PPO Plans

Benefit Summaries

Medical Benefits Participating Health Plans	PPO 2500 Health Net		PPO 3500 Health Net		PPO 4500 Health Net	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Deductible[1] / Family Maximum	$2,500/$5,000		$3,500/$7,000		$4,500/$9,000	
DR. OFFICE VISITS	**$25 copay†**	**50%†**	**$35 copay†**	**50%†**	**$45 copay†**	**50%†**
Adult Annual Preventive Physical Exam	$100%[2] (Deductible waived)	Not Covered	$100%[2] (Deductible waived)	Not Covered	$100%[2] (Deductible waived)	Not Covered
Lab and X-Ray	70%†	50%†	70%†	50%†	60%†	50%†
MRI, CT and PET	70%†	50%†	70%†	50%†	60%†	50%†
HOSPITAL SERVICES	**70%†**	**50% - Max $600 per day[3]†** Additional $250 deductible applies	**70%†**	**50% - Max $600 per day[3]†** Additional $250 deductible applies	**60%†**	**50% - Max $600 per day[3]†** Additional $250 deductible applies
In-Patient Physician Fees	70%†	50%†	70%†	50%†	60%†	50%†
Emergency Room	70%†	70%† Additional $100 deductible applies if not admitted to inpatient facility	70%†	70%† Additional $100 deductible applies if not admitted to inpatient facility	60%†	60%† Additional $100 deductible applies if not admitted to inpatient facility
Rx BENEFITS						
Generic Formulary	**$15 copay†**	**$15 copay†**	**$15 copay†**	**$15 copay†**	**$15 copay†**	**$15 copay†**
Formulary Brand	**$30 copay†**	**$30 copay†**	**$30 copay†**	**$30 copay†**	**$30 copay†**	**$30 copay†**
Non-Formulary Brand	**$50 copay†**	**$50 copay†**	**$50 copay†**	**$50 copay†**	**$50 copay†**	**$50 copay†**
Oral Contraceptives	Covered	Covered	Covered	Covered	Covered	Covered
Maternity	Same as any other illness		Same as any other illness		Same as any other illness	
Chiropractic	$25 copay† 12 visit maximum per year	Not Covered	$35 copay† 12 visit maximum per year	Not Covered	$45 copay† 12 visit maximum per year	Not Covered
Out-of-Pocket Max-Ind/Fam	**$5,000/$10,000** (includes deductible)		**$5,000/$10,000** (includes deductible)		**$5,600/$11,200** (includes deductible)	
Lifetime Maximum	Unlimited		Unlimited		Unlimited	
2nd Surgical Opinion	$25 copay†	50%†	$35 copay†	50%†	$45 copay†	50%†
Out-Patient Surgery	70%†	50%† Additional $250 deductible applies	70%†	50%† Additional $250 deductible applies	60%†	50%† Additional $250 deductible applies
Home Health Care	70%†	50%- if authorized† Max of $110 allowable per day	70%†	50%- if authorized† Max of $110 allowable per day	60%†	50%- if authorized† Max of $110 allowable per day
Hospital Pre-Authorization	Additional $250 per admission. Payment reduced to 50%.		Additional $250 per admission. Payment reduced to 50%.		Additional $250 per admission. Payment reduced to 50%.	
Hospice:						
Routine Home Care	70%†	50%- if authorized†	70%†	50%- if authorized†	60%†	50%- if authorized†
24 HR Continuous Care	70%†	50% if authorized†	70%†	50% if authorized†	60%†	50% if authorized†
Skilled Nursing Facility	70%†	50% - Max $250 per day† Additional $250 deductible applies	70%†	50% - Max $250 per day† Additional $250 deductible applies	60%†	50% - Max $250 per day† Additional $250 deductible applies
Ambulance	**70%†+addl. $50 ded.**	**50%†+addl. $50 ded.**	**70%†+addl. $50 ded.**	**50%†+addl. $50 ded.**	**60%†+addl. $50 ded.**	**50%†+addl. $50 ded.**
Mental & Nervous Benefits						
Out-Patient - Severe Condition	$25 copay†	50%†	$35 copay†	50%†	$45 copay†	50%†
In-Patient - Severe Condition	70%†	50% - Max $600 per day[3]† Additional $250 deductible applies	70%†	50% - Max $600 per day[3]† Additional $250 deductible applies	60%†	50% - Max $600 per day[3]† Additional $250 deductible applies
Out-Patient - Non-Severe	70%†	50%† $25 max allowable per visit	70%†	50%† $25 max allowable per visit	60%†	50%† $25 max allowable per visit
In-Patient - Non-Severe	70%†	50%† $250 max allowable per day	70%†	50%† $250 max allowable per day	60%†	50%† $250 max allowable per day
Drug & Alcohol Benefits						
Doctor Fees – Out-Patient	70%†	50%† $25 max allowable per visit	70%†	50%† $25 max allowable per visit	60%†	50%† $25 max allowable per visit
Hospital Fees – In-Patient	70%†	50%† $250 max allowable per day	70%†	50%† $250 max allowable per day	60%†	50%† $250 max allowable per day

† All services are subject to the Calendar Year deductible unless otherwise noted.

1 Employees enrolling for individual coverage must satisfy the individual deductible. For employees enrolling with dependent coverage, the family deductible must be met before any member receives benefits. The deductible includes In-Network and Out-of-Network expenses combined.

2 Limited to one exam each calendar year (age 17 and older only).

3 The maximum allowed charge for non-emergency hospital services received from an Out-of-Network hospital is $600 per day. Members are responsible for their 50% share of the coinsurance times the allowed charge up to $600 plus all charges, if any, in excess of the $600. Physician Services are covered separately at the coinsurance amount times the allowed charge.

Please refer to the HSA California brochure for more detailed plan benefit information.

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).

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HMO Plans

Benefit Summaries

Medical Benefits Participating Health Plans	HMO 2200 Kaiser Permanente	HMO 2600 Kaiser Permanente	HMO 1800 Western Health Advantage	HMO 2800B Western Health Advantage
Deductible Ind/Family[1]	$2,200/$4,400	$2,600/$5,200	$1,800/$3,600	$2,800/$5,600
DR. OFFICE VISITS	**$20 copay†**	**$30 copay†**	**100%†**	**$40 copay†**
Annual Physical Exam	100% (not subject to deductible)	100% (not subject to deductible)	100% (not subject to deductible)	100% (not subject to deductible)
Lab And X-Ray	$10 copay†	$10 copay†	100%†	100%†
MRI, CT, and PET	$50 copay†	$50 copay†	100%†	100%†
HOSPITAL SERVICES	**75%†**	**70%†**	**100%†**	**$500 per day†**
In-Patient Physician Fees	75%†	70%†	100%†	100%†
Emergency Room	75%†	70%†	100%†	$100 copay† (waived if admitted)
Rx BENEFIT[3]				
Generic	**$10†**	**$10†**	**100%†**	**$10 copay†**
Brand Name	**$20†**	**$30†**	**100%†**	**$30 copay†**
Non-Formulary Brand	**Medically Necessary**	**Medically Necessary**	**100%†**	**$50 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]	**$4,500/$9,000** (includes deductible)	**$5,600/$11,200** (includes deductible)	**$1,800/$3,600** (includes deductible)	**$4,000/$8,000** (includes deductible)
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
2nd Surgical Opinion	$20†	$30†	100%†	$40 copay†
Out-Patient Surgery	75%†	70%†	100%†	$250 copay†
Home Health Care	100%† 100 visits per calendar year	100%† 100 visits per calendar year	100%† 100 visits per calendar year	100%† 100 visits per calendar year
Hospice:				
Routine Home Care	100%†	100%†	100%†	100%†
24 HR Continuous Care	No Charge†	No Charge†	100%†	100%†
Skilled Nursing Facility				
Per Disability	75%† 100 day maximum per benefit period	70%† 100 day maximum per benefit period	100%† 100 day maximum per calendar year	$500 per day† 100 day maximum per calendar year
Ambulance	**$100 per trip†**	**$100 per trip†**	**100%†**	**100%†**
Pre-Existing Conditions	Covered	Covered	Covered	Covered
Mental / Nervous Non-Severe:[4]				
Doctor Fees	$20†	$30†	100%†	$40 copay†
Hospital Fees	75%†	70%†	100%†	$500 per day†
Drug / Alcohol:				
Doctor Fees - Out-Patient	$20†	$30†	100%†	$40 copay†
Hospital Fees - In-Patient	75%† Acute Detox Only	70%† Acute Detox Only	100%† Acute Detox Only	$500 copay per day† Acute Detox Only

Note: Kaiser Permanente and Western Health Advantage plans do not include a pre-existing condition clause.

† All services are subject to the Calendar Year deductible unless otherwise noted.

1 Employees enrolling for individual coverage must satisfy the individual deductible. For employees enrolling with dependent coverage, the family deductible must be met before any member receives benefits. For HMO 2600 & 2800B, the family deductible contains an embedded individual deductible, meaning any member of the family never satisfies more than the individual deductible.

2 The annual out-of-pocket maximum is the total amount that an individual or family pays for covered services during any calendar year. For HMO 2600 & 2800B, each family member in the Family unit must meet the Individual amount before not having to pay any more copayments or deductibles, unless the family meets the Family amount first. Please refer to the *Evidence of Coverage* for detailed information.

3 Prescription drugs are covered in accord with our formulary when prescribed by a Plan physician and obtained at Plan pharmacies. A few drugs have different copayments; please refer to the *Evidence of Coverage* for detailed information about prescription drug copayments.

4 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, schizophrenic disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorders, obsessive-compulsive disorder, pervasive development disorder or autism, anorexia and bulimia nervosa.

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