

51+

For Employers with 51 - 199 Employees

HSA - QUALIFIED PLANS

BENEFIT SUMMARIES

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
DR. OFFICE VISITS	80%	60%	70%	50%
Preventative 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	80%	60%	70%	50%
Inpatient: Severe Condition	80% ⁶	60% ⁶	70% ⁶	50% ⁶
Outpatient: Non-Severe	80%	60%	Not Covered	Not Covered
	Max - \$25 Per Visit / Max 20 Visits Per Year			
Inpatient: Non-Severe	80% ⁶	60%	Not Covered	Not Covered
	Max - \$175 Per Day / Max 30 Days			
Drug & Alcohol Benefits:				
Outpatient	Not Covered	Not Covered	Not Covered	Not Covered
Inpatient (Detox Only)	80% ⁶	60% ⁶ / Maximum \$600 per day	70% ⁶	50% ⁶ / Maximum \$600 per day
	Maximum 3 days per year		Maximum 3 days per year	

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 preventative care includes: mammography, cervical cancer screening test/pelvic and breast exams, sigmoidoscopy and prostate cancer screening test (age 17 and older). Children preventative 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.





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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 ⁵ :		
Doctor Fees		\$0 Per Visits After Deductible ⁶
Annual Maximum		20 Visits Per Calendar Year
Hospital Fees		\$0 Per Admission After Deductible (<i>Up To 30 Days Per Calendar Year</i>)
Lifetime Maximum		No Maximum
Drug/Alcohol:		
Doctor Fees		\$0 Per Visit After Deductible
Hospital Fees		\$0 Per Admission After Deductible

* 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.

⁵ 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, copays 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.

⁶ Visit or day limits do not apply to serious emotional disturbances of children and severe mental illness as described in the *Evidence of Coverage*.

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