Health Net's Starting Line-Up *Portfolio*

2016 Benefit Grids Booklet

Health Net®

Starting Line-Up

Portfolio 2016

With Health Net's Starting Line-Up (SLU) portfolio, you can offer your large group employers sustainable cost savings, along with the simplicity and innovation of our most popular plans and networks. Our SLU portfolio has benefit and plan options that keep employees healthy and companies going strong.

Inside

2016 SLU Portfolio *Quick Reference Guide*

HMO/HMO ExcelCare Network and EOA/EOA ExcelCare Network plans

Plan description	*HMO*		*HMO ExcelCare Network*		*EOA*		*EOA ExcelCare Network*	
	Medical plan codes	**Mental health plan codes**[1]	**Medical plan codes**	**Mental health plan codes**[1]	**Medical plan codes**	**Mental health plan codes**[1]	**Medical plan codes**	**Mental health plan codes**[1]
10/0 ($1,500/$4,500)					BJW	MV3		
15/0 ($1,500/$4,500)	BJG	MTU						
15/250a ($1,500/$4,500)					BJZ	MV6	BMS	MUP
20/250a ($1,500/$4,500)	BJJ	MTW	BM7	MTA	BJV	MV2	BMN	MUL
20/500a ($2,000/$6,000)	BJK	MTX	BM8	MTB	BK2	MV9	BMV	MUS
20/500d ($2,000/$6,000)	BJN	MU0			BK5	MVC		
20/20% ($1,500/$4,500)	BJP	UQA			BK6	UQR	BMZ	UQL
30/1000a ($2,000/$6,000)	BJL	MTY	BM9	MTC	BK3	MVA	BMW	MUT
30/20% ($1,500/$4,500)	BJQ	UQB			BK7	UQS	BN0	UQM
30/30% ($2,000/$6,000)	BJS	UQD	BMG	UQ7	BK8	UQT	BN1	UQN
40/20% ($1,500/$4,500)	BJR	UQC			BK9	UQU	BN2	UQO
40/30% ($2,000/$6,000)	BJT	UQE	BMH	UQ8	BKB	UQV	BN3	UQP
40/40% ($4,500/$9,000)	BJU	UQF	BMM	UQ9	BKC	UQW	BN4	UQQ
50/1500d ($4,850/$9,700)	CK7	Y3Y	CKC	Y4C	CKG	Y4G	CKH	Y4H
60/1500a ($4,850/$9,700)	CK8	Y3Z	CKD	Y4D	CKE	Y4E	CKF	Y4F
60/1500a ($4,850/$9,700)	CNX	Y5F	CNY	Y5H	CNW	Y5I	CNZ	Y5J

HMO SmartCare Network plans

Plan description		
	Medical plan codes	**Mental health plan codes**
15/250a ($1,500/$3,000)	BJ6	U2X
20/500a ($2,500/$5,000)	BJ7	U2Y
30/250d ($3,500/$7,000)	BJ8	UF7
40/500d ($3,500/$7,000)	BJ9	UF6
50/50% ($4,500/$9,000)	BJB	URR
50/1500d ($4,850/$9,700)	CK9	Y4A
60/1500a ($4,850/$9,700)	CKB	Y4B
60/1500a ($4,850/$9,700)	CNV	Y5G

Salud HMO y Más℠ plans

Plan description	*Medical plan codes*	*Mental health plan codes*[1]	*San Diego*	*San Diego mental health plan codes*
15/250a ($1,500/$4,500)	BKD	UAI	BKE	UAJ
15/20% ($1,500/$4,500)	BKG	US0	BKF	URZ
30/20% ($1,500/$4,500)	BKJ	US2	BKL	US4
30/30% ($2,000/$6,000)	BKH	US1	BKK	US3
40/40% ($4,500/$9,000)	C8B	Y0T	C8C	Y0U

[1]All mental health plans within SLU include severe and non-severe coverage.

[2]PPO insurance plans include both severe and non-severe mental health coverage.

[3]Pharmacy coverage embedded in each plan.

PPO insurance plans[2]

Plan description	*Medical plan codes*	
	Maximum allowable amount (MAA)	**Resource-based relative value scale (RBRVS)**
10/0/90/70 ($2,000/$4,000)		BKX
10/250/90/70 ($2,000/$4,000)	BLG	
15/250/90/70 ($2,000/$4,000)		BL1
10/250/80/60 ($3,000/$6,000)	BLJ	
15/500/90/70 ($2,000/$4,000)	BLL	BL2
15/500/80/60 ($3,000/$6,000)		BL4
20/250/90/70 ($2,000/$4,000)		BL5
20/250/80/60 ($3,000/$6,000)		BL6
20/500/80/60 ($3,000/$6,000)	BLR	BL7
30/500/90/70 ($2,000/$4,000)	BLS	BL8
30/500/80/60 ($3,000/$6,000)		BL9
30/1000/80/60 ($3,000/$6,000)		BLB
30/500/70/50 ($3,000/$6,000)	BLV	BBW
30/2000/70/50 ($4,000/$8,000)	BLW	BLC
30/3000/70/50 ($5,000/$10,000)		BLD
30/4000/70/50 ($5,600/$11,200)		BLE
60/5000/70/50 ($6,350/$12,700)		BA3

HSA-compatible PPO insurance plans[3]

Plan description	*Medical plan codes*	*HSA Rx plan*	
	Resource-based relative value scale (RBRVS)	**In-state**	**Out-of-state**
1500/70/50 ($3,000/$6,000)	CHF	41A	42A
2000/70/50 ($5,000/$10,000)	CHG	41B	42B
3000/70/50 ($5,000/$10,000)	CHE	41C	42C
2000/100/50 ($2,000/$4,000)	BM1	18K	19K
3000/100/50 ($3,000/$6,000)	BM2	18L	19L
4000/100/50 ($4,000/$8,000)	CHH	41D	42D

HSA/HRA integrated insurance plans

Plan description	*Medical plan codes*	*HSA Rx plan*	
	Resource-based relative value scale (RBRVS)	**In-state**	**Out-of-state**
1500/70/50 ($5,000/$10,000)	CGU	41P	42P
2000/70/50 ($5,000/$10,000)	CGV	41Q	42Q
3000/70/50 ($5,000/$10,000)	CGW	41R	42R
3000/80/60 ($4,000/$8,000)	CGX	41S	42S
5000/80/60 ($6,000/$12,000)	CGY	41T	42T
1500/70/50 ($3,000/$6,000)	CH4	41E	42E
2600/70/50 ($5,000/$10,000)	CH5	41F	42F
3000/70/50 ($5,000/$10,000)	CH6	41G	42G
3000/80/60 ($4,000/$8,000)	CH7	41H	42H
5000/80/60 ($6,000/$12,000)	CH8	41J	42J
2000/100/50 ($2,000/$4,000)	CUX	21U	21V
3000/100/50 ($3,000/$6,000)	CUW	21W	21X
4000/100/50 ($4,000/$8,000)	CUV	21Y	21Z

2016 SLU Portfolio *Quick Reference Guide (continued)*

HMO/EOA Rx plans (including sexual dysfunction coverage)

Plan description	*HMO*	*EOA*
15/35/55 (no brand deductible)	17L	17T
15/35/55 ($100 brand deductible)	17M	17V
15/40/60 ($300 brand deductible)	17N	17W
10/30/50 ($100 brand deductible)	17P	17U
10/30/50 (no brand deductible)	17S	17X
20/40/60 ($300 brand deductible)	22X	22Z

Salud y Más Rx plans (including sexual dysfunction coverage)

Plan description	*HMO RX Network*
5/25/45 (no brand deductible)	17Y
10/30/50 (no brand deductible)	17Z

PPO Rx plans (including sexual dysfunction coverage)

Plan description	*PPO*	*OOS PPO*
15/40/60 ($300 brand deductible)	18A	19A
15/40/60 ($300 brand deductible)	18B	19B
15/40/60 ($300 brand deductible)	18C	19C
10/30/50 (no brand deductible)	18S	19S
10/30/50 (no brand deductible)	18T	19T
15/35/55 (no brand deductible)	18U	19U
15/35/55 (no brand deductible)	18V	19V
10/30/50 ($100 brand deductible)	18W	19W
10/30/50 ($100 brand deductible)	18X	19X
15/35/55 ($100 brand deductible)	18Y	19Y
15/35/55 ($100 brand deductible)	18Z	19Z

Andre Hamil,
Health Net
We partner with you to promote workforce health.

HMO/HMO ExcelCare Network plans

Benefit description	*Member responsibility*		
	15/0 **HMO: BJG**	**20/250a** **HMO: BJJ** **HMO ExcelCare: BM7**	**20/500a** **HMO: BJK** **HMO ExcelCare: BM8**
Plan maximums Out-of-pocket maximum	$1,500 / $4,500	$1,500 / $4,500	$2,000 / $6,000
Lifetime maximum	Unlimited	Unlimited	Unlimited
Professional services Office visit copay (including specialist consultation)[5]	$15	$20	$20
Preventive care services[1,5]	No charge	No charge	No charge
X-ray and laboratory procedures[5]	No charge	No charge	No charge
Complex radiology (includes CT, SPECT, PET, MUGA, and MRI)	$100	$100	$100
Rehabilitation therapy[2]	$15	$20	$20
Self-injectables	30%	30%	30%
Hospital services Inpatient care	No charge	$250/admit	$500/admit
Outpatient services	No charge	No charge	No charge
Outpatient surgery	No charge	$250 per surgery	$500 per surgery
Skilled nursing facility	No charge (days 1–10) / $25/admit (days 11–100)	No charge (days 1–10) / $25/admit (days 11–100)	No charge (days 1–10) / $25/admit (days 11–100)
Emergency services Emergency room (copay waived if admitted)	$100	$100	$100
Urgent care facility	$15	$20	$20
Ambulance services (ground and air)	$100	$100	$100
Mental health and chemical dependency services[3] Outpatient consultation	$15	$20	$20
Outpatient other (includes partial hospitalization, day treatment, intensive outpatient programs)	No charge	No charge	No charge
Inpatient (includes detoxification)	No charge	$250/admit	$500/admit
Other services Durable medical equipment[5]	No charge	No charge	No charge
Orthotics and prosthetics[4]	No charge	No charge	No charge
Diabetic equipment	No charge	No charge	No charge
Chiropractic services	Optional rider available	Optional rider available	Optional rider available
Acupuncture	Optional rider available	Optional rider available	Optional rider available

[1]Preventive care: Includes annual preventive physical, newborn and well-child care, well-woman exams, preventive lab and X-ray services.

[2]Rehabilitation therapy: Includes physical, speech, occupational, cardiac, and pulmonary rehabilitation therapy.

[3]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).

[4]Corrective footware/custom foot orthotics are excluded. Please refer to the *Evidence of Coverage* for terms and conditions of coverage.

[5]As of 8/1/2012, 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, applicable female counseling for sexually transmitted infections, HIV, domestic violence, contraceptives, and breastfeeding support.

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.

Member responsibility				
20/500d HMO: BJN	**20/20% HMO: BJP**	**30/1000a HMO: BJL HMO ExcelCare: BM9**	**30/20% HMO: BJQ**	**30/30%/$4,850 HMO: BJS HMO ExcelCare: BMG**
$2,000 / $6,000	$1,500 / $4,500	$2,000 / $6,000	$1,500 / $4,500	$2,000 / $6,000
Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
$20	$20	$30	$30	$30
No charge	No charge	No charge	No charge	No charge
No charge	No charge	No charge	No charge	No charge
$100	$100	$100	$100	$100
$20	$20	$30	$30	$30
30%	30%	30%	30%	30%
$500/day[3]	20%	$1,000/admit	20%	30%
No charge	No charge	No charge	No charge	No charge
$500 per surgery	20%	$1,000 per surgery	20%	30%
No charge (days 1–10) / $25/admit (days 11–100)	No charge (days 1–10) / $25/admit (days 11–100)	No charge (days 1–10) / $25/admit (days 11–100)	No charge (days 1–10) / $25/admit (days 11–100)	No charge (days 1–10) / $25/admit (days 11–100)
$100	$100	$100	$100	$100
$20	$20	$30	$30	$30
$100	$100	$100	$100	$100
$20	$20	$30	$30	$30
No charge	No charge	No charge	No charge	No charge
$500/day	20%	$1,000/admit	20%	30%
No charge	No charge	No charge	No charge	No charge
No charge	No charge	No charge	No charge	No charge
No charge	No charge	No charge	No charge	No charge
Optional rider available	Optional rider available	Optional rider available	Optional rider available	Optional rider available
Optional rider available	Optional rider available	Optional rider available	Optional rider available	Optional rider available

HMO/HMO ExcelCare Network plans (continued)

Benefit description	*Member responsibility*		
	40/20% **HMO: BJR**	**40/30%** **HMO: BJT** **HMO ExcelCare: BMH**	**40/40%** **HMO: BJU** **HMO ExcelCare: BMM**
Plan maximums Out-of-pocket maximum	$1,500 / $4,500	$2,000 / $6,000	$4,500 / $9,000
Lifetime maximum	Unlimited	Unlimited	Unlimited
Professional services Office visit copay (including specialist consultation)[6]	$40	$40	$40
Preventive care services[1,6]	No charge	No charge	No charge
X-ray and laboratory procedures[6]	No charge	No charge	No charge
Complex radiology (includes CT, SPECT, PET, MUGA, and MRI)	$100	$100	$100
Rehabilitation therapy[2]	$40	$40	$40
Self-injectables	30%	30%	30%
Hospital services Inpatient care	20%	30%	40%
Outpatient services	No charge	No charge	No charge
Outpatient surgery	20%	30%	40%
Skilled nursing facility	No charge (days 1–10) / $25/admit (days 11–100)	No charge (days 1–10) / $25/admit (days 11–100)	No charge (days 1–10) / $25/admit (days 11–100)
Emergency services Emergency room (copay waived if admitted)	$100	$100	$100
Urgent care facility	$40	$40	$40
Ambulance services (ground and air)	$100	$100	$100
Mental health and chemical dependency services[4] Outpatient consultation	$40	$40	$40
Outpatient other (includes partial hospitalization, day treatment, intensive outpatient programs)	No charge	No charge	No charge
Inpatient (includes detoxification)	20%	30%	40%
Other services Durable medical equipment[6]	No charge	No charge	No charge
Orthotics and prosthetics[5]	No charge	No charge	No charge
Diabetic equipment	No charge	No charge	No charge
Chiropractic services	Optional rider available	Optional rider available	Optional rider available
Acupuncture	Optional rider available	Optional rider available	Optional rider available

[1]Preventive care: Includes annual preventive physical, newborn and well-child care, well-woman exams, preventive lab and X-ray services.

[2]Rehabilitation therapy: Includes physical, speech, occupational, cardiac, and pulmonary rehabilitation therapy.

[3]The inpatient hospital copayment is required each day for the first four days of confinement per admission.

[4]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).

[5]Corrective footware/custom foot orthotics are excluded. Please refer to the *Evidence of Coverage* for terms and conditions of coverage.

Member responsibility		
50/1500d HMO: CK7 HMO ExcelCare: CKC	**60/1500a HMO: CK8 HMO ExcelCare: CKD**	**60/1500a HMO: CNX HMO ExcelCare: CNY**
$4,850 / $9,700	$4,850 / $9,700	$4,850 / $9,700
Unlimited	Unlimited	Unlimited
$50	$60	$60
No charge	No charge	No charge
$10	20%	20%
20%	20%	20%
$50	20%	20%
30%	30%	30%
$1,500/day, 3 day maximum/admit[7]	$1,500/admit + 40%	$1,500/admit + 40%
$10	20%	50%
50%	50%	50%
No charge (days 1–10) / $25/admit (days 11–100)	20%	$1,500/admit + 40%
30%	30%	$300 + 30%
$100	$100	30%
$100	$300	30%
$50	$60	$60
No charge	No charge	No charge
$1,500/day	$1,500/admit + 40%	$1,500/admit + 40%
No charge	30%	50%
No charge	30%	50%
No charge	30%	30%
Optional rider available	Optional rider available	Optional rider available
Optional rider available	Optional rider available	Optional rider available

[6]As of 8/1/2012, 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, applicable female counseling for sexually transmitted infections, HIV, domestic violence, contraceptives, and breastfeeding support.

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.

SmartCare HMO plans

Benefit description	*Member responsibility*		
	15/250a HMO SmartCare: BJ6	**20/500a HMO SmartCare: BJ7**	**30/250d HMO SmartCare: BJ8**
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 benefit maximum	Unlimited	Unlimited	Unlimited
Professional services Office visit (including specialist consultation)	$15 copay	$20 copay	$30 copay
MinuteClinic services[1]	$15 copay	$20 copay	$30 copay
Preventive care services[2]	No charge	No charge	No charge
X-ray and laboratory procedures[3]	No charge	No charge	No charge
Self-injectables	30%	30%	30%
Hospital services Inpatient care (includes maternity)	$250/admit	$500/admit	$250 copay/day; 3-day copay max/admit
Outpatient facility services (other than surgery)	No charge	No charge	No charge
Outpatient surgery (hospital charges only)	$250 copay	$500 copay	$250 copay
Outpatient surgery (ambulatory surgery center charges only)	$100 copay	$200 copay	$100 copay
Emergency services Emergency room facility and professional services (copay waived if admitted)	$100 copay	$100 copay	$100 copay
Urgent care facility (copay waived if admitted)	$15 copay	$20 copay	$30 copay
Mental health and chemical dependency services[4] Outpatient consultation	$15	$20	$30
Outpatient other (includes partial hospitalization, day treatment, intensive outpatient programs)	No charge	No charge	No charge
Inpatient (includes detoxification)	$250/admit	$500/admit	$250 copay/day; 3-day copay max/admit
Other services Diabetic equipment	No charge	No charge	No charge
Acupuncture and chiropractic services	$15 copay (rider included; 10 visits per calendar year, chiropractic and acupuncture combined)	$15 copay (rider included; 10 visits per calendar year, chiropractic and acupuncture combined)	$15 copay (rider included; 10 visits per calendar year, chiropractic and acupuncture combined)
Prescription drug coverage[5] Note: The three options can be used with any of the plans.	**Option 1**	**Option 2**	**Option 3**
Brand-name calendar year deductible (per member)	$100	$100	$300
Prescription drugs (up to a 30-day supply)[6]	$10 / $30 / $50	$15 / $30 / $50	$20 / $40 / $60

[1] For additional information about MinuteClinic services and locations, please visit www.minuteclinic.com.

[2] Includes annual preventive physical, newborn and well-child care, well-woman exams, preventive lab and X-ray services. Preventive services through MinuteClinics are covered in full.

[3] Complex radiology (includes CT, SPECT, PET, and MRI) requires a $100 copayment.

[4] All mental health and chemical dependency services are provided or contracted through Managed Health Network (MHN). Please contact MHN for details.

SmartCare Wellness Incentive Program

SmartCare members can earn a $50 gift card reward to select retailers just by spending a little time on their health.

Member responsibility				
40/500d HMO SmartCare: BJ9	**50/50% HMO SmartCare: BJB**	**50/1500d HMO SmartCare: CK9**	**60/1500a HMO SmartCare: CKB**	**60/1500a HMO SmartCare: CNV**
$3,500 single / $7,000 family	$4,500 single / $9,000 family	$4,850 single / $9,700 family	$4,850 single / $9,700 family	$4,850 single / $9,700 family
Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
$40 copay	$50 copay	$50	$60	$60
$30 copay	$30 copay	$30	$30	$30
No charge	No charge	No charge	No charge	No charge
No charge	No charge	$10	20%	20%
30%	30%	30%	30%	30%
$500 copay/day; 3-day copay max/admit	50%	$1,500 copay/day; 3-day copay max/admit	$1,500/admit + 40%	$1,500/admit + 40%
No charge	No charge	$10	20%	50%
$500 copay	50%	50%	50%	50%
$200 copay	40%	50%	50%	50%
$100 copay	$100 copay	30%	30%	$300 + 30%
$40 copay	$50 copay	$100	$100	30%
$40	$50	$50	$60	$60
No charge	No charge	No charge	No charge	No charge
$500 copay/day; 3-day copay max/admit	50%	$1,500/day	$1,500/admit + 40%	$1,500/admit + 40%
No charge	No charge	No charge	30%	30%
$15 copay (rider included; 10 visits per calendar year, chiropractic and acupuncture combined)	$15 copay (rider included; 10 visits per calendar year, chiropractic and acupuncture combined)	$25 copay (rider included; 10 visits per calendar year, chiropractic and acupuncture combined)	$25 copay (rider included; 10 visits per calendar year, chiropractic and acupuncture combined)	$25 copay (rider included; 10 visits per calendar year, chiropractic and acupuncture combined)
Option 1		**Option 2**		**Option 3**
$100		$100		$300
$10 / $30 / $50		$15 / $30 / $50		$20 / $40 / $60

[5] 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.

[6] The three prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary.

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.

EOA/EOA ExcelCare Network plans

Benefit description	*Member responsibility*	
	10/0 **EOA: BJW**	**15/250a** **EOA: BJZ** **EOA ExcelCare: BMS**
Plan maximums Out-of-pocket maximum[8]	HMO: $1,500 / $4,500 PPO: $4,500 / $9,000	HMO: $1,500 / $4,500 PPO: $4,500 / $9,000
Lifetime maximum	Unlimited	Unlimited
Professional services Office visit copay (including specialist consultation)[7]	HMO $10 / PPO $30	HMO $15 / PPO $35
Preventive care services[1,7]	No charge	No charge
X-ray and laboratory procedures[7]	No charge	No charge
Complex radiology (includes CT, SPECT, PET, MUGA, and MRI)	$100	$100
Rehabilitation therapy[2]	HMO $10 / PPO $30	HMO $15 / PPO $35
Self-injectables[3]	30%	30%
Hospital services[4] Inpatient care	No charge	$250/admit
Outpatient services	No charge	No charge
Outpatient surgery	No charge	$250 per surgery
Skilled nursing facility	No charge (days 1–10) / $25/admit (days 11–100)	No charge (days 1–10) / $25/admit (days 11–100)
Emergency services Emergency room facility (copay waived if admitted)	$100	$100
Urgent care facility	$10	$15
Ambulance services (ground and air)	$100	$100
Mental health and chemical dependency services[5] Outpatient consultation	HMO $10 / PPO $30	HMO $15 / PPO $35
Outpatient other (includes partial hospitalization, day treatment, intensive outpatient programs)	HMO no charge / PPO not covered	HMO no charge / PPO not covered
Inpatient (includes detoxification)	HMO no charge / PPO not covered	HMO $250/admit / PPO not covered
Other services Durable medical equipment[4]	No charge	No charge
Orthotics and prosthetics[7]	No charge	No charge
Diabetic equipment	No charge	No charge
Acupuncture	Optional rider available	Optional rider available
Chiropractic services	Optional rider available	Optional rider available

[1]Preventive care: Includes annual preventive physical, newborn and well-child care, well-woman exams, preventive lab and X-ray services.

[2]Rehabilitation therapy: Includes physical, speech, occupational, cardiac, and pulmonary rehabilitation therapy.

[3]Through PPO, precertification is required by Health Net Pharmacy.

[4]Under Elect Open Access℠ plans, inpatient hospital, professional hospital services, durable medical equipment, complex radiology, laboratory, and surgery services 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.

[5]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).

[6]Corrective footware/custom foot orthotics are excluded. Please refer to the *Evidence of Coverage* for terms and conditions of coverage.

Member responsibility	
20/250a **EOA: BJV** **EOA ExcelCare: BMN**	**20/500a** **EOA: BK2** **EOA ExcelCare: BMV**
HMO: $1,500 / $4,500 PPO: $4,500 / $9,000	HMO: $2,000 / $6,000 PPO: $4,500 / $9,000
Unlimited	Unlimited
HMO $20 / PPO $40	HMO $20 / PPO $40
No charge	No charge
No charge	No charge
$100	$100
HMO $20 / PPO $40	HMO $20 / PPO $40
30%	30%
$250/admit	$500/admit
No charge	No charge
$250 per surgery	$500 per surgery
No charge (days 1–10) / $25/admit (days 11–100)	No charge (days 1–10) / $25/admit (days 11–100)
$100	$100
$20	$20
$100	$100
HMO $20 / PPO $40	HMO $20 / PPO $40
HMO no charge / PPO not covered	HMO no charge / PPO not covered
HMO $250/admit / PPO not covered	HMO $500/admit / PPO not covered
No charge	No charge
No charge	No charge
No charge	No charge
Optional rider available	Optional rider available
Optional rider available	Optional rider available

[7]As of 8/1/2012, 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, applicable female counseling for sexually transmitted infections, HIV, domestic violence, contraceptives, and breastfeeding support.

[8]The in-network HMO and PPO tiers both cross-accumulate to the out-of-pocket maximum amounts.

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.

EOA/EOA ExcelCare Network plans (continued)

Benefit description	*Member responsibility*		
	20/500d **EOA: BK5**	**20/20%** **EOA: BK6** **EOA ExcelCare: BMZ**	**30/1000a** **EOA: BK3** **EOA ExcelCare: BMW**
Plan maximums Out-of-pocket maximum[8]	HMO: $2,000 / $6,000 PPO:$4,500 / $9,000	HMO: $1,500 / $4,500 PPO: $4,500 / $9,000	HMO: $2,000 / $6,000 PPO: $4,500 / $9,000
Lifetime maximum	Unlimited	Unlimited	Unlimited
Professional services Office visit copay (including specialist consultation)[7]	HMO $20 / PPO $40	HMO $20 / PPO $40	HMO $30 / PPO $50
Preventive care services[1,7]	No charge	No charge	No charge
X-ray and laboratory procedures[7]	No charge	No charge	No charge
Complex radiology (includes CT, SPECT, PET, MUGA, and MRI)	$100	$100	$100
Rehabilitation therapy[2]	HMO $20 / PPO $40	HMO $20 / PPO $40	HMO $30 / PPO $50
Self-injectables[3]	30%	30%	30%
Hospital services[4] Inpatient care	$500 per day[6]	20%	$1,000/admit
Outpatient services	No charge	No charge	No charge
Outpatient surgery	$500 per surgery	20%	$1,000 per surgery
Skilled nursing facility	No charge (days 1–10) / $25/admit (days 11–100)	No charge (days 1–10) / $25/admit (days 11–100)	No charge (days 1–10) / $25/admit (days 11–100)
Emergency services Emergency room facility (copay waived if admitted)	$100	$100	$100
Urgent care facility	$20	$20	$30
Ambulance services (ground and air)	$100	$100	$100
Mental health and chemical dependency services[5] Outpatient consultation	HMO $20 / PPO $40	HMO $20 / PPO $40	HMO $30 / PPO $50
Outpatient other (includes partial hospitalization, day treatment, intensive outpatient programs)	HMO no charge / PPO not covered	HMO no charge / PPO not covered	HMO no charge / PPO not covered
Inpatient (includes detoxification)	HMO $500 per day / PPO not covered	HMO 20% / PPO not covered	HMO $1,000/admit / PPO not covered
Other services Durable medical equipment[4]	No charge	No charge	No charge
Orthotics and prosthetics[6]	No charge	No charge	No charge
Diabetic equipment	No charge	No charge	No charge
Acupuncture	Optional rider available	Optional rider available	Optional rider available
Chiropractic services	Optional rider available	Optional rider available	Optional rider available

[1]Preventive care: Includes annual preventive physical, newborn and well-child care, well-woman exams, preventive lab and X-ray services.

[2]Rehabilitation therapy: Includes physical, speech, occupational, cardiac, and pulmonary rehabilitation therapy.

[3]Through PPO, precertification is required by Health Net Pharmacy.

[4]Under Elect Open Access℠ plans, inpatient hospital, professional hospital services, durable medical equipment, complex radiology, laboratory, and surgery services 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.

[5]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).

Member responsibility			
30/20% EOA: BK7 EOA ExcelCare: BN0	**30/30% EOA: BK8 EOA ExcelCare: BN1**	**40/20% EOA: BK9 EOA ExcelCare: BN2**	**40/30% EOA: BKB EOA ExcelCare: BN3**
HMO: $1,500 / $4,500 PPO: $4,500 / $9,000	HMO: $2,000 / $6,000 PPO: $4,500 / $9,000	HMO: $1,500 / $4,500 PPO: $4,500 / $9,000	HMO: $2,000 / $6,000 PPO: $4,500 / $9,000
Unlimited	Unlimited	Unlimited	Unlimited
HMO $30 / PPO $50	HMO $30 / PPO $50	HMO $40 / PPO $60	HMO $40 / PPO $60
No charge	No charge	No charge	No charge
No charge	No charge	No charge	No charge
$100	$100	$100	$100
HMO $30 / PPO $50	HMO $30 / PPO $50	HMO $40 / PPO $60	HMO $40 / PPO $60
30%	30%	30%	30%
20%	30%	20%	30%
No charge	No charge	No charge	No charge
20%	30%	20%	30%
No charge (days 1–10) / $25/admit (days 11–100)	No charge (days 1–10) / $25/admit (days 11–100)	No charge (days 1–10) / $25/admit (days 11–100)	No charge (days 1–10) / $25/admit (days 11–100)
$100	$100	$100	$100
$30	$30	$40	$40
$100	$100	$100	$100
HMO $30 / PPO $50	HMO $30 / PPO $50	HMO $40 / PPO $60	HMO $40 / PPO $60
HMO no charge / PPO not covered	HMO no charge / PPO not covered	HMO no charge / PPO not covered	HMO no charge / PPO not covered
HMO 20% / PPO not covered	HMO 30% / PPO not covered	HMO 20% / PPO not covered	HMO 30% / PPO not covered
No charge	No charge	No charge	No charge
No charge	No charge	No charge	No charge
No charge	No charge	No charge	No charge
Optional rider available	Optional rider available	Optional rider available	Optional rider available
Optional rider available	Optional rider available	Optional rider available	Optional rider available

[6]Corrective footware/custom foot orthotics are excluded. Please refer to the *Evidence of Coverage* for terms and conditions of coverage.

[7]As of 8/1/2012, 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, applicable female counseling for sexually transmitted infections, HIV, domestic violence, contraceptives, and breastfeeding support.

[8]The in-network HMO and PPO tiers both cross-accumulate to the out-of-pocket maximum amounts.

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.

EOA/EOA ExcelCare Network plans (continued)

Benefit description	**40/40% EOA: BKC EOA ExcelCare: BN4**	**50/1500d EOA: CKG EOA ExcelCare: CKH**	**60/1500a EOA: CKE EOA ExcelCare: CKF**	**60/1500a EOA: CNW EOA ExcelCare: CNZ**
Plan maximums Out-of-pocket maximum[8]	HMO: $4,500 / $9,000 PPO:$4,500 / $9,000	HMO: $4,850 / $9,700 PPO: $4,850 / $9,700	HMO: $4,850 / $9,700 PPO: $4,850 / $9,700	HMO: $4,850 / $9,700 PPO: $4,850 / $9,700
Lifetime maximum	Unlimited	Unlimited	Unlimited	Unlimited
Professional services Office visit copay (including specialist consultation)[7]	HMO $40 / PPO $60	HMO $50 / PPO $70	HMO $60 / PPO $80	HMO $60 / PPO $80
Preventive care services[1,7]	No charge	No charge	No charge	No charge
X-ray and laboratory procedures[7]	No charge	HMO $10 / PPO 30%	HMO 20% / PPO 30%	HMO 20% / PPO 30%
Complex radiology (includes CT, SPECT, PET, MUGA, and MRI)	$100	20%	20%	20%
Rehabilitation therapy[2]	HMO $40 / PPO $60	HMO $10 / PPO 30%	20%	HMO 20% / PPO $80
Self-injectables[3]	30%	30%	30%	30%
Hospital services[4] Inpatient care	40%	$1,500 copay/day; 3-day copay max/admit	$1,500/admit + 40%	$1,500/admit + 40%
Outpatient services	No charge	$10	20%	50%
Outpatient surgery	40%	50%	50%	50%
Skilled nursing facility	No charge (days 1–10) / $25/admit (days 11–100)	No charge (days 1–10) / $25/admit (days 11–100)	20%	$1,500/admit + 40%
Emergency services Emergency room facility (copay waived if admitted)	$100	30%	30%	$300 + 30%
Urgent care facility	$40	$100	$100	30%
Ambulance services (ground and air)	$100	$300	$300	30%
Mental health and chemical dependency services[5] Outpatient consultation	HMO $40 / PPO $60	HMO $50 / PPO $70	HMO $60 / PPO $80	HMO $60 / PPO $80
Outpatient other (includes partial hospitalization, day treatment, intensive outpatient programs)	HMO no charge / PPO not covered	HMO no charge / PPO not covered	HMO no charge / PPO not covered	HMO no charge / PPO not covered
Inpatient (includes detoxification)	HMO 40% / PPO not covered	HMO $1,500/day / PPO not covered	HMO $1,500/admit + 40% / PPO not covered	HMO $1,500/admit + 40% / PPO not covered
Other services Durable medical equipment[4]	No charge	No charge	30%	50%
Orthotics and prosthetics[6]	No charge	No charge	30%	50%
Diabetic equipment	No charge	No charge	30%	30%
Acupuncture	Optional rider available	Optional rider available	Optional rider available	Optional rider available
Chiropractic services	Optional rider available	Optional rider available	Optional rider available	Optional rider available

[1]Preventive care: Includes annual preventive physical, newborn and well-child care, well-woman exams, preventive lab and X-ray services.

[2]Rehabilitation therapy: Includes physical, speech, occupational, cardiac, and pulmonary rehabilitation therapy.

[3]Through PPO, precertification is required by Health Net Pharmacy.

[4]Under Elect Open Access[SM] plans, inpatient hospital, professional hospital services, durable medical equipment, complex radiology, laboratory, and surgery services 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.

[5]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).

[6]Corrective footware/custom foot orthotics are excluded. Please refer to the *Evidence of Coverage* for terms and conditions of coverage.

[7]As of 8/1/2012, 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, applicable female counseling for sexually transmitted infections, HIV, domestic violence, contraceptives, and breastfeeding support.

[8]The in-network HMO and PPO tiers both cross-accumulate to the out-of-pocket maximum amounts.

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.

Salud HMO y Más℠ plans

Benefit description	*Member responsibility*	
	Salud HMO y Más 15/250a (BKD) **San Diego only: BKE**	
	SIMNSA Network (Mexico)[1]	**Salud Network (CA)**[1]
Plan maximums Out-of-pocket maximum	$1,500 / $4,500	
Lifetime maximum	Unlimited	
Professional services Office visit copay (including specialist consultation)[9]	$5	$15
Preventive care services[2,9]	No charge	No charge
X-ray and laboratory procedures (includes CT, SPECT, PET, MUGA, and MRI)[9]	No charge	No charge
Rehabilitation therapy[3]	$5	$15
Self-injectables	No charge	30%
Hospital services Inpatient care	No charge	$250
Outpatient services	No charge	20%
Outpatient surgery	No charge	20%
Skilled nursing facility	No charge	20% (100 days combined per calendar year)
Emergency services[5] Emergency room (copay waived if admitted)	$10	$50
Urgent care facility	$10	$15
Ambulance services (ground and air)	No charge	$50
Mental health and chemical dependency services[5] Outpatient consultation	$5	$15
Outpatient other (includes partial hospitalization, day treatment, intensive outpatient programs)	No charge	
Inpatient (includes detoxification)	$0	$250
Other services Durable medical equipment[9]	No charge	No charge
Orthotics and prosthetics[6]	No charge	No charge
Diabetic equipment	No charge	No charge
Acupuncture	Not covered	Optional rider available
Chiropractic services	Not covered	Optional rider available
Prescription drug coverage[10] Prescription drugs	$5[7]	Optional rider available[8]

[1]Members residing in California may self-refer to participating SIMNSA providers.

[2]Preventive care: Includes annual preventive physical, newborn and well-child care, well-woman exams, preventive lab and X-ray services.

[3]Rehabilitation therapy: Includes physical, speech, occupational, cardiac, and pulmonary rehabilitation therapy.

[4]Mental health and chemical dependency rehabilitation services must be provided by a SIMNSA provider.

[5]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).

[6]Corrective footware/custom foot orthotics are excluded. Please refer to the *Evidence of Coverage* for terms and conditions of coverage.

[7]Prescriptions must be filled at a SIMNSA participating pharmacy.

[8]For details regarding a specific drug, go to www.healthnet.com.

[9]As of 8/1/2012, 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, applicable female counseling for sexually transmitted infections, HIV, domestic violence, contraceptives, and breastfeeding support.

Member responsibility			
Salud HMO y Más 15/20% (BKG) **San Diego only: BKF**		**Salud HMO y Más 40/40% (C8B)** **San Diego only: C8C**	
SIMNSA Network (Mexico)[1]	**SALUD Network (CA)**[1]	**SIMNSA Network (Mexico)**[1]	**SALUD Network (CA)**[1]
$1,500 / $4,500		$1,500 / $4,500	$4,500 / $9,000
Unlimited		Unlimited	
$5	$15	$5	$40
No charge	No charge	No charge	No charge
No charge	No charge	No charge	No charge
$5	$15	$5	$40
No charge	30%	30%	30%
No charge	20%	No charge	40%
No charge	20%	No charge	$0
No charge	20%	No charge	40%
No charge (100 days combined per calendar year)	20%	No charge	No charge (days 1–10) / $25/admit (days 11–100)
$10	$50	10%	$100
$10	$15	$10	$40
No charge	$50	No charge	$100
$5	$15	$5	$40
No charge		No charge	
$0	20%	No charge	40%
No charge	No charge	No charge	No charge
No charge	No charge	No charge	No charge
No charge	No charge	No charge	No charge
Not covered	Optional rider available	Optional rider available	Optional rider available
Not covered	Optional rider available	Optional rider available	Optional rider available
$5[7]	Optional rider available[8]	$5[7]	Optional rider available[8]

[10]Effective 8/1/12, 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 and SIMNSA's Recommended Drug List (RDL) for coverage, cost-share and tier information.

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.

Salud HMO y Más℠ plans (continued)

Benefit description	*Member responsibility*	
	Salud HMO y Más 30/20% (BKJ) **San Diego only: BKL**	
	SIMNSA Network (Mexico)[1]	**Salud Network (CA)**[1]
Plan maximums Out-of-pocket maximum	$1,500 / $4,500	
Lifetime maximum	Unlimited	
Professional services Office visit copay (including specialist consultation)[8]	$5	$30
Preventive care services[2,8]	No charge	No charge
X-ray and laboratory procedures (includes CT, SPECT, PET, MUGA, and MRI)[8]	No charge	No charge
Rehabilitation therapy[3]	$5	$30
Self-injectables	No charge	30%
Hospital services Inpatient care	No charge	20%
Outpatient services	No charge	20%
Outpatient surgery	No charge	20%
Skilled nursing facility	No charge	20% (100 days combined per calendar year)
Emergency services Emergency room (copay waived if admitted)	$10	$50
Urgent care facility	$10	$30
Ambulance services (ground and air)	No charge	$50
Mental health and chemical dependency services[5] Outpatient consultation	$5	$30
Outpatient other (includes partial hospitalization, day treatment, intensive outpatient programs)	No charge	
Inpatient (includes detoxification)	$0	20%
Other services Durable medical equipment[8]	No charge	No charge
Orthotics and prosthetics[6]	No charge	No charge
Diabetic equipment	No charge	No charge
Acupuncture	Not covered	Optional rider available
Chiropractic services	Not covered	Optional rider available
Prescription drug coverage[9] Prescription drugs	$5[7]	Optional rider available

[1]Members residing in California may self-refer to participating SIMNSA providers.

[2]Preventive care: Includes annual preventive physical, newborn and well-child care, well-woman exams, preventive lab and X-ray services.

[3]Rehabilitation therapy: Includes physical, speech, occupational, cardiac, and pulmonary rehabilitation therapy.

[4]Mental health and chemical dependency rehabilitation services must be provided by a SIMNSA provider.

[5]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).

[6]Corrective footware/custom foot orthotics are excluded. Please refer to the *Evidence of Coverage* for terms and conditions of coverage.

Member responsibility	
Salud HMO y Más 30/30% (BKH) **San Diego only: BKK**	
SIMNSA Network (Mexico)[1]	**SALUD Network (CA)**[1]
$2,000 / $6,000	
Unlimited	
$5	$30
No charge	No charge
No charge	No charge
$5	$30
No charge	30%
No charge	30%
No charge	30%
No charge	30%
No charge	30%
(100 days combined per calendar year)	
$10	$50
$10	$30
No charge	$50
$5	$30
No charge	
$0	30%
No charge	No charge
No charge	No charge
No charge	No charge
Not covered	Optional rider available
Not covered	Optional rider available
$5[7]	Optional rider available

[7]Prescriptions must be filled at a SIMNSA participating pharmacy.

[8]As of 8/1/2012, 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, applicable female counseling for sexually transmitted infections, HIV, domestic violence, contraceptives, and breastfeeding support.

[9]Effective 8/1/12, 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 and SIMNSA's Recommended Drug List (RDL) for coverage, cost-share and tier information.

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.

PPO insurance plans

There are two plan options for each PPO insurance plan shown based on out-of-network reimbursement (except plan BA3). MAA plan options are plans with the out-of-network reimbursement based on the maximum allowable amount. With MAA, the covered person is responsible for charges in excess of maximum allowable charges in addition to the coinsurance shown. Refer to the definition section of the *Certificate of Insurance* for details. Resource-Based Relative

Benefit description	*Covered person(s) responsibility*	
	PPO 10/0/90/70 **RBRVS: BKX**	
	In-network	**Out-of-network**
Plan maximums Calendar year deductible	$0	$250 / $750
Coinsurance	10%	30%
Out-of-pocket maximum	$2,000 / $6,000	$4,000 / $12,000
Lifetime maximum	Unlimited	
Professional services Office visit copay (including specialist consultation)[5]	$10 (deductible waived)	30%
Preventive care services[1,5]	$0 copay (deductible waived)	Not covered
X-ray and laboratory procedures (includes CT, SPECT, PET, MUGA, and MRI)[5]	10%	30%
Rehabilitation therapy[2]	10%	30%
Self-injectables[3]	30%	Not covered
Hospital services Inpatient care	10%	30%
Outpatient services	10%	30%
Outpatient surgery	10%	30%
Skilled nursing facility	10%	30% Limit of 100 days
Emergency services *For all services which meet the criteria for emergency care, the coinsurance will be the percentage shown for in-network PPO, even if the services were provided by an out-of-network provider.* Emergency room facility (copay waived if admitted)	$100 + 10%	$100 + 30%
Urgent care facility	$10 (deductible waived)	30%
Ambulance services (ground and air)	$50 + 10%	$50 + 30%
Mental health and chemical dependency services[4] Outpatient consultation	$10 (deductible waived)	30%
Outpatient other (includes partial hospitalization, day treatment, intensive outpatient programs)	10%	30%
Inpatient (includes detoxification)	10%	30%
Other services Durable medical equipment[5]	10%	30%
Orthotics and prosthetics	10%	30%
Diabetic equipment	10%	30%
Chiropractic care	$10 (deductible waived)	30% ($25 max payable per visit) $1,500 max per calendar year (in- and out-of-network combined)
Acupuncture	10%	30%

[1]Preventive care: Includes annual preventive physical, newborn and well-child care, well-woman exams, preventive lab, and X-ray services.

[2]Rehabilitation therapy: Includes physical, speech, occupational, cardiac, and pulmonary rehabilitation therapy.

[3]Through PPO, precertification is required by Health Net Pharmacy.

[4]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).

Value Scale (RBRVS) plan options are plans with out-of-network reimbursement based on a Limited Fee Schedule. This Limited Fee Schedule is a percentage of RBRVS. With RBRVS, the covered person is responsible for charges in excess of the allowed amount in addition to the coinsurance shown. Refer to the definition section of the *Certificate of Insurance* for details.

Covered person(s) responsibility			
PPO 10/250/90/70 **MAA: BLG**		**PPO 15/250/90/70** **RBRVS: BL1**	
In-network	**Out-of-network**	**In-network**	**Out-of-network**
$250 / $750 (in- and out-of-network combined)		$250 / $750 (in- and out-of-network combined)	
10%	30%	10%	30%
$2,000 / $6,000	$4,000 / $12,000	$2,000 / $6,000	$4,000 / $12,000
Unlimited		Unlimited	
$10 (deductible waived)	30%	$15 (deductible waived)	30%
$0 copay (deductible waived)	Not covered	$0 copay (deductible waived)	Not covered
10%	30%	10%	30%
10%	30%	10%	30%
30%	Not covered	30%	Not covered
10%	30%	10%	30%
10%	30%	10%	30%
10%	30%	10%	30%
10%	30%	10%	30%
Limit of 100 days		Limit of 100 days	
$100 + 10%	$100 + 30%	$100 + 10%	$100 + 30%
$10 (deductible waived)	30%	$15 (deductible waived)	30%
$50 + 10%	$50 + 30%	$50 + 10%	$50 + 30%
$10 (deductible waived)	30%	$15 (deductible waived)	30%
10%	30%	10%	30%
10%	30%	10%	30%
10%	30%	10%	30%
10%	30%	10%	30%
10%	30%	10%	30%
$10 (deductible waived)	30% ($25 max payable per visit)	$15 (deductible waived)	30% ($25 max payable per visit)
$1,500 max per calendar year (in- and out-of-network combined)		$1,500 max per calendar year (in- and out-of-network combined)	
10%	30%	10%	30%

[5]As of 8/1/2012, 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, applicable female counseling for sexually transmitted infections, HIV, domestic violence, contraceptives, and breastfeeding support.

This is a summary of your benefits. It does not include all services, limitations or exclusions. Please refer to the *Certificate of Insurance* for terms and conditions of coverage. PPO insurance plans are underwritten by Health Net Life Insurance Company.

PPO insurance plans (continued)

Benefit description	*Covered person(s) responsibility*	
	PPO 20/250/90/70 **RBRVS: BL5**	
	In-network	**Out-of-network**
Plan maximums Calendar year deductible	$250 / $750 (in- and out-of-network combined)	
Coinsurance	10%	30%
Out-of-pocket maximum	$2,000 / $6000	$4,000 / $12,000
Lifetime maximum	Unlimited	
Professional services Office visit copay (including specialist consultation)[5]	$20 (deductible waived)	30%
Preventive care services[1,5]	$0 copay (deductible waived)	Not covered
X-ray and laboratory procedures (includes CT, SPECT, PET, MUGA, and MRI)[5]	10%	30%
Rehabilitation therapy[2]	10%	30%
Self-injectables[3]	30%	Not covered
Hospital services Inpatient care	10%	30%
Outpatient services	10%	30%
Outpatient surgery	10%	30%
Skilled nursing facility	10%	30%
	Limit of 100 days	
Emergency services *For all services which meet the criteria for emergency care, the coinsurance will be the percentage shown for in-network PPO, even if the services were provided by an out-of-network provider.* Emergency room facility (copay waived if admitted)	$100 + 10%	$100 + 30%
Urgent care facility	$20 (deductible waived)	30%
Ambulance services (ground and air)	$50 + 10%	$50 + 30%
Mental health and chemical dependency services[4] Outpatient consultation	$20 (deductible waived)	30%
Outpatient other (includes partial hospitalization, day treatment, intensive outpatient programs)	10%	30%
Inpatient (includes detoxification)	10%	30%
Other services Durable medical equipment[5]	10%	30%
Orthotics and prosthetics	10%	30%
Diabetic equipment	10%	30%
Chiropractic care	$20 (deductible waived)	30% ($25 max payable per visit)
	$1,500 max per calendar year (in- and out-of-network combined)	
Acupuncture	10%	30%

[1]Preventive care: Includes annual preventive physical, newborn and well-child care, well-woman exams, preventive lab and X-ray services.

[2]Rehabilitation therapy: Includes physical, speech, occupational, cardiac, and pulmonary rehabilitation therapy.

[3]Precertification is required by Health Net Pharmacy.

[4]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).

Covered person(s) responsibility			
PPO 15/500/90/70 **RBRVS: BL2 / MAA: BLL**		**PPO 30/500/90/70** **RBRVS: BL8 / MAA: BLS**	
In-network	**Out-of-network**	**In-network**	**Out-of-network**
$500 / $750 (in- and out-of-network combined)		$500 / $1,500 (in- and out-of-network combined)	
10%	30%	10%	30%
$2,000 / $6,000	$4,000 / $12,000	$2,000 / $6,000	$4,000 / $12,000
Unlimited		Unlimited	
$15 (deductible waived)	30%	$30 (deductible waived)	30%
$0 copay (deductible waived)	Not covered	$0 copay (deductible waived)	Not covered
10%	30%	10%	30%
10%	30%	10%	30%
30%	Not covered	30%	Not covered
10%	30%	10%	30%
10%	30%	10%	30%
10%	30%	10%	30%
10%	30%	10%	30%
Limit of 100 days		Limit of 100 days	
$100 + 10%	$100 + 30%	$100 + 10%	$100 + 30%
$15 (deductible waived)	30%	$30 (deductible waived)	30%
$50 + 10%	$50 + 30%	$50 + 10%	$50 + 30%
$15 (deductible waived)	30%	$30 (deductible waived)	30%
10%	30%	10%	30%
10%	30%	10%	30%
10%	30%	10%	30%
10%	30%	10%	30%
10%	30%	10%	30%
$15 (deductible waived)	30% ($25 max payable per visit)	$30 (deductible waived)	30% ($25 max payable per visit)
$1,500 max per calendar year (in- and out-of-network combined)		$1,500 max per calendar year (in- and out-of-network combined)	
10%	30%	10%	30%

[5]As of 8/1/2012, 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, applicable female counseling for sexually transmitted infections, HIV, domestic violence, contraceptives, and breastfeeding support.

This is a summary of your benefits. It does not include all services, limitations or exclusions. Please refer to the *Certificate of Insurance* for terms and conditions of coverage. Insurance plan is underwritten by Health Net Life Insurance Company.

PPO insurance plans (continued)

Benefit description	*Covered person(s) responsibility*	
	PPO 20/250/80/60 **RBRVS: BL6**	
	In-network	**Out-of-network**
Plan maximums Calendar year deductible	$250 / $750 (in- and out-of-network combined)	
Coinsurance	20%	40%
Out-of-pocket maximum	$3,000 / $9,000	$6,000 / $18,000
Lifetime maximum	Unlimited	
Professional services Office visit copay (including specialist consultation)[5]	$20 (deductible waived)	40%
Preventive care services[1,5]	$0 copay (deductible waived)	Not covered
X-ray and laboratory procedures (includes CT, SPECT, PET, MUGA, and MRI)[5]	20%	40%
Rehabilitation therapy[2]	20%	40%
Self-injectables[3]	30%	Not covered
Hospital services Inpatient care	20%	40%
Outpatient services	20%	40%
Outpatient surgery	20%	40%
Skilled nursing facility	20%	40% Limit of 100 days
Emergency services *For all services which meet the criteria for emergency care, the coinsurance will be the percentage shown for in-network PPO, even if the services were provided by an out-of-network provider.* Emergency room facility (copay waived if admitted)	$100 + 20%	$100 + 40%
Urgent care facility	$20 (deductible waived)	40%
Ambulance services (ground and air)	$50 + 20%	$50 + 40%
Mental health and chemical dependency services[4] Outpatient consultation	$20 (deductible waived)	40%
Outpatient other (includes partial hospitalization, day treatment, intensive outpatient programs)	20%	40%
Inpatient (includes detoxification)	20%	40%
Other services Durable medical equipment[5]	20%	40%
Orthotics and prosthetics	20%	40%
Diabetic equipment	20%	40%
Chiropractic care	$20 (deductible waived) $1,500 max per calendar year (in- and out-of-network combined)	40% ($25 max payable per visit)
Acupuncture	20%	40%

[1]Preventive care: Includes annual preventive physical, newborn and well-child care, well-woman exams, preventive lab and X-ray services.

[2]Rehabilitation therapy: Includes physical, speech, occupational, cardiac, and pulmonary rehabilitation therapy.

[3]Precertification is required by Health Net Pharmacy.

[4]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).

Covered person(s) responsibility			
PPO 15/500/80/60 **RBRVS: BL4**		**PPO 20/500/80/60** **RBRVS: BL7 / MAA: BLR**	
In-network	**Out-of-network**	**In-network**	**Out-of-network**
$500 / $1,500 (in- and out-of-network combined)		$500 / $1,500 (in- and out-of-network combined)	
20%	40%	20%	40%
$3,000 / $9,000	$6,000 / $18,000	$3,000 / $9,000	$6,000 / $18,000
Unlimited		Unlimited	
$15 (deductible waived)	40%	$20 (deductible waived)	40%
$0 copay (deductible waived)	Not covered	$0 copay (deductible waived)	Not covered
20%	40%	20%	40%
20%	40%	20%	40%
30%	Not covered	30%	Not covered
20%	40%	20%	40%
20%	40%	20%	40%
20%	40%	20%	40%
20%	40%	20%	40%
Limit of 100 days		Limit of 100 days	
$100 + 20%	$100 + 40%	$100 + 20%	$100 + 40%
$15 (deductible waived)	40%	$20 (deductible waived)	40%
$50 + 20%	$50 + 40%	$50 + 20%	$50 + 40%
$15 (deductible waived)	40%	$20 (deductible waived)	40%
20%	40%	20%	40%
20%	40%	20%	40%
20%	40%	20%	40%
20%	40%	20%	40%
20%	40%	20%	40%
$15 (deductible waived)	40% ($25 max payable per visit)	$20 (deductible waived)	40% ($25 max payable per visit)
$1,500 max per calendar year (in- and out-of-network combined)		$1,500 max per calendar year (in- and out-of-network combined)	
20%	40%	20%	40%

[5]As of 8/1/2012, 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, applicable female counseling for sexually transmitted infections, HIV, domestic violence, contraceptives, and breastfeeding support.

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PPO insurance plans (continued)

Benefit description	*Covered person(s) responsibility*	
	PPO 30/500/80/60 **RBRVS: BL9**	
	In-network	**Out-of-network**
Plan maximums Calendar year deductible	$500 / $1,500 (in- and out-of-network combined)	
Coinsurance	20%	40%
Out-of-pocket maximum	$3,000 / $9,000	$6,000 / $9,000
Lifetime maximum	Unlimited	
Professional services Office visit copay (including specialist consultation)[5]	$30 (deductible waived)	40%
Preventive care services[1,5]	$0 copay (deductible waived)	Not covered
X-ray and laboratory procedures (includes CT, SPECT, PET, MUGA, and MRI)[5]	20%	40%
Rehabilitation therapy[2]	20%	40%
Self-injectables[3]	30%	Not covered
Hospital services Inpatient care	20%	40%
Outpatient services	20%	40%
Outpatient surgery	20%	40%
Skilled nursing facility	20%	40% Limit of 100 days
Emergency services *For all services which meet the criteria for emergency care, the coinsurance will be the percentage shown for in-network PPO, even if the services were provided by an out-of-network provider.* Emergency room facility (copay waived if admitted)	$100 + 20%	$100 + 40%
Urgent care facility	$30 (deductible waived)	40%
Ambulance services (ground and air)	$50 + 20%	$50 + 40%
Mental health and chemical dependency services[4] Outpatient consultation	$30 (deductible waived)	40%
Outpatient other (includes partial hospitalization, day treatment, intensive outpatient programs)	20%	40%
Inpatient (includes detoxification)	20%	40%
Other services Durable medical equipment[5]	20%	40%
Orthotics and prosthetics	20%	40%
Diabetic equipment	20%	40%
Chiropractic care	$30 (deductible waived)	40% ($25 max payable per visit) $1,500 max per calendar year (in- and out-of-network combined)
Acupuncture	20%	40%

[1]Preventive care: Includes annual preventive physical, newborn and well-child care, well-woman exams, preventive lab and X-ray services.

[2]Rehabilitation therapy: Includes physical, speech, occupational, cardiac, and pulmonary rehabilitation therapy.

[3]Precertification is required by Health Net Pharmacy.

[4]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).

Covered person(s) responsibility			
PPO 30/1000/80/60 **RBRVS: BLB**		**PPO 30/500/70/50** **RBRVS: BBW / MAA: BLV**	
In-network	**Out-of-network**	**In-network**	**Out-of-network**
$1,000 / $3,000 (in- and out-of-network combined)		$500 / $1,500 (in- and out-of-network combined)	
20%	40%	30%	50%
$3,000 / $9,000	$6,000 / $18,000	$3,000 / $9,000	$6,000 / $9,000
Unlimited		Unlimited	
$30 (deductible waived)	40%	$30 (deductible waived)	50%
$0 copay (deductible waived)	Not covered	$0 copay (deductible waived)	Not covered
20%	40%	30%	50%
20%	40%	30%	50%
30%	Not covered	30%	Not covered
20%	40%	30%	50%
20%	40%	30%	50%
20%	40%	30%	50%
20%	40%	30%	50%
Limit of 100 days		Limit of 100 days	
$100 + 20%	$100 + 40%	$100 + 30%	$100 + 50%
$30 (deductible waived)	40%	$30 (deductible waived)	50%
$50 + 20%	$50 + 40%	$50 + 30%	$50 + 50%
$30 (deductible waived)	40%	$30 (deductible waived)	50%
20%	40%	30%	50%
20%	40%	30%	50%
20%	40%	30%	50%
20%	40%	30%	50%
20%	40%	30%	50%
$30 (deductible waived)	40% ($25 max payable per visit)	$30 (deductible waived)	50% ($25 max payable per visit)
$1,500 max per calendar year (in- and out-of-network combined)		$1,500 max per calendar year (in- and out-of-network combined)	
20%	40%	30%	50%

[5]As of 8/1/2012, 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, applicable female counseling for sexually transmitted infections, HIV, domestic violence, contraceptives, and breastfeeding support.

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PPO insurance plans (continued)

Benefit description	*Covered person(s) responsibility*	
	PPO 30/2000/70/50 **RBRVS: BLC / MAA: BLW**	
	In-network	**Out-of-network**
Plan maximums Calendar year deductible	$2,000 / $6,000 (in- and out-of-network combined)	
Coinsurance	30%	50%
Out-of-pocket maximum	$4,000 / $8,000	$8,000 / $24,000
Lifetime maximum	Unlimited	
Professional services Office visit copay (including specialist consultation)[5]	$30 (deductible waived)	50%
Preventive care services[1,5]	$0 copay (deductible waived)	Not covered
X-ray and laboratory procedures (includes CT, SPECT, PET, MUGA, and MRI)[5]	30%	50%
Rehabilitation therapy[2]	30%	50%
Self-injectables[3]	30%	Not covered
Hospital services Inpatient care	30%	50%
Outpatient services	30%	50%
Outpatient surgery	30%	50%
Skilled nursing facility	30%	40% Limit of 100 days
Emergency services *For all services which meet the criteria for emergency care, the coinsurance will be the percentage shown for in-network PPO, even if the services were provided by an out-of-network provider.* Emergency room facility (copay waived if admitted)	$100 + 30%	$100 + 50%
Urgent care facility	$30 (deductible waived)	50%
Ambulance services (ground and air)	$50 + 30%	$50 + 50%
Mental health and chemical dependency services[4] Outpatient consultation	$30 (deductible waived)	50%
Outpatient other (includes partial hospitalization, day treatment, intensive outpatient programs)	30%	50%
Inpatient (includes detoxification)	30%	50%
Other services Durable medical equipment[5]	30%	50%
Orthotics and prosthetics	30%	50%
Diabetic equipment	30%	50%
Chiropractic care	$30 (deductible waived)	50% ($25 max payable per visit) $1,500 max per calendar year (in- and out-of-network combined)
Acupuncture	30%	50%

[1]Preventive care: Includes annual preventive physical, newborn and well-child care, well-woman exams, preventive lab and X-ray services.

[2]Rehabilitation therapy: Includes physical, speech, occupational, cardiac, and pulmonary rehabilitation therapy.

[3]Precertification is required by Health Net Pharmacy.

[4]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).

Covered person(s) responsibility			
PPO 30/3000/70/50 RBRVS: BLD		**PPO 30/4000/70/50 RBRVS: BLE**	
In-network	**Out-of-network**	**In-network**	**Out-of-network**
$3,000 / $9,000 (in- and out-of-network combined)		$4,000 / $11,000 (in- and out-of-network combined)	
30%	50%	30%	50%
$5,000 / $10,000	$10,000 / $30,000	$5,600 / $11,200	$12,000 / $36,000
Unlimited		Unlimited	
$30 (deductible waived)	50%	$30 (deductible waived)	50%
$0 copay (deductible waived)	Not covered	$0 copay (deductible waived)	Not covered
30%	50%	30%	50%
30%	50%	30%	50%
30%	Not covered	30%	Not covered
30%	50%	30%	50%
30%	50%	30%	50%
30%	50%	30%	50%
30%	50%	30%	50%
Limit of 100 days		Limit of 100 days	
$100 + 30%	$100 + 50%	$100 + 30%	$100 + 50%
$30 (deductible waived)	50%	$30 (deductible waived)	50%
$50 + 30%	$50 + 50%	$50 + 30%	$50 + 50%
$30 (deductible waived)	50%	$30 (deductible waived)	50%
30%	50%	30%	50%
30%	50%	30%	50%
30%	50%	30%	50%
30%	50%	30%	50%
30%	50%	30%	50%
$30 (deductible waived)	50% ($25 max payable per visit)	$30 (deductible waived)	50% ($25 max payable per visit)
$1,500 max per calendar year (in- and out-of-network combined)		$1,500 max per calendar year (in- and out-of-network combined)	
30%	50%	30%	50%

[5]As of 8/1/2012, 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, applicable female counseling for sexually transmitted infections, HIV, domestic violence, contraceptives, and breastfeeding support.

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PPO insurance plans (continued)

Benefit description	*Covered person(s) responsibility*	
	PPO 60/5000/70/50 **RBRVS: BA3**	
	In-network	**Out-of-network**[1]
Plan maximums Calendar year deductible	$5,000 / $10,000	$10,000 / $20,000
Coinsurance	30%	50%
Out-of-pocket maximum (medical and pharmacy out-of-pocket maximums are combined)	$6,350 / $12,700	$12,700 / $25,400
Lifetime maximum	Unlimited	
Professional services Office visit copay[6]	Visits 1–3 $60 deductible waived / Visits 4+ $60 deductible applies[7] (specialist consultations $70 deductible applies)	50%
Preventive care services[2,6]	$0 copay (deductible waived)	Not covered
X-ray and laboratory procedures (includes CT, SPECT, PET, MUGA, and MRI)[6]	30%	50%
Rehabilitation therapy[3]	30%	50%
Self-injectables[4]	30%	Not covered
Hospital services Inpatient care	30%	50%
Outpatient services	30%	50%
Outpatient surgery	30%	50%
Skilled nursing facility	30%	40%
	Limit of 100 days	
Emergency services *For all services which meet the criteria for emergency care, the coinsurance will be the percentage shown for in-network PPO, even if the services were provided by an out-of-network provider.* Emergency room facility (copay waived if admitted)	$300	$300
Urgent care facility	Visits 1–3 $120 deductible waived / Visits 4+ $120 deductible applies[7]	50% deductible applies
Ambulance services (ground and air)	$50 + 30%	$50 + 50%
Mental health and chemical dependency services Outpatient consultation[5]	Visits 1–3 $60 (deductible waived) / Visits 4+ $60 (deductible applies)	50%
Outpatient other (includes partial hospitalization, day treatment, intensive outpatient programs)	30%	50%
Inpatient (includes detoxification)	30%	50%
Other services Durable medical equipment[6]	30%	Not covered
Orthotics and prosthetics	30%	Not covered
Diabetic equipment	30%	Not covered
Chiropractic care	Not covered	Not covered
Acupuncture	Not covered	Not covered

Footnotes for plan BA3:

[1]Out-of-network reimbursement based on the PPO Fee Schedule. The covered person is responsible for charges in excess of the scheduled amount in addition to the coinsurance shown. Refer to the definition section of the *Certificate of Insurance* for details.

[2]Preventive care: Includes annual preventive physical, newborn and well-child care, well-woman exams, preventive lab and X-ray services.

[3]Rehabilitation therapy: Includes physical, speech, occupational, cardiac, and pulmonary rehabilitation therapy.

[4]Precertification is required by Health Net Pharmacy.

[5]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).

[6]As of 8/1/2012, 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, applicable female counseling for sexually transmitted infections, HIV, domestic violence, contraceptives, and breastfeeding support.

[7]Visits 1–3 (combined between office visits, urgent care, postnatal visits, outpatient mental health/substance abuse visits): A $60 copayment is required for PCP and postnatal and a $120 copayment for urgent care, and the deductible is waived. Visits 4–unlimited: A $60 copayment is required for PCP and postnatal and a $120 copayment for urgent care, then deductible is applied.

[8]The copayment will not be required if the member is admitted as a hospital inpatient directly from the emergency room.

[9]Copayment applies and then deductible applies.

This is a summary of your benefits. It does not include all services, limitations or exclusions. Please refer to the *Certificate of Insurance* for terms and conditions of coverage. PPO insurance plans are underwritten by Health Net Life Insurance Company.

HSA-compatible and HSA/HRA Integrated PPO insurance plans

Benefit description	*Covered person(s) responsibility*	
	HSA-Comp PPO 1500/70/50 / RBRVS: CHF **HSA-Integrated PPO 1500/70/50 / RBRVS: CH4**	
	In-network	**Out-of-network**[1]
Plan maximums Calendar year deductible[2]	$1,500 member / $3,000 family[3]	
Coinsurance	30%	50%
Out-of-pocket maximum	$3,000 member / $6,000 family[3]	
Lifetime maximum	Unlimited	
Professional services Office visit copay (including specialist consultation)[9]	30%	50%
Preventive care services[4,9]	$0 copay (deductible waived)	Not covered
X-ray and laboratory procedures (includes CT, SPECT, PET, MUGA, and MRI)[9]	30%	50%
Rehabilitation therapy[5]	30%	50%
Self-injectables[6]	30%	Not covered
Hospital services Inpatient care	30%	50%
Outpatient services	30%	50%
Outpatient surgery	30%	50%
Skilled nursing facility	30%	50% Limit of 100 days
Emergency services *For all services which meet the criteria for emergency care, the coinsurance will be the percentage shown for in-network PPO, even if the services were provided by an out-of-network provider.* Emergency room facility (copay waived if admitted)	$100 + 30%	$100 + 50%
Urgent care facility	30%	50%
Ambulance services (ground and air)	30%	50%
Mental health and chemical dependency services Outpatient consultation[7]	30%	50%
Outpatient other (includes partial hospitalization, day treatment, intensive outpatient programs)	30%	50%
Inpatient (includes detoxification)	30%	50%
Other services Durable medical equipment[9]	30%	50%
Orthotics and prosthetics	30%	50%
Diabetic equipment	30%	50%
Acupuncture	Not covered	
Chiropractic care	Not covered	
Prescription drug coverage[8,10] Retail pharmacy (up to a 30-day supply)	$10 Level I / $25 Level II / $50 Level III	Applicable copay + 50% average wholesale cost (subject to annual deductible)
Prescriptions by mail[8]	$30 Level I / $62.50 Level II / $125 Level III	Not covered

[1]Coinsurance is based on a Limited Fee Schedule. Limited Fee Schedule is a percentage of RBRVS. The covered person is responsible for charges in excess of the scheduled amount in addition to the coinsurance shown.

[2]All benefits including prescription are subject to deductible, except preventive care.

[3]For family coverage, there is no per-member deductible or out-of-pocket maximum (OOPM). These are combined family deductible and OOPM.

[4]Preventive care: Includes annual preventive physical, newborn and well-child care, well-woman exams, preventive lab and X-ray services.

[5]Rehabilitation therapy: Includes physical, speech, occupational, cardiac, and pulmonary rehabilitation therapy.

[6]Precertification is required by Health Net Pharmacy.

[7]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).

Covered person(s) responsibility			
HSA-COMP PPO 2600/70/50/RBRVS: CHG HSA-Integrated PPO 2600/70/50/RBRVS: CH5		**HRA-Integrated PPO 2000/70/50 RBRVS: CGV**	
In-network	**Out-of-network[1]**	**In-network**	**Out-of-network[1]**
$2,600 member / $5,200 family[3]		$2,000 member / $4,000 family[3]	
30%	50%	30%	50%
$5,000 member / $10,000 family[3]		$5,000 member / $10,000 family[3]	
Unlimited		Unlimited	
30%	50%	30%	50%
$0 charge (deductible waived)	Not covered	$0 copay (deductible waived)	Not covered
30%	50%	30%	50%
30%	50%	30%	50%
30%	Not covered	30%	Not covered
30%	50%	30%	50%
30%	50%	30%	50%
30%	50%	30%	50%
30%	50%	30%	50%
Limit of 100 days		Limit of 100 days	
$100 + 30%	$100 + 50%	$100 + 30%	$100 + 50%
30%	50%	30%	50%
30%	50%	30%	50%
30%	50%	30%	50%
30%	50%	30%	50%
30%	50%	30%	50%
30%	50%	30%	50%
30%	50%	30%	50%
30%	50%	30%	50%
Not covered		Not covered	
Not covered		Not covered	
$10 Level I / $25 Level II / $50 Level III	Applicable copay + 50% average wholesale cost (subject to annual deductible)	$10 Level I / $25 Level II / $50 Level III	Applicable copay + 50% average wholesale cost (subject to annual deductible)
$20 Level I / $62.50 Level II / $125 Level III	Not covered	$20 Level I / $62.50 Level II / $125 / Level III	Not covered

[8]For details regarding a specific drug, go to www.healthnet.com.

[9]As of 8/1/2012, 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, applicable female counseling for sexually transmitted infections, HIV, domestic violence, contraceptives, and breastfeeding support.

[10]Effective 8/1/12, 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.

[11]For family coverage, there is an embedded per member deductible and OOPM accrual.

This is a summary of your benefits. It does not include all services, limitations or exclusions. Please refer to the *Certificate of Insurance* for terms and conditions of coverage. PPO insurance plans are underwritten by Health Net Life Insurance Company.

HSA-compatible and HSA/HRA Integrated PPO insurance plans (continued)

Benefit description	*Covered person(s) responsibility*	
	HSA-COMP PPO 3000/70/50 / RBRVS: CHE[11] **HSA-Integrated PPO 3000/70/50 / RBRVS: CH6**[11] **HRA-Integrated PPO 3000/70/50 / RBRVS: CGW**[11]	
	In-network	**Out-of-network**[1]
Plan maximums Calendar year deductible[2]	$3,000 member / $6,000 family[3]	
Coinsurance	30%	50%
Out-of-pocket maximum	$5,000 member / $10,000 family[3]	
Lifetime maximum	Unlimited	
Professional services Office visit copay (including specialist consultation)[9]	30%	50%
Preventive care services[4,9]	$0 copay (deductible waived)	Not covered
X-ray and laboratory procedures (includes CT, SPECT, PET, MUGA, and MRI)[9]	30%	50%
Rehabilitation therapy[5]	30%	50%
Self-injectables[6]	30%	Not covered
Hospital services Inpatient care	30%	50%
Outpatient services	30%	50%
Outpatient surgery	30%	50%
Skilled nursing facility	30%	50% Limit of 100 days
Emergency services *For all services which meet the criteria for emergency care, the coinsurance will be the percentage shown for in-network PPO, even if the services were provided by an out-of-network provider.* Emergency room facility (copay waived if admitted)	$100 + 30%	$100 + 50%
Urgent care facility	30%	50%
Ambulance services (ground and air)	30%	50%
Mental health and chemical dependency services Outpatient consultation[7]	30%	50%
Outpatient other (includes partial hospitalization, day treatment, intensive outpatient programs)	30%	50%
Inpatient (includes detoxification)	30%	50%
Other services Durable medical equipment[9]	30%	50%
Orthotics and prosthetics	30%	50%
Diabetic equipment	30%	50%
Acupuncture	Not covered	
Chiropractic care	Not covered	
Prescription drug coverage[8,10] Retail pharmacy (up to a 30-day supply)	$10 Level I / $25 Level II / $50 Level III	Applicable copay + 50% average wholesale cost (subject to annual deductible)
Prescriptions by mail[8]	$20 Level I / $62.50 Level II / $125 Level III	Not covered

[1]Coinsurance is based on a Limited Fee Schedule. Limited Fee Schedule is a percentage of RBRVS. The covered person is responsible for charges in excess of the scheduled amount in addition to the coinsurance shown.

[2]All benefits including prescription are subject to deductible, except preventive care.

[3]For family coverage, there is no per-member deductible or out-of-pocket maximum (OOPM). These are combined family deductible and OOPM.

[4]Preventive care: Includes annual preventive physical, newborn and well-child care, well-woman exams, preventive lab, and X-ray services.

[5]Rehabilitation therapy: Includes physical, speech, occupational, cardiac, and pulmonary rehabilitation therapy.

[6]Precertification is required by Health Net Pharmacy.

[7]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).

Covered person(s) responsibility

HRA-Integrated PPO 1500/70/50 / RBRVS: CGU[11]

In-network	**Out-of-network**[1]
$1,500 member / $3,000 family[3]	
30%	50%
$5,000 member / $10,000 family[3]	
Unlimited	
30%	50%
$0 copay (deductible waived)	Not covered
30%	50%
30%	50%
30%	Not covered
30%	50%
30%	50%
30%	50%
30%	50%
Limit of 100 days	
$100 + 30%	$100 + 50%
30%	50%
30%	50%
30%	50%
30%	50%
30%	50%
30%	50%
30%	50%
30%	50%
Not covered	
Not covered	
$10 Level I / $25 Level II / $50 Level III	Applicable copay + 50% average wholesale cost (subject to annual deductible)
$30 Level I / $62.50 Level II / $125 Level III	Not covered

[8]For details regarding a specific drug, go to www.healthnet.com.

[9]As of 8/1/2012, 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, applicable female counseling for sexually transmitted infections, HIV, domestic violence, contraceptives, and breastfeeding support.

[10]Effective 8/1/12, 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.

[11]For family coverage, there is an embedded per member deductible and OOPM accrual.

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HSA-compatible and HSA Integrated PPO insurance plans (continued)

Benefit description	*Covered person(s) responsibility*	
	HSA-COMP PPO 2000/100/50 / RBRVS: BM1 **HSA Integrated PPO 2000/100/50 / RBRVS: CUX**	
	In-network	**Out-of-network[1]**
Plan maximums Calendar year deductible[2]	$2,000 member / $4,000 family[3]	
Coinsurance	0%	50%
Out-of-pocket maximum	$2,000 member / $4,000 family[3]	$4,000 member / $8,000 family[3]
Lifetime maximum	Unlimited	
Professional services Office visit copay (including specialist consultation)[9]	$0 copay (deductible not waived)	50%
Preventive care services[4,9]	$0 copay (deductible waived)	Not covered
X-ray and laboratory procedures (includes CT, SPECT, PET, MUGA, and MRI)[9]	0% copay (deductible not waived)	50%
Rehabilitation therapy[5]	0%	50%
Self-injectables[6]	0%	Not covered
Hospital services Inpatient care	0%	50%
Outpatient services	0%	50%
Outpatient surgery	0%	50%
Skilled nursing facility	0%	50% Limit of 100 days
Emergency services *For all services which meet the criteria for emergency care, the coinsurance will be the percentage shown for in-network PPO, even if the services were provided by an out-of-network provider.* Emergency room facility (copay waived if admitted)	0%	
Urgent care facility	0%	
Ambulance services (ground and air)	0%	50%
Mental health and chemical dependency services Outpatient consultation[7]	$0 (deductible not waived)	50%
Outpatient other (includes partial hospitalization, day treatment, intensive outpatient programs)	0%	50%
Inpatient (includes detoxification)	0%	50%
Other services Durable medical equipment[9]	0%	50%
Orthotics and prosthetics	0%	50%
Diabetic equipment	0%	50%
Acupuncture	0%	50%
Chiropractic care ($1,500 max per calendar year)	$0	Not covered
Prescription drug coverage[8,10] Retail pharmacy (up to a 30-day supply)	$0	50%
Prescriptions by mail[8]	$0	Not covered

[1]Coinsurance is based on a Limited Fee Schedule. Limited Fee Schedule is a percentage of RBRVS. The covered person is responsible for charges in excess of the scheduled amount in addition to the coinsurance shown.

[2]All benefits including prescriptions are subject to deductible, except preventive care.

[3]For family coverage, there is no per member deductible or out-of-pocket maximum (OOPM). These are combined family deductible and OOPM.

[4]Preventive care: Includes annual preventive physical, newborn and well-child care, well-woman exams, preventive lab and X-ray services.

[5]Rehabilitation therapy: Includes physical, speech, occupational, cardiac, and pulmonary rehabilitation therapy.

[6]Precertification is required by Health Net Pharmacy.

[7]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).

Covered person(s) responsibility			
HSA-COMP PPO 3000/100/50 / RBRVS: BM2 **HSA Integrated PPO 3000/100/50 / RBRVS: CUW**		**HSA-COMP PPO 4000/100/50 / RBRVS: CHH**[11] **HSA Integrated PPO 4000/100/50 / RBRVS: CUV**[11]	
In-network	**Out-of-network**[1]	**In-network**	**Out-of-network**[1]
$3,000 member / $6,000 family[3]		$4,000 member / $8,000 family[3]	
0%	50%	0%	50%
$3,000 member / $6,000 family[3]	$6,000 member / $12,000 family[3]	$4,000 member / $8,000 family[3]	$8,000 member / $16,000 family[3]
Unlimited		Unlimited	
$0 copay (deductible not waived)	50%	$0 copay (deductible not waived)	50%
$0 copay (deductible waived)	Not covered	$0 copay (deductible waived)	Not covered
$0 copay (deductible not waived)	50%	$0 copay (deductible not waived)	50%
0%	50%	0%	50%
0%	Not covered	0%	Not covered
0%	50%	0%	50%
0%	50%	0%	50%
0%	50%	0%	50%
0%	50%	0%	50%
Limit of 100 days		Limit of 100 days	
0%		0%	
0%		0%	
0%	50%	0%	50%
$0 (deductible not waived)	50%	$0 (deductible not waived)	50%
0%	50%	0%	50%
0%	50%	0%	50%
0%	50%	0%	50%
0%	50%	0%	50%
0%	50%	0%	50%
0% (deductible not waived)	50%	0% (deductible not waived)	50%
0%	Not covered	0%	Not covered
$0	50%	$0	50%
$0	Not covered	$0	Not covered

[8]For details regarding a specific drug, go to www.healthnet.com.

[9]As of 8/1/2012, 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, applicable female counseling for sexually transmitted infections, HIV, domestic violence, contraceptives, and breastfeeding support.

[10]Effective 8/1/12, 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.

[11]For family coverage, there is an embedded per member deductible and OOPM accrual.

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HSA/HRA Integrated insurance plans

Benefit description	*Covered person(s) responsibility*	
	PPO (HRA-integrated) 3000/80/60 CGX[11]	
	In-network	**Out-of-network**[1]
Plan maximums Calendar year deductible[2]	$3,000 member / $6,000 family[3]	$3,000 member / $6,000 family[3]
Coinsurance	20%	40%
Out-of-pocket maximum	$4,000 member / $8,000 family[3]	$4,000 member / $8,000 family[3]
Lifetime maximum	Unlimited	
Professional services Office visit copay (including specialist consultation)[9]	50% (deductible not waived)	Not covered
Preventive care services[4,9]	No charge	N/A
X-ray and laboratory procedures (includes CT, SPECT, PET, MUGA, and MRI)[9]	20%	40%
Complex radiology	20%	40%
Rehabilitation therapy[5]	20% (12 visits)	40% (12 visits)
Self-injectables[6]	30%	Not covered
Hospital services Inpatient care	20%	40%
Outpatient services	20%	40%
Outpatient surgery	20%	40%
Skilled nursing facility	20%	40%
	Limit of 100 days	
Emergency services *For all services which meet the criteria for emergency care, the coinsurance will be the percentage shown for in-network PPO, even if the services were provided by an out-of-network provider.* Emergency room facility (copay waived if admitted)	Professional services: $10 (deductible not waived) ER facility: 20% + $100 copay (copay waived if admitted)	
Urgent care facility	$50 copay + 20%	$50 copay + 40%
Ambulance services (ground and air)	$50 copay + 20%	$50 copay + 40%
Mental health and chemical dependency services Outpatient consultation[7]	20%	40%
Outpatient other (includes partial hospitalization, day treatment, intensive outpatient programs)	20%	40%
Inpatient (includes detoxification)	20%	40%
Acute care detox	20%	40%
Other services Durable medical equipment[9]	20%	40%
Orthotics and prosthetics	20%	40%
Diabetic equipment	20%	40%
Acupuncture	20%	40%
Chiropractic care ($1,500 max per calendar year in- and out-of-network combined)	$20 (deductible not waived)	Not covered
Prescription drug coverage[8,10] Retail pharmacy (up to a 30-day supply)	$10 Level I / $25 Level II / $50 Level III	Applicable copay + 50% average wholesale cost (subject to annual deductible)
Prescriptions by mail[8]	$20 Level I / $62.50 Level II / $125 Level III	Not covered

[1]Coinsurance is based on a Limited Fee Schedule. Limited Fee Schedule is a percentage of RBRVS. The covered person is responsible for charges in excess of the scheduled amount in addition to the coinsurance shown.

[2]All benefits including prescriptions are subject to deductible, except preventive care.

[3]For family coverage, there is no per member deductible or out-of-pocket maximum (OOPM). These are combined family deductible and OOPM.

[4]Preventive care: Includes annual preventive physical, newborn and well-child care, well-woman exams, preventive lab and X-ray services.

[5]Rehabilitation therapy: Includes physical, speech, occupational, cardiac, and pulmonary rehabilitation therapy.

[6]Precertification is required by Health Net Pharmacy.

[7]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).

Covered person(s) responsibility			
PPO (HRA-integrated) 5000/80/60 CGY[11]		**PPO (HSA-integrated) 3000/80/60 CH7**[11]	
In-network	**Out-of-network**[1]	**In-network**	**Out-of-network**[1]
$5,000 member / $10,000 family[3]	$5,000 member / $10,000 family[3]	$3,000 member / $6,000 family[3]	$3,000 member / $6,000 family[3]
20%	40%	20%	40%
$6,000 member / $12,000 family[3]	$6,000 member / $12,000 family[3]	$4,000 member / $8,000 family[3]	$4,000 member / $8,000 family[3]
Unlimited		Unlimited	
50% (deductible not waived)	Not covered	50% (deductible not waived)	Not covered
No charge	N/A	No charge	N/A
20%	40%	20%	40%
20%	40%	20%	40%
20% (12 visits)	40% (12 visits)	20% (12 visits)	40% (12 visits)
30%	Not covered	30%	Not covered
20%	40%	20%	40%
20%	40%	20%	40%
20%	40%	20%	40%
20%	40%	20%	40%
Limit of 100 days		Limit of 100 days	
Professional services: $10 (deductible not waived) ER facility: 20% + $100 copay (copay waived if admitted)		Professional services: $10 (deductible not waived) ER facility: 20% + $100 copay (copay waived if admitted)	
$50 copay + 20%	$50 copay + 40%	$50 copay + 20%	$50 copay + 40%
$50 copay + 20%	$50 copay + 40%	$50 copay + 20%	$50 copay + 40%
20%	40%	20%	40%
20%	40%	20%	40%
20%	40%	20%	40%
20%	40%	20%	40%
20%	40%	20%	40%
20%	40%	20%	40%
20%	40%	20%	40%
20%	40%	20%	40%
$20 (deductible not waived)	Not covered	$20 (deductible not waived)	Not covered
$10 Level I / $25 Level II / $50 Level III	Applicable copay + 50% average wholesale cost (subject to annual deductible)	$10 Level I / $25 Level II / $50 Level III	Applicable copay + 50% average wholesale cost (subject to annual deductible)
$20 Level I / $62.50 Level II / $125 Level III	Not covered	$20 Level I / $62.50 Level II / $125 Level III	Not covered

[8]For details regarding a specific drug, go to www.healthnet.com.

[9]As of 8/1/2012, 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, applicable female counseling for sexually transmitted infections, HIV, domestic violence, contraceptives, and breastfeeding support.

[10]Effective 8/1/12, 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.

[11]For family coverage, there is an embedded per member deductible and OOPM accrual.

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HSA/HRA Integrated insurance plans

Benefit description	*Covered person(s) responsibility*	
	PPO (HSA-integrated) 5000/80/60 CH8[11]	
	In-network	**Out-of-network**[1]
Plan maximums Calendar year deductible[2]	$5,000 member / $10,000 family[3]	$5,000 member / $10,000 family[3]
Coinsurance	20%	40%
Out-of-pocket maximum	$6,000 member / $12,000 family[3]	$6,000 member / $12,000 family[3]
Lifetime maximum	Unlimited	
Professional services Office visit copay (including specialist consultation)[9]	50% (deductible not waived)	Not covered
Preventive care services[4,9]	No charge	N/A
X-ray and laboratory procedures (includes CT, SPECT, PET, MUGA, and MRI)[9]	20%	40%
Complex radiology	20%	40%
Rehabilitation therapy[5]	20% (12 visits)	40% (12 visits)
Self-injectables[6]	30%	Not covered
Hospital services Inpatient care	20%	40%
Outpatient services	20%	40%
Outpatient surgery	20%	40%
Skilled nursing facility	20%	40% Limit of 100 days
Emergency services *For all services which meet the criteria for emergency care, the coinsurance will be the percentage shown for in-network PPO, even if the services were provided by an out-of-network provider.* Emergency room facility (copay waived if admitted)	Professional services: $10 (deductible not waived) ER facility: 20% + $100 copay (copay waived if admitted)	
Urgent care facility	$50 copay + 20%	$50 copay + 40%
Ambulance services (ground and air)	$50 copay + 20%	$50 copay + 40%
Mental health and chemical dependency services Outpatient consultation[7]	20%	40%
Outpatient other (includes partial hospitalization, day treatment, intensive outpatient programs)	20%	40%
Inpatient (includes detoxification)	20%	40%
Acute care detox	20%	40%
Other services Durable medical equipment[9]	20%	40%
Orthotics and prosthetics	20%	40%
Diabetic equipment	20%	40%
Acupuncture	20%	40%
Chiropractic care ($1,500 max per calendar year in- and out-of-network combined)	$20 (deductible not waived)	Not covered
Prescription drug coverage[8,10] Retail pharmacy (up to a 30-day supply)	$10 Level I / $25 Level II / $50 Level III	Applicable copay + 50% average wholesale cost (subject to annual deductible)
Prescriptions by mail[8]	$20 Level I / $62.50 Level II / $125 Level III	Not covered

[1]Coinsurance is based on a Limited Fee Schedule. Limited Fee Schedule is a percentage of RBRVS. The covered person is responsible for charges in excess of the scheduled amount in addition to the coinsurance shown.

[2]All benefits including prescriptions are subject to deductible, except preventive care.

[3]For family coverage, there is no per member deductible or out-of-pocket maximum (OOPM). These are combined family deductible and OOPM.

[4]Preventive care: Includes annual preventive physical, newborn and well-child care, well-woman exams, preventive lab and X-ray services.

[5]Rehabilitation therapy: Includes physical, speech, occupational, cardiac, and pulmonary rehabilitation therapy.

[6]Precertification is required by Health Net Pharmacy.

[7]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).

[8]For details regarding a specific drug, go to www.healthnet.com.

[9]As of 8/1/2012, 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, applicable female counseling for sexually transmitted infections, HIV, domestic violence, contraceptives, and breastfeeding support.

[10]Effective 8/1/12, 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.

[11]For family coverage, there is an embedded per member deductible and OOPM accrual.

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Pharmacy *Plans*

Please note that Health Net included an out-of-pocket maximum (OOPM) on all 2016 pharmacy plans to comply with federal ACA guidelines. The total combined OOPM amount allowable for medical and pharmacy plans in 2016 is $6,850 individual and $13,700 for family (two or more persons). We have also introduced a new 3-tier formulary with a specialty tier. All 2016 SLU plans cover specialty drugs at 30%.

HMO/EOA

Benefit description	*Member responsibility*[1]			
	HMO: 17L EOA: 17T	**HMO: 17M EOA: 17V**	**HMO: 17N EOA: 17W**	**HMO: 22X EOA: 22Z**
Retail pharmacy (up to a 30-day supply)	$15 Level I $35 Level II $55 Level III	$15 Level I $35 Level II $55 Level III	$15 Level I $40 Level II $60 Level III	$20 Level I $40 Level II $60 Level III
Brand-name deductible	N/A	$100	$300	$300
Prescriptions by mail (up to a 90-day calendar day supply)	$30 Level I $87.50 Level II $137.50 Level III	$30 Level I $87.50 Level II $137.50 Level III	$30 Level I $100 Level II $150 Level III	$40 Level I $100 Level II $150 Level III
Brand-name deductible	N/A	$100	$300	$300
Out-of-pocket maximum	$2,000 individual / $4,000 family	$2,000 individual / $4,000 family	$2,000 individual / $4,000 family	$2,000 individual / $4,000 family

Salud HMO y Más

Benefit description	*Member responsibility*[1]			
	17Y		**17Z**	
	SIMNSA participating pharmacy	**Health Net participating pharmacy**	**SIMNSA participating pharmacy**	**Health Net participating pharmacy**
Drugs dispensed by SIMNSA	$5	N/A	$5	N/A
Retail pharmacy (up to a 30-day supply)	N/A Level I N/A Level II Not covered Level III	$5 Level I $25 Level II $45 Level III	N/A Level I N/A Level II Not covered Level III	$10 Level I $30 Level II $50 Level III
Out-of-pocket maximum	$2,000 individual / $4,000 familyl	$2,000 individual / $4,000 family	$2,000 individual / $4,000 family	$2,000 individual / $4,000 family

Member responsibility	
HMO: 17P **EOA: 17U**	**HMO: 17S** **EOA: 17X**
$10 Level I $30 Level II $50 Level III	$10 Level I $30 Level II $50 Level III
$100	N/A
$20 Level I $75 Level II $125 Level III	$20 Level I $75 Level II $125 Level III
$100	N/A
$2,000 individual / $4,000 family	$2,000 individual / $4,000 family

Pharmacy *Plans*

PPO (in- and out-of-state)

Benefit description	*Covered person(s) responsibility*[2]			
	In-state: 18A **Out-of-state: 19A**		**In-state: 18B** **Out-of-state: 19B**	
	Participating pharmacy copayment	**Non-participating pharmacy copayment**	**Participating pharmacy copayment**	**Non-participating pharmacy copayment**
Retail pharmacy (up to a 30-day supply)	$15 Level I $40 Level II $60 Level III	Applicable copay + 50% average wholesale price	$15 Level I $40 Level II $60 Level III	Applicable copay + 50% average wholesale price
Brand-name deductible	$300		$300	
Prescriptions by mail (up to a 90-day calendar day supply)	$30 Level I $100 Level II $150 Level III	N/A	$30 Level I $100 Level II $150 Level III	N/A
Brand-name deductible	$300		$300	
Out-of-pocket maximum	$1,000 individual / $2,000 family		$2,000 individual / $4,000 family	

PPO (in- and out-of-state)

Benefit description	*Covered person(s) responsibility*[2]			
	In-state: 18W **Out-of-state: 19W**		**In-state: 18X** **Out-of-state: 19X**	
	Participating pharmacy copayment	**Non-participating pharmacy copayment**	**Participating pharmacy copayment**	**Non-participating pharmacy copayment**
Retail pharmacy (up to a 30-day supply)	$10 Level I $30 Level II $50 Level III	Applicable copay + 50% average wholesale price	$10 Level I $30 Level II $50 Level III	Applicable copay + 50% average wholesale price
Brand-name deductible	$100		$100	
Prescription by mail (up to a 90-day calendar day supply)	$20 Level I $75 Level II $125 Level III	N/A	$20 Level I $75 Level II $125 Level III	N/A
Brand-name deductible	$100		$100	
Out-of-pocket maximum	$1,000 individual / $2,000 family		$2,000 individual / $4,000 family	

When filling prescriptions at nonparticipating pharmacies, you are required to pay the listed dollar copayment (if applicable), plus 50% of the prescription drug's Average Wholesale Price (AWP). You are also obligated to pay any amounts the pharmacy charges in excess of the AWP.

Covered person(s) responsibility[2]									
In-state: 18C Out-of-state: 19C		**In-state: 18S Out-of-state: 19S**		**In-state: 18T Out-of-state: 19T**		**In-state: 18U Out-of-state: 19U**		**In-state: 18V Out-of-state: 19V**	
Participating pharmacy copayment	**Non-participating pharmacy copayment**	**Participating pharmacy copayment**	**Non-participating pharmacy copayment**	**Participating pharmacy copayment**	**Non-participating pharmacy copayment**	**Participating pharmacy copayment**	**Non-participating pharmacy copayment**	**Participating pharmacy copayment**	**Non-participating pharmacy copayment**
$15 Level I $40 Level II $60 Level III	Applicable copay + 50% average wholesale price	$10 Level I $30 Level II $50 Level III	Applicable copay + 50% average wholesale price	$10 Level I $30 Level II $50 Level III	Applicable copay + 50% average wholesale price	$15 Level I $35 Level II $55 Level III	Applicable copay + 50% average wholesale price	$15 Level I $35 Level II $55 Level III	Applicable copay + 50% average wholesale price
$300		N/A		N/A		N/A		N/A	
$30 Level I $100 Level II $150 Level III	N/A	$20 Level I $75 Level II $125 Level III	N/A	$20 Level I $75 Level II $125 Level III	N/A	$30 Level I $87.50 Level II $137.50 Level III	N/A	$30 Level I $87.50 Level II $137.50 Level III	N/A
$300		N/A		N/A		N/A		N/A	
$6,350 individual / $12,700 family (combined with medical out-of-pocket maximum)		$1,000 individual / $2,000 family		$2,000 individual / $4,000 family		$1,000 individual / $2,000 family		$2,000 individual / $4,000 family	

Covered person(s) responsibility[2]			
In-state: 18Y Out-of-state: 19Y		**In-state: 18Z Out-of-state: 19Z**	
Participating pharmacy copayment	**Non-participating pharmacy copayment**	**Participating pharmacy copayment**	**Non-participating pharmacy copayment**
$15 Level I $35 Level II $55 Level III	Applicable copay + 50% average wholesale price	$15 Level I $35 Level II $55 Level III	Applicable copay + 50% average wholesale price
$100		$100	
$30 Level I $87.50 Level II $137.50 Level III	N/A	$30 Level I $87.50 Level II $137.50 Level III	N/A
$100		$100	
$1,000 individual / $2,000 family		$2,000 individual / $4,000 family	

[1]Prior Authorization (PA) Light is a prescription management program for PPO Rx plans that reduces the list of medications requiring prior authorization from more than 81 (Regular PA) to fewer than 35 (list is subject to change). With fewer medications requiring pre-approval and fewer restrictions, most members can fill prescriptions faster and in fewer steps.

[2]Effective 8/1/12, 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.

Dental *Plans*

PPO insurance plans

Benefit description[1]	*Classic Plus 1 & 2 2000*		*Classic 1 & 2 1500*		*Classic 3 & 4 1500*		*Classic 5 & 6 1500*	
	In-network	**Out-of-network**[2]	**In-network**	**Out-of-network**[2]	**In-network**	**Out-of-network**[2]	**In-network**	**Out-of-network**[2]
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
Prenatal dental care program (extra services for pregnant members: additional prophylaxis, deep cleaning, debridement and periodontal maintenance when medically necessary)	100% deductible waived / does not apply to calendar year maximum		100% deductible waived / does not apply to calendar year maximum		100% deductible waived / does not apply to calendar year maximum		100% deductible waived / does not apply to calendar year maximum	
General services (fillings, general anesthetics, oral surgery, periodontics, endodontics)	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
Orthodontia (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	

PPO footnotes

[1]Refer to the *Certificate of Insurance* for the full list of covered procedures and exclusions and limitations.

[2]Out-of-network benefits are reimbursed at the usual, customary and reasonable (UCR) amounts as determined by Unimerica Life Insurance Company.

[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]Endodontics, periodontics and oral surgery are covered under "Major services" under the Essential Value plan, and are not covered services under the Basic 500 plan. Please refer to the "General services" benefit description section on this page.

HMO footnotes

[1]Refer to the *Evidence of Coverage* for the full list of covered procedures and exclusions and limitations.

Essential 1 & 2 1000		*Essential 3 & 4 1000*		*Essential 5 & 6 1500*		*Essential Value 1 1000*		*Basic 500*	
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
100% deductible waived / does not apply to calendar year maximum		100% deductible waived / does not apply to calendar year maximum		100% deductible waived / does not apply to calendar year maximum		100% deductible waived / does not apply to calendar year maximum		100% deductible waived / does not apply to calendar year maximum	
80% after deductible	80% after deductible	80% after deductible	80% after deductible	80% after deductible	80% after deductible	80% after deductible	50% after deductible	60% after deductible[4]	50% after deductible[4]
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 2: Not covered		Essential 3: 50% after deductible / $1,000 lifetime maximum Essential 4: Not covered		Essential 5: 50% after deductible / $1,500 lifetime maximum Essential 6: Not covered		Not covered		Not covered	
Not covered		Not covered		Not covered		Not covered		Not covered	

HMO plans

Partial list of covered procedures[1]	*Member copayment*		
	HN Plus DHMO 100	**HN Plus DHMO 150**	**HN Plus DHMO 185**
Diagnostic care D0120 Periodic oral evaluation	$0	$0	$0
D0210 Full-mouth X-rays	$0	$0	$0
D9491 Office visit (including all fees for sterilization and infection control)	$5	$5	$5
Preventive care D1110 Prophylaxis – adult	$0	$0	$0
Restorative treatment D2140 Amalgam filling	$0	$0	$0
D2331 Resin-based composite	$0	$0	$0
Endodontics D3320 Root canal	$65	$95	$115
Periodontics D4341 Periodontal scaling and root planing	$25	$35	$40
Oral surgery D7240 Removal of impacted teeth	$75	$80	$80
Crowns and pontics 2751 Crown porcelain fused to predominantly base metal	$100	$150	$185
Orthodontics D8070 Complete orthodontic treatment (child through age 19)	$1,450	$1,695	$1,695
D8080 Comprehensive orthodontic treatment (adult age 20 and older)	$1,450	$1,695	$1,695

Vision *Plans*

PPO insurance plans

Benefit description[1]	
Vision exam copayment	Choice of $0 or $10
Materials copayment	Choice of $0, $10 or $25
Benefit frequency	
Exam	Once every 12 months
Frames	Once every 12 months
Eyeglasses or contact lenses	Choice of once every 12 or 24 months
Retail frame allowance (in-network)	
Elite plans	$150
Supreme plans	$120
Preferred plans	$100
Contact lens allowance (in-network)	
Elite plans	$120
Supreme plans	$105
Preferred plans	$90

Benefit description[1]	*In-network (covered person's cost)*	*Out-of-network (maximum benefit allowed)*
Vision exam		
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
Lens options (in-network only)		
UV coating	$15 copay	Lens options are not covered out-of-network
Tint (solid and gradient)	$15 copay	Lens options are not covered out-of-network
Standard scratch-resistant coating	$15 copay	Lens options are not covered out-of-network
Standard polycarbonate	$40 copay	Lens options are not covered out-of-network
Standard progressive (add-on to bifocal)	$65 copay	Lens options are not covered out-of-network
Standard anti-reflective coating	$45 copay	Lens options are not covered out-of-network
Other add-ons and services	20% discount	Lens options are not covered out-of-network
Frames		
Any frame available at provider location	Up to plan allowance + 20% off balance over allowance	Up to $45
Contact lens (materials only)		
Medically necessary	$0	Up to $210
Conventional	Up to plan allowance + 15% discount off balance over allowance	Up to $105
Disposable	Up to plan allowance + 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 are used	40% off retail	Not covered

[1]Refer to the *Certificate of Insurance* for the full list of covered procedures and exclusions and limitations.

Chiropractic *and* Chiropractic/Acupuncture *Plans*

Chiropractic or chiropractic/acupuncture services can be added to any of our Starting Line-Up plans.

Benefit description	*Member responsibility*	
	Chiropractic plan	**Chiropractic / acupuncture plan**
Office visit copay ($10)	$10 per visit / 30 visits per calendar year	$10 per visit / 30 visits per calendar year (maximum visits are combined for acupuncture and chiropractic services[1])
Office visit copay ($25)	$25 copay visit / 30 visits per calender year	$25 copay visit / 30 visits per calender year (maximum visits are combined for acupuncture and chiropractic services[1])
Annual chiropractic appliance allowance	$50 toward the purchase of items necessary for chiropractic appliance such as cervical collars, cervical pillows, heel lifts, non-electric heat pads, cushions, rib belts, and home traction-lumbar	$50 toward the purchase of items necessary for chiropractic appliance such as cervical collars, cervical pillows, heel lifts, non-electric heat pads, cushions, rib belts, and home traction-lumbar

[1]Includes emergencies and urgent care visits and referral visits to nonparticipating acupuncturists and nonparticipating chiropractors.

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. Please contact your Health Net sales representative for additional details.

With Health Net's Starting Line-Up Portfolio, your clients get more coverage options, and you get more sales opportunities. We're committed to health and the growth of your business.

Learn more about how Health Net offers solutions for the health of California employers and employees. Contact your Health Net sales consultant, visit us online at www.healthnet.com/broker, or call our expert Broker Services team at 1-800-448-4411, option 4.

We are your Health Net.™

Quick contacts

For benefit and eligibility verification or claims issues:

Medical 1-800-547-2967
Life 1-800-865-6288
Vision 1-866-392-6058
Dental 1-866-249-2382
Chiropractic/Acupuncture
1-800-361-3366

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