Schools Insurance Group

Health Net Plan Comparison

Fiscal Year 7/1/14- 6/30/15

This information sheet is for reference only. Please refer to Evidence of Coverage requirements, limitations or exclusions on services.

Benefit	Health Net PPO High Deductible w/HSA B6N $1300/$2600	Health Net PPO High Deductible w/HSA B6L $2250/$4500	Health Net HMO Plan B6K *California Based HMO Plan*
	No network restrictions, non-network providers are limited to contracted allowed charges		**Primary Care Physicians and referrals required.**
Calendar Year Deductible See detailed summary and/or Evidence of Coverage booklet for services that do & do not apply to deductible	$1,300 if single coverage $2,600 if two or more are covered	$2,250 if single coverage $4,500 if two or more are covered	None
Co-Insurance Determined by type of Provider being utilized on a calendar year basis. Non-network: applicable % plus amounts above allowed charges.	**In Network**: Individual pays 20% when using Preferred Providers **Non- Network:** 50% of allowed charges when using Non-Preferred Providers + amounts above allowed charges		None
Calendar-Year Copayment Maximum per calendar year See Health Net's Summary of Benefits for benefits that do not count toward the copayment maximum.	Includes plan deductible. **In Network**: $2,750 if single coverage $5,500 if two or more covered **Non- Network:** $2,750 if single coverage $5,500 if two or more covered		Calendar year Co-payment Maximum: $1,500 per individual $3,000 per two-party $4,500 per family
Office Visit Co-pay	**In Network**: 20% **Non-Network**: 50% plus amounts above allowed charges		$20 per visit
Prescription Co-pays Retail: Up to a 30 day supply Mail Order: Up to a 90 day supply Oral Contraceptives, diaphragms, covered diabetic drugs and testing supplies are included. PPO deductible applies each calendar year.	***Prescriptions are subject to deductible*** **Retail Pharmacy** Medically Necessary Drugs 20% **Mail Order (Caremark)** Medically Necessary Drugs 20%		**Retail Pharmacy** Level I (primarily generic): $15.00 Level II (formulary): $30.00 Level III (Non-Formulary): $50.00 **Mail Order (Caremark) – 90 day supply** Level I (primarily generic): $30.00 Level II (formulary): $60.00 Level III (Non-Formulary): $100.00

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Self Administered Injectables This service requires certification for coverage	**In-Network:** 20% **Non-Network**: 50% plus amounts above allowed charges		20% ($100 maximum co-payment)
Out-Patient X-ray & Lab	**In-Network** provider and facility: 20% **Non-Network**: 50% plus amounts above allowed charges		No charge for routine x-ray & lab work $100 for complex radiology (CT, MRI, PET, etc)
Allergy Testing/Treatment Co-pays	**In-Network** provider: 20% **Non-Network**: 50% plus amounts above allowed charges		$20 per visit
Diabetes Equipment & Non-Testing Supplies	**In-Network** provider: 20% **Non-Network**: 50% after deductible plus amounts above allowed charges For testing supplies, see Prescription Drug Coverage		Covered in Full For testing supplies, see Prescription Drug Coverage
Chiropractic Office Visit Co-Pay Medically necessary chiropractic services.	**In-Network** provider: 20% **Non-Network**: 50% plus amounts above allowed charges 20 visits per calendar year		$10 per visit 30 visits per calendar year; $50 annual Chiropractic appliance allowance. Limited to American Specialty Health Plans of California contracted chiropractors.
Acupuncture	20% (up to $25 per visit) up to 20 visits per year.		Not Covered
Preventive Care - Adult (Not subject to calendar year deductible. Note for PPO members: if during a screening colonoscopy or sigmoidoscopy, a therapeutic (surgical) procedure is performed, then outpatient surgery deductible and copayments will apply.)	**In-Network** provider: No Charge • Periodic health evaluations, including well-woman exam and annual preventive physical examinations (age 19 and older). • Cancer screenings, immunizations, vision & hearing screenings. • FDA approved contraceptive methods for women including sterilization **Non-Network** provider: Not Covered		No Charge Periodic health evaluations, including well-woman exam and annual preventive physical examinations (age 18 and older). Cancer screenings, immunizations, vision & hearing screenings FDA approved contraceptive methods for women including sterilization
Preventive Care - Child (Not subject to calendar year deductible)	**In-Network** provider: No Charge • Periodic health evaluations, including newborn, well-baby care, annual preventive physical examinations (birth through age 18). • Laboratory tests, standard immunizations **Non-Network** provider: Not Covered		No Charge Periodic health evaluations, including newborn, well-baby care, annual preventive physical examinations (birth through age 17). Laboratory tests, standard immunizations

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Family Planning	Tubal Ligation (see Preventive Care – Adult) Vasectomy **In-Network**: 20% **Non-Network**: 50% + amt above allowed charges Infertility services (lifetime max benefit $2000) $500 additional deductible **In-Network**: 20% **Non-Network**: 50% of allowed charges		Tubal ligation: No charge Vasectomy: $75 per surgery Infertility services: 50%
Maternity Care	**In-Network** provider: 20% for prenatal and postnatal care **Non-Network** provider: 50% plus amounts above allowed charges for prenatal and postnatal care All necessary inpatient hospital services- same as in-patient Hospital		No charge for prenatal and postnatal care Inpatient Hospital: $500/ day, max 4 days [Refer to calendar year co-payment maximum above] No charge for in-patient physician services for normal delivery and cesarean section
Out-Patient Surgery	**In a participating Ambulatory Surgery Center:** 20% **In-Network:** 20% **Non-Network**: 50% plus amounts above allowed maximum of $350/day		$100 per surgery
In-Patient Hospital Pre-Authorization required	**In-Network** facility: 20% after calendar year deductible has been met **Non-Network** facility: 50% plus amounts above allowed charges **Professional Services:** 20% network 50% non-network		$500/ day up to max of 4 days [Refer to calendar year co-payment maximum above] No charge for in-patient physician services
Ambulance Ground or air	**In Network** provider: 20% **Non-Network** provider: 50% Air ambulance requires certification for coverage		$50 co-payment

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Emergency Health Coverage	**In-Network and Non-Network true emergency**: 20% **Non-Network non-emergency:** 50% plus amounts above allowed charges		$100 co-payment (Waived if admitted directly to the hospital as an inpatient; however hospitalization copayment charges apply)
Rehabilitative Therapy	**In-Network** provider: 20% **Non-Network**: 50% plus amounts above allowed charges		$20 per Visit
Durable Medical Equipment	Allowable amount up to $2,000 per year **In Network** provider: 20% **Non-Network** provider: 50% plus amounts above allowed charges		20% of Allowed Charges
Skilled Nursing Facility (SNF) services Pre-Authorization required	Semi-private accommodations (up to 100 days per yr) **In-Network**: 20% **Non-Network**: 50% + amt above allowed charges		Days 1-10: Covered in Full Days 11-100: $25 per day (maximum 100 days per calendar year)
Home Health Services	**In-Network**: 20% **Non-Network**: 50% Requires certification for coverage		$20 per Visit (maximum 100 visits per calendar year)
Hospice Care Covered hospice services received from any hospice agency must be pre-authorized by Health Net. For prior authorizations, please contact Health Net at (800) 977-7282	**In-Network**: 20% **Non-Network**: 50% Requires certification for coverage		No Charge
Chemical Dependency Services (Substance Abuse)	Inpatient services for *medical acute detoxification:* See Hospitalization Charges **In-Network provider**: 20% **Non-Network provider:** 50%		Inpatient services for *medical acute detoxification:* See Hospitalization Charges Outpatient visits: $20/visit Benefits are administered by MHN Services
Out-Patient Mental Health Counseling	**In-Network** provider: 20% **Non-Network** provider: 50% plus amounts above allowed charges		Outpatient visits: $20 per visit

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In-Patient Mental Health Services	**In-Network**: 20% **Non-Network**: 50% plus amounts above allowed charges		$500/ day up to max of 4 days [Refer to calendar year co-payment maximum above] Pre-authorization required thru MHN Services
Dependent children – natural, step or adopted	Up to age 26		Up to age 26 *Emergency coverage only if attending school outside the service area or out of state*
Monthly Rates for Active Employees			
Subscriber Only	**$652**	**$526**	**$1023**
Subscriber + Spouse	**$1304**	**$1052**	**$2046**
Subscriber + Child(ren)	**$1001**	**$806**	**$1565**
Subscriber + Family	**$1500**	**$1209**	**$2418**
Note: Rates do not include district contribution			

IMPORTANT NOTES

Retiree rates are available through the retiree's District Office. If the member is retired and eligible for Medicare, Medicare is the primary payer. Health Net coverage becomes secondary. Retirees are required to enroll in Medicare Part A and purchase Part B and provide a copy of their Medicare card in order to qualify for a Medicare rate. If there is an active group policy in addition to the retired Medicare coverage, please contact Health Net to verify which plan assumes primary status. Active Group Plans are always primary over Medicare. For current provider listings under the Health Net HMO and PPO plans, refer to their web site at www.healthnet.com .

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Summary of Benefits & Disclosure Form* and *Evidence of Coverage* should be consulted for a detailed description of coverage benefits and limitations.