

HMO

Benefit Summaries

26 plans with office copays from \$15 to \$40

Medical Benefits	CalChoice® HMO 15 ²	CalChoice HMO 25 ²	CalChoice HMO 25 ²	CalChoice HMO 25 ²
Participating Health Plans	Anthem Blue Cross*, Health Net*, Kaiser Permanente, Sharp, Western Health Advantage	Anthem Blue Cross*	Health Net*	Kaiser Permanente
Deductible	No Deductible	No Deductible	No Deductible	No Deductible
DR OFFICE VISITS	\$15 Copay	\$25 Copay	\$25 Copay	\$25 Copay
Lab and X-Ray	\$15 Copay	\$25 Copay	\$25 Copay	\$5 Copay
MRI, CT, and PET	\$100 Copay	\$100 Copay	\$100 Copay	\$50 Copay
HOSPITAL SERVICES	\$400 Copay - 100%	\$450 Copay per day - Max \$1,800	\$450 Copay per day - Max \$1,800	\$400 Copay - 100%
Inpatient Physician Fees	100%	100%	100%	100%
Emergency Room	\$100 Copay (waived if admitted)	\$150 Copay (waived if admitted)	\$150 Copay (waived if admitted)	\$150 Copay (waived if admitted)
Rx BENEFITS				
Generic	\$10 Copay	\$15 Copay	\$15 Copay	\$10 Copay
Brand ³	\$20 Copay	\$100 Ded. - \$30 Copay	\$100 Ded. - \$30 Copay	\$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	\$25 Copay ⁷	Not Covered	Not Covered
Out-of-Pocket Max Ind/Fam	\$2,000/\$4,000	\$3,000 / \$6,000	\$3,000/\$6,000	\$2,500/\$5,000
2nd Surgical Opinion	\$15 Copay	\$25 Copay	\$25 Copay	\$25 Copay
Outpatient Surgery	\$200 Copay	\$400 Copay	\$400 Copay	\$300 Copay
Home Health Care	100%	\$25 Copay	\$45 Copay	100%
Skilled Nursing Facility				
Per Disability	\$400 Copay – Max 100 days per year	100%	\$450 Copay per day – Max \$1,800/100 days per year	\$100 Copay – Max 100 days per year
Ambulance	\$50 per trip	\$100 per trip	\$200 per trip	\$100 per trip
Pre-Existing Conditions	Covered	Covered	Covered	Covered
Mental/Nervous Non-Severe ^{1,4,5}				
Doctor Fees	\$30 Copay	\$25 Copay	\$40 Copay	\$25 Copay
Annual Maximum	20 visits per year	No Maximum	20 visits per year	No Maximum
Hospital Fees	Not Covered	\$450 Copay per day – Max \$1,800	Not Covered	\$400 Copay - 100%
Drug/Alcohol ^{4,5}				
Hospital Fees	\$400 Copay - 100% Acute detox only	\$450 Copay per day – Max \$1,800	\$450 Copay per day – Max \$1,800, Acute detox only	\$400 Copay - 100% Acute detox only

See footnotes on back page

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Benefit Summaries

Medical Benefits	CalChoice® HMO 25 ²	CalChoice HMO 25 ²	CalChoice HMO 25 Value	CalChoice HMO 25 Value
Participating Health Plans	Sharp	Western Health Advantage	Health Net*	Anthem Blue Cross*
Deductible	No Deductible	No Deductible	No Deductible	\$1,000 Sgl. \$2,000 Fam. (applies to Max OOP)
DR OFFICE VISITS	\$25 Copay	\$25 Copay	\$25 Copay	\$25 Copay
Lab and X-Ray	\$25 Copay	\$25 Copay	\$25 Copay	\$25 Copay
MRI, CT, and PET	100%	100%	\$100 Copay	\$100 Copay
HOSPITAL SERVICES	\$400 Copay per day Max \$1,200	\$400 Copay per day – Max \$1,200	75%	80% after deductible
Inpatient Physician Fees	100%	100%	100%	100%
Emergency Room	\$150 Copay (waived if admitted)	\$150 Copay (waived if admitted)	\$150 Copay (waived if admitted)	\$150 Copay after deductible (waived if admitted)
Rx BENEFITS	\$15 Copay	\$15 Copay	\$15 Copay	\$15 Copay
Generic	\$100 Ded. - \$30 Copay	\$100 Ded.-\$30 Copay	\$100 Ded. - \$30 Copay	\$200 Ded. - \$30 Copay
Brand ³	Covered	Covered	Covered	Covered
Oral Contraceptives	Covered as any illness	Covered as any illness	Covered as any illness	Covered as any illness
Maternity	Not Covered	Not Covered	Not Covered	\$25 Copay ⁷
Chiropractic	\$2,500/\$5,000	\$2,500/\$5,000	\$3,000/\$6,000	\$3,000/\$6,000
Out-of-Pocket Max Ind/Fam	\$25 Copay	\$25 Copay	\$25 Copay	\$25 Copay
2nd Surgical Opinion	\$300 Copay	\$300 Copay	75%	80% after deductible
Outpatient Surgery	\$30 Copay	\$30 Copay	\$45 Copay	\$25 Copay
Home Health Care				
Skilled Nursing Facility				
Per Disability	\$400 Copay per day Max \$1,200/100 days per year	\$400 Copay per day – Max \$1,200/100 days per year	75% Max 100 days per year	100% after deductible
Ambulance	\$100 per trip	\$100 per trip	\$200 per trip	\$100 per trip
Pre-Existing Conditions	Covered	Covered	Covered	Covered
Mental/Nervous Non-Severe ^{1,4,5}				
Doctor Fees	\$40 Copay	\$25 Copay	\$40 Copay	\$25 Copay
Annual Maximum	20 visits per year	No Maximum	20 visits per year	No Maximum
Hospital Fees	Not Covered	\$400 Copay per day – Max \$1,200	Not Covered	80% after deductible
Drug/Alcohol ^{4,5}				
Hospital Fees	\$400 Copay per day – Max \$1,200, Acute detox only	\$400 Copay per day – Max \$1,200, Acute detox only	75% Acute detox only	80% after deductible

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Medical Benefits	Elect Open Access 25 Plus	Elect Open Access	Salud HMO y Más ⁶	CalChoice [®] HMO 30 ²
Participating Health Plans	Health Net*	Health Net*	Health Net	Anthem Blue Cross*
Deductible	No Deductible	No Deductible	No Deductible	No Deductible
DR OFFICE VISITS	\$25 Copay HMO \$40 Copay PPO	\$25 Copay HMO \$40 Copay PPO	\$25 Copay	\$30 Copay
Lab and X-Ray	\$25 Copay	\$25 Copay	100%	\$30 Copay
MRI, CT, and PET	\$100 Copay	\$100 Copay	100%	\$100 Copay
HOSPITAL SERVICES	\$450 Copay per day – Max \$1,800	75%	\$500 Copay per day – Max \$1,000	\$450 Copay per day – Max \$1,800
Inpatient Physician Fees	\$25 Copay	\$25 Copay	100%	100%
Emergency Room	\$150 Copay (waived if admitted)	\$150 Copay (waived if admitted)	\$100 Copay (waived if admitted)	\$200 Copay (waived if admitted)
Rx BENEFITS				
Generic	\$15 Copay	\$15 Copay	\$15 Copay	\$15 Copay
Brand ³	\$100 Ded. - \$30 Copay	\$100 Ded. - \$30 Copay	\$25 Copay	\$150 Ded.- \$30 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	\$30 Copay ⁷
Out-of-Pocket Max Ind/Fam	\$3,000 Ind/\$6,000 Two Party/\$7,000 Fam	\$3,000 Ind/\$6,000 Two Party/\$7,000 Fam	\$2,500/\$5,000	\$3,000/\$6,000
2nd Surgical Opinion	\$25 Copay	\$25 Copay	\$25 Copay	\$30 Copay
Outpatient Surgery	\$400 Copay	75%	\$300 Copay	\$400 Copay
Home Health Care	100%	100%	\$30 Copay	\$30 Copay
Skilled Nursing Facility				
Per Disability	75% Max 100 days per year	75% Max 100 days per year	\$500 Copay per day – Max \$1,000/100 days per year	100%
Ambulance	100%	100%	\$50 per trip	\$200 per trip
Pre-Existing Conditions	Covered	Covered	Covered	Covered
Mental/Nervous Non-Severe ^{1,4,5}				
Doctor Fees	\$30 Copay	\$30 Copay	\$40 Copay	\$30 Copay
Annual Maximum	20 visits per year	20 visits per year	20 visits per year	No Maximum
Hospital Fees	\$450 Copay per day – Max \$1,800, 30 Days per year	75% (30 days per year)	Not Covered	\$450 Copay per day – Max \$1,800
Drug/Alcohol ^{4,5}				
Hospital Fees	\$450 Copay per day – Max \$1,800, Acute detox only	75% Acute detox only	\$500 Copay per day – Max \$1,000, Acute detox only	\$450 Copay per day – Max \$1,800

See footnotes on back page



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Benefit Summaries

Medical Benefits	CalChoice® HMO 30 ²	CalChoice HMO 30 ²	CalChoice HMO 30 ²	CalChoice HMO 30 ²
Participating Health Plans	Health Net*	Kaiser Permanente	Sharp	Western Health Advantage
Deductible	No Deductible	No Deductible	No Deductible	No Deductible
DR OFFICE VISITS	\$30 Copay	\$30 Copay	\$30 Copay	\$30 Copay
Lab and X-Ray	\$25 Copay	\$10 Copay	\$30 Copay	\$30 Copay
MRI, CT, and PET	\$100 Copay	\$50 Copay	\$50 Copay	\$50 Copay
HOSPITAL SERVICES	\$450 Copay per day – Max \$1,800	\$450 Copay - 100%	\$450 Copay per day – Max \$1,800	\$450 Copay per day – Max \$1,800
Inpatient Physician Fees	100%	100%	100%	100%
Emergency Room	\$200 Copay (waived if admitted)	\$200 Copay (waived if admitted)	\$200 Copay (waived if admitted)	\$200 Copay (waived if admitted)
Rx BENEFITS				
Generic	\$15 Copay	\$15 Copay	\$15 Copay	\$15 Copay
Brand ³	\$150 Ded. - \$30 Copay	\$30 Copay	\$150 Ded. - \$30 Copay	\$150 Ded.-\$30 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	\$3,000/\$6,000	\$3,000/\$6,000	\$3,000/\$6,000	\$3,000/\$6,000
2nd Surgical Opinion	\$30 Copay	\$30 Copay	\$30 Copay	\$30 Copay
Outpatient Surgery	\$400 Copay	\$400 Copay	\$400 Copay	\$400 Copay
Home Health Care	\$45 Copay	100%	\$45 Copay	\$45 Copay
Skilled Nursing Facility				
Per Disability	\$450 Copay per day – Max \$1,800/100 days per year	\$100 Copay – Max 100 days per year	\$450 Copay per day – Max \$1,800/100 days per year	\$450 Copay per day – Max \$1,800/100 days per year
Ambulance	\$200 per trip	\$200 per trip	\$200 per trip	\$200 per trip
Pre-Existing Conditions	Covered	Covered	Covered	Covered
Mental/Nervous Non-Severe ^{1,4,5}				
Doctor Fees	\$40 Copay	\$30 Copay	\$40 Copay	\$30 Copay
Annual Maximum	20 visits per year	No Maximum	20 visits per year	No Maximum
Hospital Fees	Not Covered	\$450 Copay - 100%	Not Covered	\$450 Copay per day – Max \$1,800
Drug/Alcohol ^{4,5}				
Hospital Fees	\$450 Copay per day – Max \$1,800, Acute detox only	\$450 Copay - 100% Acute detox only	\$450 Copay per day – Max \$1,800, Acute detox only	\$450 Copay per day – Max \$1,800, Acute detox only

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Medical Benefits	CalChoice® HMO 30 Value	CalChoice HMO 40 ²	CalChoice HMO 40 ²	CalChoice HMO 40 ²
Participating Health Plans	Health Net*	Anthem Blue Cross*	Health Net*	Kaiser Permanente
Deductible	No Deductible	No Deductible	No Deductible	No Deductible
DR OFFICE VISITS	\$30 Copay	\$40 Copay	\$40 Copay	\$40 Copay
Lab and X-Ray	\$30 Copay	\$40 Copay	\$25 Copay	\$10 Copay
MRI, CT, and PET	\$100 Copay	\$100 Copay	\$100 Copay	\$50 Copay
HOSPITAL SERVICES	70%	\$500 Copay per day	\$500 Copay per day	\$500 Copay per day
Inpatient Physician Fees	100%	100%	100%	100%
Emergency Room	\$200 Copay (waived if admitted)	\$250 Copay (waived if admitted)	\$250 Copay (waived if admitted)	\$250 Copay (waived if admitted)
Rx BENEFITS				
Generic	\$20 Copay	\$20 Copay	\$20 Copay	\$15 Copay
Brand ³	\$200 Ded. - \$30 Copay	\$200 Ded. - \$30 Copay	\$200 Ded. - \$30 Copay	\$30 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	\$40 Copay ⁷	Not Covered	Not Covered
Out of Pocket Max Ind/Fam	\$3,500/\$7,000	\$3,500 / \$7,000	\$3,500/\$7,000	\$3,500/\$7,000
2nd Surgical Opinion	\$30 Copay	\$40 Copay	\$40 Copay	\$40 Copay
Outpatient Surgery	70%	\$500 Copay	\$500 Copay	\$500 Copay
Home Health Care	\$45 Copay	\$40 Copay	\$50 Copay	100%
Skilled Nursing Facility				
Per Disability	70% Max 100 days per year	100%	\$500 Copay per day – Max 100 days per year	\$100 Copay – Max 100 days per year
Ambulance	\$200 per trip	\$200 per trip	\$200 per trip	\$200 per trip
Pre-Existing Conditions	Covered	Covered	Covered	Covered
Mental/Nervous Non-Severe ^{1,4,5}				
Doctor Fees	\$40 Copay	\$40 Copay	\$50 Copay	\$40 Copay
Annual Maximum	20 visits per year	No Maximum	20 visits per year	No Maximum
Hospital Fees	Not Covered	\$500 Copay per day	Not Covered	\$500 Copay per day
Drug/Alcohol ^{4,5}				
Hospital Fees	70% Acute detox only	\$500 Copay per day	\$500 Copay per day – Acute detox only	\$500 Copay per day – Acute detox only

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Benefit Summaries

Medical Benefits	CalChoice® HMO 40 ²	CalChoice HMO 40 ²	CalChoice HMO 40 Value	CalChoice HMO 40 Value
Participating Health Plans	Sharp	Western Health Advantage	Anthem Blue Cross*	Health Net*
Deductible	No Deductible	No Deductible	\$1,500 Sgl. \$3,000 Fam. (applies to Max OOP)	No Deductible
DR OFFICE VISITS	\$40 Copay	\$40 Copay	\$40 Copay	\$40 Copay
Lab and X-Ray	\$40 Copay	\$40 Copay	\$40 Copay	\$40 Copay
MRI, CT, and PET	\$50 Copay	\$50 Copay	\$100 Copay	\$100 Copay
HOSPITAL SERVICES	\$500 Copay per day	\$500 Copay per day	70% after deductible	60%
Inpatient Physician Fees	100%	100%	100%	100%
Emergency Room	\$250 Copay (waived if admitted)	\$250 Copay (waived if admitted)	\$250 Copay after deductible (waived if admitted)	\$250 Copay (waived if admitted)
Rx BENEFITS	\$20 Copay	\$20 Copay	\$15 Copay	\$20 Copay
Generic	\$20 Copay	\$20 Copay	\$250 Ded. - \$30 Copay	\$200 Ded. - \$30 Copay
Brand ³	\$200 Ded. - \$30 Copay	\$200 Ded.-\$30 Copay	\$250 Ded. - \$30 Copay	\$200 Ded. - \$30 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	\$40 Copay ⁷	Not Covered
Out of Pocket Max Ind/Fam	\$3,500/\$7,000	\$3,500/\$7,000	\$4,000/\$8,000	\$3,500/\$7,000
2nd Surgical Opinion	\$40 Copay	\$40 Copay	\$40 Copay	\$40 Copay
Outpatient Surgery	\$500 Copay	\$500 Copay	70% after deductible	60%
Home Health Care	\$50 Copay	\$50 Copay	\$40 Copay	\$50 Copay
Skilled Nursing Facility				
Per Disability	\$500 Copay per day – Max 100 days per year	\$500 Copay per day – Max 100 days per year	100% after deductible	60% Max 100 days per year
Ambulance	\$200 per trip	\$200 per trip	\$200 per trip	\$200 per trip
Pre-Existing Conditions	Covered	Covered	Covered	Covered
Mental/Nervous Non-Severe ^{1,4,5}				
Doctor Fees	\$50 Copay	\$40 Copay	\$40 Copay	\$50 Copay
Annual Maximum	20 visits per year	No Maximum	No Maximum	20 visits per year
Hospital Fees	Not Covered	\$500 Copay per day	70% after deductible	Not Covered
Drug/Alcohol ^{4,5}				
Hospital Fees	\$500 Copay per day – Acute detox only	\$500 Copay per day – Acute detox only	70% after deductible	60%, Acute detox only

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Medical Benefits	CalChoice® HMO 40 Value	Elect Open Access 40 Plus
Participating Health Plans	Western Health Advantage	Health Net*
Deductible	\$2,500 Sgl. \$5,000 Fam.	No Deductible
DR OFFICE VISITS	\$40 Copay	\$40 Copay HMO \$55 Copay PPO
Lab and X-Ray	100%	\$40 Copay
MRI, CT, and PET	\$50 Copay	\$100 Copay
HOSPITAL SERVICES	\$500 Copay per day – after deductible (applies to Max OOP)	\$500 Copay per day
Inpatient Physician Fees	100%	\$40 Copay
Emergency Room	\$250 Copay after deductible (waived if admitted)	\$250 Copay (waived if admitted)
Rx BENEFITS	\$20 Copay	\$20 Copay
Generic	\$20 Copay	\$20 Copay
Brand ³	\$250 Ded. - \$30 Copay	\$200 Ded. - \$30 Copay
Oral Contraceptives	Covered	Covered
Maternity	Covered as any illness	Covered as any illness
Chiropractic	Not Covered	Not Covered
Out of Pocket Max Ind/Fam	\$5,000/\$10,000	\$3,500 Ind/\$7,000 Two Party/\$8,000 Fam
2nd Surgical Opinion	\$40 Copay	\$40 Copay
Outpatient Surgery	\$250 Copay	\$500 Copay
Home Health Care	100%	100%
Skilled Nursing Facility		
Per Disability	\$500 Copay per day – Max 100 days per year	60% Max 100 days per year
Ambulance	\$50 per trip	100%
Pre-Existing Conditions	Covered	Covered
Mental/Nervous Non-Severe ^{1,4,5}		
Doctor Fees	\$40 Copay	\$30 Copay
Annual Maximum	No Maximum	20 visits per year
Hospital Fees	\$500 Copay per day – after deductible	\$500 Copay per day – 30 Days per year
Drug/Alcohol ^{4,5}		
Hospital Fees	\$500 Copay per day – after deductible, Acute detox only	\$500 Copay per day – Acute detox only

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Medical Benefit Notes

* Anthem Blue Cross and Health Net offer the option of an additional provider network. Those additional options are noted as: Anthem Blue Cross Select HMO and Health Net Silver HMO. Prior to enrollment, the employer may elect to offer the standard network OR these provider networks to their employees.

¹ 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 inpatient, partial hospitalization and outpatient 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, copay and individual and family deductibles. "Severe mental illness" includes: schizophrenia, schizophrenic disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorders, obsessive-compulsive disorder, pervasive development disorder or autism, anorexia and bulimia nervosa.

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

³ For Anthem Blue Cross - If a member selects a brand-name drug when a generic-equivalent is available, the member will be responsible for the generic copay plus the difference in cost between the brand-name drug and the generic-equivalent drug unless the physician writes "dispense as written" or "do not substitute". The amount paid does not apply to the member's brand-name deductible as applicable.

⁴ For Anthem Blue Cross - Pre-service review is required for the following mental or nervous disorders and substance abuse services: 1) Facility-based treatment or you will be required to pay a \$250 copayment if pre-service review is not obtained; and 2) Outpatient professional services after twelve visits.

⁵ For complete information as to the mental health/substance abuse benefits and eligibility required under California and federal law, please see mental health/substance abuse benefit description provided by Plan/*CHOICE* Administrators® Insurance Services. Note: Certain small groups, depending on their size, may be eligible to receive mental health and substance abuse benefits in "parity" with (equivalent to) their medical benefits from Plan.

⁶ Salud HMO y Más benefits are shown for Salud Network. Please see Salud Application/Brochure for SIMNSA Network benefits.

⁷ In lieu of physical therapy visits. Must be approved by PMG/IPA.

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits. This summary of benefits, as updated, is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care (as applicable).