

# HMO - SUMMARY BENEFITS & FEATURES

	Cal Choice HMO - 10	Cal Choice HMO - 25	Cal Choice HMO - 40	ELECT Open Access
<b>MEDICAL BENEFITS</b>				<b>Available only through Health Net</b>
Deductible	No Deductible	No Deductible	No Deductible	No Deductible
<b>DR. OFFICE VISITS</b>	<b>\$ 10 Copay</b>	<b>\$ 25 Copay</b>	<b>\$ 40 Copay<sup>2</sup></b>	<b>\$ 25 Copay HMO \$ 40 Copay PPO</b>
Lab And X-Ray	100%	100%	\$ 10 Copay <sup>2,3</sup>	100%
<b>HOSPITAL SERVICES</b>	<b>\$300 Copay - 100%</b>	<b>\$500 Copay per day Max \$1,000</b>	<b>\$500 Copay per day<sup>2</sup></b>	<b>\$500 Copay per day Max. \$1,000</b>
In-Patient Physician Fees	100%	100%	100% <sup>2</sup>	100%
Emergency Room	\$ 50 Copay (waived if admitted)	\$ 100 Copay (waived if admitted)	\$ 250 Copay <sup>2</sup> (waived if admitted)	\$ 100 Copay (waived if admitted)
<b>RX BENEFIT</b> - Generic	<b>\$ 10 Copay</b>	<b>\$ 15 Copay</b>	<b>\$ 20 Copay<sup>2</sup></b>	<b>\$ 15 Copay</b>
- Brand Name	<b>\$ 20 Copay</b>	<b>\$ 25 Copay</b>	<b>\$ 35 Copay<sup>2</sup></b>	<b>\$ 25 Copay</b>
Oral Contraceptives	Covered	Covered	Covered	Covered
Maternity	Covered As Any Illness	Covered As Any Illness	Covered As Any Illness	Covered As Any Illness
Chiropractic	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-Pocket Maximum-Ind/Fam	\$2,000 / \$ 4,000	\$2,500 / \$5,000	\$3,000 / \$ 6,000	\$2,500 / \$5,000
2nd Surgical Opinion	\$ 10 Copay	\$ 25 Copay	\$ 40 Copay <sup>2</sup>	\$ 25 Copay
Out-Patient Surgery	\$100 Copay	\$300 Copay	\$500 Copay <sup>2</sup>	\$ 300 Copay
Home Health Care	100%	\$ 30 Copay	\$ 50 Copay <sup>2</sup>	\$ 30 Copay
Skilled Nursing Facility: Per Disability	30 days - \$300 Copay Max. 100 days per year	30 days - \$500 per day Max. \$1,000 / 100 days per year	30 days - \$500 per day Max. 100 days per year	30 days - \$500 per day Max. \$1,000 / 100 days per year
Ambulance	\$50 Per Trip	\$50 Per Trip	\$200 Per Trip <sup>2</sup>	\$50 Per Trip
Pre-Existing Conditions	Covered	Covered	Covered	Covered
Mental / Nervous Non-Severe: <sup>1</sup>				
Doctor Fees	\$ 30 Copay	\$ 40 Copay	\$ 50 Copay	\$ 40 Copay
- Annual Maximum	20 Visits Per Year	20 Visits Per Year	20 Visits Per Year	20 Visits Per Year
Hospital Fees	Not Covered	Not Covered	Not Covered	Not Covered
Lifetime Maximum	Limited to Mental & Nervous Doctor Fees	Limited to Mental & Nervous Doctor Fees	Limited to Mental & Nervous Doctor Fees	Limited to Mental & Nervous Doctor Fees
Drug / Alcohol:				
Doctor Fees	Combined Benefit with Mental & Nervous	Combined Benefit with Mental & Nervous	Combined Benefit with Mental & Nervous	Combined Benefit with Mental & Nervous
Hospital Fees	\$300 Copay - 100% Acute Detox Only	\$ 500 Copay per day Max \$1,000 - Acute Detox Only	\$500 Copay per day <sup>2</sup> Acute Detox Only	\$500 Copay per day – max \$1,000 – acute detox only

<sup>1</sup> Health plans that provide hospital, medical or surgical coverage must provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and serious emotional disturbances of a child, as specified, under the same terms and conditions applied to other medical conditions.

These benefits will include in-patient, partial hospitalization and out-patient services and prescription drugs, if the plan includes drug coverage.

The mental health benefits must be applied the same as any other medical benefit including, but not limited to, maximum lifetime benefits, copayments and individual and family deductibles.

"Severe mental illness" includes: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorders, obsessive-compulsive disorder, pervasive development disorder or autism, anorexia and bulimia nervosa.

<sup>2</sup> Copayment shall be up to the designated amount, or 50% of the provider's contracted rate, whichever is less.

<sup>3</sup> The copay for an MRI, CT or PET scan is \$50

# PPO - SUMMARY BENEFITS & FEATURES

	Cal Choice PPO 250		Cal Choice PPO 500		Cal Choice PPO 1000	
MEDICAL BENEFITS	In-network	Out-of-Network	In-network	Out-of-Network	In-network	Out-of-Network
Deductible <sup>1</sup> / Family Max	\$250 - 2 aggregate	\$250 - 2 aggregate	\$500 - 3 aggregate	\$500 - 3 aggregate	\$1000 - 2 aggregate	\$1000 - 2 aggregate
<b>DR. OFFICE VISITS</b>	<b>\$20 copay<sup>2</sup></b>	<b>70%<sup>1</sup></b>	<b>\$30 copay<sup>2</sup></b>	<b>60%<sup>1</sup></b>	<b>\$35 copay<sup>2</sup></b>	<b>50%<sup>1</sup></b>
Annual Physical Exam	\$20 copay <sup>2</sup>	Not Covered	\$30 copay <sup>2</sup>	Not Covered	\$35 copay <sup>2</sup>	Not Covered
Lab And X-Ray	\$20 copay <sup>2</sup>	70%	\$30 copay <sup>2</sup>	60%	\$35 copay <sup>2</sup>	50%
<b>HOSPITAL SERVICES</b>	<b>\$250 copay - 90%</b>	<b>70%<sup>1,3</sup></b>	<b>\$500 copay - 80%</b>	<b>60%<sup>1,3</sup></b>	<b>\$1000 Ded. - 70%</b>	<b>50%<sup>1,3</sup></b>
In-Patient Physician Fees	90%	70% <sup>3</sup>	80%	60% <sup>3</sup>	70%	50% <sup>3</sup>
Emergency Room	\$75 copay <sup>1</sup> - 90%	\$75 copay <sup>1</sup> - 90%	\$125 copay <sup>1</sup> - 80%	\$125 copay <sup>1</sup> - 80%	\$100 copay <sup>1</sup> - 70%	\$100 copay <sup>1</sup> - 70%
<b>Rx Benefit<sup>1</sup></b>	<b>\$10 copay</b>	<b>\$10 copay</b>	<b>\$10 copay</b>	<b>\$10 copay</b>	<b>\$10 copay</b>	<b>\$10 copay</b>
Generic	\$20 copay	\$20 copay	\$125 Ded. - \$25 copay	\$125 Ded. - \$25 copay	\$150 Ded. - \$25 copay	\$150 Ded. - \$25 copay
Formulary brand	\$35 copay	\$35 copay	\$125 Ded. - \$40 copay	\$125 Ded. - \$40 copay	\$150 Ded. - \$40 copay	\$150 Ded. - \$40 copay
Non-formulary brand						
Oral contraceptives	Covered	Covered	Covered	Covered	Covered	Covered
Maternity	See hospital services		See hospital services		See hospital services	
Chiropractic	\$25 copay – Max 12 visits per year	70% - Max 12 visits per year	\$25 copay – Max 12 visits per year	60% - Max 12 visits per year	\$25 copay – Max 12 visits per year	50% - Max 12 visits per year
Out of pocket max. – Ind./Fam	\$2,500 / \$5,000	\$6,000 / \$12,000	\$3,500 / \$7,000	\$6,000 / \$12,000	\$4,000 / \$8,000	\$6,000 / \$12,000
Lifetime maximum	\$6,000,000	\$6,000,000	\$6,000,000	\$6,000,000	\$6,000,000	\$6,000,000
Outpatient surgery	\$150 copay <sup>1</sup> - 90%	70% <sup>1,3</sup>	\$500 copay <sup>1</sup> - 80%	60% <sup>1,3</sup>	\$500 copay <sup>1</sup> - 70%	50% <sup>1,3</sup>
Hospital pre-authorization	Required or additional \$250 per hospital admission		Required or additional \$250 per hospital admission		Required or additional \$250 per hospital admission	
Hospice:						
Routine home care	100%	Not covered	100%	Not covered	100%	Not covered
24 hr. continuous care	90%	Not covered	80%	Not covered	70%	Not covered
Skilled nursing facility	90%	70%	80%	60%	70%	50%
Ambulance	90%	90%	80%	80%	70%	70%
Mental / Nervous:						
Out-patient: Severe Condition	\$20 copay <sup>2</sup>	70% <sup>1</sup>	\$30 copay <sup>2</sup>	60% <sup>1</sup>	\$35 copay <sup>2</sup>	50% <sup>1</sup>
In-patient: Severe Condition	\$250 copay - 90%	70% <sup>1,3</sup>	\$500 copay - 80%	60% <sup>1,3</sup>	\$1,000 Ded. - 70%	50% <sup>1,3</sup>
Out-patient – Non-Severe	\$25 copay <sup>1</sup> - max. 20 visits yr.	Not covered	\$30 copay <sup>1</sup> - max. 20 visits yr.	Not covered	\$25 copay <sup>1</sup> - max. 20 visits yr.	Not covered
Inpatient– Non-Severe	\$250 copay - 90%	70% <sup>1,3</sup>	\$500 copay - 80%	60% <sup>1,3</sup>	\$1,000 Ded. - 70%	50% <sup>1,3</sup>
Drug / alcohol:						
Out-patient	Combined benefit with non-severe mental and nervous		Combined benefit with non-severe mental and nervous		Combined benefit with non-severe mental and nervous	
In-patient (detox only)	\$250 copay – 90%	70% <sup>1,3</sup>	\$500 copay – 80%	60% <sup>1,3</sup>	\$1,000 Ded. – 70%	50% <sup>1,3</sup>

Note: Out-of-network benefits are covered at a negotiated fee. Plans exclude coverage for pre-existing conditions (except for pregnancy) for the first six months of coverage unless replacing prior creditable coverage.

<sup>1</sup> Co-payment for services does not count toward the co-payment maximum and continue to be charged once the co-payment maximum is reached

<sup>2</sup> The office visit co-payment does not count toward the plan deductible. Other covered services received during or in connection with the office visit, such as lab tests and X-rays, are subject to the plan deductible and the applicable co-payment.

<sup>3</sup> The maximum allowed charge for non-emergency hospital services received from a non-preferred hospital is \$600 per day. Members are responsible for 30%, 40% or 50% (based on plan selection) of this \$600 per day, plus all charges in excess of \$600. These co-payments do not count toward the calendar year co-payment maximum, and continue to be charged after it is reached. Physician services are covered separately at 30%, 40% or 50% of allowable amounts.

Some services rendered by Blue Shield Affiliated providers will have higher copays.

# PPO - SUMMARY BENEFITS & FEATURES

## Cal Choice PPO 2400

MEDICAL BENEFITS	In-network	Out-of-Network	
Deductible / Family Maximum	\$2,400 / \$4,800 <sup>1</sup>	\$2,400 / \$4,800 <sup>1</sup>	
<b>DR. OFFICE VISITS</b>	<b>80%</b>	<b>50%</b>	
Annual Physical Exam Lab And X-Ray	\$35 copay <sup>2</sup> 80%	Not Covered 50%	
<b>HOSPITAL SERVICES</b>	<b>80%</b>	<b>50%<sup>5</sup></b>	
In-Patient Physician Fees Emergency Room	80% \$50 copay - 80% <sup>3</sup>	50% \$50 copay - 80% <sup>3</sup>	
<b>Rx Benefit</b>	<b>80%<sup>4</sup></b>	<b>80%<sup>4</sup></b>	
Oral contraceptives	Covered	Covered	
Maternity	See hospital services		Plan availability will be determined by the number of medically enrolled employees.
Chiropractic	80% - Max. 20 visits per year	50% - Max. 20 visits per year	<b>Number of enrollees</b>
Out of pocket max. - Ind./Fam	\$3,200 / \$5,800 Includes plan deductible	\$3,200 / \$5,800 Includes plan deductible	2 - 4
Lifetime maximum	\$6,000,000	\$6,000,000	<b>Available plans</b>
Outpatient surgery	80%	50% <sup>5</sup>	All HMO plans, PPO 1000 and PPO 2400
Hospital pre-authorization	Required or additional \$250 per hospital admission		5 - 9
Hospice: Routine home care 24 hr. continuous care	100% 80%	Not covered Not covered	10 or more
Skilled nursing facility	80% of semi-private R&B - max. 100 days per year	50% <sup>5</sup> of semi-private R&B - max. 100 days per year	All HMO plans, PPO 500, PPO 1000 and PPO 2400
Ambulance	80%	80%	
Mental / Nervous: Out-patient - Severe Out-patient - Non-Severe	80% 50% - max 20 visits	50% Not covered	
Inpatient - All Conditions	80%	50% <sup>5</sup>	
Drug / alcohol: Out-patient	Combined benefit with non-severe mental and nervous		
In-patient (detox only)	80%	50% <sup>5</sup>	

Note: Out-of-network benefits are covered at a negotiated fee. Plans exclude coverage for pre-existing conditions (except for pregnancy) for the first six months of coverage unless replacing prior creditable coverage.

<sup>1</sup> Employees enrolling for single coverage must satisfy the single deductible; for employees enrolling with dependent coverage, the family deductible must be met before any member receives benefits.

<sup>2</sup> The preventive care and well-baby care office visit co-payment does not count toward the plan deductible. Other covered services received during or in connection with the office visits, such as lab tests and X-rays, are subject to the applicable co-payment.

<sup>3</sup> If emergency room services are later determined to have been non-emergency, standard plan co-payments will apply (20% or 50%, depending on the hospital used), after the member has met the plan deductible and the additional \$50 deductible per emergency room visit.

<sup>4</sup> Includes coverage for medically necessary drugs (subject to the plan deductible). Member pays full price and submits prescription drug claims to Blue Shield of California.

<sup>5</sup> The maximum allowed charge for non-emergency hospital services received from a non-preferred hospital is \$600 per day. Members are responsible for 50% of this \$600 per day, plus all charges in excess of \$600. Payments that exceed the allowed charge do not count toward the calendar year co-payment maximum, and continue to be charged after it is reached. Physician services are covered separately at 50% of allowed amounts.

Some services rendered by Blue Shield Affiliated providers will have higher copays.