

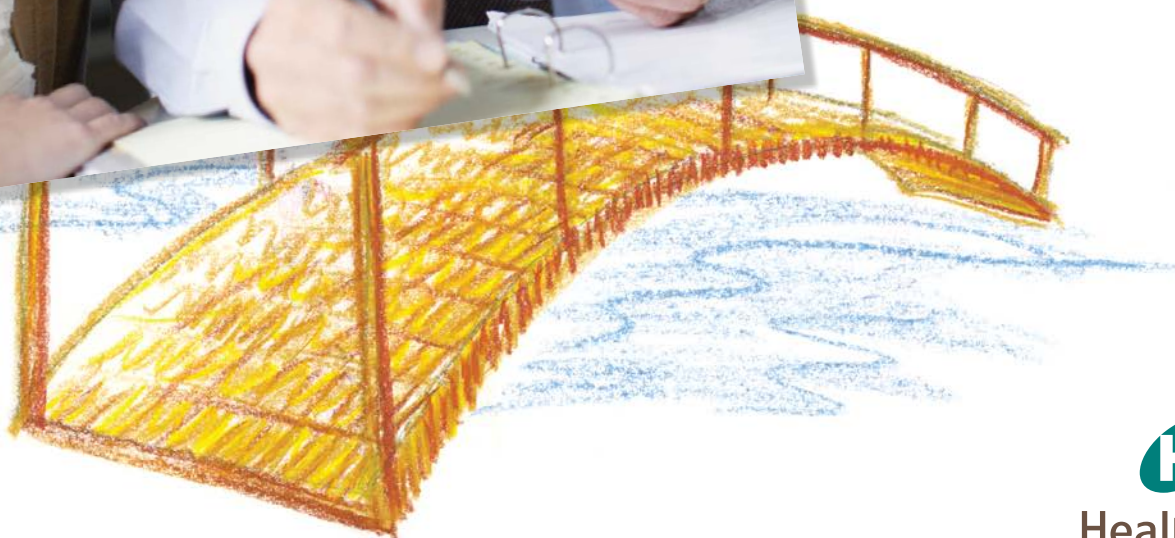
Health Net 51–100 Choice Portfolio Guide

Innovative sales opportunities tailored for success

Effective January 1, 2015



Karen Boyd,
Health Net
*We translate
expertise into
innovation.*



Health Net®

Flexible plan combinations. Contribution choices. Composite rates. We're bringing it all together in a new way to connect your clients with the health coverage that works for them. Created exclusively for groups with 51–100 employees – Making it easy to do business is what Health Net 51–100 Choice is all about.



**Kim Aung,
Health Net**

*We work to ensure
your clients experience
reliability and
top-notch service.*



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The Right Fit *Begins Here*

Health Net has always offered the full spectrum of health plan designs – from traditional and open access HMOs to PPOs and consumer-directed health plans. Through marketplace awareness and a drive to innovate, we blend cultural and community knowledge with health plan options that meet the needs of local populations.

Now we're bringing our robust portfolio and flexibility to groups with 51–100 employees, so they can:

- Offer employees any number and type of plan from our full portfolio. We have more than 100 plans simplified into three convenient packages.
- Choose the contribution level that works for their business – either a percentage or flat dollar amount.
- Enjoy a simple 4-tier rate structure.
- Streamline decision making – Employees pick the plans from the choices their employer selects.

Plus! We prepare employee worksheets for you. Customized to the plans your client decides to offer, the worksheets detail employee benefits and costs so it's easy for them to make their choices.

Working together for the long-term

We work collaboratively with our business partners like you to develop and deliver innovative solutions that meet the needs of our customers today, and continue to provide value in the future.

- Easy administration with a single point of contact, regardless of regional vicinity.
- Our team of sales, account and service professionals work in concert to ensure your clients experience reliability, understanding and follow-through.
- Local experience and strong community ties help us respond to the ever-changing marketplace.
- We bring together provider group collaboration, proprietary programs and specialty services to reach and affect people throughout the continuum of care.



You specialize in
connecting your
clients with the health
care coverage that
works for them.
Health Net 51–100
Choice makes it
easier to do what
you do best.

Solutions *That Work for* Your Clients

Tailored network innovations

Designed for value

Our tailored network-based solutions are among our most popular. We pioneered the concept back in 2002, forming strategic provider partnerships – subsets of our full HMO network – to create networks tailored to specific geographic areas.

The idea was to give employers a way to save without cutting benefits or shifting costs to employees. By partnering with select providers, our tailored networks like

ExcelCare and Salud did just that – boosting affordability and value for employers while giving employees access to trusted health care resources.

We evolved the concept with our SmartCare line – merging the tailored network advantages with expanded benefits and incentives to promote healthy habits and prioritize the doctor-patient relationship.

Tailored network service areas

ExcelCare Network

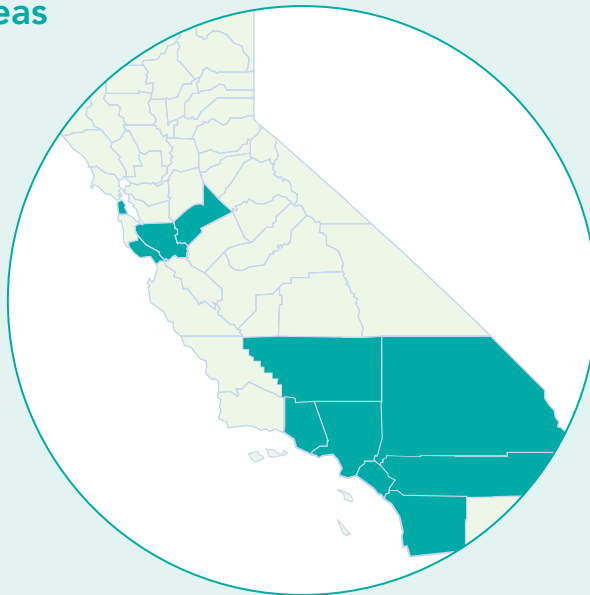
Available in all or parts of Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Francisco, Santa Clara, Stanislaus, and Ventura counties.

SmartCare Network

Available in all or parts of Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Clara, and Santa Cruz counties.

Salud Network

Available in all or parts of Kern, Los Angeles, Orange, Riverside, San Bernardino, and San Diego counties.



Health Net SmartCare

The new generation of health coverage

Health Net SmartCare brings together the advantages of a tailored network, expanded benefits and health incentives in one simple package.

A proven, expanded network

The SmartCare Network delivers affordability without compromise, so both employers and employees get the value they want.

A subset of our full HMO network, SmartCare connects employees to trusted, high-quality provider groups and hospitals. Plus, SmartCare delivers even more with access to CVS MinuteClinics for an easy, convenient way to get treatment for common family illnesses and injuries, vaccinations, and monitoring for chronic conditions.

SmartCare is built to flex over time with planned expansions in geographic coverage, prominent participating provider groups and other resources to match the evolving needs of group clients.

Streamlined plan choices to meet budgets and exceed expectations

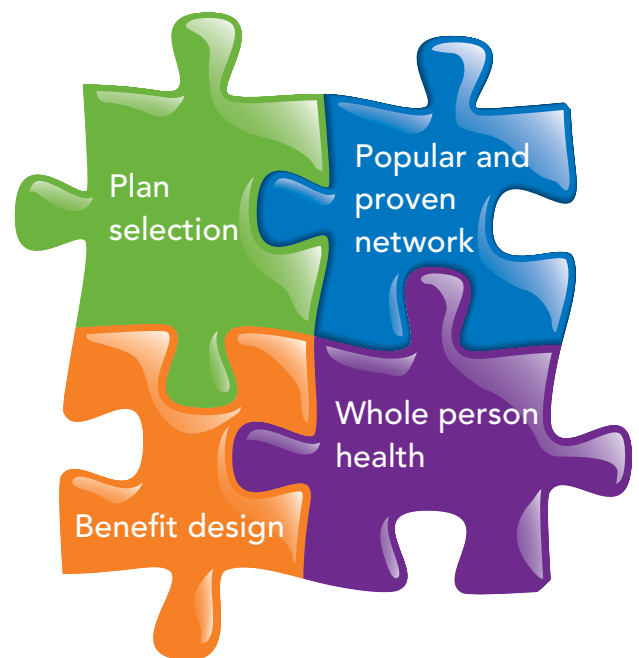
SmartCare takes a 360° view of health when it comes to benefits. We start with easy-to-understand, choose and use HMO plans to keep decision-making clear and simple. Beyond medical coverage, every plan includes

acupuncture, chiropractic and prescription drug coverage. Of course, preventive care is \$0 for members.

More ways to build healthy habits

By supporting well-being as a way of life, SmartCare promotes patient engagement, which in turn leads to better health, lower costs and higher workplace performance.

For example, adult SmartCare members can earn an annual \$50 gift card reward just by investing in their health. They complete the online Health Risk Questionnaire (HRQ), share the results with their primary care provider (PCP) at a scheduled preventive care physical, and note the physician visit in their **www.healthnet.com** account.



Salud con Health Net®

Coverage for diverse workforces

A Health Net specialty is matching the cultural and community needs of growing markets. Our Salud con Health Net plans, for example, are designed to fit California's fast-growing Latino market. With cost-savings for employers and predictable costs for employees, it's health care coverage that won't break the bank.

The Salud difference

Designed for members of the Hispanic community, Salud offers access to affordable, local and culturally competent health care, including:

- Quality medical professionals who understand the cultural preferences and health concerns of Latinos.
- The ability to offer cost-savings to employers without giving up quality – premiums lower than our statewide networks. Note that rate savings vary by plan and service area.

And when Salud is paired alongside another Health Net plan, it's a combination that's perfectly matched for a diverse workforce.

Salud Network – that local touch

The Salud Network is a culturally-based, carefully selected group of caring medical physicians and staff in California who understand the health care preferences of Latinos. In addition, our health care delivery system was designed to respond to the diverse values and behaviors that affect access to care for Latinos, so members can feel confident about the health care services they receive.

Dedicated service

Our team of dedicated professionals arrive each day ready to take care of our customers.

- Our Health Net team of client managers, account executives and other professionals work together to ensure a smooth and positive experience for your clients.
- We offer a comprehensive language assistance program that enables members to speak in the language they prefer, enhancing their communication and comfort level.
- Our Health Net website is also available in Spanish.

With Salud con Health Net, it all adds up to cost-savings for employers and Latino-focused health care for employees.



Health Net of California, Inc. is proud to have earned the NCQA Distinction Status in Multicultural Health Care (MHC) for our commercial lines of business.



Standard, Value *and* Advantage

Plans for every budget

Meeting the diverse and growing needs of businesses was the inspiration behind the way we've structured our HMO, Elect Open AccessSM (EOA) and PPO plans.

Each design type comes in three price and benefit combinations, so your clients can get maximum value for every health care plan purchase.

- **Standard** – This line of well-priced, comprehensive benefit plans gives your clients the most for their money.
- **Value** – The Value plans enable clients to stretch their health care budget with more employee cost-sharing.
- **Advantage** – Our most economical line is the optimal solution for clients who need to trim costs, as well as those who haven't been able to provide health benefits.

Most benefits are the same for Standard, Value and Health Net Advantage.

The variable benefits are:

- Copayment amount
- Hospital services
- PPO plan deductibles
- Prescription brand deductibles
- Out-of-pocket maximums

The variable benefits adjust in consistent increments with the increase in copayment amounts.

Consumer-directed health plans

We're also the one-stop source for your clients who want to increase employee involvement

in the way they use and pay for health care services.

- **Health Savings Account (HSA)-compatible PPO insurance plan** – A great way for your clients to give employees the ability to use their health care dollars in ways that work best for them while enjoying tax-saving opportunities.¹ This plan includes access to our full PPO provider network.
- **Health Reimbursement Arrangement (HRA)-eligible PPO insurance plans** – A choice of two high-deductible PPO health insurance plans that can be used for self-funding or wrapping purposes, giving business owners even more control over their health care budget. Among the employer advantages are no third-party administrator (TPA) restrictions or limits to the plans clients wrap.
- **HSA/HRA Integrated** – Are your clients looking for greater convenience, service and choice in consumer-directed health care benefits? Our high-deductible health plan PPO products are being offered with integrated HSA/HRA account options through HealthEquity. A proven expert in financial arrangement integration and administration, HealthEquity offers easy-to-use tools and comprehensive resources. For more information, please contact your Health Net sales representative.

Point-of-Service (POS)

We also offer POS plans where members select a primary physician like they would in an HMO, but they can choose between two tiers of benefits – HMO or PPO – each time they access covered services. Out-of-pocket costs are less when members use their HMO benefits.

¹References are to federal taxes only. State taxes may apply. Tax information is for general purposes only. For more detailed information about the tax implications of an HSA, please contact a professional tax advisor.

Choice Packages

1 Choose a network

Health Net 51–100 Choice comes in three packages:

- **Enhanced Choice** pairs health plan benefits with our full HMO network. Available throughout California, our full HMO network features more than 58,000 physicians and specialists, and 265 hospitals.
- **SmartCare Choice** brings together the advantages of a tailored network, expanded benefits and health incentives in one simple package. Every SmartCare plan includes acupuncture, chiropractic and prescription drug coverage. Connecting members to trusted, high-quality provider groups and hospitals is the SmartCare network, a subset of our full HMO network. SmartCare also features access to CVS MinuteClinics for an easy, convenient way to get treatment for common family illnesses and injuries, vaccinations and monitoring for chronic conditions.
- **ExcelCare Choice** is a tailored network solution that features our ExcelCare Network and is paired with any of our HMO and Elect Open Access (EOA) plans. By partnering with select providers, we are able to create value and lower costs for employers while connecting employees to local, high-quality health care resources.

Extra option: Dual Network

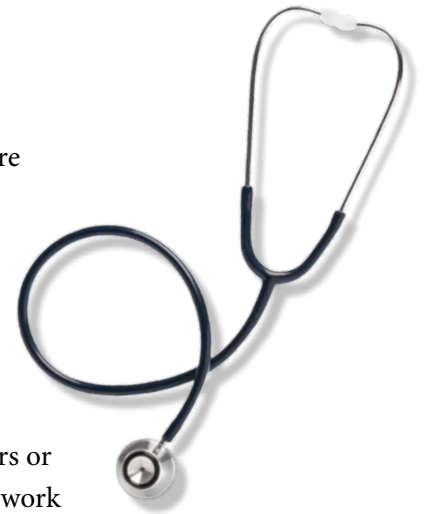
Both our SmartCare and ExcelCare tailored networks feature select providers with whom we've partnered in order to enhance value and lower costs for employers. But we know that your clients may have employees who need access to specific doctors or hospitals. So we have four full network HMO plans that can be offered alongside SmartCare Choice or ExcelCare Choice. It's the solution for groups that want the value of a tailored network but need the flexibility of our full network.

2 Select a base plan and premium

Each of our three packages includes an extensive collection of plans, as shown on the following page. Your clients simply:

- Select a base plan from the options shown, and
- Pick their employer contribution:
 - A minimum 50% of the base plan premium; or
 - Fixed dollar amount as low as \$175 per month.

Then each employee chooses the plan he or she wants. They pay the difference between the premium amount of the plan they pick and what their employer contributes. *Simple!*



Plus! Clients can add any number of PPO, HSA-compatible, HRA-compatible, or Salud plans available in the network package they choose.

Every Health Net
51–100 plan comes
with wellness
resources and high-
tech conveniences
that help employees
build healthy habits,
which in turn help
improve outcomes
and productivity.

<i>Enhanced Choice</i>	
Standard HMO 10, 15, 20, 25, 30, 35, 40, and 50	Standard PPO 10, 15, 20, 25, 30, 35, 40, and 45
Standard HMO Dual Network 20 and 30	Value PPO 10, 15, 20, 25, 30, 35, 40, and 45
Value HMO 10, 20, 30, 40, and 50	Advantage PPO 45
Value HMO Dual Network 30 and 40	Value HSA 4500
Advantage HMO 25, 35 and 45	HRA 3000 and 5000
Standard EOA 10, 15, 20, 25, 30, 35, 40, and 50	Salud HMO y Más 15, 25 and 35
Value EOA 10, 20, 30, 40, and 50	Salud Mexico
Advantage EOA 25, 35 and 45	
POS 10 and 20	
<i>SmartCare Choice</i>	
Standard HMO SmartCare 10, 20, 30, 40, and 50	Advantage PPO 45
Standard HMO Dual Network 20 and 30	Value HSA 4500
Value HMO SmartCare 50	HRA 3000 and 5000
Value HMO Dual Network 30 and 40	Salud HMO y Más 15, 25 and 35
Standard PPO 10, 15, 20, 25, 30, 35, 40, and 45	Salud Mexico
Value PPO 10, 15, 20, 25, 30, 35, 40, and 45	
<i>ExcelCare Choice</i>	
Standard HMO ExcelCare 10, 15, 20, 25, 30, 35, 40, and 50	Standard PPO 10, 15, 20, 25, 30, 35, 40, and 45
Standard HMO Dual Network 20 and 30	Value PPO 10, 15, 20, 25, 30, 35, 40, and 45
Value HMO ExcelCare 10, 20, 30, 40, and 50	Advantage PPO 45
Value HMO Dual Network 30 and 40	Value HSA 4500
Advantage HMO ExcelCare 25, 35 and 45	HRA 3000 and 5000
Standard EOA ExcelCare 10, 15, 20, 25, 30, 35, 40, and 50	Salud HMO y Más 15, 25 and 35
Value EOA ExcelCare 10, 20, 30, 40, and 50	Salud Mexico
Advantage EOA ExcelCare 25, 35 and 45	

Choice Plans

At-a-Glance

Health Net Works for You

At Health Net, we champion solutions uniquely designed to embody the clients you serve. We utilize our deep and longstanding presence in the western United States to generate innovative health plans that respond to local needs – like 51-100 Choice.

Supporting individuals and families through various stages of life is what we've been doing for more than 35 years. And it is what we'll continue to do for decades to come.



**Carol Kim,
Health Net**

*We bring smart value
to businesses large
and small.*

SmartCare Portfolio

Note: Plan codes listed for SmartCare are in order of Southern and Northern California.

Benefit description	SmartCare HMO 10 Standard (AA0) (AA6) ¹	SmartCare HMO 20 Standard (AA1) (AA7) ¹	SmartCare HMO 30 Standard (AA2) (AA8) ¹
Plan maximums			
Out-of-pocket maximum	\$1,500 single / \$3,000 family	\$2,500 single / \$5,000 family	\$3,500 single / \$7,000 family
Lifetime medical benefit maximum	No maximum	No maximum	No maximum
Professional services			
Office visit (including specialist consultation) ²	\$10 copay	\$20 copay	\$30 copay
CVS MinuteClinic services ³	\$10 copay	\$20 copay	\$30 copay
Preventive care services ^{2,4}	Covered in full	Covered in full	Covered in full
X-ray and laboratory procedures ^{2,5}	Covered in full	Covered in full	Covered in full
Specialty drugs (medical self injectables and prescription oral specialty drugs)	30%	30%	30%
Hospital services			
Inpatient hospital facility services (includes maternity)	\$250 copay/day (3-day copay max/admit)	\$500 copay/day (3-day copay max/admit)	\$750 copay/day (3-day copay max/admit)
Outpatient facility services (other than surgery)	10%	20%	30%
Outpatient surgery (hospital charges only)	\$250 copay	\$500 copay	\$750 copay
Outpatient surgery (ambulatory surgery center charges only)	\$100 copay	\$250 copay	\$500 copay
Skilled nursing facility	Days 1–10: Covered in full Days 11–100: \$25/day	Days 1–10: Covered in full Days 11–100: \$25/day	Days 1–10: Covered in full Days 11–100: \$25/day
Emergency services			
Professional services	Covered in full	Covered in full	Covered in full
Emergency room facility (copay waived if admitted)	\$100 copay	\$150 copay	\$200 copay
Urgent care facility (copay waived if admitted)	\$50 copay	\$50 copay	\$50 copay
Ambulance services (ground and air)	\$100 copay	\$100 copay	\$100 copay
Behavioral services⁶			
Severe mental health (outpatient office visit/inpatient)	\$10 copay / \$250 copay/day (3-day copay max/admit)	\$20 copay / \$500 copay/day (3-day copay max/admit)	\$30 copay / \$750 copay/day (3-day copay max/admit)
Non-severe mental health (outpatient office visit/inpatient)	\$10 copay / \$250 copay/day (3-day copay max/admit)	\$20 copay / \$500 copay/day (3-day copay max/admit)	\$30 copay / \$750 copay/day (3-day copay max/admit)
Chemical dependency rehabilitation (outpatient office visit/inpatient)	\$10 copay / \$250 copay/day (3-day copay max/admit)	\$20 copay / \$500 copay/day (3-day copay max/admit)	\$30 copay / \$750 copay/day (3-day copay max/admit)
Inpatient acute care detoxification	\$250 copay/day (3-day copay max/admit)	\$500 copay/day (3-day copay max/admit)	\$750 copay/day (3-day copay max/admit)
Other services			
Durable medical equipment ²	50%	50%	50%
Orthotics and prosthetics	Covered in full	Covered in full	Covered in full
Diabetic equipment	20%	20%	20%
Acupuncture and chiropractic services	\$15 copay (rider included; 10 visits/ calendar year, chiropractic and acupuncture combined)	\$15 copay (rider included; 10 visits/calendar year, chiropractic and acupuncture combined)	\$15 copay (rider included; 10 visits/calendar year, chiropractic and acupuncture combined)
Prescription drug coverage⁷			
Brand-name calendar year deductible (per member)	\$100	\$150	\$200
Prescription drugs (up to a 30-day supply) ⁸	\$15 / \$40 / \$60	\$15 / \$40 / \$60	\$15 / \$40 / \$60

Plan footnotes found on pages 55–58.

<i>SmartCare HMO 40</i>		<i>SmartCare HMO 50</i>	
Standard (AA3) (AA9) ¹		Standard (AA4) (AAB) ¹	Value (AA5) (AAC) ¹
\$4,500 single / \$9,000 family		\$5,500 single / \$11,000 family	\$5,500 single / \$11,000 family
No maximum		No maximum	No maximum
\$40 copay		\$50 copay	\$50 copay
\$30 copay		\$30 copay	\$30 copay
Covered in full		Covered in full	Covered in full
Covered in full		Covered in full	Covered in full
30%		30%	30%
\$1,000 copay/day (3-day copay max/admit)		\$1,500 copay/day (3-day copay max/admit)	50%
40%		50%	50%
\$1,000 copay		\$1,500 copay	50%
\$750 copay		\$1,250 copay	45%
Days 1–10: Covered in full Days 11–100: \$25/day		Days 1–10: Covered in full Days 11–100: \$25/day	Days 1–10: Covered in full Days 11–100: \$25/day
Covered in full		Covered in full	Covered in full
\$250 copay		\$300 copay	\$300 copay
\$75 copay		\$75 copay	\$75 copay
\$100 copay		\$100 copay	\$100 copay
\$40 copay / \$1,000 copay/day (3-day copay max/admit)		\$50 copay / \$1,500 copay/day (3-day copay max/admit)	\$50 copay / 50%
\$40 copay / \$1,000 copay/day (3-day copay max/admit)		\$50 copay / \$1,500 copay/day (3-day copay max/admit)	\$50 copay / 50%
\$40 copay / \$1,000 copay/day (3-day copay max/admit)		\$50 copay / \$1,500 copay/day (3-day copay max/admit)	\$50 copay / 50%
\$1,000 copay/day (3-day copay max/admit)		\$1,500 copay/day (3-day copay max/admit)	50%
50%		50%	50%
Covered in full		Covered in full	Covered in full
20%		20%	20%
\$15 copay (rider included; 10 visits/calendar year, chiropractic and acupuncture combined)		\$15 copay (rider included; 10 visits/calendar year, chiropractic and acupuncture combined)	\$15 copay (rider included; 10 visits/calendar year, chiropractic and acupuncture combined)
\$250		\$300	\$300
\$15 / \$40 / \$60		\$15 / \$40 / \$60	\$15 / \$40 / \$60

HMO Portfolio

Please note: All highlighted plan boxes reflect standardized benefits between Standard and Value plans.
Dual Network HMO plans also available as standalone plans.

Benefit description	HMO 20 (Dual Network)	HMO 30 (Dual Network)	
	Standard (A4M) ¹	Standard (A4N) ¹	Value (A4P) ¹
Plan maximums			
Out-of-pocket maximum	\$2,000 single / \$4,000 family	\$3,000 single / \$6,000 family	\$3,500 single / \$7,000 family
Lifetime medical benefit maximum	No maximum	No maximum	No maximum
Professional services			
Office visit ²	\$20 copay	\$30 copay	\$30 copay
Specialist consultation ²	\$30 copay	\$40 copay	\$50 copay
Preventive care services ^{2,3}	Covered in full	Covered in full	Covered in full
X-ray and laboratory procedures ^{2,4}	Covered in full	Covered in full	Covered in full
Rehabilitation therapy ⁵	\$20 copay	\$30 copay	\$30 copay
Specialty drugs (medical self injectables and prescription oral specialty drugs)	30%	30%	30%
Hospital services			
Inpatient hospital facility services (includes maternity)	\$250 copay/day (3-day copay max/admit)	\$500 copay/day (3-day copay max/admit)	30%
Outpatient facility services (other than surgery)	20%	30%	30%
Outpatient surgery (hospital or outpatient surgery center charges only)	\$250 copay	\$500 copay	30%
Skilled nursing facility	Days 1–10: Covered in full Days 11–100: \$25/day	Days 1–10: Covered in full Days 11–100: \$25/day	Days 1–10: Covered in full Days 11–100: \$25/day
Emergency services			
Professional services	Covered in full	Covered in full	Covered in full
Emergency room facility (copay waived if admitted)	\$150 copay	\$150 copay	\$150 copay
Urgent care facility	\$50 copay	\$50 copay	\$50 copay
Ambulance services (ground and air)	\$100 copay	\$100 copay	\$100 copay
Behavioral services⁶			
Severe mental health (outpatient office visit/inpatient)	\$20 copay / \$250 copay/day (3-day copay max/admit)	\$30 copay / \$500 copay/day (3-day copay max/admit)	\$30 copay / 30%
Non-severe mental health (outpatient office visit/inpatient)	\$20 copay / \$250 copay/day (3-day copay max/admit)	\$30 copay / \$500 copay/day (3-day copay max/admit)	\$30 copay / 30%
Chemical dependency rehabilitation (outpatient office visit/inpatient)	\$20 copay / \$250 copay/day (3-day copay max/admit)	\$30 copay / \$500 copay/day (3-day copay max/admit)	\$30 copay / 30%
Inpatient acute care detoxification	\$250 copay/day (3-day copay max/admit)	\$500 copay/day (3-day copay max/admit)	30%
Other services			
Durable medical equipment	50%	50%	50%
Orthotics and prosthetics	Covered in full	Covered in full	Covered in full
Diabetic supplies	20%	20%	20%
Acupuncture, chiropractic services ⁷	Optional rider available	Optional rider available	Optional rider available
Prescription drug coverage			
Brand-name calendar year deductible (per member)	No deductible	No deductible	\$200
Prescription drugs (up to a 30-day supply) ⁸	\$15 / \$30 / \$50	\$15 / \$30 / \$50	\$15 / \$30 / \$50

Plan footnotes found on pages 55–58.

HMO 40 (Dual Network)

Value (A4Q) ¹
\$4,500 single / \$9,000 family
No maximum
\$40 copay
\$60 copay
Covered in full
Covered in full
30%
40%
40%
40%
Days 1–10: Covered in full Days 11–100: \$25/day
Covered in full
\$150 copay
\$50 copay
\$100 copay
\$40 copay / 40%
\$40 copay / 40%
\$40 copay / 40%
40%
50%
Covered in full
20%
Optional rider available
\$250
\$15 / \$30 / \$50



Janis E. Carter,
Health Net
We use high-tech to be high touch.



Benefit description	HMO 10		HMO 15
	Standard (A44)(A6F) ¹	Value (A4D) (A6P) ¹	Standard (A45) (A6G) ¹
Plan maximums			
Out-of-pocket maximum	\$1,500 single / \$3,000 family	\$2,000 single / \$4,000 family	\$1,500 single / \$3,000 family
Lifetime medical benefit maximum	No maximum	No maximum	No maximum
Professional services			
Office visit (including specialist consultation) ²	\$10 copay	\$10 copay	\$15 copay
Preventive care services ^{2,3}	Covered in full	Covered in full	Covered in full
X-ray and laboratory procedures ^{2,4}	Covered in full	Covered in full	Covered in full
Rehabilitation therapy ⁵	\$10 copay	\$10 copay	\$15 copay
Specialty drugs (medical self injectables and prescription oral specialty drugs)	30%	30%	30%
Hospital services			
Inpatient hospital facility services (includes maternity)	Covered in full	10%	\$250 copay/day (3-day copay max/admit)
Outpatient facility services (other than surgery)	Covered in full	10%	15%
Outpatient surgery (hospital or outpatient surgery center charges only)	Covered in full	10%	\$250 copay
Skilled nursing facility	Days 1–10: Covered in full Days 11–100: \$25/day	Days 1–10: Covered in full Days 11–100: \$25/day	Days 1–10: Covered in full Days 11–100: \$25/day
Emergency services			
Professional services	Covered in full	Covered in full	Covered in full
Emergency room facility (copay waived if admitted)	\$100 copay	\$100 copay	\$150 copay
Urgent care facility	\$50 copay	\$50 copay	\$50 copay
Ambulance services (ground and air)	\$100 copay	\$100 copay	\$100 copay
Behavioral services⁶			
Severe mental health (outpatient office visit/inpatient)	\$10 copay / Covered in full	\$10 copay / 10%	\$15 copay / \$250 copay/day (3-day copay max/admit)
Non-severe mental health (outpatient office visit/inpatient)	\$10 copay / Covered in full	\$10 copay / 10%	\$15 copay / \$250 copay/day (3-day copay max/admit)
Chemical dependency rehabilitation (outpatient office visit/inpatient)	\$10 copay / Covered in full	\$10 copay / 10%	\$15 copay / \$250 copay/day (3-day copay max/admit)
Inpatient acute care detoxification	Covered in full	10%	\$250 copay/day (3-day copay max/admit)
Other services			
Durable medical equipment	50%	50%	50%
Orthotics and prosthetics	Covered in full	Covered in full	Covered in full
Diabetic supplies	20%	20%	20%
Acupuncture, chiropractic services ⁷	Optional rider available	Optional rider available	Optional rider available
Prescription drug coverage			
Brand-name calendar year deductible (per member)	No deductible	\$100	No deductible
Prescription drugs (up to a 30-day supply) ⁸	\$10 / \$25 / \$50	\$10 / \$25 / \$50	\$15 / \$30 / \$50

HMO 20		HMO 25
Standard (A46) (A6H)¹	Value (A4E) (A6Q)¹	Standard (A47) (A6J)¹
\$2,000 single / \$4,000 family	\$2,500 single / \$5,000 family	\$2,000 single / \$4,000 family
No maximum	No maximum	No maximum
\$20 copay	\$20 copay	\$25 copay
Covered in full	Covered in full	Covered in full
Covered in full	Covered in full	Covered in full
\$20 copay	\$20 copay	\$25 copay
30%	30%	30%
\$250 copay/day (3-day copay max/admit)	20%	\$500 copay/day (3-day copay max/admit)
20%	20%	25%
\$250 copay	20%	\$500 copay
Days 1–10: Covered in full Days 11–100: \$25/day	Days 1–10: Covered in full Days 11–100: \$25/day	Days 1–10: Covered in full Days 11–100: \$25/day
Covered in full	Covered in full	Covered in full
\$100 copay	\$100 copay	\$150 copay
\$50 copay	\$50 copay	\$50 copay
\$100 copay	\$100 copay	\$100 copay
\$20 copay / \$250 copay/day (3-day copay max/admit)	\$20 copay / 20%	\$25 copay / \$500 copay/day (3-day copay max/admit)
\$20 copay / \$250 copay/day (3-day copay max/admit)	\$20 copay / 20%	\$25 copay / \$500 copay/day (3-day copay max/admit)
\$20 copay / \$250 copay/day (3-day copay max/admit)	\$20 copay / 20%	\$25 copay / \$500 copay/day (3-day copay max/admit)
\$250 copay/day (3-day copay max/admit)	20%	\$500 copay/day (3-day copay max/admit)
50%	50%	50%
Covered in full	Covered in full	Covered in full
20%	20%	20%
Optional rider available	Optional rider available	Optional rider available
No deductible	\$150	No deductible
\$15 / \$30 / \$50	\$15 / \$30 / \$50	\$15 / \$30 / \$50

Benefit description	HMO 30		HMO 35
	Standard (A48) (A6K) ¹	Value (A4F) (A6R) ¹	Standard (A49) (A6L) ¹
Plan maximums			
Out-of-pocket maximum	\$3,000 single / \$6,000 family	\$3,500 single / \$7,000 family	\$3,000 single / \$6,000 family
Lifetime medical benefit maximum	No maximum	No maximum	No maximum
Professional services			
Office visit (including specialist consultation) ²	\$30 copay	\$30 copay	\$35 copay
Preventive care services ^{2,3}	Covered in full	Covered in full	Covered in full
X-ray and laboratory procedures ^{2,4}	Covered in full	Covered in full	Covered in full
Rehabilitation therapy ⁵	\$30 copay	\$30 copay	\$35 copay
Specialty drugs (medical self injectables and prescription oral specialty drugs)	30%	30%	30%
Hospital services			
Inpatient hospital facility services (includes maternity)	\$500 copay/day (3-day copay max/admit)	30%	\$750 copay/day (3-day copay max/admit)
Outpatient facility services (other than surgery)	30%	30%	35%
Outpatient surgery (hospital or outpatient surgery center charges only)	\$500 copay	30%	\$750 copay
Skilled nursing facility	Days 1–10: Covered in full Days 11–100: \$25/day	Days 1–10: Covered in full Days 11–100: \$25/day	Days 1–10: Covered in full Days 11–100: \$25/day
Emergency services			
Professional services	Covered in full	Covered in full	Covered in full
Emergency room facility (copay waived if admitted)	\$100 copay	\$100 copay	\$150 copay
Urgent care facility	\$50 copay	\$50 copay	\$50 copay
Ambulance services (ground and air)	\$100 copay	\$100 copay	\$100 copay
Behavioral services⁶			
Severe mental health (outpatient office visit/inpatient)	\$30 copay / \$500 copay/day (3-day copay max/admit)	\$30 copay / 30%	\$35 copay / \$750 copay/day (3-day copay max/admit)
Non-severe mental health (outpatient office visit/inpatient)	\$30 copay / \$500 copay/day (3-day copay max/admit)	\$30 copay / 30%	\$35 copay / \$750 copay/day (3-day copay max/admit)
Chemical dependency rehabilitation (outpatient office visit/inpatient)	\$30 copay / \$500 copay/day (3-day copay max/admit)	\$30 copay / 30%	\$35 copay / \$750 copay/day (3-day copay max/admit)
Inpatient acute care detoxification	\$500 copay/day (3-day copay max/admit)	30%	\$750 copay/day (3-day copay max/admit)
Other services			
Durable medical equipment	50%	50%	50%
Orthotics and prosthetics	Covered in full	Covered in full	Covered in full
Diabetic supplies	20%	20%	20%
Acupuncture, chiropractic services ⁷	Optional rider available	Optional rider available	Optional rider available
Prescription drug coverage			
Brand-name calendar year deductible (per member)	No deductible	\$200	No deductible
Prescription drugs (up to a 30-day supply) ⁸	\$15 / \$30 / \$50	\$15 / \$30 / \$50	\$15 / \$30 / \$50

HMO 40		HMO 50	
Standard (A4B) (A6M)¹	Value (A4G) (A6S)¹	Standard (A4C) (A6N)¹	Value (A4H) (A6T)¹
\$4,000 single / \$8,000 family	\$4,500 single / \$9,000 family	\$4,500 single / \$9,000 family	\$5,500 single / \$11,000 family
No maximum	No maximum	No maximum	No maximum
\$40 copay	\$40 copay	\$50 copay	\$50 copay
Covered in full	Covered in full	Covered in full	Covered in full
Covered in full	Covered in full	Covered in full	Covered in full
\$40 copay	\$40 copay	\$50 copay	\$50 copay
30%	30%	30%	30%
\$1,000 copay/day (3-day copay max/admit)	40%	\$1,500 copay/day (3-day copay max/admit)	50%
40%	40%	50%	50%
\$1,000 copay	40%	\$1,500 copay	50%
Days 1–10: Covered in full Days 11–100: \$25/day	Days 1–10: Covered in full Days 11–100: \$25/day	Days 1–10: Covered in full Days 11–100: \$25/day	Days 1–10: Covered in full Days 11–100: \$25/day
Covered in full	Covered in full	Covered in full	Covered in full
\$100 copay	\$100 copay	\$200 copay	\$300 copay
\$50 copay	\$50 copay	\$50 copay	\$50 copay
\$100 copay	\$100 copay	\$100 copay	\$100 copay
\$40 copay / \$1,000 copay/day (3-day copay max/admit)	\$40 copay / 40%	\$50 copay / \$1,500 copay/day (3-day copay max/admit)	\$50 copay / 50%
\$40 copay / \$1,000 copay/day (3-day copay max/admit)	\$40 copay / 40%	\$50 copay / \$1,500 copay/day (3-day copay max/admit)	\$50 copay / 50%
\$40 copay / \$1,000 copay/day (3-day copay max/admit)	\$40 copay / 40%	\$50 copay / \$1,500 copay/day (3-day copay max/admit)	\$50 copay / 50%
\$1,000 copay/day (3-day copay max/admit)	40%	\$1,500 copay/day (3-day copay max/admit)	50%
50%	50%	50%	50%
Covered in full	Covered in full	Covered in full	Covered in full
20%	20%	20%	20%
Optional rider available	Optional rider available	Optional rider available	Optional rider available
No deductible	\$250	No deductible	\$250
\$15 / \$30 / \$50	\$15 / \$30 / \$50	\$15 / \$30 / \$50	\$15 / \$30 / \$50

Benefit description	Advantage HMO 25 (A4J) (A6U) ¹	Advantage HMO 35 (A4K) (A6V) ¹
Plan maximums		
Out-of-pocket maximum	\$3,000 single / \$6,000 family	\$4,000 single / \$8,000 family
Lifetime medical benefit maximum	No maximum	No maximum
Professional services		
Office visit (including specialist consultation) ²	\$25 copay	\$35 copay
Preventive care services ^{2,3}	Covered in full	Covered in full
X-ray and laboratory procedures ^{2,4}	Covered in full	Covered in full
Rehabilitation therapy ⁵	\$25 copay	\$35 copay
Specialty drugs (medical self injectables and prescription oral specialty drugs)	30%	30%
Hospital services		
Inpatient hospital facility services (includes maternity)	25%	35%
Outpatient facility services (other than surgery)	25%	35%
Outpatient surgery (hospital or outpatient surgery center charges only)	25%	35%
Skilled nursing facility	Days 1–10: Covered in full Days 11–100: \$25/day	Days 1–10: Covered in full Days 11–100: \$25/day
Emergency services		
Professional services	Covered in full	Covered in full
Emergency room facility (copay waived if admitted)	\$100 copay	\$100 copay
Urgent care facility	\$50 copay	\$50 copay
Ambulance services (ground and air)	\$100 copay	\$100 copay
Behavioral services⁶		
Severe mental health (outpatient office visit/inpatient)	\$25 copay / 25%	\$35 copay / 35%
Non-severe mental health (outpatient office visit/inpatient)	\$25 copay / 25%	\$35 copay / 35%
Chemical dependency rehabilitation (outpatient office visit/inpatient)	\$25 copay / 25%	\$35 copay / 35%
Inpatient acute care detoxification	25%	35%
Other services		
Durable medical equipment ²	50%	50%
Orthotics and prosthetics	Covered in full	Covered in full
Diabetic supplies	20%	20%
Acupuncture, chiropractic services ⁷	Optional rider available	Optional rider available
Prescription drug coverage		
Brand-name calendar year deductible (per member)	\$200	\$250
Prescription drugs (up to a 30-day supply) ⁸	\$15 / \$40 / \$60	\$15 / \$40 / \$60

Plan footnotes found on pages 55–58.

Advantage HMO 45 (A4L) (A6W)¹

\$5,000 single / \$10,000 family

No maximum

\$45 copay

Covered in full

Covered in full

\$45 copay

30%

45%

45%

45%

Days 1–10: Covered in full

Days 11–100: \$25/day

Covered in full

\$100 copay

\$50 copay

\$100 copay

\$45 copay / 45%

\$45 copay / 45%

\$45 copay / 45%

45%

50%

Covered in full

20%

Optional rider available

\$300

\$15 / \$40 / \$60

Benefit description	EOA 10		EOA 15
	Standard (C6G) (C6Y) ¹	Value (C6Q) (C76) ¹	Standard (C6V) (C6Z) ¹
Plan maximums			
Out-of-pocket maximum (single / family)	HMO: \$1,500 / \$3,000 PPO: \$4,500 / \$9,000	HMO: \$2,000 / \$4,000 PPO: \$4,500 / \$9,000	HMO: \$1,500 / \$3,000 PPO: \$4,500 / \$9,000
Lifetime medical benefit maximum	No maximum	No maximum	No maximum
Professional services²			
Office visit (including specialist consultation) ³	HMO: \$10 copay PPO: \$25 copay	HMO: \$10 copay PPO: \$25 copay	HMO: \$15 copay PPO: \$30 copay
Preventive care services ^{3,4}	Covered in full	Covered in full	Covered in full
X-ray and laboratory procedures ^{3,5,6}	Covered in full	Covered in full	Covered in full
Rehabilitation therapy ⁷	HMO: \$10 copay PPO: \$25 copay (12 visits/calendar year)	HMO: \$10 copay PPO: \$25 copay (12 visits/calendar year)	HMO: \$15 copay PPO: \$30 copay (12 visits/calendar year)
Specialty drugs (medical self injectables and prescription oral specialty drugs)	30%	30%	30%
Hospital services⁸			
Inpatient hospital facility services (includes maternity)	Covered in full	10%	\$250 copay/day (3-day copay max/admit)
Outpatient facility services (other than surgery)	Covered in full	10%	15%
Outpatient surgery (hospital or outpatient surgery center charges only) ⁶	Covered in full	10%	\$250 copay
Skilled nursing facility	Days 1–10: Covered in full Days 11–100: \$25/day	Days 1–10: Covered in full Days 11–100: \$25/day	Days 1–10: Covered in full Days 11–100: \$25/day
Emergency services			
Professional services	Covered in full	Covered in full	Covered in full
Emergency room facility (copay waived if admitted)	\$100 copay	\$100 copay	\$150 copay
Urgent care facility	\$50 copay	\$50 copay	\$50 copay
Ambulance services (ground and air)	\$100 copay	\$100 copay	\$100 copay
Behavioral services⁹			
Severe mental health (outpatient office visit/inpatient)	\$10 copay / Covered in full	\$10 copay / 10%	\$15 copay / \$250 copay/day (3-day copay max/admit)
Non-severe mental health (outpatient office visit/inpatient)	\$10 copay / Covered in full	\$10 copay / 10%	\$15 copay / \$250 copay/day (3-day copay max/admit)
Chemical dependency rehabilitation (outpatient office visit/inpatient)	\$10 copay / Covered in full	\$10 copay / 10%	\$15 copay / \$250 copay/day (3-day copay max/admit)
Inpatient acute care detoxification	Covered in full	10%	\$250 copay/day (3-day copay max/admit)
Other services			
Durable medical equipment ^{3,8}	50%	50%	50%
Orthotics and prosthetics ⁸	Covered in full	Covered in full	Covered in full
Diabetic supplies ⁸	20%	20%	20%
Acupuncture, chiropractic services ¹⁰	Optional rider available	Optional rider available	Optional rider available
Prescription drug coverage			
Brand-name calendar year deductible (per member)	No deductible	\$100	No deductible
Prescription drugs (up to a 30-day supply) ¹¹	\$10 / \$25 / \$50	\$10 / \$25 / \$50	\$15 / \$30 / \$50

EOA 20		EOA 25		EOA 30	
Standard (C6M) (C70) ¹	Value (C6L) (C77) ¹	Standard (C6W) (C71) ¹		Standard (C6N) (C72) ¹	Value (C6R) (C78) ¹
HMO: \$2,000 / \$4,000 PPO: \$4,500 / \$9,000	HMO: \$2,500 / \$5,000 PPO: \$4,500 / \$9,000	HMO: \$2,000 / \$4,000 PPO: \$4,500 / \$9,000		HMO: \$3,000 / \$6,000 PPO: \$4,500 / \$9,000	HMO: \$3,500 / \$7,000 PPO: \$4,500 / \$9,000
No maximum	No maximum	No maximum		No maximum	No maximum
HMO: \$20 copay PPO: \$35 copay	HMO: \$20 copay PPO: \$35 copay	HMO: \$25 copay PPO: \$40 copay		HMO: \$30 copay PPO: \$45 copay	HMO: \$30 copay PPO: \$45 copay
Covered in full	Covered in full	Covered in full		Covered in full	Covered in full
Covered in full	Covered in full	Covered in full		Covered in full	Covered in full
HMO: \$20 copay PPO: \$35 copay (12 visits/calendar year)	HMO: \$20 copay PPO: \$35 copay (12 visits/calendar year)	HMO: \$25 copay PPO: \$40 copay (12 visits/calendar year)		HMO: \$30 copay PPO: \$45 copay (12 visits/calendar year)	HMO: \$30 copay PPO: \$45 copay (12 visits/calendar year)
30%	30%	30%		30%	30%
\$250 copay/day (3-day copay max/admit)	20%	\$500 copay/day (3-day copay max/admit)		\$500 copay/day (3-day copay max/admit)	30%
20%	20%	25%		30%	30%
\$250 copay	20%	\$500 copay		\$500 copay	30%
Days 1–10: Covered in full Days 11–100: \$25/day	Days 1–10: Covered in full Days 11–100: \$25/day	Days 1–10: Covered in full Days 11–100: \$25/day		Days 1–10: Covered in full Days 11–100: \$25/day	Days 1–10: Covered in full Days 11–100: \$25/day
Covered in full	Covered in full	Covered in full		Covered in full	Covered in full
\$100 copay	\$100 copay	\$150 copay		\$100 copay	\$100 copay
\$50 copay	\$50 copay	\$50 copay		\$50 copay	\$50 copay
\$100 copay	\$100 copay	\$100 copay		\$100 copay	\$100 copay
\$20 copay / \$250 copay/day (3-day copay max/admit)	\$20 copay / 20%	\$25 copay / \$500 copay/day (3-day copay max/admit)		\$30 copay / \$500 copay/day (3-day copay max/admit)	\$30 copay / 30%
\$20 copay / \$250 copay/day (3-day copay max/admit)	\$20 copay / 20%	\$25 copay / \$500 copay/day (3-day copay max/admit)		\$30 copay / \$500 copay/day (3-day copay max/admit)	\$30 copay / 30%
\$20 copay / \$250 copay/day (3-day copay max/admit)	\$20 copay / 20%	\$25 copay / \$500 copay/day (3-day copay max/admit)		\$30 copay / \$500 copay/day (3-day copay max/admit)	\$30 copay / 30%
\$250 copay/day (3-day copay max/admit)	20%	\$500 copay/day (3 day copay max/admit)		\$500 copay/day (3-day copay max/admit)	30%
50%	50%	50%		50%	50%
Covered in full	Covered in full	Covered in full		Covered in full	Covered in full
20%	20%	20%		20%	20%
Optional rider available	Optional rider available	Optional rider available		Optional rider available	Optional rider available
No deductible	\$150	No deductible		No deductible	\$200
\$15 / \$30 / \$50	\$15 / \$30 / \$50	\$15 / \$30 / \$50		\$15 / \$30 / \$50	\$15 / \$30 / \$50

Benefit description ²	EOA 35	EOA 40	
	Standard (C6X) (C73) ¹	Standard (C6P) (C74) ¹	Value (C6S) (C79) ¹
Plan maximums			
Out-of-pocket maximum (single / family)	HMO: \$3,000 / \$6,000 PPO: \$4,500 / \$9,000	HMO: \$4,000 / \$8,000 PPO: \$4,500 / \$9,000	HMO: \$4,500 / \$9,000 PPO: \$4,500 / \$9,000
Lifetime medical benefit maximum	No maximum	No maximum	No maximum
Professional services²			
Office visit (including specialist consultation) ³	HMO: \$35 copay PPO: \$50 copay	HMO: \$40 copay PPO: \$55 copay	HMO: \$40 copay PPO: \$55 copay
Preventive care services ^{3,4}	Covered in full	Covered in full	Covered in full
X-ray and laboratory procedures ^{3,5,6}	Covered in full	Covered in full	Covered in full
Rehabilitation therapy ⁷	HMO: \$35 copay PPO: \$50 copay (12 visits/calendar year)	HMO: \$40 copay PPO: \$55 copay (12 visits/calendar year)	HMO: \$40 copay PPO: \$55 copay (12 visits/calendar year)
Specialty drugs (medical self injectables and prescription oral specialty drugs)	30%	30%	30%
Hospital services⁸			
Inpatient hospital facility services (includes maternity)	\$750 copay/day (3-day copay max/admit)	\$1,000 copay/day (3-day copay max/admit)	40%
Outpatient facility services (other than surgery)	35%	40%	40%
Outpatient surgery (hospital or outpatient surgery center charges only) ⁶	\$750 copay	\$1,000 copay	40%
Skilled nursing facility	Days 1–10: Covered in full Days 11–100: \$25/day	Days 1–10: Covered in full Days 11–100: \$25/day	Days 1–10: Covered in full Days 11–100: \$25/day
Emergency services			
Professional services	Covered in full	Covered in full	Covered in full
Emergency room facility (copay waived if admitted)	\$150 copay	\$100 copay	\$100 copay
Urgent care facility	\$50 copay	\$50 copay	\$50 copay
Ambulance services (ground and air)	\$100 copay	\$100 copay	\$100 copay
Behavioral services⁹			
Severe mental health (outpatient office visit/inpatient)	\$35 copay / \$750 copay/day (3-day copay max/admit)	\$40 copay / \$1,000 copay/day (3-day copay max/admit)	\$40 copay / 40%
Non-severe mental health (outpatient office visit/inpatient)	\$35 copay / \$750 copay/day (3-day copay max/admit)	\$40 copay / \$1,000 copay/day (3-day copay max/admit)	\$40 copay / 40%
Chemical dependency rehabilitation (outpatient office visit/inpatient)	\$35 copay / \$750 copay/day (3-day copay max/admit)	\$40 copay / \$1,000 copay/day (3-day copay max/admit)	\$40 copay / 40%
Inpatient acute care detoxification	\$750 copay/day (3 day copay max/admit)	\$1,000 copay/day (3-day copay max/admit)	40%
Other services			
Durable medical equipment ^{3,8}	50%	50%	50%
Orthotics and prosthetics ⁸	Covered in full	Covered in full	Covered in full
Diabetic supplies ⁸	20%	20%	20%
Acupuncture, chiropractic services ¹⁰	Optional rider available	Optional rider available	Optional rider available
Prescription drug coverage			
Brand-name calendar year deductible (per member)	No deductible	No deductible	\$250
Prescription drugs (up to a 30-day supply) ¹¹	\$15 / \$30 / \$50	\$15 / \$30 / \$50	\$15 / \$30 / \$50

EOA 50

Standard (C6U) (C75)¹	Value (C6T) (C7B)¹
HMO: \$4,500 / \$9,000 PPO: \$4,500 / \$9,000	HMO: \$5,500 / \$11,000 PPO: \$4,500 / \$9,000
No maximum	No maximum
HMO: \$50 copay PPO: \$65 copay	HMO: \$50 copay PPO: \$65 copay
Covered in full	Covered in full
Covered in full	Covered in full
HMO: \$50 copay PPO: \$65 copay (12 visits/calendar year)	HMO: \$50 copay PPO: \$65 copay (12 visits/calendar year)
30%	30%
\$1,500 copay/day (3-day copay max/admit)	50%
50%	50%
\$1,500 copay	50%
Days 1–10: Covered in full Days 11–100: \$25/day	Days 1–10: Covered in full Days 11–100: \$25/day
Covered in full	Covered in full
\$200 copay	\$300 copay
\$50 copay	\$50 copay
\$100 copay	\$100 copay
\$50 copay / \$1,500 copay/day (3-day copay max/admit)	\$50 copay / 50%
\$50 copay / \$1,500 copay/day (3-day copay max/admit)	\$50 copay / 50%
\$50 copay / \$1,500 copay/day (3-day copay max/admit)	\$50 copay / 50%
\$1,500 copay/day (3 day copay max/admit)	50%
50%	50%
Covered in full	Covered in full
20%	20%
Optional rider available	Optional rider available
No deductible	\$250
\$15 / \$30 / \$50	\$15 / \$30 / \$50

Benefit description	Advantage EOA 25 (C6H) (C7C) ¹	Advantage EOA 35 (C6J) (C7D) ¹
Plan maximums		
Out-of-pocket maximum (single / family)	HMO: \$3,000 / \$6,000 PPO: \$4,500 / \$9,000	HMO: \$4,000 / \$8,000 PPO: \$4,500 / \$9,000
Lifetime medical benefit maximum	No maximum	No maximum
Professional services²		
Office visit (including specialist consultation) ³	HMO: \$25 copay PPO: \$45 copay	HMO: \$35 copay PPO: \$55 copay
Preventive care services ^{3,4}	Covered in full	Covered in full
X-ray and laboratory procedures ^{3,5,6}	Covered in full	Covered in full
Rehabilitation therapy ⁷	HMO: \$25 copay / PPO: \$45 copay (12 visits/calendar year)	HMO: \$35 copay / PPO: \$55 copay (12 visits/calendar year)
Specialty drugs (medical self injectables and prescription oral specialty drugs)	30%	30%
Hospital services⁸		
Inpatient hospital facility services (includes maternity)	25%	35%
Outpatient facility services (other than surgery)	25%	35%
Outpatient surgery (hospital or outpatient surgery center charges only) ⁶	25%	35%
Skilled nursing facility	Days 1–10: Covered in full Days 11–100: \$25/day	Days 1–10: Covered in full Days 11–100: \$25/day
Emergency services		
Professional services	Covered in full	Covered in full
Emergency room facility (copay waived if admitted)	\$100 copay	\$100 copay
Urgent care facility	\$50 copay	\$50 copay
Ambulance services (ground and air)	\$100 copay	\$100 copay
Behavioral services⁹		
Severe mental health (outpatient office visit/inpatient)	\$25 copay / 25%	\$35 copay / 35%
Non-severe mental health (outpatient office visit/inpatient)	\$25 copay / 25%	\$35 copay / 35%
Chemical dependency rehabilitation (outpatient office visit/inpatient)	\$25 copay / 25%	\$35 copay / 35%
Inpatient acute care detoxification	25%	35%
Other services		
Durable medical equipment ^{3,8}	50%	50%
Orthotics and prosthetics ⁸	Covered in full	Covered in full
Diabetic supplies ⁸	20%	20%
Acupuncture, chiropractic services ¹⁰	Optional rider available	Optional rider available
Prescription drug coverage		
Brand-name calendar year deductible (per member)	\$200	\$250
Prescription drugs (up to a 30-day supply) ¹¹	\$15 / \$40 / \$60	\$15 / \$40 / \$60

Plan footnotes found on pages 55–58.

Advantage EOA 45 (C6K) (C7E)¹

HMO: \$5,000 / \$10,000

PPO: \$4,500 / \$9,000

No maximum

HMO: \$45 copay

PPO: \$65 copay

Covered in full

Covered in full

HMO: \$45 copay / PPO: \$65 copay
(12 visits/calendar year)

30%

45%

45%

45%

Days 1–10: Covered in full
Days 11–100: \$25/day

Covered in full

\$100 copay

\$50 copay

\$100 copay

\$45 copay / 45%

\$45 copay / 45%

\$45 copay / 45%

45%

50%

Covered in full

20%

Optional rider available

\$300

\$15 / \$40 / \$60

POS Portfolio

Benefit description ¹	POS 10 (AAY)		
	HMO	PPO ²	Out-of-network ^{3,4}
Plan maximums			
Calendar year deductible (single / family)	No deductible	\$250 / \$500	\$500 / \$1,000
Out-of-pocket maximum (single / family)	\$1,500 / \$3,000	\$3,000 / \$6,000	\$6,000 / \$12,000
Lifetime medical benefit maximum	No maximum		
Professional services			
Office visit (including specialist consultation) ⁵	\$10 copay	\$20 copay	50%
Preventive care services ^{5,6}	Covered in full	Covered in full	Not covered
X-ray and laboratory procedures ⁵	Covered in full	10%	50%
Rehabilitation therapy ⁷	\$10 copay	10% (12 visits/calendar year, PPO and OON combined)	50%
Specialty drugs (medical self injectables and prescription oral specialty drugs)	30%	30%	50%
Hospital services			
Inpatient hospital facility services (includes maternity)	Covered in full	10% ⁸ (\$250 deductible/calendar year, PPO and OON combined) ⁹	50% (\$600 maximum allowable/day) ⁸
Outpatient facility services (other than surgery)	Covered in full	10% ⁸	50% (50% maximum allowable) ⁸
Outpatient surgery (hospital or outpatient surgery center charges only)	Covered in full	10% ⁸ (\$250 deductible/calendar year, PPO and OON combined) ¹⁰	50% (50% maximum allowable) ⁸
Skilled nursing facility	Days 1–10: Covered in full Days 11–100: \$25/day	10% ⁸ (\$250 deductible/calendar year, PPO and OON combined) ⁹	50% (\$250 maximum allowable/day) ⁸
Emergency services			
Professional services	Covered in full	10%	50%
Emergency room facility (copay waived if admitted)	\$100 copay	\$100 copay + 10%	\$100 copay + 50%
Urgent care facility	\$50 copay	\$50 copay + 10%	\$50 copay + 50%
Ambulance services (ground and air)	\$100 copay	\$50 copay + 10% ⁸ (Air limited to a maximum of \$750 each incident. Ground limited to a maximum distance of 75 miles an incident through PPO and out-of-network.)	\$50 copay + 50% ⁸
Behavioral services¹¹			
Severe mental health (outpatient office visit/inpatient)	\$10 copay / Covered in full	\$20 copay/10% ⁸ (\$250 deductible/calendar year, PPO and out-of-network combined) ⁹	50%/50% ⁸
Non-severe mental health (outpatient office visit/inpatient)	\$10 copay / Covered in full	\$20 copay/10% ⁸ (\$250 deductible/calendar year, PPO and out-of-network combined) ⁹	50%/50% ⁸
Chemical dependency rehabilitation (outpatient office visit/inpatient)	\$10 copay / Covered in full	\$20 copay/10% ⁸ (\$250 deductible/calendar year, PPO and out-of-network combined) ⁹	50%/50% ⁸
Inpatient acute care detoxification	Covered in full	10% ⁸ (\$250 deductible/calendar year, PPO and out-of-network combined) ⁹	50% ⁸
Other services			
Durable medical equipment ⁵	50%	50% ⁹	
Orthotics	Covered in full	10% ⁸	50% ⁸
Prosthetics	Covered in full	10% ⁸	50% ⁸
Diabetic supplies	20%	10% ⁸	50% ⁸
Chiropractic services ¹²	\$10 copay	\$20 copay (12 visits/calendar year)	Not covered
Acupuncture ¹²	\$10 copay	Not covered	
Prescription drug coverage^{13,14}			
Calendar year deductible (per member)	\$100 brand deductible	\$100 brand deductible	\$100
Prescription drugs (up to a 30-day supply) ¹⁴	\$10 / \$25 / \$50		50%

POS 20 (AAZ)

HMO	PPO²	Out-of-network^{3,4}
No deductible	\$500 / \$1,000	\$1,000 / \$2,000
\$2,000 / \$4,000	\$3,500 / \$7,000	\$7,000 / \$14,000
No maximum		
\$20 copay	\$30 copay	50%
Covered in full	Covered in full	Not covered
Covered in full	20% ⁸	50% ⁸
\$20 copay	20% ⁸ (12 visits/calendar year, PPO and OON combined)	50% ⁸
30%	30% ⁸	50% ⁸
\$250 copay/day (3-day copay maximum)	20% ⁸ (\$250 deductible/calendar year, PPO and OON combined) ⁹	50% (\$600 maximum allowable/day) ⁸
20%	20% ⁸	50% (50% maximum allowable) ⁸
\$250 copay	20% ⁸ (\$250 deductible/calendar year, PPO and OON combined) ⁹	50% (50% maximum allowable) ⁸
Days 1–10: Covered in full Days 11–100: \$25/day	20% ⁸ (\$250 deductible/calendar year, PPO and OON combined) ⁹	50% (\$250 maximum allowable/day) ⁸
Covered in full	20%	50%
\$100 copay	\$100 copay + 20%	\$100 + 50%
\$50 copay	\$50 copay + 20%	\$50 + 50%
\$100 copay	\$50 copay + 20% ⁸	\$50 copay + 50% ⁸
\$20 copay / \$250/day (3-day copay max/admit)	\$30 copay/20% ⁸ (\$250 deductible/calendar year, PPO and OON combined) ⁹	50%/50% ⁸
\$20 copay / \$250/day (3-day copay max/admit)	\$30 copay/20% ⁸ (\$250 deductible/calendar year, PPO and OON combined) ⁹	50%/50% ⁸
\$20 copay / \$250/day (3-day copay max/admit)	\$30 copay/20% ⁸ (\$250 deductible/calendar year, PPO and OON combined) ⁹	50%/50% ⁸
\$250 copay/day (3-day copay max/admit)	20% (\$250 deductible/calendar year, PPO and OON combined) ⁹	50%
50%	50% ⁸	
Covered in full	20% ⁸	50% ⁸
Covered in full	20% ⁸	50% ⁸
20%	20% ⁸	50% ⁸
\$20 copay	\$30 copay (12 visits/calendar year)	Not covered
\$20 copay	Not covered	Not covered
\$100 brand deductible	\$100 brand deductible	\$100
\$15 / \$30 / \$50		50%

Benefit description ¹	PPO 10			
	Standard (AD0)		Value (AD8)	
	PPO ²	Out-of-network ³	PPO ²	Out-of-network ³
Plan maximums				
Calendar year deductible (single / family)	No deductible	\$500 / \$1,000	\$1,000 / \$2,000	\$2,000 / \$4,000
Out-of-pocket maximum (single / family)	\$2,500 / \$5,000	\$5,000 / \$10,000	\$2,500 / \$5,000	\$5,000 / \$10,000
Lifetime medical benefit maximum	No maximum		No maximum	
Professional services				
Office visit ⁴	\$10 copay (deductible waived)	40%	\$10 copay (deductible waived)	40%
Specialist consultation ⁴	\$10 copay (deductible waived)	40%	\$10 copay (deductible waived)	40%
Preventive care services ^{4,5}	Covered in full	Not covered	Covered in full	Not covered
X-ray and laboratory procedures ^{4,6}	10%	40%	20%	40%
Rehabilitation therapy ^{6,7}	10%	40%	20%	40%
	(12 visits/calendar year, PPO and OON combined)		(12 visits/calendar year, PPO and OON combined)	
Hospital services⁶				
Inpatient hospital facility services (includes maternity)	10%	40%	20%	40%
Outpatient facility services (other than surgery)	10%	40%	20%	40%
Outpatient surgery (hospital or outpatient surgery center charges only)	10%	40%	20%	40%
Skilled nursing facility	10%	40%	20%	40%
	(100 days/calendar year, PPO and OON combined)		(100 days/calendar year, PPO and OON combined)	
Emergency services				
Professional services	\$10 copay (deductible waived)		\$10 copay (deductible waived)	
Emergency room facility (copay waived if admitted)	\$100 copay + 10%		\$100 copay + 20%	
Urgent care facility	\$50 copay + 10%		\$50 copay + 20%	
Ambulance services (ground and air) ⁶	\$50 copay + 10%	\$50 copay + 40%	\$50 copay + 20%	\$50 copay + 40%
Behavioral services⁶				
Severe mental health (outpatient office visit/inpatient)	\$10 copay (deductible waived) / 10%	40%	\$10 copay (deductible waived) / 20%	40%
Non-severe mental health (outpatient office visit/inpatient)	\$10 copay (deductible waived) / 10%	40%	\$10 copay (deductible waived) / 20%	40%
Chemical dependency rehabilitation (outpatient office visit/inpatient)	\$10 copay (deductible waived) / 10%	40%	\$10 copay (deductible waived) / 20%	40%
Inpatient acute care detoxification	10%	40%	20%	40%
Other services				
Durable medical equipment ^{4,6}	10%	40%	20%	40%
Orthotics and prosthetics ⁶	10%	40%	20%	40%
Diabetic supplies	10%	40%	20%	40%
Chiropractic services	\$10 copay (deductible waived) (12 visits/calendar year)	Not covered	\$10 copay (deductible waived) (12 visits/calendar year)	Not covered
Acupuncture	10%	40%	20%	40%
	(12 visits/calendar year, PPO and OON combined)		(12 visits/calendar year, PPO and OON combined)	
Prescription drug coverage¹⁰				
Calendar year deductible (per insured)	No deductible	\$100	\$100 brand deductible	\$100
Prescription drugs (up to a 30-day supply) ¹¹	\$10 / \$25 / \$50	50%	\$10 / \$25 / \$50	50%
Specialty drugs (most self-injectables)	30% (\$250 copay maximum per prescription)	Not covered	30% (\$250 copay maximum per prescription)	Not covered

PPO 15

Standard (AD1)		Value (AD9)	
PPO²	Out-of-network³	PPO²	Out-of-network³
\$250 / \$500	\$500 / \$1,000	\$750 / \$1,500	\$1,500 / \$3,000
\$3,000 / \$6,000	\$6,000 / \$12,000	\$4,000 / \$8,000	\$8,000 / \$16,000
No maximum		No maximum	
\$15 copay (deductible waived)	50%	\$15 copay (deductible waived)	50%
\$25 copay (deductible waived)	50%	\$25 copay (deductible waived)	50%
Covered in full	Not covered	Covered in full	Not covered
15%	50%	25%	50%
15%	50%	25%	50%
(12 visits/calendar year, PPO and OON combined)		(12 visits/calendar year, PPO and OON combined)	
15%	50%	25%	50%
(\$250 deductible/calendar year, PPO and OON combined) ⁸		(\$250 deductible/calendar year, PPO and OON combined) ⁸	
15%	50%	25%	50%
15%	50%	25%	50%
15%	50%	25%	50%
(100 days/calendar year, PPO and OON combined)		(100 days/calendar year, PPO and OON combined)	
\$15 copay (deductible waived)		\$15 copay (deductible waived)	
\$200 copay + 15%		\$250 copay + 25%	
\$50 copay + 15%		\$50 copay + 25%	
\$50 copay + 15%	\$50 copay + 50%	\$50 copay + 25%	\$50 copay + 50%
\$15 copay (deductible waived) / 15%	50%	\$15 copay (deductible waived) / 25%	50%
\$15 copay (deductible waived) / 15%	50%	\$15 copay (deductible waived) / 25%	50%
\$15 copay (deductible waived) / 15%	50%	\$15 copay (deductible waived) / 25%	50%
15%	50%	25%	50%
15%	50%	25%	50%
15%	50%	25%	50%
15%	50%	25%	50%
\$15 copay (deductible waived) (12 visits/calendar year)	Not covered	\$15 copay (deductible waived) (12 visits/calendar year)	Not covered
15%	50%	25%	50%
(12 visits/calendar year, PPO and OON combined)		(12 visits/calendar year, PPO and OON combined)	
No deductible	\$100	\$100 brand deductible	\$100
\$10 / \$25 / \$50	50%	\$10 / \$25 / \$50	50%
30% (\$250 copay maximum per prescription)	Not covered	30% (\$250 copay maximum per prescription)	Not covered

Benefit description ¹	PPO 20			
	Standard (AD2)		Value (ADB)	
	PPO ²	Out-of-network ³	PPO ²	Out-of-network ³
Plan maximums				
Calendar year deductible (single / family)	\$250 / \$500	\$500 / \$1,000	\$1,250 / \$2,500	\$2,500 / \$5,000
Out-of-pocket maximum (single / family)	\$3,000 / \$6,000	\$6,000 / \$12,000	\$3,500 / \$7,000	\$7,000 / \$14,000
Lifetime medical benefit maximum	No maximum		No maximum	
Professional services				
Office visit ³	\$20 copay (deductible waived)	50%	\$20 copay (deductible waived)	50%
Specialist consultation ⁴	\$20 copay (deductible waived)	50%	\$20 copay (deductible waived)	50%
Preventive care services ^{4,5}	Covered in full	Not covered	Covered in full	Not covered
X-ray and laboratory procedures ^{4,6}	10%	50%	20%	50%
Rehabilitation therapy ^{6,7}	10%	50%	20%	50%
	(12 visits/calendar year, PPO and OON combined)		(12 visits/calendar year, PPO and OON combined)	
Hospital services⁶				
Inpatient hospital facility services (includes maternity)	10%	50%	20%	50%
	(\$250 deductible/calendar year, PPO and OON combined) ⁸		(\$250 deductible/calendar year, PPO and OON combined) ⁸	
Outpatient facility services (other than surgery)	10%	50%	20%	50%
Outpatient surgery (hospital or outpatient surgery center charges only)	10%	50%	20%	50%
	(\$250 deductible/calendar year, PPO and OON combined) ⁹		(\$250 deductible/calendar year, PPO and OON combined) ⁹	
Skilled nursing facility	10%	50%	20%	50%
	(100 visits and \$250 deductible/calendar year, PPO and OON combined) ⁸		(100 visits and \$250 deductible/calendar year, PPO and OON combined) ⁸	
Emergency services				
Professional services	\$20 copay (deductible waived)		\$20 copay (deductible waived)	
Emergency room facility (copay waived if admitted)	\$100 copay + 10%		\$100 copay + 20%	
Urgent care facility	\$50 copay + 10%		\$50 copay + 20%	
Ambulance services (ground and air) ⁶	\$50 copay + 10%	\$50 copay + 50%	\$50 copay + 20%	\$50 copay + 50%
Behavioral services⁶				
Severe mental health (outpatient office visit/inpatient)	\$20 copay (deductible waived) / 10%	50% / 50%	\$20 copay (deductible waived) / 20%	50% / 50%
	(\$250 deductible/calendar year, PPO and OON combined) ⁸		(\$250 deductible/calendar year, PPO and OON combined) ⁸	
Non-severe mental health (outpatient office visit/inpatient)	\$20 copay (deductible waived) / 10%	50%	\$20 copay (deductible waived) / 20%	50% / 50%
Chemical dependency rehabilitation (outpatient office visit/inpatient)	\$20 copay (deductible waived) / 10%	50%	\$20 copay (deductible waived) / 20%	50% / 50%
Inpatient acute care detoxification	10%	50%	20%	50%
Other services				
Durable medical equipment ^{4,6}	10%	50%	20%	50%
Orthotics and prosthetics ⁶	10%	50%	20%	50%
Diabetic supplies	10%	50%	20%	50%
Chiropractic services	\$20 copay (deductible waived) (12 visits/calendar year)	Not covered	\$20 copay (deductible waived) (12 visits/calendar year)	Not covered
Acupuncture	10%	50%	20%	50%
	(12 visits/calendar year, PPO and OON combined)		(12 visits/calendar year, PPO and OON combined)	
Prescription drug coverage¹⁰				
Calendar year deductible (per insured)	No deductible	\$100	\$150 brand deductible	\$100
Prescription drugs (up to a 30-day supply) ¹¹	\$15 / \$30 / \$50	50%	\$15 / \$30 / \$50	50%
Specialty drugs (most self-injectables)	30% (\$250 copay maximum per prescription)	Not covered	30% (\$250 copay maximum per prescription)	Not covered

PPO 25

Standard (AD3)		Value (ADC)	
PPO²	Out-of-network³	PPO²	Out-of-network³
\$500 / \$1,000	\$1,000 / \$2,000	\$1,000 / \$2,000	\$2,000 / \$4,000
\$3,500 / \$7,000	\$7,000 / \$14,000	\$5,000 / \$10,000	\$10,000 / \$20,000
No maximum		No maximum	
\$25 copay (deductible waived)	50%	\$25 copay (deductible waived)	50%
\$35 copay (deductible waived)	50%	\$35 copay (deductible waived)	50%
Covered in full	Not covered	Covered in full	Not covered
25%	50%	35%	50%
25%	50%	35%	50%
(12 visits/calendar year, PPO and OON combined)		(12 visits/calendar year, PPO and OON combined)	
25%	50%	35%	50%
(\$250 deductible/calendar year, PPO and OON combined) ⁸		(\$250 deductible/calendar year, PPO and OON combined) ⁸	
25%	50%	35%	50%
25%	50%	35%	50%
(\$250 deductible/calendar year, PPO and OON combined) ⁹		(\$250 deductible/calendar year, PPO and OON combined) ⁹	
25%	50%	35%	50%
(100 visits and \$250 deductible/calendar year, PPO and OON combined) ⁸		(100 visits and \$250 deductible/calendar year, PPO and OON combined) ⁸	
\$25 copay (deductible waived)		\$25 copay (deductible waived)	
\$200 copay + 25%		\$250 copay + 35%	
\$50 copay + 25%		\$50 copay + 35%	
\$50 copay + 25%	\$50 copay + 50%	\$50 copay + 35%	\$50 copay + 50%
\$25 copay (deductible waived) / 25%	50% / 50%	\$25 copay (deductible waived) / 35%	50% / 50%
(\$250 deductible/calendar year, PPO and OON combined) ⁸		(\$250 deductible/calendar year, PPO and OON combined) ⁸	
\$25 copay (deductible waived) / 25%	50%	\$25 copay (deductible waived) / 35%	50%
\$25 copay (deductible waived) / 25%	50%	\$25 copay (deductible waived) / 35%	50%
25%	50%	35%	50%
25%	50%	35%	50%
25%	50%	35%	50%
\$25 copay (deductible waived) (12 visits/calendar year)	Not covered	\$25 copay (deductible waived) (12 visits/calendar year)	Not covered
25%	50%	35%	50%
(12 visits/calendar year, PPO and OON combined)		(12 visits/calendar year, PPO and OON combined)	
No deductible	\$100	\$150 brand deductible	\$100
\$15 / \$30 / \$50	50%	\$15 / \$30 / \$50	50%
30% (\$250 copay maximum per prescription)	Not covered	30% (\$250 copay maximum per prescription)	Not covered

Benefit description ¹	PPO 30			
	Standard (AD4)		Value (ADD)	
	PPO ²	Out-of-network ³	PPO ²	Out-of-network ³
Plan maximums				
Calendar year deductible (single / family)	\$500 / \$1,000	\$1,000 / \$2,000	\$1,500 / \$3,000	\$3,000 / \$6,000
Out-of-pocket maximum (single / family)	\$3,500 / \$7,000	\$7,000 / \$14,000	\$4,500 / \$9,000	\$9,000 / \$18,000
Lifetime medical benefit maximum	No maximum		No maximum	
Professional services				
Office visit ³	\$30 copay (deductible waived)	50%	\$30 copay (deductible waived)	50%
Specialist consultation ⁴	\$30 copay (deductible waived)	50%	\$30 copay (deductible waived)	50%
Preventive care services ^{4,5}	Covered in full	Not covered	Covered in full	Not covered
X-ray and laboratory procedures ^{4,6}	20%	50%	30%	50%
Rehabilitation therapy ^{6,7}	20%	50%	30%	50%
	(12 visits/calendar year, PPO and OON combined)		(12 visits/calendar year, PPO and OON combined)	
Hospital services⁵				
Inpatient hospital facility services (includes maternity)	20%	50%	30%	50%
	(\$250 deductible/calendar year, PPO and OON combined) ⁸		(\$250 deductible/calendar year, PPO and OON combined) ⁸	
Outpatient facility services (other than surgery)	20%	50%	30%	50%
Outpatient surgery (hospital or outpatient surgery center charges only)	20%	50%	30%	50%
	(\$250 deductible/calendar year, PPO and OON combined) ⁹		(\$250 deductible/calendar year, PPO and OON combined) ⁹	
Skilled nursing facility	20%	50%	30%	50%
	(100 visits and \$250 deductible/calendar year, PPO and OON combined) ⁸		(100 visits and \$250 deductible/calendar year, PPO and OON combined) ⁸	
Emergency services				
Professional services	\$30 copay (deductible waived)		\$30 copay (deductible waived)	
Emergency room facility (copay waived if admitted)	\$100 copay + 20%		\$100 copay + 30%	
Urgent care facility	\$50 copay + 20%		\$50 copay + 30%	
Ambulance services (ground and air) ⁶	\$50 copay + 20%	\$50 copay + 50%	\$50 copay + 30%	\$50 copay + 50%
Behavioral services⁶				
Severe mental health (outpatient/inpatient)	\$30 copay (deductible waived) / 20%	50% / 50%	\$30 copay (deductible waived) / 30%	50% / 50%
	(\$250 deductible/calendar year, PPO and OON combined) ⁸		(\$250 deductible/calendar year, PPO and OON combined) ⁸	
Non-severe mental health (outpatient office visit/inpatient)	\$30 copay (deductible waived) / 20%	50%	\$30 copay (deductible waived) / 30%	50% / 50%
Chemical dependency rehabilitation (outpatient office visit/inpatient)	\$30 copay (deductible waived) / 20%	50%	\$30 copay (deductible waived) / 30%	50% / 50%
Inpatient acute care detoxification	20%	50%	30%	50%
Other services				
Durable medical equipment ^{4,6}	20%	50%	30%	50%
Orthotics and prosthetics ⁶	20%	50%	30%	50%
Diabetic supplies	20%	50%	30%	50%
Chiropractic services	\$30 copay (deductible waived) (12 visits/calendar year)	Not covered	\$30 copay (deductible waived) (12 visits/calendar year)	Not covered
Acupuncture	20%	50%	30%	50%
	(12 visits/calendar year, PPO and OON combined)		(12 visits/calendar year, PPO and OON combined)	
Prescription drug coverage¹⁰				
Calendar year deductible (per insured)	No deductible	\$100	\$200 brand deductible	\$100
Prescription drugs (up to a 30-day supply) ¹¹	\$15 / \$30 / \$50	50%	\$15 / \$30 / \$50	50%
Specialty drugs (most self-injectables)	30% (\$250 copay maximum per prescription)	Not covered	30% (\$250 copay maximum per prescription)	Not covered

PPO 35

Standard (AD5)		Value (ADE)	
PPO²	Out-of-network³	PPO²	Out-of-network³
\$750 / \$1,500	\$1,500 / \$3,000	\$1,250 / \$2,500	\$2,500 / \$5,000
\$4,000 / \$8,000	\$8,000 / \$16,000	\$6,000 / \$12,000	\$12,000 / \$24,000
No maximum		No maximum	
\$35 copay (deductible waived)	50%	\$35 copay (deductible waived)	50%
\$45 copay (deductible waived)	50%	\$45 copay (deductible waived)	50%
Covered in full	Not covered	Covered in full	Not covered
35%	50%	45%	50%
35%	50%	45%	50%
(12 visits/calendar year, PPO and OON combined)		(12 visits/calendar year, PPO and OON combined)	
35%	50%	45%	50%
(\$250 deductible/calendar year, PPO and OON combined) ⁸		(\$250 deductible/calendar year, PPO and OON combined) ⁸	
35%	50%	45%	50%
35%	50%	45%	50%
(\$250 deductible/calendar year, PPO and OON combined) ⁹		(\$250 deductible/calendar year, PPO and OON combined) ⁹	
35%	50%	45%	50%
(100 visits and \$250 deductible/calendar year, PPO and OON combined) ⁸		(100 visits and \$250 deductible/calendar year, PPO and OON combined) ⁸	
\$35 copay (deductible waived)		\$35 copay (deductible waived)	
\$200 copay + 35%		\$250 copay + 45%	
\$50 copay + 35%		\$50 copay + 45%	
\$50 copay + 35%	\$50 copay + 50%	\$50 copay + 45%	\$50 copay + 50%
\$35 copay (deductible waived) / 35%	50% / 50%	\$35 copay (deductible waived) / 45%	50% / 50%
(\$250 deductible/calendar year, PPO and OON combined) ⁸		(\$250 deductible/calendar year, PPO and OON combined) ⁸	
\$35 copay (deductible waived) / 35%	50%	\$35 copay (deductible waived) / 45%	50%
\$35 copay (deductible waived) / 35%	50%	\$35 copay (deductible waived) / 45%	50%
35%	50%	45%	50%
35%	50%	45%	50%
35%	50%	45%	50%
35%	50%	45%	50%
\$35 copay (deductible waived) (12 visits/calendar year)	Not covered	\$35 copay (deductible waived) (12 visits/calendar year)	Not covered
35%	50%	45%	50%
(12 visits/calendar year, PPO and OON combined)		(12 visits/calendar year, PPO and OON combined)	
No deductible	\$100	\$200 brand deductible	\$100
\$15 / \$30 / \$50	50%	\$15 / \$30 / \$50	50%
30% (\$250 copay maximum per prescription)	Not covered	30% (\$250 copay maximum per prescription)	Not covered

Benefit description ¹	PPO 40			
	Standard (AD6)		Value (ADF)	
	PPO ²	Out-of-network ³	PPO ²	Out-of-network ³
Plan maximums				
Calendar year deductible (single / family)	\$500 / \$1,000	\$1,000 / \$2,000	\$1,500 / \$3,000	\$3,000 / \$6,000
Out-of-pocket maximum (single / family)	\$5,000 / \$10,000	\$10,000 / \$20,000	\$5,000 / \$10,000	\$10,000 / \$20,000
Lifetime medical benefit maximum	No maximum		No maximum	
Professional services				
Office visit ⁴	\$40 copay (deductible waived)	50%	\$40 copay (deductible waived)	50%
Specialist consultation ⁴	\$40 copay (deductible waived)	50%	\$40 copay (deductible waived)	50%
Preventive care services ^{4,5}	Covered in full	Not covered	Covered in full	Not covered
X-ray and laboratory procedures ^{4,6}	40%	50%	50%	50%
Rehabilitation therapy ^{6,7}	40%	50%	50%	50%
	(12 visits/calendar year, PPO and OON combined)		(12 visits/calendar year, PPO and OON combined)	
Hospital services⁶				
Inpatient hospital facility services (includes maternity)	40%	50%	50%	50%
	(\$500 deductible/calendar year, PPO and OON combined) ⁸		(\$500 deductible/calendar year, PPO and OON combined) ⁸	
Outpatient facility services (other than surgery)	40%	50%	50%	50%
Outpatient surgery (hospital or outpatient surgery center charges only)	40%	50%	50%	50%
	(\$250 deductible/calendar year, PPO and OON combined) ⁹		(\$250 deductible/calendar year, PPO and OON combined) ⁹	
Skilled nursing facility	40%	50%	50%	50%
	(100 visits and \$500 deductible/calendar year, PPO and OON combined) ⁸		(100 visits and \$500 deductible/calendar year, PPO and OON combined) ⁸	
Emergency services				
Professional services	\$40 copay (deductible waived)		\$40 copay (deductible waived)	
Emergency room facility (copay waived if admitted)	\$100 copay + 40%		\$100 copay + 50%	
Urgent care facility	\$50 copay + 40%		\$50 copay + 50%	
Ambulance services (ground and air) ⁶	\$50 copay + 40%	\$50 copay + 50%	\$50 copay + 50%	
Behavioral services⁶				
Severe mental health (outpatient/inpatient)	\$40 copay (deductible waived) / 40%	50% / 50%	\$40 copay (deductible waived) / 50%	50% / 50%
	(\$500 deductible/calendar year, PPO and OON combined) ⁸		(\$500 deductible/calendar year, PPO and OON combined) ⁸	
Non-severe mental health (outpatient/inpatient)	\$40 copay (deductible waived) / 40%	50% / 50%	\$40 copay (deductible waived) / 50%	50% / 50%
Chemical dependency rehabilitation (outpatient/inpatient)	\$40 copay (deductible waived) / 40%	50% / 50%	\$40 copay (deductible waived) / 50%	50% / 50%
Inpatient acute care detoxification	40%	50%	50%	50%
Other services				
Durable medical equipment ^{4,6}	40%	50%	50%	50%
Orthotics and prosthetics ⁶	40%	50%	50%	50%
Diabetic supplies	40%	50%	50%	50%
Chiropractic services	\$40 copay (deductible waived) (12 visits/calendar year)	Not covered	\$40 copay (deductible waived) (12 visits/calendar year)	Not covered
Acupuncture	40%	50%	50%	50%
	(12 visits/calendar year, PPO and OON combined)		(12 visits/calendar year, PPO and OON combined)	
Prescription drug coverage¹⁰				
Calendar year deductible (per insured)	No deductible	\$100	\$250 brand deductible	\$100
Prescription drugs (up to a 30-day supply) ¹¹	\$15 / \$30 / \$50	50%	\$15 / \$30 / \$50	50%
Specialty drugs (most self-injectables)	30% (\$250 copay maximum per prescription)	Not covered	30% (\$250 copay maximum per prescription)	Not covered

PPO 45

Standard (AD7)		Value (ADG)	
PPO²	Out-of-network³	PPO²	Out-of-network³
\$1,000 / \$2,000	\$2,000 / \$4,000	\$1,500 / \$3,000	\$3,000 / \$6,000
\$5,000 / \$10,000	\$10,000 / \$20,000	\$6,350 / \$12,700	\$14,000 / \$28,000
No maximum		No maximum	
\$45 copay (deductible waived)	50%	\$45 copay (deductible waived)	50%
\$55 copay (deductible waived)	50%	\$55 copay (deductible waived)	50%
Covered in full	Not covered	Covered in full	Not covered
45%	50%	50%	50%
45%	50%	50%	50%
(12 visits/calendar year, PPO and OON combined)		(12 visits/calendar year, PPO and OON combined)	
45%	50%	50%	50%
(\$500 deductible/calendar year, PPO and OON combined) ⁸		(\$500 deductible/calendar year, PPO and OON combined) ⁸	
45%	50%	50%	50%
45%	50%	50%	50%
(\$250 deductible/calendar year, PPO and OON combined) ⁹		(\$250 deductible/calendar year, PPO and OON combined) ⁹	
45%	50%	50%	50%
(100 visits and \$500 deductible/calendar year, PPO and OON combined) ⁸		(100 visits and \$500 deductible/calendar year, PPO and OON combined) ⁸	
\$45 copay (deductible waived)		\$45 copay (deductible waived)	
\$200 copay + 45%		\$250 copay + 50%	
\$50 copay + 45%		\$50 copay + 50%	
\$50 copay + 45%	\$50 copay + 50%	\$50 copay + 50%	\$50 copay + 50%
\$45 copay (deductible waived) / 45%	50% / 50%	\$45 copay (deductible waived) / 50%	50% / 50%
(\$500 deductible/calendar year, PPO and OON combined) ⁸		(\$500 deductible/calendar year, PPO and OON combined) ⁸	
\$45 copay (deductible waived) / 45%	50% / 50%	\$45 copay (deductible waived) / 50%	50%
\$45 copay (deductible waived) / 45%	50% / 50%	\$45 copay (deductible waived) / 50%	50% / 50%
45%	50% / 50%	50%	50%
45%	50%	50%	50%
45%	50%	50%	50%
45%	50%	50%	50%
\$45 copay (deductible waived) (12 visits/calendar year)	Not covered	\$45 copay (deductible waived) (12 visits/calendar year)	Not covered
45%	50%	50%	50%
(12 visits/calendar year, PPO and OON combined)		(12 visits/calendar year, PPO and OON combined)	
No deductible	\$100	\$250 brand deductible	\$100
\$15 / \$30 / \$50	50%	\$15 / \$30 / \$50	50%
30% (\$250 copay maximum per prescription)	Not covered	30% (\$250 copay maximum per prescription)	Not covered

PPO Portfolio

Benefit description ¹		Advantage PPO 45 (ADJ)	
		PPO ²	Out-of-network ³
Plan maximums			
Calendar year deductible (single / family)		\$4,000 / \$8,000	
Out-of-pocket maximum (single / family)		\$6,350 / \$12,700	\$16,000 / \$32,000
Lifetime medical benefit maximum		No maximum	
Professional services			
Office visit ³		\$45 copay (deductible waived)	50%
Specialist consultation ⁴		\$55 copay (deductible waived)	50%
Preventive care services ^{4,5}		Covered in full	Not covered
X-ray and laboratory procedures ^{4,6}		50%	50%
Rehabilitation therapy ^{6,7}		50%	50%
		(12 visits/calendar year, PPO and OON combined)	
Hospital services⁶			
Inpatient hospital facility services (includes maternity)		50%	50%
Outpatient facility services (other than surgery)		50%	50%
Outpatient surgery (hospital charges only)		50%	50%
Outpatient surgery (ambulatory surgery center charges only)		45%	50%
Skilled nursing facility		50%	50%
		(100 days/calendar year, PPO and OON combined)	
Emergency services			
Professional services		\$45 copay	
Emergency room facility (copay waived if admitted)		\$150 copay + 50%	
Urgent care facility		\$50 copay + 50%	
Ambulance services (ground and air) ⁶		\$50 copay + 50%	\$50 copay + 50%
Behavioral services⁶			
Severe mental health (outpatient/inpatient)		\$45 copay (deductible waived) / 50%	50% / 50%
Non-severe mental health (outpatient/inpatient)		\$45 copay (deductible waived) / 50%	50%
Chemical dependency rehabilitation (outpatient/inpatient)		\$45 copay (deductible waived) / 50%	50%
Inpatient acute care detoxification		50%	50%
Other services			
Durable medical equipment ^{4,6}		50%	50%
Orthotics and prosthetics ⁶		50%	50%
Diabetic supplies		50%	50%
Chiropractic services		\$45 copay (deductible waived) (12 visits/calendar year)	Not covered
Acupuncture		50%	50%
		(12 visits/calendar year, PPO and OON combined)	
Prescription drug coverage¹⁰			
Brand-name calendar year deductible (per insured)		\$250 brand deductible	\$100
Prescription drugs (up to a 30-day supply) ¹¹		\$15 / \$30 / \$50	50%
Specialty drugs (most self-injectables)		30% (\$250 copay maximum per prescription)	Not covered

Benefit description ¹	Value HSA 4500 (ACX) (BIC)	
	PPO ²	Out-of-network ³
Plan maximums		
Calendar year deductible ⁴	\$4,500 single (employee-only coverage) / \$9,000 family (employee and dependent coverage)	
Out-of-pocket maximum	\$5,950 single (employee-only coverage) / \$11,900 family (employee and dependent coverage)	\$10,000 single (employee-only coverage) / \$20,000 family (employee and dependent coverage)
Lifetime medical benefit maximum	No maximum	
Professional services		
Office visit (including specialist consultation) ⁵	\$40 copay (deductible not waived)	
Preventive care services ^{5,6}	Covered in full	Not covered
X-ray and laboratory procedures ^{5,7}	50%	50%
Rehabilitation therapy ^{7,8}	50%	50%
	(12 visits/calendar year, PPO and OON combined)	
Hospital services⁷		
Inpatient hospital facility services (includes maternity)	50%	50%
	(\$500 deductible/calendar year, PPO and OON combined) ⁹	
Outpatient facility services (other than surgery)	50%	50%
Outpatient surgery (hospital or outpatient surgery center charges only)	50%	50%
	(\$250 deductible/calendar year, PPO and OON combined) ¹⁰	
Skilled nursing facility	50%	50%
	(100 days and \$500 deductible/calendar year, PPO and OON combined) ⁹	
Emergency services		
Professional services	\$40 copay (deductible not waived)	
Emergency room facility (copay waived if admitted)	\$100 copay + 50%	
Urgent care facility	\$50 copay + 50%	
Ambulance services (ground and air) ⁷	\$50 copay + 50%	
Behavioral services		
Severe mental health (outpatient office visit/inpatient)	\$40 copay (deductible not waived) / 50%	50% / 50%
	(\$500 inpatient deductible/calendar year, PPO and OON combined) ⁹	
Non-severe mental health (outpatient office visit/inpatient)	\$40 copay (deductible not waived) / 50%	50% / 50%
Chemical dependency rehabilitation (outpatient office visit/inpatient)	\$40 copay (deductible not waived) / 50%	50% / 50%
Inpatient acute care detoxification	50%	50%
Other services		
Durable medical equipment ^{5,7}	50%	50%
Orthotics and prosthetics ⁷	50%	50%
Diabetic supplies	50%	50%
Chiropractic services	\$40 copay (deductible not waived, 12 visits/calendar year)	Not covered
Acupuncture	50%	50%
	(12 visits/calendar year, PPO and OON combined)	
Prescription drug coverage¹¹		
Calendar year deductible (per insured)	Subject to annual deductible	
Prescription drugs (up to a 30-day supply) ¹²	\$15 / \$30 / \$50	50%
Specialty drugs (most self-injectables)	30%	Not covered

Benefit description ¹	HRA 3000 (ACY) (B1E)	
	PPO ²	Out-of-network ³
All benefits including Rx are subject to the deductible.		
Plan maximums		
Calendar year deductible ⁴	\$3,000 single (employee-only coverage) / \$6,000 family (employee and dependent coverage)	
Out-of-pocket maximum	\$4,000 single (employee-only coverage) / \$8,000 family (employee and dependent coverage)	
Lifetime medical benefit maximum	No maximum	
Professional services		
Office visit (including specialist consultation) ⁵	50% (deductible not waived)	Not covered
Preventive care services ^{5,6}	Covered in full	Not covered
X-ray and laboratory procedures ⁷	20%	40%
Rehabilitation therapy ^{7,8}	20%	40%
	(12 visits/calendar year, PPO and OON combined)	
Hospital services⁷		
Inpatient hospital facility services (includes maternity)	20%	40%
Outpatient facility services (other than surgery)	20%	40%
Outpatient surgery (hospital or outpatient surgery center charges only)	20%	40%
Skilled nursing facility	20%	40%
	(100 days/calendar year, PPO and OON combined)	
Emergency services		
Professional services	\$10 copay (deductible not waived)	
Emergency room facility (copay waived if admitted)	\$100 copay + 20%	
Urgent care facility	\$50 copay + 20%	
Ambulance services (ground and air) ⁷	\$50 copay + 20%	\$50 copay + 40%
Behavioral services⁷		
Severe mental health (outpatient office visit/inpatient)	20% / 20%	40% / 40%
Non-severe mental health (outpatient office visit/inpatient)	20% / 20%	40% / 40%
Chemical dependency rehabilitation (outpatient office visit/inpatient)	20% / 20%	40% / 40%
Inpatient acute care detoxification	20%	40%
Other services		
Durable medical equipment and orthotics ⁵	20%	40%
Diabetic supplies	20%	40%
Chiropractic services	\$20 (deductible not waived, 12 visits/ calendar year)	Not covered
Acupuncture	20%	40%
	(12 visits/calendar year, PPO and OON combined)	
Prescription drug coverage⁹	Subject to calendar year medical deductible (per insured)	
Prescription drugs (up to a 30-day supply) ¹⁰	\$10 / \$25 / \$50	50%
Specialty drugs (most self-injectables)	30%	Not covered

HRA 5000 (ACZ) (B1D)	
PPO²	Out-of-network³
\$5,000 single (employee-only coverage) / \$10,000 family (employee and dependent coverage)	
\$6,000 single (employee-only coverage) / \$12,000 family (employee and dependent coverage)	
No maximum	
50% (deductible not waived)	Not covered
Covered in full	Not covered
20%	40%
20%	40%
(12 visits/calendar year, PPO and OON combined)	
20%	40%
20%	40%
20%	40%
20%	40%
(100 days/calendar year, PPO and OON combined)	
\$10 copay (deductible not waived)	
\$100 copay + 20%	
\$50 copay + 20%	
\$50 copay + 20%	\$50 copay + 40%
20% / 20%	40% / 40%
20% / 20%	40% / 40%
20% / 20%	40% / 40%
20%	40%
20%	40%
20%	40%
\$20 (deductible not waived, 12 visits/calendar year)	Not covered
20%	40%
(12 visits/calendar year, PPO and OON combined)	
Subject to calendar year medical deductible (per insured)	
\$10 / \$25 / \$50	50%
30%	Not covered

Salud con Health Net *Portfolio*

Benefit description ¹	Salud HMO y Más 15 (AAP)		
	SIMNSA Network ² (Mexico members)	Salud Network (California members)	SIMNSA Network ² (self-referral for California members)
Plan maximums			
Out-of-pocket maximum ³	\$1,500 single / \$3,000 two-party / \$4,500 family		
Lifetime medical benefit maximum	No maximum		
Professional services			
Office visit ⁴ (including specialist consultation)	\$5 copay	\$15 copay	\$5 copay
Preventive care services ^{4,5}	Covered in full	Covered in full	Covered in full
X-ray and laboratory procedures ⁵	Covered in full	Covered in full	Covered in full
Rehabilitation therapy ⁷	\$5 copay	\$15 copay	\$5 copay
Self-injectable drugs	Covered in full	Covered in full	Covered in full
Hospital services			
Inpatient hospital facility services (includes maternity)	Covered in full	\$250 per admission copay	Covered in full
Outpatient facility services (other than surgery)	Covered in full	20%	Covered in full
Outpatient surgery (hospital or outpatient surgery center charges only)	Covered in full	20%	Covered in full
Skilled nursing facility (100 days per calendar year)	Covered in full	20%	Covered in full
Emergency services			
Professional services	Covered in full	Covered in full	Covered in full
Emergency room facility (copay waived if admitted)	\$10 copay	\$50 copay	\$10 copay
Urgent care facility	\$10 copay	\$15 copay	\$10 copay
Ambulance services (ground and air)	Covered in full	\$50 copay	Covered in full
Behavioral services⁸			
Severe mental health (outpatient/inpatient)	\$5 copay / Covered in full	\$15 copay / Covered in full	\$5 copay / Covered in full
Non-severe mental health (outpatient/inpatient)	\$5 copay / Covered in full	\$15 copay / Covered in full	\$5 copay / Covered in full
Chemical dependency rehabilitation (outpatient/inpatient)	\$5 copay / Covered in full	\$15 copay / Covered in full	\$5 copay / Covered in full
Acute care detoxification	Covered in full ⁸	Covered in full	Covered in full ⁸
Other services			
Durable medical equipment ⁴	Covered in full	Covered in full	Covered in full
Orthotics and prosthetics	Covered in full	Covered in full	Covered in full
Diabetic supplies	Covered in full	Covered in full	Covered in full
Acupuncture, chiropractic services ⁹	Not covered	Optional rider available	Not covered
Prescription drug coverage			
Brand-name calendar year deductible (per insured)	No deductible	No deductible	No deductible
Prescription drugs (up to a 30-day supply) ¹⁰	\$5 copay	\$5 / \$15 / \$35	\$5 copay

Plan footnotes found on pages 55–58.

Benefit description	Salud HMO y Más 25 (AAM)		
	SIMNSA Network ² (Mexico members)	Salud Network (California members)	SIMNSA Network ² (self-referral for California members)
Plan maximums			
Out-of-pocket maximum ³	\$1,500 single / \$3,000 two-party / \$4,500 family	\$3,500 single / \$7,000 family	\$1,500 single / \$3,000 two-party / \$4,500 family
Lifetime medical benefit maximum	No maximum		
Professional services			
Office visit ⁴ (including specialist consultation)	\$5 copay	\$25 copay	\$5 copay
Preventive care services ^{4,5}	Covered in full	Covered in full	Covered in full
X-ray and laboratory procedures ⁵	Covered in full	Covered in full ⁶	Covered in full
Rehabilitation therapy ⁷	\$5 copay	\$25 copay	\$5 copay
Self-injectable drugs	Covered in full	Covered in full	Covered in full
Hospital services			
Inpatient hospital facility services (includes maternity)	Covered in full	\$250/day (4-day copay maximum)	Covered in full
Outpatient facility services (other than surgery)	Covered in full	20%	Covered in full
Outpatient surgery (hospital or outpatient surgery center charges only)	Covered in full	20%	Covered in full
Skilled nursing facility (100 days per calendar year)	Covered in full	20%	Covered in full
Emergency services			
Professional services	Covered in full	Covered in full	Covered in full
Emergency room facility (copay waived if admitted)	\$10 copay	\$100 copay	\$10 copay
Urgent care facility	\$10 copay	\$25 copay	\$10 copay
Ambulance services (ground and air)	Covered in full	\$100 copay	Covered in full
Behavioral services⁸			
Severe mental health (outpatient/inpatient)	\$5 copay / Covered in full	\$25 copay / Covered in full	\$5 copay / Covered in full
Non-severe mental health (outpatient/inpatient)	\$5 copay / Covered in full	\$25 copay / Covered in full	\$5 copay / Covered in full
Chemical dependency rehabilitation (outpatient/inpatient)	\$5 copay / Covered in full	\$25 copay / Covered in full	\$5 copay / Covered in full
Acute care detoxification	Covered in full ⁸	Covered in full	Covered in full ⁸
Other services			
Durable medical equipment ⁴	Covered in full	30%	Covered in full
Orthotics and prosthetics	Covered in full	Covered in full	Covered in full
Diabetic supplies	Covered in full	Covered in full	Covered in full
Acupuncture, chiropractic services ⁹	Not covered	Optional rider available	Not covered
Prescription drug coverage			
Brand-name calendar year deductible (per insured)	No deductible	\$250	No deductible
Prescription drugs (up to a 30-day supply) ¹⁰	\$5 copay	\$10 / \$35 / \$50	\$5 copay

Salud con Health Net *Portfolio*

Benefit description ¹	Salud HMO y Más 35 (AAN)		
	SIMNSA Network ² (Mexico members)	Salud Network (California members)	SIMNSA Network ² (self-referral for California members)
Plan maximums			
Out-of-pocket maximum ³	\$1,500 single / \$3,000 two-party / \$4,500 family	\$4,000 single / \$8,000 family	\$1,500 single / \$3,000 two-party / \$4,500 family
Lifetime medical benefit maximum	No maximum		
Professional services			
Office visit ⁴ (including specialist consultation)	\$5 copay	\$35 copay	\$5 copay
Preventive care services ^{4,5}	Covered in full	Covered in full	Covered in full
X-ray and laboratory procedures ⁵	Covered in full	Covered in full ⁶	Covered in full
Rehabilitation therapy ⁷	\$5 copay	\$35 copay	\$5 copay
Self-injectable drugs	Covered in full	Covered in full	Covered in full
Hospital services			
Inpatient hospital facility services (includes maternity)	Covered in full	\$500/day (4-day copay maximum)	Covered in full
Outpatient facility services (other than surgery)	Covered in full	20%	Covered in full
Outpatient surgery (hospital or outpatient surgery center charges only)	Covered in full	20%	Covered in full
Skilled nursing facility (100 days per calendar year)	Covered in full	20%	Covered in full
Emergency services			
Professional services	Covered in full	Covered in full	Covered in full
Emergency room facility (copay waived if admitted)	\$10 copay	\$100 copay	\$10 copay
Urgent care facility	\$10 copay	\$35 copay	\$10 copay
Ambulance services (ground and air)	Covered in full	\$100 copay	Covered in full
Behavioral services⁸			
Severe mental health (outpatient/inpatient)	\$5 copay / Covered in full	\$35 copay / Covered in full	\$5 copay / Covered in full
Non-severe mental health (outpatient/inpatient)	\$5 copay / Covered in full	\$35 copay / Covered in full	\$5 copay / Covered in full
Chemical dependency rehabilitation (outpatient/inpatient)	\$5 copay / Covered in full	\$35 copay / Covered in full	\$5 copay / Covered in full
Acute care detoxification	Covered in full ⁸	Covered in full	Covered in full ⁸
Other services			
Durable medical equipment ⁴	Covered in full	30%	Covered in full
Orthotics and prosthetics	Covered in full	Covered in full	Covered in full
Diabetic supplies	Covered in full	Covered in full	Covered in full
Acupuncture, chiropractic services ⁹	Not covered	Optional rider available	Not covered
Prescription drug coverage			
Brand-name calendar year deductible (per insured)	No deductible	\$250	No deductible
Prescription drugs (up to a 30-day supply) ¹⁰	\$5 copay	\$10 / \$35 / \$50	\$5 copay

Plan footnotes found on pages 55–58.

Salud Mexico HMO (AAK)
SIMNSA Network only²

\$1,500 single /
\$3,000 two-party /
\$4,500 family
No maximum

\$5 copay

Covered in full

Covered in full

\$5 copay

Covered in full

Covered in full

Covered in full

Covered in full

Covered in full

Covered in full

\$10 copay (in Mexico) /
\$50 copay (outside Mexico)

\$10 copay

Covered in full
(air ambulance not covered)

\$5 copay / Covered in full

\$5 copay / Covered in full

\$5 copay / Covered in full

Covered in full⁸

Covered in full

Covered in full

Covered in full

Not covered

No deductible

\$5 copay



Geoffrey Gomez,
Health Net
*We partner with you to
promote workforce health.*



Ancillary Products

At-a-Glance



Lisa Pasillas-Le,
Health Net
*We're part of your
health team.*

Dental Plans That Make Them Smile

Health Net makes available a choice of HMO and PPO dental plan designs, along with access to one of the largest dental networks in California. Health Net Dental HMO and Dental PPO plans include robust benefits covering most dental procedures. All of these dental plans may be purchased on a standalone basis or in conjunction with a Health Net medical plan.

Dental, Vision, Chiropractic, Acupuncture, Life and AD&D.

Helping your clients' employees gain and maintain healthier lifestyles is a key selling point! At Health Net, we offer the essentials to complement medical coverage with a variety of healthy life choices. These benefits are designed to help members lead a healthier lifestyle, which can lead to greater overall productivity.

It's a win-win for both employer and employee – and a big sales win for you!

Your clients can save up to 2%.

Groups with 51–100 eligible employees can pay less for medical premiums when they add Health Net Dental, Vision and/or Life to the quote.

Product added	Savings realized
Dental	1.0%
Vision	0.5%
Life	0.5%

Contact your Health Net sales representative for more details.

Experts – by the numbers

Ancillary statewide network:

- More than 2,000 dental HMO providers in California
- More than 31,000 dental PPO providers in California and over 185,000 DPPO providers nationwide
- More than 5,500 vision providers in California and 45,000 vision providers nationwide

Alternative medicine statewide network:

- More than 3,300 chiropractors
- More than 1,400 acupuncturists

Dental plan highlights

Dental HMO

The Dental HMO (DHMO) plans give members access to an extensive network of providers, and the convenience of having a set copayment for many dental procedures. Among the covered benefits are:

- Cleanings and adult fluoride.
- Material upgrades, such as porcelain and semiprecious or precious metal molar crowns.
- General anesthesia, cosmetic and elective dentistry – procedures typically not covered under most other carriers' dental plans.

The DHMO plans may be purchased separately or as a dual choice with Dental PPO plans, and they are underwritten by Dental Benefit Providers of California, Inc. The key coverage details for these plans are shown on the next page.

Dental PPO

Health Net makes available a range of affordable, flexible Dental PPO plans (DPPO), underwritten by Unimerica Life Insurance Company, that offer:

- A wide range of deductibles and coinsurance choices.
- Access to a large statewide and national network of DPPO providers.
- No waiting periods.
- Cleanings and periodontal maintenance when medically necessary for pregnant women (not subject to deductible and does not apply to the calendar year maximum).

- Full amount of the orthodontia lifetime maximum for employees and dependents, even if they have begun treatment under another carrier's dental PPO plan (applies only to DPPO plans with orthodontia coverage).
- The option for employers to purchase separately or as a dual choice with Dental HMO plans.

Plus, periodontics, endodontics and oral surgery are covered as general services with our Classic and Classic Plus plans.

For easy comparison, we've provided a chart of our DPPO plans with key coverage details.



Josefina Bravo,
Health Net
*We help members
build healthy habits.*



Category	Procedure code	Description	Member copayment	
			Plus DHMO 150	Plus DHMO 225
Diagnostic	D0150	Comprehensive oral evaluation	\$0	\$0
	D0210	Intraoral X-rays – complete series	\$0	\$0
	D9491	Office visit (Including all fees for sterilization and infection control)	\$5	\$5
Preventive	D1110	Prophylaxis (cleaning) – adult	\$0	\$0
	D1110	Additional prophylaxis (up to 2 per year) – adult	\$20	\$35
	D1204	Topical application of fluoride – adult	\$0	\$0
Restorative	D2150	Amalgam (silver filling) – two surfaces	\$0	\$0
	D2331	Composite (white filling) – two surfaces anterior	\$0	\$0
	D2392	Composite (white filling) – two surfaces posterior	\$30	\$45
Crowns and pontics	D2751 ¹	Crown – porcelain fused to predominantly base metal	\$150	\$225
	D2960	Labial veneer (resin laminate) – chairside	\$250	\$250
Endodontics	D3320	Root canal – bicuspid (excluding final restoration)	\$95	\$125
	D3330	Root canal – molar (excluding final restoration)	\$125	\$210
Periodontics	D4341	Periodontal scaling and root planing – 4 or more teeth per quadrant	\$35	\$40
Prosthodontics	D5110	Complete denture – upper	\$175	\$260
Oral surgery	D7220	Removal of impacted tooth – soft tissue	\$35	\$45
Orthodontics	D8070–80	Comprehensive orthodontic treatment – adult or child	\$1,695	\$1,695
Other general services	D9230	Nitrous oxide, analgesia, anxiolysis (inhalation)	\$15 per half hour	\$15 per half hour
	D9972	External bleaching (teeth whitening) – per arch	\$125	\$125



This is only a summary of benefits. Please refer to the *Evidence of Coverage* for terms and conditions of coverage, including which services are limited or excluded from coverage.

Plan footnotes found on page 58.

MaxAdvantage *with* Classic Plus 2000

Plans 1 and 2

Our Classic Plus 2000 Plans 1 and 2 come with another employee-friendly benefit: calendar year maximum rollover. MaxAdvantage allows employees and dependents to carry forward a portion of their unused calendar year maximum for future use.

It's easy to use – We do all the tracking!

An award balance is established for each enrolled employee and dependent when the total of all the submitted claims for each person is \$1,000 or less for the calendar year.

Each enrolled person qualifies for the MaxAdvantage award if they use in- or out-of-network providers, and use his or her dental benefits at least once a year. Plus, members can earn an additional \$100 bonus if all claims are for network providers.

Example:

In 2015, Joe receives two oral exams, two cleanings, has X-rays taken, and gets two fillings, all from an in-network dentist.

Total amount of claims = \$650.

MaxAdvantage reward: \$500 + \$100 in-network bonus = \$600 annual award.

Note that if Joe's annual claim total exceeded \$1,000, he would not be eligible for the award.

In 2016, Joe's – and any enrolled dependents – calendar year maximum resets to \$2,000 (the plan maximum) + \$600 award = \$2,600 calendar year maximum.

Joe can use the award for covered services (except for orthodontia or dental implants) in future years if he exceeds the calendar year maximum.

The average person can submit hundreds of dollars in dental claims every year, so MaxAdvantage is a real advantage for many employees and dependents! With MaxAdvantage, they can save for more extensive services – such as a crown.

Note that the maximum award amount is \$600 per year, and \$3,500 is the highest calendar year maximum with all awards. Funds are not physical and cannot be withdrawn. Employees and dependents must enroll by October 1 in order to qualify for the award on January 1.

**Sharyl Barney,
Health Net**

*We help improve the
health care experience.*



	Classic Plus 1 & 2 2000		Classic 1 & 2 1500		Classic 3 & 4 1500		Classic 5 & 6 1500	
	In-network	Out-of-network²	In-network	Out-of-network²	In-network	Out-of-network²	In-network	Out-of-network²
Calendar year maximum	\$2,000		\$1,500		\$1,500		\$1,500	
Calendar year deductible	\$50 single \$150 family	\$75 single \$225 family	\$50 single \$150 family	\$75 single \$225 family	\$50 single \$150 family	\$75 single \$225 family	\$50 single \$150 family	\$75 single \$225 family
Preventive services (initial/routine oral exam, teeth cleaning and routine scaling, fluoride treatment, sealant – children under 16, space maintainers, X-rays as part of a general exam, emergency exam)	100% deductible waived		100% deductible waived		100% deductible waived		100% deductible waived	80% deductible waived
General services (fillings, general anesthetics, oral surgery, periodontics, endodontics) ³	90% after deductible	80% after deductible	90% after deductible	80% after deductible	80% after deductible	80% after deductible	80% after deductible	80% after deductible
Major services (crowns, removable and fixed bridges, complete and partial dentures)	60% after deductible	50% after deductible	60% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Orthodontia⁴ (adult and child)	50% after deductible / \$1,500 lifetime maximum		Classic 1 50% after deductible / \$1,500 lifetime maximum Classic 2 Not covered		Classic 3 50% after deductible / \$1,500 lifetime maximum Classic 4 Not covered		Classic 5 50% after deductible / \$1,500 lifetime maximum Classic 6 Not covered	
Dental implants	Classic Plus 1 50% after deductible / \$1,500 calendar year maximum Classic Plus 2 Not covered		Not covered		Not covered		Not covered	

Reimbursement: Classic and Classic Plus plans reimburse out-of-network benefits at Usual, Customary and Reasonable (UCR) amounts. Essential and Basic plans reimburse out-of-network benefits on a limited fee schedule. This is only a summary of benefits. Please refer to the Certificate of Insurance for terms and conditions of coverage, including which services are limited or excluded from coverage. See footnotes on page 58.

<i>Essential 1 & 2 1000</i>		<i>Essential 3 & 4 1000</i>		<i>Essential 5 & 6 1500</i>		<i>Essential Value 1 1000</i>		<i>Basic 500</i>	
In-network	Out-of-network ³	In-network	Out-of-network ³	In-network	Out-of-network ³	In-network	Out-of-network ³	In-network	Out-of-network ³
\$1,000		\$1,000		\$1,500		\$1,000		\$500	
\$50 single \$150 family	\$75 single \$225 family	\$50 single \$150 family	\$75 single \$225 family	\$50 single \$150 family	\$75 single \$225 family	\$50 single \$150 family	\$75 single \$225 family	\$50 per person	\$50 per person
100% deductible waived		100% deductible waived	80% deductible waived	100% deductible waived		100% deductible waived	50% deductible waived	100% deductible waived	80% deductible waived
80% after deductible	80% after deductible	80% after deductible	80% after deductible	80% after deductible	80% after deductible	80% ⁵ after deductible	50% ⁵ after deductible	60% ⁵ after deductible	50% ⁵ after deductible
50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	Not covered	
Essential 1 50% after deductible / \$1,000 lifetime maximum		Essential 3 50% after deductible / \$1,000 lifetime maximum		Essential 5 50% after deductible / \$1,500 lifetime maximum		Not covered		Not covered	
Essential 2 Not covered		Essential 4 Not covered		Essential 6 Not covered		Not covered		Not covered	
Not covered		Not covered		Not covered		Not covered		Not covered	

Limitations

Initial / routine oral exam	2 per consecutive 12 months
Teeth cleaning	2 per consecutive 12 months (additional services available for pregnant members)
Fluoride treatment	2 per consecutive 12 months
Sealants	1 per 36 months, children under 16 years on permanent molars only
Emergency treatment	For relief of pain only

Vision Plans with a Clear Advantage

Health Net PPO Vision insurance plans provide the convenience of a large national network, our hassle-free implementation and administrative processing, and:

- A diverse network of independent and retail providers, including LensCrafters.
- Low copayments.
- The option for employees and dependents to see any provider they choose, either in-network or out-of-network, and be covered under the plan.
- Discounts of 5–15% of LASIK and PRK from U.S. Laser Network.
- The only difference between the full service plans, Preferred 1025-2 and 1025-3, is the replacement of lenses, contact lenses or frames either every 12 or 24 months. For materials only, Health Net makes available the Preferred Value 10-2 plan.



<i>Schedule of benefits and coverage</i>	<i>Preferred Plan 1025-2</i>	<i>Preferred Plan 1025-3</i>	<i>Preferred Value Plan 10-2</i>
Vision exam copayment	\$10	\$10	Not covered
Lens copayment	\$25	\$25	\$10
Frequency			
Exam	Every 12 months	Every 12 months	Not covered
Eyeglass or contact lenses	Every 12 months	Every 24 months	Every 12 months
Frames	Every 24 months	Every 24 months	Every 24 months
Retail frame allowance (in-network)	\$100	\$100	\$100
Contact lens allowance (in-network)	\$90	\$90	\$90

<i>Health Net Vision plan benefits</i>	<i>In-network (member cost)</i>	<i>Out-of-network (maximum benefit allowed)</i>
Vision exam (Preferred 1025-2 and Preferred 1025-3 plans only)		
Exam (with dilation as necessary)	\$0 after copay	Up to \$40
Standard contact lens fit and follow-up exam	Up to \$55	Not covered
Standard plastic lenses		
Single vision	\$0 after copay	Up to \$40
Bifocal	\$0 after copay	Up to \$60
Trifocal	\$0 after copay	Up to \$80
Standard progressive (add-on to bifocal)	\$65 copay (in addition to lens copayment)	\$60
Premium progressive (add-on to bifocal)	\$65 copay (in addition to lens copayment), plus 80% of retail charge less \$120 allowance	\$60
Lens options (in-network only)		
UV coating	\$15 copay	Not covered
Tint (solid and gradient)	\$15 copay	Not covered
Standard scratch-resistant	\$15 copay	Not covered
Standard polycarbonate	\$40 copay	Not covered
Standard anti-reflective	\$45 copay	Not covered
Other add-ons and services	20% discount	Not covered
Frames (any frame available at a provider location)	Up to plan allowance, plus 20% discount off balance over allowance	Up to \$45
Contact lenses (materials only)		
Medically necessary	\$0	Up to \$210
Conventional	Up to plan allowance, plus 15% discount off balance over allowance	Up to \$105
Disposable	Up to plan allowance, plus balance over allowance	Up to \$105
Laser vision correction (in-network only)		
LASIK or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	Not covered
Secondary purchase plan (in-network only)		
Discounts on eyewear purchases after initial benefits	40% off retail	Not covered

Employees and dependents will receive a 20 percent discount on remaining balance beyond plan coverage at participating providers, which may not be combined with any other discounts or promotional offers, and the discount does not apply to provider's professional services or to contact lenses. Retail prices vary by location.

Discounts do not apply for benefits provided by other group benefit plans. Allowances are one-time-use benefits; no remaining balance. Lost or broken materials are not covered. Health Net Vision plans are underwritten by Fidelity Security Life Insurance Company and are serviced by EyeMed Vision Care, LLC (together, the "Fidelity Entities").

This is only a summary of benefits. Please refer to the *Certificate of Insurance* or *Evidence of Coverage* for terms and conditions of coverage, including which services are limited or excluded from coverage.

Chiropractic and Acupuncture

Health Net makes available quality, affordable chiropractic and acupuncture coverage – natural complements to traditional medical coverage. Available as separate riders, chiropractic and acupuncture services are provided through American Specialty Health Plans of California, Inc., a wholly owned subsidiary of American Specialty Health Incorporated (ASH).⁶ Key features are:

- Self-referral for medically necessary covered chiropractic and/or acupuncture services.
- Copayment for chiropractic and acupuncture office visits.

- Chiropractic plans cover medically necessary X-rays and lab tests.
- Annual chiropractic allowance applies toward purchase of medically necessary items such as thoracic and lumbar supports, cervical collars and pillows, heel lifts, ice packs, lumbar cushions, orthotics, rib belts, and home traction units.

All Health Net SmartCare plans include acupuncture and chiropractic services as value-added benefits. For all other plans, employers can add chiropractic and acupuncture coverage in conjunction with their purchase of a 51–100 Choice medical plan. This coverage does not come standalone.



	<i>Chiropractic and acupuncture coverage highlights</i>
Office visits⁷	\$10 copayment per visit \$15 copayment per visit
Visits per calendar year	20 visits 10 visits for SmartCare plans Maximum visits are combined for chiropractic and acupuncture services
Acupuncture covered conditions	<ul style="list-style-type: none"> • Neuromusculoskeletal conditions, including conditions such as fibromyalgia and myofascial pain • Pain, including low back pain, postoperative pain and postoperative dental pain • Nausea, including adult postoperative nausea and vomiting, chemotherapy nausea and vomiting, and nausea of pregnancy • Carpal tunnel syndrome • Headaches • Menstrual cramps • Osteoarthritis • Stroke rehabilitation • Tennis elbow
Lab tests	Covered when medically necessary for both chiropractic care and acupuncture
X-rays	Covered for medically necessary chiropractic care
Annual chiropractic appliance allowance	\$50 toward the purchase of medically necessary items such as thoracic and lumbar supports, cervical collars and pillows, heel lifts, ice packs, lumbar cushions, orthotics, rib belts, and home traction units

Please see full exclusions and limitations.

Life and AD&D

From group and supplemental term life to Accidental Death and Dismemberment (AD&D) benefits, Health Net has a range of coverage options for additional security.

Health Net Life Insurance Company underwrites Group Term Life Benefit Insurance, Accidental Death & Dismemberment, and Dependent Life Insurance.⁸

Health Net Group Term Life

Our Group Term Life Insurance is available in flat amounts of:

- \$15,000
- \$25,000
- \$50,000

AD&D

AD&D benefits are included with a group life policy. The benefit is payable as a result of an accident, loss of life or any of the physical losses specified in the group policy. The benefit payable depends on the loss:

- The maximum benefit amount is equal to the basic life amount shown in the policy and is payable for the loss of life, loss of sight in both eyes, loss of both hands or both feet, or any two or more of these physical losses in the same accident.
- One-half of the maximum benefit amount is payable for the loss of sight in one eye, loss of one hand, or loss of one foot.

Each policy type comes standard with:

- **Waiver of premium provisions.**
- **Accelerated death benefit** – This can be paid to an insured when the physician certifies a terminal illness. The accelerated benefit is a portion of the basic life insurance amount and is payable in a lump sum. The remaining portion is paid upon death to the insured's beneficiary.
- **Conversion privilege** – A conversion privilege to whole life insurance is available to certain individuals whose coverage terminates due to reasons specified in the group policy.

Footnotes

SmartCare HMO

- ¹ This is a summary of benefits. It does not include all services, limitations or exclusions. Please refer to the *Evidence of Coverage* for terms and conditions of coverage. The SmartCare Network service area is parts of Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Clara, and Santa Cruz counties.
- ² Preventive care services for women also includes: female contraceptive services, devices and supplies; female family planning; female preventive sterilizations; screening for gestational diabetes, domestic violence and HIV; breastfeeding devices and supplies; and applicable female counseling for sexually transmitted infections, HIV, domestic violence, contraceptives, and breastfeeding.
- ³ For additional information on CVS MinuteClinic services and locations, please visit www.minuteclinic.com.
- ⁴ Includes annual preventive physical, newborn and well-child care, well-woman exams, preventive lab, and X-ray services. Preventive services through CVS MinuteClinics are covered in full.
- ⁵ Complex radiology (includes CT, SPECT, PET, and MRI) requires a copayment. Please refer to the *Evidence of Coverage* for plan-specific copayments.
- ⁶ All mental health and chemical dependency services are administered by MHN Services (an affiliate of Managed Health Network). The following conditions are considered severe mental illnesses: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorders, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa, and serious emotional disturbances of children (SED).
- ⁷ Maintenance drugs must be obtained through the mail order drug program. Prescription drugs filled through mail order (up to a 90-day supply) require twice the level of copayment. For details regarding a specific drug, go to www.healthnet.com.
- ⁸ The three prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand nonformulary. Some plans will cover most female prescription contraceptives at \$0 cost-share. Coverage on some drugs may not follow the generic and brand tier system. Please refer to your plan documents and Health Net's Recommended Drug List (RDL) for coverage, cost-share and tier information. *Evidence of Coverage* (EOC) and *Certificate of Insurance* (COI) are legally binding documents. If the information in this brochure differs from the information in the EOC or COI, the EOC or COI applies.

HMO

- ¹ This is a summary of benefits. It does not include all services, limitations or exclusions. Please refer to the *Evidence of Coverage* for terms and conditions of coverage. The two plan codes are: full network and ExcelCare Network. The ExcelCare Network service area is all or parts of Kern, Los Angeles, Orange, San Bernardino, San Diego, San Francisco, Santa Clara, Stanislaus, Riverside, and Ventura counties.
- ² Preventive care services for women also includes: female contraceptive services, devices and supplies; female family planning; female preventive sterilizations; screening for gestational diabetes, domestic violence and HIV; breastfeeding devices and supplies; and applicable female counseling for sexually transmitted infections, HIV, domestic violence, contraceptives, and breastfeeding.
- ³ Includes annual preventive physical, preventive vision/hearing screening, newborn and well-child care, well-woman exams, preventive lab, and X-ray services.
- ⁴ Complex radiology (includes CT, SPECT, PET, and MRI) requires a \$100 copayment.
- ⁵ Includes physical, speech, occupational, cardiac, and pulmonary rehabilitation therapy.
- ⁶ All mental health and chemical dependency services are administered by MHN Services (an affiliate of Managed Health Network). The following conditions are considered severe mental illnesses: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorders, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa, and serious emotional disturbances of children (SED).
- ⁷ Chiropractic and/or acupuncture rider coverage is available as an optional benefit with the HMO plan shown. Features of Health Net's chiropractic coverage include a \$10 per visit copayment and up to 20 visits per calendar year.
- ⁸ The three prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand nonformulary. Coverage on some drugs may not follow the generic and brand tier system. Please refer to your plan documents and Health Net's Recommended Drug List (RDL) for coverage, cost-share and tier information. *Evidence of Coverage* (EOC) and *Certificate of Insurance* (COI) are legally binding documents. If the information in this brochure differs from the information in the EOC or COI, the EOC or COI applies.

EOA

- ¹ This is a summary of benefits. It does not include all services, limitations or exclusions. Please refer to the *Evidence of Coverage* for terms and conditions of coverage. The two plan codes are: full network and ExcelCare Network. The ExcelCare Network service area is all or parts of Kern, Los Angeles, Orange, San Bernardino, San Diego, San Francisco, Santa Clara, Stanislaus, Riverside, and Ventura counties.
- ² For the PPO level, self-referral to a PPO network physician.

- ³ Preventive care services for women also includes: female contraceptive services, devices and supplies; female family planning; female preventive sterilizations; screening for gestational diabetes, domestic violence and HIV; breastfeeding devices and supplies; and applicable female counseling for sexually transmitted infections, HIV, domestic violence, contraceptives, and breastfeeding.
- ⁴ Includes annual preventive physical, preventive vision/hearing screenings, newborn and well-child care, well-woman exams, preventive lab, and X-ray services.
- ⁵ Complex radiology (includes CT) requires a \$100 copayment under HMO and PPO. MRI, MUGA, PET, and SPECT services are not covered through PPO level.
- ⁶ Under Elect Open Access, radiographic X-ray and laboratory services will be covered only when provided or coordinated by your primary care physician and approved by the PPG/IPA, except when provided at a PPO physician's office or contracted PPO lab or facility.
- ⁷ Includes physical, speech, occupational, cardiac, and pulmonary rehabilitation therapy.
- ⁸ Under Elect Open Access, inpatient hospital and professional services, durable medical equipment, and orthotics and prosthetics are covered when provided or coordinated by the primary care physician only and approved by the PPG/IPA. Inpatient care and outpatient services are not covered on the PPO level.
- ⁹ All mental health and chemical dependency services are administered by MHN Services (an affiliate of Managed Health Network). The following conditions are considered severe mental illnesses: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorders, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa, and serious emotional disturbances of children (SED).
- ¹⁰ Chiropractic and/or acupuncture rider coverage is available as an optional benefit with the EOA plan shown. Features of Health Net's chiropractic coverage include a \$10 per visit copayment and up to 20 visits per calendar year.
- ¹¹ The three prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand nonformulary. Some plans will cover most female prescription contraceptives at \$0 cost-share. Coverage on some drugs may not follow the generic and brand tier system. Please refer to your plan documents and Health Net's Recommended Drug List (RDL) for coverage, cost-share and tier information. *Evidence of Coverage* (EOC) and *Certificate of Insurance* (COI) are legally binding documents. If the information in this brochure differs from the information in the EOC or COI, the EOC or COI applies.

POS

- ¹ This is a summary of benefits. It does not include all services, limitations or exclusions. Please refer to the *Evidence of Coverage* for terms and conditions of coverage.
- ² Member pays the negotiated rate, which is the rate the participating or preferred providers have agreed to accept for providing a covered service.
- ³ Please refer to the *Evidence of Coverage* for out-of-network reimbursement methodology.
- ⁴ The 50% coinsurance through the OON level will apply toward the member's out-of-pocket maximum.
- ⁵ Preventive care services for women also includes: female contraceptive services, devices and supplies; female family planning; female preventive sterilizations; screening for gestational diabetes, domestic violence and HIV; breastfeeding devices and supplies; and applicable female counseling for sexually transmitted infections, HIV, domestic violence, contraceptives, and breastfeeding.
- ⁶ Includes annual preventive physical, newborn and well-child care, preventive vision/hearing screening, well-woman exams, preventive lab, and X-ray services.
- ⁷ Includes physical, speech, occupational, cardiac, and pulmonary rehabilitation therapy.
- ⁸ Some services require prior certification. If prior certification is not acquired, the benefits are reduced to 50%. In addition, for uncertified outpatient services, a \$50 deductible is required for each visit; for uncertified inpatient admission, a \$250 deductible is required for each admission.
- ⁹ This deductible is required only for the first inpatient hospital or skilled nursing facility admission each calendar year. Once the deductible is satisfied, no deductible is required for subsequent admissions in the same calendar year. This deductible is in addition to the plan calendar year deductible.
- ¹⁰ Once the outpatient surgery deductible is satisfied, no deductible is required for subsequent outpatient surgeries in the same calendar year. This deductible is in addition to the plan calendar year deductible.
- ¹¹ All mental health and chemical dependency services are administered by MHN Services (an affiliate of Managed Health Network). The following conditions are considered severe mental illnesses: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorders, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa, and serious emotional disturbances of children (SED).
- ¹² Chiropractic and/or acupuncture rider coverage is available as an optional benefit with the POS plan as shown.
- ¹³ Prescription drugs filled through mail order (up to a 90-day supply) require twice the level of copayment. For details regarding a specific drug, go to www.healthnet.com.
- ¹⁴ The three prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand nonformulary. Some plans will cover most female prescription contraceptives at \$0 cost-share. Coverage on some drugs may not follow the generic and brand tier system. Please refer to your plan documents and Health Net's Recommended Drug List (RDL) for coverage, cost-share and tier information. *Evidence of Coverage* (EOC) and *Certificate of Insurance* (COI) are legally binding documents. If the information in this brochure differs from the information in the EOC or COI, the EOC or COI applies.

PPO

- ¹ This is a summary of benefits. It does not include all services, limitations or exclusions. Please refer to the *Certificate of Insurance* for terms and conditions of coverage.
- ² Insured pays the negotiated rate, which is the rate participating or preferred providers have agreed to accept for providing a covered service.
- ³ Please refer to the *Certificate of Insurance* for out-of-network reimbursement methodology.
- ⁴ Preventive care services for women also includes: female contraceptive services, devices and supplies; female family planning; female preventive sterilizations; screening for gestational diabetes, domestic violence and HIV; breastfeeding devices and supplies; and applicable female counseling for sexually transmitted infections, HIV, domestic violence, contraceptives, and breastfeeding.
- ⁵ Includes annual preventive physical, preventive vision/hearing screening, newborn and well-child care, well-woman exams, preventive lab, and X-ray services.
- ⁶ Some services require prior certification. If prior certification is not acquired, benefits are reduced to 50%. In addition, for uncertified outpatient services, a \$50 deductible is required for each visit; for uncertified inpatient admissions, a \$250 deductible is required for each admission.
- ⁷ Includes physical, speech, occupational, cardiac, and pulmonary rehabilitation therapy.
- ⁸ This deductible is required only for the first inpatient hospital or skilled nursing facility admission each calendar year. Once the deductible is satisfied, no deductible is required for subsequent admissions in the same calendar year. This deductible is in addition to the plan calendar year deductible.
- ⁹ Once the outpatient surgery deductible is satisfied, no deductible is required for subsequent outpatient surgeries in the same calendar year. This deductible is in addition to the plan calendar year deductible and applies to the out-of-pocket maximum.
- ¹⁰ The three prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand nonformulary. Some plans will cover most female prescription contraceptives at \$0 cost-share. Coverage on some drugs may not follow the generic and brand tier system. Please refer to your plan documents and Health Net's Recommended Drug List (RDL) for coverage, cost-share and tier information. *Evidence of Coverage* (EOC) and *Certificate of Insurance* (COI) are legally binding documents. If the information in this brochure differs from the information in the EOC or COI, the EOC or COI applies.
- ¹¹ Prescription drugs filled through mail order (up to a 90-day supply) require twice the level of copayment. For details regarding a specific drug, go to www.healthnet.com.

HSA

- ¹ This is a summary of benefits. It does not include all services, limitations or exclusions. Please refer to the *Certificate of Insurance* for terms and conditions of coverage.
- ² Insured pays the negotiated rate, which is the rate participating or preferred providers have agreed to accept for providing a covered service.
- ³ Please refer to the *Certificate of Insurance* for out-of-network reimbursement methodology.
- ⁴ For family coverage, the enrolled employee and dependents must collectively pay the family amount before Health Net begins to pay.
- ⁵ Preventive care services for women also includes: female contraceptive services, devices and supplies; female family planning; female preventive sterilizations; screening for gestational diabetes, domestic violence and HIV; breastfeeding devices and supplies; and applicable female counseling for sexually transmitted infections, HIV, domestic violence, contraceptives, and breastfeeding.
- ⁶ Includes annual preventive physical, preventive vision/hearing screening, newborn and well-child care, well-woman exams, preventive lab, and X-ray services.
- ⁷ Some services require prior certification. If prior certification is not acquired, benefits are reduced to 50%. In addition, for uncertified outpatient services, a \$50 deductible is required for each visit; for uncertified inpatient admission, a \$250 deductible is required for each admission.
- ⁸ Includes physical, speech, occupational, cardiac, and pulmonary rehabilitation therapy.
- ⁹ This deductible is only required for the first inpatient hospital or skilled nursing facility admission each calendar year. The deductible does not apply to inpatient detoxification or to inpatient care for non-severe mental illness. Once the deductible is satisfied, no deductible is required for subsequent admissions in the same calendar year. This deductible is in addition to the plan calendar year deductible and applies to the out-of-pocket maximum (OOPM).
- ¹⁰ Once the outpatient surgery deductible is satisfied, no deductible is required for subsequent outpatient surgeries in the same calendar year. This deductible is in addition to the plan calendar year deductible and applies to the OOPM.
- ¹¹ Prescription drugs filled through mail order (up to a 90-day supply) require twice the level of copayment. For details regarding a specific drug, go to www.healthnet.com.
- ¹² The three prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand nonformulary. Some plans will cover most female prescription contraceptives at \$0 cost-share. Coverage on some drugs may not follow the generic and brand tier system. Please refer to your plan documents and Health Net's Recommended Drug List (RDL) for coverage, cost-share and tier information. *Evidence of Coverage* (EOC) and *Certificate of Insurance* (COI) are legally binding documents. If the information in this brochure differs from the information in the EOC or COI, the EOC or COI applies.

HRA

- ¹ This is a summary of benefits. It does not include all services, limitations or exclusions. Please refer to the *Certificate of Insurance* for terms and conditions of coverage.
- ² Insured pays the negotiated rate, which is the rate participating or preferred providers have agreed to accept for providing a covered service.
- ³ Please refer to the *Certificate of Insurance* for out-of-network reimbursement methodology.
- ⁴ For family coverage, the enrolled employee and dependents must collectively pay the family amount before Health Net begins to pay.
- ⁵ Preventive care services for women also includes: female contraceptive services, devices and supplies; female family planning; female preventive sterilizations; screening for gestational diabetes, domestic violence and HIV; breastfeeding devices and supplies; and applicable female counseling for sexually transmitted infections, HIV, domestic violence, contraceptives, and breastfeeding.
- ⁶ Includes annual preventive physical, newborn and well-child care, well-woman exams, preventive lab, and X-ray services.
- ⁷ Some services require prior certification. If prior certification is not acquired, benefits are reduced to 50%. In addition, for uncertified outpatient services, a \$50 deductible is required for each visit; for uncertified inpatient admission, a \$250 deductible is required for each admission.
- ⁸ Includes physical, speech, occupational, cardiac, and pulmonary rehabilitation therapy.
- ⁹ Prescription drugs filled through mail order (up to a 90-day supply) require twice the level of copayment. For details regarding a specific drug, go to www.healthnet.com.
- ¹⁰ The three prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand nonformulary. Some plans will cover most female prescription contraceptives at \$0 cost-share. Coverage on some drugs may not follow the generic and brand tier system. Please refer to your plan documents and Health Net's Recommended Drug List (RDL) for coverage, cost-share and tier information. *Evidence of Coverage* (EOC) and *Certificate of Insurance* (COI) are legally binding documents. If the information in this brochure differs from the information in the EOC or COI, the EOC or COI applies.

Salud con Health Net HMO y Más and Salud Mexico

- ¹ This is a summary of benefits. It does not include all services, limitations or exclusions. Please refer to the *Evidence of Coverage* for terms and conditions of coverage.
- ² Out-of-network providers, facilities or pharmacies in Mexico (other than those in the SIMNSA Network) are not covered by this plan.
- ³ The out-of-pocket maximum is combined for SIMNSA networks in Mexico and California.
- ⁴ Preventive care services for women also includes: female contraceptive services, devices and supplies; female family planning; female preventive sterilizations; screening for gestational diabetes, domestic violence and HIV; breastfeeding devices and supplies; and applicable female counseling for sexually transmitted infections, HIV, domestic violence, contraceptives, and breastfeeding.
- ⁵ Includes annual preventive physical, newborn and well-child care, preventive vision/hearing screening, well-woman exams, preventive lab, and X-ray services.
- ⁶ Complex radiology (includes CT, SPECT, PET, and MRI) requires a \$100 copay.
- ⁷ Includes physical, speech, occupational, cardiac, and pulmonary rehabilitation therapy.
- ⁸ Mental health and substance abuse services must be provided by a SIMNSA provider.
- ⁹ Chiropractic and/or acupuncture rider coverage is available as an optional benefit with the Salud HMO y Más plan shown. Features of Health Net's chiropractic coverage include \$10 per visit copayment and up to 20 visits per calendar year.
- ¹⁰ The three prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand nonformulary. Some plans will cover most female prescription contraceptives at \$0 cost-share. Coverage on some drugs may not follow the generic and brand tier system. Please refer to your plan documents and Health Net's Recommended Drug List (RDL) for coverage, cost-share and tier information. *Evidence of Coverage* (EOC) and *Certificate of Insurance* (COI) are legally binding documents. If the information in this brochure differs from the information in the EOC or COI, the EOC or COI applies.

Ancillary

- ¹ There is a maximum charge of \$150 in addition to the listed copayment if noble, high noble or titanium metal is used. Porcelain on molars is an additional charge of \$75.
- ² Out-of-network benefits for Classic Plus and Classic plans are reimbursed at the Usual, Customary and Reasonable (UCR) amounts as determined by FAIR Health, Inc.
- ³ Out-of-network benefits for Essential, Essential Value and Basic plans are based on the allowable amount applicable for the same service that would have been rendered by a network provider.
- ⁴ For employer-paid DPPO plans and voluntary DPPO plans, orthodontia available for groups of 10 or more enrollees.
- ⁵ Endodontics, periodontics and oral surgery are covered under Major Services under the Essential Value plan and not covered services under the Basic 500 plan.
- ⁶ Chiropractic and acupuncture care are offered by Health Net of California, Inc. for HMO plans; underwritten by Health Net Life Insurance Company for PPO and EPO insurance plans; and administered by American Specialty Health Plans of California, Inc., a subsidiary of American Specialty Health Incorporated (ASH).
- ⁷ Includes emergencies and urgent care visits and referral visits to nonparticipating acupuncturists.
- ⁸ Group Term Life, Supplemental Group Term Life and AD&D products are underwritten by Health Net Life Insurance Company, a subsidiary of Health Net, Inc.

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