

<b>2007</b>	<b>County of Kern Retirees Benefits</b>
\$80 per enrollee per month	
<b>MAXIMUM OUT-OF-POCKET LIMIT (MOOP)</b>	NA
<b>OFFICE VISIT PCP/SPEC</b>	\$10
<b>URGENT CARE</b>	\$50 - waived if admitted
<b>EMERGENCY CARE</b>	\$50 - waived if admitted
<b>AMBULANCE</b>	No charge
<b>IN-PATIENT HOSPITAL</b>	\$200 -unlimited days each benefit period
<b>SKILLED NURSING FACILITY (100 DAYS PER BENEFIT PERIOD) (5)</b>	\$200 -covered for 100 days each benefit period
<b>OUT-PATIENT SURGERY IN AN ASC</b>	No charge
<b>OUT-PATIENT SURGERY IN A HOSPITAL</b>	No charge
<b>OUTPATIENT SERVICES, OTHER THAN SURGERY, IN A HOSPITAL</b>	No charge
<b>DME</b>	No charge
<b>PROSTHETICS / ORTHOTICS</b>	No charge
<b>HOME HEALTH</b>	No charge
<b>PHYSICAL, OCCUPATIONAL, OR SPEECH THERAPY</b>	No charge
<b>HEMODIALYSIS</b>	No charge
<b>CHEMOTHERAPY - DRUGS</b>	No charge
<b>CHEMOTHERAPY - PROFESSIONAL SERVICE</b>	No charge
<b>RADIATION THERAPY</b>	No charge
<b>RADIOLOGY - MRI, PET, CT</b>	No charge
<b>INJECTIONS AND INJECTED SUBSTANCES: DRUGS AND BIOLOGICALS ADMINISTERED IM OR IV BY A PHYSICIAN</b>	No charge
<b>SELF-INJECTABLES / MEDICARE-COVERED DRUGS ONLY</b>	No charge
<b>HEARING SERVICES</b>	\$10 -exam/hearing aids not covered
<b>VISION / MEDICARE-COVERED EXAM</b>	\$10
<b>EYEWEAR / IN ADDITION TO POST-CATARACT SURGERY EYEWEAR</b>	Lenses are covered (in full or subject to an eyewaer allowance) \$100 allowance for frames every two years.
<b>SELF REFERRAL BENEFIT</b>	Not covered
<b>TRANSPORTATION (ROUTINE)</b>	Not covered

<b>DRUG BENEFIT</b>	
<b>Deductible</b>	NA
<b>Coverage gap begins (based on costs paid by both you and your plan)</b>	NA
<b>30-Day Supply</b>	\$10
	\$20
<b>90-Day Supply Retail Pharmacy</b>	n/a
	n/a
<b>90-Day Supply Mail-order Pharmacy</b>	\$20
	\$40
<b>Catastrophic coverage (based on out-of-pocket drug costs)</b>	NA
<b>Diabetic supplies (insulin needles and syringes, pen needles and reusable pen devices)</b>	\$20 -each item up to a 30 days supply