit
Diabetes Care			
Covered Diabetic drugs and testing supplies	See 'Prescription Drugs' Testing supplies no charge under formulary	See 'Prescription Drugs'	
Diabetes Self Management Training & Education	No charge	No charge	You pay a \$30 copay
Devices, Equipment, and Non-Testing Supplies	See Durable Medical Equipment	No charge	Covered under Level 1 Benefit
Maternity Care			
Prenatal and Postnatal office visits	No charge	No charge	Covered under Level 1 Benefit
Delivery	No charge	No charge	Covered under Level 1 Benefit
Newborn Care	Newborn covered 31 days; must enroll through County within 60 days	Newborn covered 30 days; must enroll through County within 60 days	Covered under Level 1 Benefit
Hospital Services			
Hospital care (Physician and Facility charges)	No charge for approved services obtained in a Kaiser Permanente or other approved facility	No charge	Covered under Level 1 Benefit
Surgical Services			
Hospital - In Patient Surgical Services	No charge (Facility and Physician services)	No charge (Facility and Physician services)	Covered under Level 1 Benefit
Outpatient/Ambulatory Surgery Center	No charge (Facility and Physician services)	No charge (Facility and Physician services)	Covered under Level 1 Benefit
Alternatives to Hospital Care			
Home health services	No charge when medically necessary; up to 100 visits per calendar year	No charge	Covered under Level 1 Benefit
Hospice Inpatient & outpatient	No charge when selected as alternative to traditional services covered by Kaiser Permanente	No charge	Covered under Level 1 Benefit
Skilled nursing facilities	No charge for authorized stays; maximum 100 days per benefit period in a plan skilled nursing facility	No charge	Covered under Level 1 Benefit

Blue Shield PPO	
In-Network	Out-of-Network
You pay 20% after CY deductible	You pay 30% after CY deductible
You pay 20% after CY deductible	You pay 30% after CY deductible
See 'Prescription Drugs'	
You pay 20% after CY deductible	You pay 30% after CY deductible
You pay 20% after CY deductible	You pay 30% after CY deductible
You pay 20% after CY deductible	You pay 30% after CY deductible
You pay 20% after CY deductible	You pay 30% after CY deductible
Newborn covered 30 days; must enroll through County within 60 days	Newborn covered 30 days; must enroll through County within 60 days
You pay 20% after CY deductible	You pay 30% after CY deductible
Facility: You pay 20% after CY deductible Physician: You pay 20% after CY deductible	Facility: You pay 30% after CY deductible Physician: You pay 30% after CY deductible
Facility: You pay 20% after CY deductible Physician: You pay 20% after CY deductible	Facility: You pay 30% after CY deductible Physician: You pay 30% after CY deductible
You pay 20% after CY deductible (100 visits per calendar year combined PPO/OoN maximum)	If preauthorized you pay 20% after deductible
You pay 20% after CY deductible	If preauthorized you pay 20% after CY deductible
You pay 20% after CY deductible	Freestanding: SNF if preauthorized You pay 20% after deductible 30% for OON skilled nursing unit of a hospital (100 visits per calendar year combined PPO/OoN maximum)

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Mental Health Care and Substance Abuse Treatment			
		MHSA Participating Provider	
Non-severe mental disorders	Inpatient: No charge Outpatient: You pay a \$10 copay/\$5 copay group	Inpatient: No charge Outpatient: 1-3 visits – no charge \$10 per visit thereafter	Covered under Level 1 Benefit
Severe mental disorders	Inpatient: No charge Outpatient: You pay a \$10 copay/\$5 copay group (Severe Mental Disorder defined in EOC)	Inpatient: No charge Outpatient: 1-3 visits – no charge \$10 per visit thereafter	Covered under Level 1 Benefit
Substance abuse	Inpatient: No Charge Outpatient: \$10 copay individual, \$5 copay group	Inpatient: Inpatient Hospitalization Copay Applies Professional (Physician) Services- Outpatient Physician Visit (per calendar year): 1-3 visits- no charge \$10 per visit thereafter Professional (Physician) Services - Inpatient: No charge Partial Hospitalization/Day Treatment: No charge	Covered under Level 1 Benefit
Prescription Drugs			
Prescription drugs (per fill) Includes Diabetic drugs and testing supplies	Pharmacy (up to 100 day supply): generic - \$10 copay; brand \$15 copay; drugs prescribed for the treatment of sexual dysfunction disorders and infertility: 50% Coinsurance Mail Order is voluntary	Pharmacy (30-day supply): \$5 generic, \$10 brand name, \$25 non-formulary Specialty Pharmacies: \$10 per prescription (up to a 30-day supply) Mail Order is voluntary 90-day supply at discounted rate	Covered under Level 1 Benefit
Other Services			
Allergy testing	You pay a \$10 copay (serum covered)	You pay a \$10 copay (50% if serum purchased separately)	You pay a \$30 copay (50% if serum purchased separately)
Chiropractic care	Not covered	Not covered	
Durable medical equipment	No charge	No charge	Covered under Level 1 Benefit
Home visits (Physician)	No charge; only when medically necessary	You pay a \$10 copay	Covered under Level 1 Benefit

Blue Shield PPO	
In-Network	Out-of-Network
MHSA Participating Provider	MHSA Non-Participating Provider
Inpatient: You pay \$10 Outpatient: 1-3 visits – no charge 20% per visit thereafter (Not subject to the Calendar-Year Deductible)	Inpatient: 30% Outpatient: 30% per visit
MHSA Participating Provider	MHSA Non-Participating Provider
Inpatient: Inpatient Hospitalization Copay Applies Professional (Physician) Services - Outpatient Physician Visit (per calendar year): 1-3 visits- no charge \$10 per visit thereafter Professional (Physician) Services - Inpatient: 20% after CY deductible	Inpatient: Inpatient Hospitalization Copay Applies Professional (Physician) Services - Outpatient Physician Visit (per calendar year): 30% per visit Professional (Physician) Services - Inpatient: 30%
PARTICIPATING PHARMACY Pharmacy: \$15 generic formulary \$30 brand formulary \$30 non-formulary Specialty Pharmacies: \$15 per prescription (up to a 30-day supply) Mail Order is voluntary 90 day supply at discounted rate	NON-PARTICIPATING PHARMACY (Member pays 25% of billed amount plus copayment) Pharmacy: \$15 generic formulary, \$30 brand formulary, \$30 non-formulary Specialty Pharmacies: Not covered Mail Order not covered
Pharmacy (retail and mail order) copays do not apply toward the out-of- pocket maximum.	
Office Visit: You pay 20% (CY ded. waived) Allergy Injection Services(serum not included) \$15 visit (CY ded. waived)	Office Visit: You pay 30% Allergy Injection Services (serum not included) \$15 visit (CY ded. waived)
You pay 20% after CY deductible	You pay 30% after CY deductible
Up to 30 visits per calendar year combined PPO/OoN maximum	
You pay 20% after CY deductible	You pay 30% after CY deductible
You pay 20% (CY ded. waived)	You pay 30% after CY deductible

