**FERN RIDGE SCHOOL DISTRICT 28J**

***Summary of Benefit Plans***

**October 1, 2013 - September 30, 2014**

| | **Health Net PPO Advantage Plan ($500 Deductible)** | | **Health Net PPO Advantage Plan ($1,000 Deductible)** | | **Health Net PPO High Deductible Health Plan (HSA) - Single Coverage** | | **Health Net PPO High Deductible Health Plan (HSA) - Family Coverage** | |
|---|---|---|---|---|---|---|---|---|
| | *PPO Network* | *Out-of-Network* | *PPO Network* | *Out-of-Network* | *PPO Network* | *Out-of-Network* | *PPO Network* | *Out-of-Network* |
| **Annual Deductible** | $500 per person ^<br>$1,500 per family ^ | | $1,000 per person ^<br>$3,000 per family ^ | | $1,500 ✦ | $3,000 ✦ | $3,000 ✦ | $6,000 ✦ |
| **Annual Out-of-Pocket Maximum** | $2,500 per person ^<br>$7,500 per family ^ | | $2,500 per person ^<br>$7,500 per family ^ | | $3,000 ✦ | $9,000 ✦ | $6,000 ✦ | $18,000 ✦ |
| Preventative Care | No charge * | 40% MAA * | No charge * | 40% MAA * | No charge * | 40% MAA * | No charge | 40% MAA |
| Physician services, office call | $15 per visit * | 40% MAA * | $25 per visit * | 40% MAA * | 20% contract rate | 40% MAA | 20% contract rate | 40% MAA |
| Physician services, urgent care | $50 per visit * | $50 per visit MAA * | $50 per visit * | $50 per visit MAA * | 20% contract rate | 20% MAA | 20% contract rate | 20% MAA |
| Diagnostic X-ray/EKG/Ultrasound | 20% contract rate * | 40% MAA * | 20% contract rate * | 40% MAA * | 20% contract rate | 20% MAA | 20% contract rate | 20% MAA |
| Diagnostic laboratory tests | 20% contract rate * | 40% MAA * | 20% contract rate * | 40% MAA * | 20% contract rate | 20% MAA | 20% contract rate | 20% MAA |
| High cost imaging (CT, MRI, PET, etc.) | 20% contract rate | 40% MAA | 20% contract rate | 40% MAA | 20% contract rate | 20% MAA | 20% contract rate | 20% MAA |
| Hospital inpatient services | 20% contract rate | 40% MAA | 20% contract rate | 40% MAA | 20% contract rate | 20% MAA | 20% contract rate | 20% MAA |
| Outpatient emergency room services | $150 per visit then 20% contract rate * | $150 per visit then 20% * | $150 per visit then 20% contract rate * | $150 per visit then 20% * | 20% contract rate | 20% | 20% contract rate | 20% |
| Prescription co-pay | $15/$30/$50 | Not Covered | $15/$30/$50 | Not Covered | 20% | Not Covered | 20% | Not Covered |
| Chiropractic services | Available | Not Covered | Available | Not Covered | Available | Not Covered | Available | Not Covered |
| Acupunture services | Available | Not Covered | Available | Not Covered | Available | Not Covered | Available | Not Covered |
| Massage therapy | Available | Not Covered | Available | Not Covered | Available | Not Covered | Available | Not Covered |
| Naturopathic services | Available | Not Covered | Available | Not Covered | Available | Not Covered | Available | Not Covered |

^ *The annual out-of-pocket maximum does not include the annual deductible. After you reach the out-of-pocket maximum in a calendar year, Health Net will pay your covered services during the rest of that calendar year at 100% of the contract rates.*

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* *Deductible is waived*

| | **PacificSource Dental Plan** | |
|---|---|---|
| Diagnostic & Preventative Treatment | Plan pays 100% | $1,500 annual max per person |
| Basic and Restorative Services | Plan pays 100% | |
| Complicated Treatment | Plan pays 100% | |
| Major Treatment | Plan pays 100% | |
| Orthodontia | Plan pays 50% | $1,000 lifetime max per person |

| | **Health Net Vision Plan (EyeMed)** | |
|---|---|---|
| | *In Network* | *Out-of-Network* |
| Exam | $10 co-pay | Reimbursed $40 |
| Frames | $150 allowance | Reimbursed $45 |
| Single vision lenses | $10 co-pay | Reimbursed $40 |
| Lined bifocal lenses | $10 co-pay | Reimbursed $60 |
| Standard progressive lenses | $75 co-pay | Reimbursed $60 |