

Santa Cruz County Schools Health Insurance Group

Summary of Medical Benefits

Effective Date Carrier Name Plan Description Benefit Attributes	7/1/2006 Health Net, Inc. Standard PPO		7/1/2006 Health Net, Inc. Catastrophic PPO		7/1/2006 Health Net, Inc. HMO	7/1/2006 Health Net, Inc. HMO Low Option
	In-Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits	Schedule of Benefits	Schedule of Benefits
General Plan Information						
Annual Deductible/Individual	\$250	\$500	\$1,000	\$1,000	\$0	\$0
Annual Deductible/Family	\$750	\$1,500	\$3,000	\$3,000	\$0	\$0
Coinsurance	90%	90% based on the benefit schedule plus excess of allowed amount	80%	60% based on the benefit schedule plus excess of allowed amount	100%	100%
Office Visit/Exam	90% not subject to deductible	90% based on the benefit schedule plus excess of allowed amount	\$30 copay deductible waived	60% based on the benefit schedule plus excess of the allowed amount	\$15 copay	\$20 copay
Outpatient Specialist Visit	90% not subject to the deductible	90% based on the benefit schedule plus excess of allowed amount	\$30 copay deductible waived	60% based on the benefit schedule plus excess of allowed amount	\$15 copay	\$20 copay
Annual Out-of-Pocket Limit/Individual	\$1,000	\$1,000	\$4,000	\$6,000	\$0	\$1,500
Annual Out-of-Pocket Limit/Family	\$3,000	\$3,000	no family limit each member must meet individual limit	no family limit each member must meet individual limit	\$0	\$4,500
Deductible Included in Out-of-Pocket Limits	No	No	No	No	No	No
Lifetime Plan Maximum	Unlimited	Unlimited	\$5,000,000	\$5,000,000	Unlimited	Unlimited
Primary Care Physician Election Required	No	No	No	No	Yes	Yes
Outpatient Services						
<i>Preventive Services</i>						
Well-Child Care	100% deductible waived limited to a combined benefit maximum of \$500 per calendar year	100% deductible waived limited to a combined benefit maximum of \$500 per calendar year	\$30 copay deductible waived	Not covered	\$15 copay	\$20 copay
Immunizations	100% deductible waived limited to a combined benefit maximum of \$500 per calendar year	100% deductible waived limited to a combined benefit maximum of \$500 per calendar year	\$30 copay deductible waived	Not covered	100%	100%
Well Woman Exams	90% deductible waived	90% deductible waived	\$30 copay deductible waived	60% based on the benefit schedule plus excess of the allowed amount	\$15 copay	\$20 copay
Mammograms	100% deductible waived limited to a combined benefit maximum of \$500 per calendar year	100% deductible waived limited to a combined benefit maximum of \$500 per calendar year	80%	Not covered	100%	100%
Adult Periodic Exams with Preventive Tests	100% deductible waived limited to a combined benefit maximum of \$500 per calendar year	100% deductible waived limited to a combined benefit maximum of \$500 per calendar year	80%	Not covered	\$15 copay	\$20 copay
Diagnostic X-Ray and Lab Tests	90%	90% based on the benefit schedule plus excess of allowed amount	80%	60% based on the benefit schedule plus excess of allowed amount	100%	100%
Maternity Care						
Pregnancy and Maternity Care (Pre-Natal Care)	90%	90% based on the benefit schedule plus excess of allowed amount	80%	60% based on the benefit schedule plus excess of allowed amount	100%	100%

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Inpatient Hospital Services						
Inpatient Hospitalization	90%	90% based on the benefit schedule plus excess of allowed amount	80% after \$250 deductible per admission	60% after \$250 deductible per admission (\$600 maximum allowed per day)	100%	\$250 copay per admission
Pre-Authorization of Services Required	Yes	Yes	Yes	Yes	Yes	Yes
Semi-Private Room & Board; Including Services and Supplies	90%	90% based on the benefit schedule plus excess of allowed amount	80%	60% based on the benefit schedule plus excess of allowed amount	100%	100%
Surgical Services						
Outpatient Facility Charge	90%	90% based on the benefit schedule plus excess of allowed amount	80% plus \$250 copay if surgery performed otherwise payable at 80%	60% based on the benefit schedule plus excess of allowed amount plus \$250 copay if surgery performed otherwise payable at 60%	100%	100%
Emergency Services						
Emergency Room	90%	50% based on the benefit schedule plus excess of allowed amount	80% after \$100 copay	80% after \$100 copay	\$50 copay	\$50 copay
Copay/Deductible Waived if Admitted	Yes	Yes	Yes	Yes	Yes	Yes
Urgent Care						
Urgent Care Facility	90%	90% based on the benefit schedule plus excess of allowed amount	80% after \$100 copay	80% after \$100 copay	\$15 copay	\$20 copay
Mental Health Benefits						
Inpatient Care	90% 30 days per calendar year, combined between networks	90% 30 days per calendar year, combined between networks	80% after \$250 deductible per admission	60% after \$250 deductible per admission	100%	100%
Outpatient Care	90% 30 visits per calendar year, combined between networks	90% 30 visits per calendar year, combined between networks	80% \$25 maximum allowed per visit 20 visits per calendar year	60% \$25 maximum allowed per visit 20 visits per calendar year	\$15 copay	\$20 copay \$35 copay for non severe mental illness, 20 visits per calendar year
Alcohol & Substance Abuse						
Inpatient Care						
Inpatient Hospitalization	90% limited to \$15,000 maximum per calendar year, \$30,000 maximum per lifetime	90% limited to \$15,000 maximum per calendar year, \$30,000 maximum per lifetime	80% after \$250 deductible per admission	60% after \$250 deductible per admission	100% 30 days per calendar year	Not covered
Inpatient Detoxification Services	90% limited to 3 visits per calendar year, combined between networks	90% limited to 3 visits per calendar year, combined between networks	80% after \$250 deductible per admission limited to 3 visits per calendar year, pre-certification required	60% after \$250 deductible per admission limited to 3 visits per calendar year, pre-certification required	100% 30 days per calendar year	\$100 day
Outpatient Care						
Outpatient Services	90% limited to 30 visits per calendar year, combined between networks	90% limited to 30 visits per calendar year, combined between networks	\$30 copay 30 visits per calendar year, combined between networks	60% limited to 30 visits per calendar year, combined between networks	\$20 copay 20 visits per calendar year	\$35 copay 1 visit per day, 20 visits per 12 month period

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Prescription Drug Benefits						
Prescription Drug Deductible Generic	\$125 individual \$375 family \$5 copay after deductible	\$125 individual \$375 family \$20 copay plus 50% of Average Wholesale price after deductible	\$125 individual \$375 family \$5 copay after deductible	\$125 individual \$375 family \$20 copay plus 50% of Average Wholesale price after deductible	N/A \$5 copay	N/A \$5 copay
Brand (Non-Formulary/Non-preferred)	\$20 copay after deductible	\$20 copay plus 50% of	\$20 copay after deductible	\$20 copay plus 50% of	\$25 copay	\$25 copay
Number of Days Supply	30 days	30 days	30 days	30 days	30 days	30 days
Mail Order Mandatory	No	No	No	No	No	No
Generic	\$10 copay after deductible	Not covered	\$10 copay after deductible	Not covered	\$10 copay	Not covered
Brand (Non-Formulary/Non-preferred)	\$40 copay after deductible	Not covered	\$40 copay after deductible	Not covered	\$50 copay	Not covered
Number of Days Supply for Mail Order	90 days	N/A	90 days	N/A	90 days	N/A
Other Services and Supplies						
Durable Medical Equipment & Prosthetic Devices	90%	90% based on the benefit schedule plus excess of the allowed amount	80% up to \$1,000 per calendar year	60% up to \$1,000 per calendar year	100%	100% \$2,000 per calendar year
Home Health Care	90% 100 visits per calendar year, combined between networks	90% 100 visits per calendar year, combined between networks	80% up to \$110 maximum allowed per day 60 visits per calendar year	60% up to \$110 maximum allowed per day 60 visits per calendar year	up to 30 days for outpatient (\$15 copay starting with 31st calendar day after 1st visit)	\$20 copay three 2-hour visits per day
Skilled Nursing or Extended Care Facility	90% 100 visits per calendar year, combined between networks	90% 100 visits per calendar year, combined between networks	80% \$250 deductible per admission	60% \$250 deductible per admission \$250 maximum allowed per day	100% (100 days per calendar year)	\$250 copay per admission, 100 days per calendar year
Hospice Care	90%	90% based on the benefit schedule plus excess of the allowed amount	80% limited to \$5,000 lifetime maximum benefit allowed, combined between networks	60% limited to \$5,000 lifetime maximum benefit allowed, combined between networks	100%	100%
Chiropractic Services	90%	90% based on the benefit schedule plus excess of the allowed amount	\$30 copay	Not covered	\$15 copay 30 visits per calendar year, combined with acupuncture (ASHP)	\$20 copay 30 visits per calendar year, combined with acupuncture (ASHP)
Acupuncture	90%	90% based on the benefit schedule plus excess of the allowed amount	50%	50% based on the benefit schedule plus excess of the allowed amount	\$15 copay 30 visits per calendar year, combined with chiro (ASHP)	\$20 copay 30 visits per calendar year, combined with chiro (ASHP)
Infertility						
Diagnosis	Not Covered	Not Covered	Not Covered	Not Covered	50%	50%
Treatment	Not Covered	Not Covered	Not Covered	Not Covered	50%	50%
Outpatient Rehabilitative Therapy Services						
Physical	90%	90% based on the benefit schedule plus excess of the allowed amount	80%	60% based on the benefit schedule plus excess of the allowed amount	100%	\$20 copay 60 visits per injury
Occupational	90%	90% based on the benefit schedule plus excess of the allowed amount	80%	60% based on the benefit schedule plus excess of the allowed amount	100%	\$20 copay 60 visits per injury
Speech	90%	90% based on the benefit schedule plus excess of the allowed amount	80%	60% based on the benefit schedule plus excess of the allowed amount	100%	\$20 copay 60 visits per injury

*Disclaimer: The information described on this page is only intended to be a summary of your benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review your Summary Plan Description (SPD) for a complete summary of your benefits. If the information on this page conflicts