

51+

For Employers with 51 - 199 Employees

HMOs BENEFIT SUMMARIES

	CalChoice® 51+ HMO 15*	CalChoice 51+ HMO 25*	CalChoice 51+ HMO 40*	Elect Open Access*
MEDICAL BENEFITS				
	<i>Available only through Health Net</i>			
Deductible	No Deductible	No Deductible	No Deductible	No Deductible
DR. OFFICE VISITS	\$15 Copay	\$25 Copay	\$40 Copay¹	\$20 Copay HMO \$30 Copay PPO
Lab And X-Ray	100%	100%	\$10 Copay ^{1,2}	100%
HOSPITAL SERVICES	\$500 per Admission - Max. \$1,000	\$500 Copay per day Max. 4 days	\$500 Copay per day¹	80%
Inpatient Physician Fees	100%	100%	100% ¹	100%
Emergency Room	\$75 Copay (waived if admitted)	\$ 150 Copay (waived if admitted)	\$ 250 Copay ¹ (waived if admitted)	\$ 100 Copay (waived if admitted)
Rx BENEFITS				
Generic Formulary	\$10 Copay	\$15 Copay	\$20 Copay¹	\$15 Copay
Brand Name	\$20 Copay	\$25 Copay	\$35 Copay¹	\$25 Copay
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 Max.-Ind/Fam	\$2,000 / \$ 4,000	\$2,500 / \$5,000	\$3,000 / \$ 6,000	\$1,500 / \$4,500
2nd Surgical Opinion	\$15 Copay	\$25 Copay	\$40 Copay ¹	\$20 Copay
Outpatient Surgery	\$100 Copay	\$300 Copay	\$500 Copay ¹	\$250 Copay
Home Health Care	100%	\$30 Copay	\$50 Copay ¹	100%
Skilled Nursing Facility Per Disability	\$500 per Admission Max. \$1,000 Max. 100 days per year	\$500 per day - Max. 4 days Max. 100 days per year	\$500 per day Max. 100 days per year	80% Max. 100 days per year
Ambulance	\$50 Per Trip	\$50 Per Trip	\$200 Per Trip ¹	100%
Pre-Existing Conditions	Covered	Covered	Covered	Covered
Mental / Nervous Non Severe:				
Doctor Fees	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage
Annual Maximum	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage
Hospital Fees	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage
Drug / Alcohol:				
Doctor Fees	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage
Hospital Fees	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage

*Health Net and Kaiser Permanente plan benefits are based on calendar year.

¹ Copay shall be up to the designated amount, or 50% of the provider's contracted rate, whichever is less.

² The copay for an MRI, CT or PET scan is \$50.

866.226.7431
www.calchoiceplus.com



CaliforniaChoice 51+
Your Health. Your Choice.®

51+

For Employers with 51 - 199 Employees

PPOs

BENEFIT SUMMARIES

MEDICAL BENEFITS	CalChoice® 51+ PPO 250		CalChoice 51+ PPO 500	
	In-Network	Out-of-Network ²	In-Network	Out-of-Network ²
Deductible / Family Maximum	\$250-3 per Family	\$250-3 per Family	\$500-3 per Family	\$500-3 per Family
DR. OFFICE VISITS	\$15 Copay	70%	\$30 Copay	60%
Annual Physical Exam	\$25 Copay ¹	Not Covered	Not Covered	Not Covered
Lab And X-Ray	90% ^{2,3}	70% ^{2,3}	80% ^{2,3}	60% ^{2,3}
HOSPITAL SERVICES	\$250 Copay-90%³	\$250 Copay-70%^{3,7}	\$250 Copay-80%³	\$250 Copay-60%^{3,7}
Inpatient Physician Fees	90%	70%	80%	60%
Emergency Room	90% ⁴	90% ⁴	80% ⁴	80% ⁴
Rx BENEFITS	\$10 Copay	\$10 Copay	\$10 Copay	\$10 Copay
Formulary Generic	\$20 Copay	\$20 Copay	\$100 Ded. - \$20 Copay	\$100 Ded. - \$20 Copay
Formulary Brand	\$35 Copay	\$35 Copay	\$100 Ded. - \$35 Copay	\$100 Ded. - \$35 Copay
Non-Formulary Brand				
Maternity	90% ³	70% ³	80% ³	60% ³
Chiropractic	\$15 Copay ⁵	70% ⁵	Not Covered	Not Covered
Out-of-Pocket Maximum	\$3,000 per Ind.	\$5,000 per Ind.	\$4,000 per Ind.	\$6,000 per Ind.
Lifetime Maximum	\$5,000,000			
Outpatient Surgery	\$250 Copay - 90% ³	\$250 Copay - 70% ^{3,7}	\$250 Copay - 80% ³	\$250 Copay - 60% ^{3,7}
Hospice Care	90% ³	70% ³	80% ³	60% ³
	Lifetime maximum - \$5,000			
Skilled Nursing Facility	\$250 Copay - 90% ³	\$250 Copay - 70% ³	\$250 Copay - 80% ³	\$250 Copay - 60% ³
	Max-OON \$250 per day/max 100 days		Max-OON \$250 per day/max 60 days	
Ambulance	\$50 Copay - 90%	\$50 Copay - 70%	\$50 Copay - 80%	\$50 Copay - 60%
Mental / Nervous:				
Outpatient - Severe Condition	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage
Inpatient - Severe Condition	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage
Outpatient - Non-Severe	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage
Inpatient - Non-Severe	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage
Drug / Alcohol:				
Outpatient	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage
Inpatient (Detox Only)	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage
Inpatient	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage

Note: PPO services to which a copay applies are not subject to the calendar year deductible. For these services, Health Net will pay 100% of covered expenses (excluding the copay), whether or not the calendar year deductible has been satisfied. Services to which coinsurance applies are subject to the calendar year deductible.

¹ Limited to one exam each calendar year and a maximum payment of \$200 for the exam and all related services (age 17 and older only).

² Prior certification only required for MRI, MUGA, PET, and SPECT.

³ These services require prior certification before being provided or received. If prior certification is not acquired, benefits are reduced to 50%. In addition, for uncertified outpatient services, a \$50 deductible is required for each visit; for uncertified inpatient admissions, a \$250 deductible is required for each inpatient admission. Limited to a maximum allowable amount of \$600 each day for services received in an OON hospital or \$250 each day in an OON skilled nursing facility.

⁴ An additional \$100 emergency room or urgent care deductible is required if the member is not admitted as an inpatient. The deductible is waived if admitted.

⁵ After the initial visit, subsequent visits require an approved chiropractic treatment plan. The maximum amount payable for each OON visit is \$25 with a maximum of 12 visits per year combined between PPO and OON.

⁶ Out-of-network (OON) services: The member is responsible for the scheduled coinsurance and any charges exceeding HealthNet's limited fee schedule.

⁷ OON hospital services limited fee schedule: Maximum allowable each day inpatient hospital: \$600, outpatient hospital: 50% of billed charges

Continued on back

866.226.7431
www.calchoiceplus.com



CaliforniaChoice 51+
Your Health. Your Choice.®

MEDICAL BENEFITS	CalChoice® 51+ PPO 1000		CalChoice 51+ PPO 1500	
	In-Network	Out-of-Network ¹	In-Network	Out-of-Network ¹
Deductible / Family Maximum	\$1000-3 per Family	\$1000-3 per Family	\$1,500 -3 per Family	\$1,500 -3 per Family
DR. OFFICE VISITS	\$30 Copay	60%	\$40 Copay	60%
Annual Physical Exam	Not Covered	Not Covered	Not Covered	Not Covered
Lab And X-Ray	80% ^{1,2}	60% ^{1,2}	80% ^{1,2}	60% ^{1,2}
HOSPITAL SERVICES	\$250 Copay-80%²	\$250 Copay-60%^{2,5}	\$250 Copay-80%²	\$250 Copay-60%^{2,5}
Inpatient Physician Fees	80%	60%	80%	60%
Emergency Room	80% ³	80% ³	80% ³	80% ³
Rx BENEFITS	\$10 Copay	\$10 Copay	\$10 Copay	\$10 Copay
Formulary Generic	\$150 Ded. - \$25 Copay	\$150 Ded. - \$25 Copay	\$150 Ded. - \$25 Copay	\$150 Ded. - \$25 Copay
Formulary Brand	\$150 Ded. - \$35 Copay	\$150 Ded. - \$35 Copay	\$150 Ded. - \$35 Copay	\$150 Ded. - \$35 Copay
Non-Formulary Brand	\$150 Ded. - \$35 Copay	\$150 Ded. - \$35 Copay	\$150 Ded. - \$35 Copay	\$150 Ded. - \$35 Copay
Maternity	80% ²	60% ²	80% ²	60% ²
Chiropractic	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-Pocket Maximum	\$4,000 per Ind.	\$6,000 per Ind.	\$4,000 per Ind.	\$6,000 per Ind.
Lifetime Maximum	\$5,000,000			
Outpatient Surgery	\$250 Copay - 80% ²	\$250 Copay - 60% ^{2,5}	\$250 Copay - 80% ²	\$250 Copay - 60% ^{2,5}
Hospice Care	80% ²	60% ²	80% ²	60% ²
	Lifetime maximum - \$5,000			
Skilled Nursing Facility	\$250 Copay - 80% ²	\$250 Copay - 60% ²	\$250 Copay - 80% ²	\$250 Copay - 60% ²
	Max-OON \$250 per day/max 60 days			
Ambulance	\$50 Copay - 80%	\$50 Copay - 60%	\$50 Copay - 80%	\$50 Copay - 60%
Mental / Nervous:				
Outpatient - Severe Condition	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage
Inpatient - Severe Condition	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage
Outpatient - Non-Severe	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage
Inpatient - Non-Severe	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage
Drug / Alcohol:				
Outpatient	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage
Inpatient (Detox Only)	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage
Inpatient	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage

Note: PPO services to which a copay applies are not subject to the calendar year deductible. For these services, Health Net will pay 100% of covered expenses (excluding the copay), whether or not the calendar year deductible has been satisfied. Services to which coinsurance applies are subject to the calendar year deductible.

¹ Prior certification only required for MRI, MUGA, PET, and SPECT.

² These services require prior certification before being provided or received. If prior certification is not acquired, benefits are reduced to 50%. In addition, for uncertified outpatient services, a \$50 deductible is required for each visit; for uncertified inpatient admissions, a \$250 deductible is required for each inpatient admission. Limited to a maximum allowable amount of \$600 each day for services received in an OON hospital or \$250 each day in an OON skilled nursing facility.

³ An additional \$100 emergency room or urgent care deductible is required if the member is not admitted as an inpatient. The deductible is waived if admitted.

⁴ Out-of-Network (OON) services: The member is responsible for the scheduled coinsurance and any charges exceeding Health Net's limited fee schedule.

⁵ OON hospital services limited fee schedule: Maximum allowable each day inpatient hospital: \$600, outpatient hospital: 50% of billed charges.



MEDICAL BENEFITS	CalChoice® 51+ HSA 1500		CalChoice 51+ HSA 2000	
	In-Network ¹	Out-of-Network ²	In-Network ¹	Out-of-Network ²
Deductible/ Family Maximum	\$1,500 / \$3,000 ³	\$1,500 / \$3,000 ³	\$2,000 / \$4,000 ³	\$2,000 / \$4,000 ³
DR. OFFICE VISITS	80%	60%	70%	50%
Preventive Care	\$30 copay ⁴	Not Covered	\$30 copay ⁴	Not Covered
Lab And X-Ray	80% ⁵	60% ⁵	70% ⁵	50% ⁵
HOSPITAL SERVICES	80%⁶	60%⁶	70%⁶	50%⁶
Inpatient Physician Fees	80%	60%	70%	50%
Emergency Room	\$100 Copay - 80% (copay waived if admitted)	\$100 Copay - 80% (copay waived if admitted)	70%	70%
Rx BENEFITS	\$10 Copay After Plan Deductible		\$15 Copay After Plan Deductible	
Generic Formulary	\$25 Copay - After Plan Deductible	\$25 Copay - After Plan Deductible	\$30 Copay - After Plan Deductible	\$30 Copay - After Plan Deductible
Formulary Brand	\$50 Copay - After Plan Deductible	\$50 Copay - After Plan Deductible	\$50 Copay - After Plan Deductible	\$50 Copay - After Plan Deductible
Non-Formulary Brand	80% ⁶	60% ⁶	70% ⁶	50% ⁶
Maternity	Not Covered	Not Covered	Not Covered	Not Covered
Chiropractic	\$3,500 / \$7,000 - Includes Plan Deductible		\$4,000 / \$8,000 - Includes Plan Deductible	
Out-of-Pocket Maximum	\$5,000,000		\$5,000,000	
Lifetime Maximum	\$5,000,000		\$5,000,000	
Outpatient Surgery	80% ⁶	60% ⁶	70% ⁶	50% ⁶
Hospice Care	80% ⁶	60% ⁶	70% ⁶	50% ⁶
Skilled Nursing Facility	Lifetime Maximum \$5,000		Lifetime Maximum \$5,000	
	80% ⁶	60% ⁶ Maximum \$250 per day	70% ⁶	50% ⁶ Maximum \$250 per day
	Maximum 60 days per year		Maximum 60 days per year	
Ambulance	80%	60%	70%	50%
Mental & Nervous Benefits:				
Outpatient: Severe Condition	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage
Inpatient: Severe Condition	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage
Outpatient: Non-Severe	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage
Inpatient: Non-Severe	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage
Drug & Alcohol Benefits:				
Outpatient	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage
Inpatient (Detox Only)	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage	See Evidence of Coverage

¹ For the PPO level of benefits, the percentages that appear in this chart are based on allowable charges and contracted rates with providers.

² Out-of-Network (OON) services: The member is responsible for the scheduled copay and any charges exceeding Health Net's limited fee schedule.

³ 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. The deductible is combined between PPO and OON with all benefits subject to the deductible except Preventive Care.

⁴ Provided on the basis of age, medical need and health status. Adult preventive care includes: mammography, cervical cancer screening test/pelvic and breast exams, sigmoidoscopy and prostate cancer screening test (age 17 and older). Children preventive care includes: well child care and immunizations (for children through age 18).

⁵ Prior certification only required for MRI, MUGA, PET and SPECT.

⁶ These services require prior certification before being provided or received. If prior certification is not acquired, benefits are reduced to 50%. In addition, for uncertified outpatient services, a \$50 deductible is required for each visit; for uncertified inpatient admissions, a \$250 deductible is required for each inpatient admission. Limited to a maximum allowable amount of \$600 each day for services received in an OON hospital or \$250 each day in an OON skilled nursing facility.





For Employers with 51 - 199 Employees

HSA - QUALIFIED PLANS

BENEFIT SUMMARIES

MEDICAL BENEFITS		HDHP 1500*
		Available through Kaiser Permanente only
Deductible		\$1,500 Self-Only Enrollment / \$3,000 Family Enrollment ¹
DR. OFFICE VISITS		\$0 Per visit After Deductible
Lab And X-Ray		\$0 Per Encounter After Deductible (<i>Outpatient</i>)
		\$10 Per Encounter (<i>Preventative</i>)
HOSPITAL SERVICES		\$0 Per Admission After Deductible
In-Patient Physician Fees		\$0 Per Admission After Deductible
Emergency Room		\$0 Per visit After Deductible
Rx BENEFITS		\$0 Per Prescription After Deductible³
Generic		\$0 Per Prescription After Deductible³
Brand Name		\$0 Per Prescription After Deductible ³
Oral Contraceptives Covered		\$0 No Deductible ⁴
Maternity		Not Covered
Chiropractic		
Out-of-Pocket Maximum:		
Individual		\$1,500 Self-Only Enrollment ²
Family		\$3,000 Family Enrollment ²
2nd Surgical Opinion		\$0 Per visit After Deductible
Out-Patient Surgery		\$0 Per Procedure After Deductible
Home Health Care		\$0 Per visit After Deductible (<i>max 100 Two-Hour Visits Per Year, 3 Visit(s) Max/Day</i>)
Skilled Nursing Facility		Extended Care \$0 Per Admission After Deductible (<i>100-Day Limit Per Benefit Period</i>)
Ambulance		\$0 Per Trip After Deductible
Pre-Existing Conditions		Covered
Mental/Nervous Non-Severe:		
Doctor Fees		See Evidence of Coverage
Annual Maximum		See Evidence of Coverage
Hospital Fees		See Evidence of Coverage
Lifetime Maximum		See Evidence of Coverage
Drug/Alcohol:		
Doctor Fees		See Evidence of Coverage
Hospital Fees		See Evidence of Coverage

* HSA - Qualified High Deductible Health Plan

¹ For Self-Only enrollment coverage, the entire Individual Annual Deductible must be met before copays or coinsurance is applied for the individual member. For Family coverage, the entire Family Annual Deductible must be met before copays or coinsurance is applied for any individual family member.

² The Annual Out-of-Pocket Maximum is the limit to the total amount that an individual or family must pay for certain Services in a Calendar Year (as discussed in the *Evidence of Coverage*). For Self-Only enrollment coverage, the entire Individual Annual Out-of-Pocket maximum must be met before the limit is applied for the individual member. For Family coverage, the entire Family Annual Out-of-Pocket maximum must be met before the limit is applied for any individual family member.

³ Prescription drugs covered in accord with the Kaiser Permanente formulary when prescribed by a Plan Physician and obtained at Plan Pharmacies. A few drugs have different copays; please refer to the *Evidence of Coverage* for detailed information about prescription drug copays.

⁴ Scheduled prenatal visits.

866.226.7431
www.calchoiceplus.com



CaliforniaChoice 51+
Your Health. Your Choice.®

Flex Net	
Available only through Health Net	
MEDICAL BENEFITS	
Deductible / Family Maximum	\$300 per person / \$900 per family
DR. OFFICE VISITS	Covered at 80%
Annual Physical Exam	Not Covered
Lab And X-Ray	Covered at 80% ¹
HOSPITAL SERVICES	Covered at 80%¹
Inpatient Physician Fees	Covered at 80% ¹
Emergency Room	Covered at 80%
RX BENEFITS	
Generic Formulary	Covered at 80% – \$75 Deductible
Non-Formulary Brand	Covered at 80% – \$75 Deductible
Formulary Brand	Covered at 80% – \$75 Deductible
Maternity	Covered at 80%
Chiropractic	Covered at 80% Max \$25 per visit Max 15 visits per year
Out-of-Pocket Max.-Ind/Fam	\$1,500 / \$4,500
Lifetime Maximum	\$1,000,000
2nd Surgical Opinion	Covered at 80%
Outpatient Surgery	Covered at 80% ¹
Hospice Care	Covered at 80% Max of \$150 per day ¹
Skilled Nursing Facility	Covered at 80% Max of \$60 days per year ¹
Ambulance	Covered at 80%
Mental & Nervous Benefits:	
Outpatient: Severe Condition	See Evidence of Coverage
Inpatient: Severe Condition	See Evidence of Coverage
Outpatient: Non-Severe	See Evidence of Coverage
Inpatient: Non-Severe	See Evidence of Coverage
Drug & Alcohol:	
Outpatient Therapy	See Evidence of Coverage
Inpatient Rehabilitation	See Evidence of Coverage
Inpatient – Acute Detox Only	See Evidence of Coverage

¹ These services require prior certification before being rendered or received. If prior certification is not acquired, a \$500 deductible is required for each uncertified inpatient admission.

