

Medical Plans Comparison Chart

HEALTH NET ELECT OPEN ACCESS		
	Tier One	Tier Two
Allergy testing	You pay a \$10 copay (serum covered)	You pay a \$30 copay (serum covered)
Ambulance	No charge when medically necessary	Not covered
Chiropractic care	Not covered	Not covered
Choice of physician and other providers	Health Net HMO provider network	Health Net California PPO physicians only
Deductibles Calendar year	None	None
Hospital or ambulatory surgical center deductible	None	None
Non-certification deductible	None	PPO services that require certification are not covered
Diagnostic X-rays and lab tests	No charge	Covered only when performed in physician's office
Durable medical equipment	No charge	Not covered
Emergency room	You pay a \$50 copay (waived if admitted)	Not covered
Family planning Infertility services	You pay 50%; excludes GIFT, ZIFT and IVF	Not covered
Tubal ligation	You pay a \$10 copay	Not covered
Vasectomy	You pay a \$10 copay	Not covered

COMPARISON CHART

This Comparison Chart only highlights your benefits. It is not a summary plan description (SPD). Official plan and insurance documents govern your rights and benefits under each plan. If any discrepancy exists between the Comparison Chart and the official documents, the official plan document will prevail.

	KAISER PERMANENTE	HEALTH NET PPO	
		In-Network (PPO)	Out-of-Network (OON)
	\$10 copay (serum covered)	You pay 20% [CY ded. waived]	You pay 30% after deductible
	No charge when medically necessary	You pay 20% after deductible when medically necessary	You pay 30% after deductible when medically necessary
	Not covered	You pay 20% after CY deductible up to 30 visits per CY (combined PPO/OON)	You pay 30% after CY deductible up to 30 visits per CY (combined PPO/OON). Through OON max payable \$25 per visit
	Kaiser Permanente physicians and facilities only	Any Health Net California PPO network physician and/or facility	You may self-refer to any CA licensed providers; but you pay 30% after deductible plus any costs over the UCR amount
	None	\$250 each covered member \$750 family maximum Combined PPO/OON	\$250 each covered member \$750 family maximum Combined PPO/OON
	None	None	\$250 per hospital admission \$250 per outpatient surgery
	None	Inpatient: \$250 per admission unless preauthorization is obtained Outpatient: \$250 per visit	Inpatient: \$250 per admission unless preauthorization is obtained Outpatient: \$250 per visit
	No charge	You pay 20% after deductible	You pay 30% after deductible
	No charge	You pay 20% after deductible; up to \$5,000 combined PPO/OON per calendar year	You pay 30% after deductible; up to \$5,000 per calendar year
	You pay a \$50 copay (waived if admitted)	You pay a \$50 deductible (waived if admitted) plus 20%	You pay a \$50 deductible (waived if admitted) plus 20%
	You pay 50%; excludes GIFT, ZIFT and IVF	Not covered	Not covered
	You pay a \$10 copay	You pay 30% after deductible (coinsurance does not apply to out-of-pocket maximum)	You pay 50% after deductible (coinsurance does not apply to out-of-pocket maximum)
	You pay a \$10 copay	You pay 30% after deductible (coinsurance does not apply to out-of-pocket maximum)	You pay 50% after deductible (coinsurance does not apply to out-of-pocket maximum)

CY = Calendar Year

C&R = Customary and Reasonable
County of San Bernardino

UCR = Usual and Customary Rates

Medical Plans Comparison Chart *(continued)*

	HEALTH NET ELECT OPEN ACCESS	
	Tier One	Tier Two
Home health services	No charge when medically necessary	Not covered
Hospice Inpatient & outpatient	No charge when medically necessary	Not covered
Hospital care	No charge	Not covered
Lifetime benefits maximum	No limit	No limit
Maternity care	No charge except \$10 for first prenatal and postnatal visit	Not covered
Mental health services Non-severe mental disorders	Inpatient: No charge; up to 30 visits per year Outpatient: You pay \$20; up to 20 visits per year	Inpatient: Not covered Outpatient: Not covered
Severe mental disorders	Inpatient: No charge; unlimited days Outpatient: You pay \$10; unlimited days	Inpatient: Not covered Outpatient: Not covered
Out-of-pocket annual maximum	\$1,500 each member \$3,000 family maximum	Not applicable
Outpatient hospital services	No charge	Not covered

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	KAISER PERMANENTE	HEALTH NET PPO	
		In-Network (PPO)	Out-of-Network (OON)
	No charge when medically necessary; up to 100 two-hour visits per calendar year	You pay 20% after deductible; 100 visits combined PPO/OON per calendar year maximum	You pay 30% after deductible; 100 visits per calendar year maximum
	No charge when selected as alternative to traditional services covered by Kaiser Permanente	You pay 20% after deductible is met; \$10,000 lifetime combined PPO/OON benefit	You pay 30% after deductible; \$10,000 lifetime combined PPO/OON benefit
	No charge for approved services obtained in a Kaiser Permanente facility/approved facility	You pay 20% after deductible	You pay 30% after deductibles (per calendar year plus \$250 admission)
	No limit	\$5,000,000 combined PPO/OON	\$5,000,000
	No charge	You pay 20% after deductible	You pay 30% for outpatient visits; you pay 30% after deductible for hospital care
	<p>Inpatient: No charge; up to 30 days per calendar year</p> <p>Outpatient: You pay a \$10 copay/ \$5 copay group; up to 20 visits per calendar year</p> <p>Inpatient: No charge; unlimited days (up to 30 days per calendar year)</p> <p>Outpatient: You pay a \$10 copay; 20 visits individual per calendar year</p>	<p>Inpatient: Covered in full — no limit [CY deductible waived]</p> <p>Outpatient: Covered in full — no limit</p> <p>Inpatient: You pay 20%</p> <p>Outpatient: You pay 20% [CY deductible waived]</p>	<p>Inpatient: \$250 plus 30% after deductible</p> <p>Outpatient: You pay 30% after deductible</p> <p>Inpatient: \$250 plus 30% after deductible</p> <p>Outpatient: You pay 30% after deductible</p>
	\$1,500 each member \$3,000 family maximum	\$1,500 each member \$3,000 family maximum (Some benefits are excluded from out-of-pocket maximum. See Certificate of Insurance for details)	\$2,000 each member \$3,000 family maximum (Some benefits are excluded from out-of-pocket maximum. See Certificate of Insurance for details)
	\$10 copay per procedure	You pay 20% after deductible at network facilities	You pay 30% after deductible

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Medical Plans Comparison Chart *(continued)*

	HEALTH NET ELECT OPEN ACCESS	
	Tier One	Tier Two
Physician services		
Hearing screenings	You pay a \$10 copay	You pay a \$30 copay
Home visits	You pay a \$10 copay	Not covered
Hospital services	No charge	Not covered
Immunizations	You pay a \$10 copay	You pay a \$30 copay
Office visits	You pay a \$10 copay	You pay a \$30 copay
Periodic health exams	You pay a \$10 copay	You pay a \$30 copay
Routine physicals	You pay a \$10 copay when requested by a third party such as school, camp, etc.	Not covered
Specialists	You pay a \$10 copay	You pay a \$30 copay
Surgical services	No charge	Physician's office only
Well baby Well child care	You pay a \$10 copay	You pay a \$30 copay
Well woman exam	You pay a \$10 copay	You pay a \$30 copay
Physical and occupational therapy	You pay a \$10 copay	You pay a \$30 copay; up to 12 visits per calendar year
Preexisting condition	Fully covered	Fully covered
Prescription drugs (per fill)	<p>Pharmacy (30-day supply): \$5 generic, \$10 brand name, \$25 non-formulary</p> <p>Mail Order (90-day supply): \$10 generic, \$20 brand name, \$50 non-formulary</p>	<p>Pharmacy (30-day supply): \$5 generic, \$10 brand name, \$25 non-formulary</p> <p>Mail Order (90-day supply): \$10 generic, \$20 brand name, \$50 non-formulary</p>

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	KAISER PERMANENTE	HEALTH NET PPO	
		In-Network (PPO)	Out-of-Network (OON)
	You pay a \$10 copay	You pay 20% [CY ded. waived]	You pay 30% after deductible
	No charge; only when medically necessary	You pay 20% [CY ded. waived]	You pay 30% after deductible
	No charge	You pay 20% after deductible	You pay 30% after deductible
	No charge	You pay 20% through age 16 [CY deductible waived]	You pay 30% after deductible through age 16
	You pay a \$10 copay	You pay 20% [CY ded. waived]	You pay 30% after deductible
	See routine physicals below	You pay 20% [CY ded. waived]	You pay 30% after deductible
	You pay a \$10 copay	Not covered	Not covered
	You pay a \$10 copay	You pay 20% [CY ded. waived]	You pay 30% after deductible
	No charge	You pay 20% after deductible	You pay 30% after deductible
	No charge	You pay 20% [CY ded. waived]	You pay 30% after deductible \$20 maximum payable
	You pay a \$10 visit copay	You pay 20% [CY ded. waived]	You pay 30% after deductible
	You pay a \$10 copay	You pay 20%; up to 30 combined PPO/OON visits per calendar year [CY ded. waived]	You pay 30% plus any costs over \$25 per visit; up to 30 combined PPO/OON visits
	Fully covered	Fully covered	Fully covered
	Pharmacy (up to 100-day supply): <ul style="list-style-type: none"> • Generic: \$10 copay • Brand: \$15 copay • Drugs prescribed for the treatment of sexual dysfunction disorders: 50% coinsurance • Drugs for the treatment of infertility: 50% coinsurance 	Pharmacy: \$15 generic formulary, \$30 brand formulary, \$30 non-formulary. Mail Order: \$30 generic, 50% coinsurance for lifestyle drugs \$60 brand and non-formulary Pharmacy and mail order copays do not apply toward the out-of-pocket maximum.	Pharmacy: \$15 generic formulary, \$30 brand formulary, \$30 non-formulary plus 50% of the Rx drug covered expense.

Medical Plans Comparison Chart *(continued)*

	HEALTH NET ELECT OPEN ACCESS	
	Tier One	Tier Two
Skilled nursing facilities	No charge	Not covered
Speech therapy	You pay a \$10 copay	You pay a \$30 copay; up to 12 visits
Substance abuse		
Rehab:	Inpatient: No charge; up to 30 days per year Outpatient: You pay \$20; up to 20 visits per year	Inpatient: Not covered Outpatient: Not covered
Detox:	Inpatient: No charge; up to 3 days Outpatient: Not covered	Inpatient: Not covered Outpatient: Not covered
Urgent care	You pay a \$25 copay	Not covered
Vision (exam only)		
Adult	You pay a \$10 copay	You pay a \$30 copay
Children through age 16	You pay a \$10 copay	You pay a \$30 copay

Notes

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	KAISER PERMANENTE	HEALTH NET PPO	
		In-Network (PPO)	Out-of-Network (OON)
	No charge for authorized stays; maximum 100 days per benefit period at a contracting skilled nursing facility	You pay 20% after calendar year deductible; 100 days combined PPO/OON per year at a contracting skilled nursing facility	You pay 30% after calendar year deductible; plus \$250/100 days combined PPO/OON per calendar year at a contracting skilled nursing facility
	You pay a \$10 copay per visit	You pay 20% [CY ded. waived]; up to 24 combined PPO/OON visits per calendar year, when due to surgery, injury or organic disease	You pay 30% after deductible; up to 24 combined PPO/OON visits per calendar year; when due to surgery, injury or organic disease. Maximum payable per visit \$30.
	<p>Inpatient: \$100 per admission; up to 60 days per calendar year, not to exceed 120 days in any five-year period</p> <p>Outpatient: \$10 copay individual, \$5 copay group</p> <p>Inpatient: No charge</p> <p>Outpatient: \$10 copay individual, \$5 copay group</p>	<p>Inpatient (Rehab & Detox): You pay 100% for charges in excess of \$175 (does not apply to out-of-pocket maximum) [CY ded. waived] up to 30 days per CY for Rehab only, see Certificate of Insurance for Detox</p> <p>Outpatient (Rehab & Detox): You pay 100% over \$25 per visit; up to 50 visits (does not apply to out-of-pocket maximum) for Rehab only, see Certificate of Insurance for Detox [CY ded. waived]</p>	<p>Inpatient (Rehab & Detox): You pay 30% after CY deductible plus \$250 per admission deductible</p> <p>Outpatient (Rehab & Detox): You pay 30% after deductible</p>
	You pay a \$10 copay	You pay 20% after \$25 ded.	You pay 20% after \$25 ded., plus anything over UCR
	You pay a \$10 copay	You pay 20%	Not covered
	You pay a \$10 copay	You pay 20% [CY ded. waived]	You pay 30% after ded. plus anything over UCR