

non-Medicare plans

generally for those under 65

HEALTH NET HMO	KAISER PERMANENTE HMO	PACIFICARE SIGNATURE VALUE HMO	UNITED HEALTHCARE CHOICE PLUS PPO
800.522.0088 Group 57358-A www.healthnet.com	800.464.4000 Group 104302 www.kaiserpermanente.org	800.624.8822 Group 004501 www.pacificare.com	866.633.2446 Group 717697 www.myuhc.com
HMO plan	HMO plan	HMO plan	PPO plan

IMPORTANT NOTES

This chart provides a summary of the medical plans offered. Please refer to each plan's coverage documents for exact terms and conditions of coverage. If there is a discrepancy between this summary chart and the plan documents, the plan documents will govern in all cases.

		HMO plan		PPO plan	
		HEALTH NET HMO	KAISER PERMANENTE HMO	PACIFICARE SIGNATURE VALUE HMO	UNITED HEALTHCARE CHOICE PLUS PPO
		You are required to use the primary care physician you select from a list of providers	You are required to use Kaiser Permanente physicians and facilities	You are required to use the primary care physician you select from a list of providers	If you select from an in-network list, your benefits will be greater than if you select from an out-of-network list. You may use any physician or facility that accepts this insurance
ANNUAL DEDUCTIBLE	Any applicable deductible must be met before coverage shown is effective.	None	None	None	\$500 individual / \$1000 individual \$1,000 family / \$2,000 family
AMBULANCE	Requires pre-authorization	Covered in full	Covered in full	100%	(80% combined for in and out-of-network)
ANESTHESIA		Covered in full	Covered in full	Covered in full	80% 60%
CHIROPRACTIC VISIT	If covered, services generally include initial examinations; additional visits for treatment; x-ray and laboratory fees when prescribed. Pre-authorization may be required.	Not covered	\$10 per visit up to 20 visits	\$15 per visit up to 20 visits	100% (24 visit annual maximum combined for in and out-of-network) 60%
DURABLE MEDICAL EQUIPMENT		Covered in full	Covered in full	Covered in full up to \$5,000 per year	80% (\$2,500 maximum combined for in and out-of-network) 60%
EMERGENCY CARE	Includes accidental injury and acute illness. The co-payment shown is when visiting an emergency room and is waived if you are admitted.	\$35	\$25	\$50	\$100 (\$100 maximum combined for in and out-of-network)
HEARING CARE AND HEARING AIDS		\$20 per exam No coverage for hearing aids	\$10 per exam No coverage for hearing aids	\$20 per exam Hearing aids are covered in full up to \$5,000 every 36 months	\$20 per exam No coverage for hearing aids 60% per exam No coverage for hearing aids
HOME HEALTH CARE	Requires a physician's prescription	Covered in full up to 30 days; \$10 co-payment starts on the 31st day after the 1st visit	Covered in full	Covered in full up to 100 visits per year	80% (100 visits maximum combined for in and out-of-network) 60%
HOSPICE CARE		Covered in full	Covered in full	Covered in full	80% 60%
HOSPITAL ROOM AND BOARD	Coverage is for a semi-private room	Covered in full	Covered in full	Covered in full	80% 60%
LABORATORY FEES		Covered in full	Covered in full	Covered in full	100% (deductible does not apply) 60%
PHYSICIAN CARE (DOCTOR VISITS) UNRELATED TO HOSPITALIZATION	The co-payments shown are for office visits unrelated to hospitalization.	\$20 per office visit	\$20 per office visit	\$20 per office visit	\$20 per office visit / \$30 per specialist 60%
PHYSICIAN CARE (DOCTOR VISITS) DUE TO HOSPITALIZATION	Coverage shown is for visits due to hospitalization	Covered in full	Covered in full	Covered in full	80% 60%
PRESCRIPTION MEDICATIONS FROM A MAIL ORDER	The co-payments in all cases are for the number of days shown.	\$30 generic, \$60 brand name \$90 non-formulary 90-day supply	\$15 generic, \$30 brand name 100-day supply	\$30 generic, \$60 brand name 90 day supply	\$25 generic, \$62.50 brand name, \$112.50 non-formulary 90-day supply through Medco. Information is available through www.myuhc.com.
PRESCRIPTION MEDICATIONS FROM A PHARMACY	Unless noted, non-formulary prescriptions are covered by the same co-payments when deemed medically necessary.	\$15 generic, \$30 brand name \$45 non-formulary 30-day supply	\$15 generic, \$30 brand name 100-day supply	\$15 generic, \$30 brand name 30-day supply	\$10 generic, \$25 brand name \$45 non-formulary 30-day supply 80% after co-payment of: \$10 generic, \$25 brand name \$45 non-formulary, 30-day supply
PSYCHIATRIC CARE (INPATIENT)	An asterisk (*) indicates the plan will cover this care in full for diagnoses covered under the Mental Health Parity Act.	*Covered in full	*Covered in full Unlimited visits	Covered in full no limit on days	80% (up to 30 days maximum combined for in and out-of-network) 60%
PSYCHIATRIC CARE (OUTPATIENT)		\$20 per visit	\$20 per visit Unlimited visits	\$20 per visit; no limit on visits	\$30 (up to 20 visits maximum combined for in and out-of-network) 60%
SKILLED NURSING FACILITY		Covered in full up to 100 days	Covered in full up to 100 days	Covered in full up to 100 consecutive calendar days from first treatment	80% (60 days maximum combined for in and out-of-network) 60%
SURGERY (INPATIENT)		Covered in full	Covered in full	Covered in full	80% 60%
SURGERY (OUTPATIENT)		Covered in full	\$20 co-payment	Covered in full	80% 60%
URGENT CARE	An asterisk (*) indicates non-emergency	\$35	\$20*	\$50	\$50 60%
VISION CARE AND EYEWEAR		\$20 per exam No coverage for eyewear	\$20 per exam No coverage for eyewear	\$20 per exam No coverage for eyewear	\$20 per exam No coverage for eyewear No coverage
X-RAYS		Covered in full	Covered in full	Covered in full	\$20 minor / 80% major 60%
MONTHLY RATE per person		\$721.13	\$563.93	\$783.16	\$1,553.91

NON-MEDICARE PLANS GENERALLY FOR THOSE UNDER 65

Medicare plans generally for those over 65

IMPORTANT NOTES

This chart provides a summary of the medical plans offered. Please refer to each plan's coverage documents for exact terms and conditions of coverage. If there is a discrepancy between this summary chart and the plan documents, the plan documents will govern in all cases.

	HEALTH NET HMO	HEALTH NET SENIORITY PLUS	KAISER PERMANENTE SENIOR ADVANTAGE	UNITEDHEALTHCARE SENIOR SUPPLEMENT	SECURE HORIZONS	
	800.522.0088 Group 57358-B www.healthnet.com	800.275.4737 Group 57358-S www.healthnet.com	800.464.4000 Group 104302-00 www.kaiserpermanente.org	800.851.3802 Group 00014829 www.pacificare.com	866.622.8055 Group 004497 www.securehorizons.com	
	Medicare HMO plan; this plan's benefits are coordinated with Medicare. You are required to use the primary care physician you select from a list of providers	Medicare Advantage plan; no Medicare benefits; only this plan's benefits. You are required to use the HealthNet physician you select from a list of providers	Medicare Advantage plan; no Medicare benefits; only this plan's benefits. You are required to use Kaiser Permanente physicians and facilities	Senior Supplement plan; This plan pays secondary to Medicare and follows Medicare coverage guidelines. You may use any physician or facility that accepts Medicare.	Medicare Advantage plan; no Medicare benefits; only this plan's benefits. You are required to use the primary care physician you select from a list of providers Expanded to Arizona and Nevada.	
ANNUAL DEDUCTIBLE	Any applicable deductible must be met before coverage shown is effective.	None	None	None	None	
AMBULANCE	Requires pre-authorization	Covered in full	Covered in full	Covered in full	Covered in full. No preauthorization required	
ANESTHESIA		Covered in full	Covered in full	Covered in full	Covered in full	
CHIROPRACTIC VISIT	If covered, services generally include initial examinations; additional visits for treatment; x-ray and laboratory fees when prescribed. Pre-authorization may be required.	Not covered	\$5 per visit up to 20 visits through American Specialty Health Network	\$10 per visit up to 20 visits	Generally not covered Spinal Manipulation is allowed	\$5 per visit up to 20 visits
DURABLE MEDICAL EQUIPMENT		Covered in full	Covered in full	Covered in full	Covered in full	
EMERGENCY CARE	Includes accidental injury and acute illness. The co-payment shown is when visiting an emergency room and is waived if you are admitted.	\$35	\$20	\$20	Covered in full in the U.S.	\$20
HEARING CARE AND HEARING AIDS		\$20 per exam No coverage for hearing aids	\$20 per exam, 2 standard hearing aids every 36 months covered in full	\$10 per exam No coverage for hearing aids	Generally not covered	\$20 per exam, hearing aids covered up to \$500 every 36 months
HOME HEALTH CARE	Requires a physician's prescription	Covered in full up to 30 days; \$10 co-payment starts on the 31st day after the 1st visit	Covered in full	Covered in full Refer to evidence of coverage from the plan	Covered in full	Covered in full
HOSPICE CARE		Covered in full	Covered per Medicare guidelines	Covered in full	Covered in full	Covered per Medicare guidelines
HOSPITAL ROOM AND BOARD	Coverage is for a semi-private room	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
LABORATORY FEES		Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
PHYSICIAN CARE (DOCTOR VISITS) UNRELATED TO HOSPITALIZATION	The co-payments shown are for office visits unrelated to hospitalization.	\$20 per office visit	\$20 per office visit	\$10 per office visit	Covered in full	\$20 per office visit
PHYSICIAN CARE (DOCTOR VISITS) DUE TO HOSPITALIZATION	Coverage shown is for visits due to hospitalization	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
PRESCRIPTION MEDICATIONS FROM A MAIL ORDER	Coverage in all cases is for the number of days shown	\$30 generic, \$60 brand name \$100 non-formulary 90-day supply	\$30 generic, \$60 brand name \$90 non-formulary 90-day supply	\$10 generic, \$20 brand name 100-day supply	\$20 generic, \$40 brand name \$100 non-formulary 90-day supply	\$30 generic, \$60 brand name 90-day supply
PRESCRIPTION MEDICATIONS FROM A PHARMACY	Unless noted, non-formulary prescriptions are covered by same co-payments when deemed medically necessary.	\$15 generic, \$30 brand name \$50 non-formulary 30-day supply	\$15 generic, \$30 brand name \$45 non-formulary 30-day supply	\$10 generic, \$20 brand name 100-day supply	\$10 generic, \$35 brand name \$50 non-formulary 30-day supply	\$15 generic, \$30 brand name 30-day supply
PSYCHIATRIC CARE (INPATIENT)	An asterisk (*) indicates the plan will cover this in full for diagnoses covered under the Mental Health Parity Act.	*Covered in full	Covered in full	*Covered in full Unlimited visits	Covered in full up to 190 days per lifetime	Covered per Medicare guidelines up to 190 days per lifetime
PSYCHIATRIC CARE (OUTPATIENT)		\$20 per visit	\$20 per visit	\$10 per visit Unlimited visits	Covered in full	\$20 per visit
SKILLED NURSING FACILITY		Covered in full up to 100 days	Covered in full up to 100 days	Covered in full up to 100 days	Covered in full up to 100 days	Covered in full up to 100 days
SURGERY (INPATIENT)		Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
SURGERY (OUTPATIENT)		Covered in full	Covered in full	\$10 per procedure	Covered in full	Covered in full
URGENT CARE	An asterisk (*) indicates non-emergency	\$35	\$20	\$10*	Covered in full	\$10
VISION CARE AND EYEWEAR		\$20 per exam No coverage for eyewear	\$20 per exam \$100 paid for eyewear every 2 years	\$10 per exam \$150 allowance for eyewear every 2 years	Routine is not covered Eyewear is generally not covered	\$20 per exam \$75 per eyewear every 2 years
X-RAYS		Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
MONTHLY RATE per person	\$311.88	\$230.91	\$299.07	\$332.35	\$200.64	