

# BENEFITS GUIDE

*Choice made simple*

Effective February 1, 2007





# CHOICE MADE SIMPLE

Health Net provides maximum choice in health coverage for your small groups.

Health Net has the same great plan types as before, but we've simplified them by dividing them into **Standard** and **Value** lines. Standard is the name for our line of well-priced base plans, and Value is our more economical line of plans with more cost sharing for the client.

With a base of 4 HMO, 4 EOA and 4 PPO plans and a value plan counterpart to every standard plan (except for POS); your clients can easily make the decision about the benefits and options that suit their specific needs.

## IT'S AS SIMPLE AS 10, 20, 30, 40

We've made it easy with just four copayment amounts to consider across the product lines: \$10, \$20, \$30 and \$40. As you move up in copayment amounts, the variable benefits adjust in consistent increments.

Most benefits between Standard and Value are the same. There are **only 5 variable benefits** that differentiate the plans and are highlighted on the right side of this page.

We still offer the wide selection of HMO, EOA, PPO, HSA-compatible and POS plans you've come to expect, plus additional plans and package options that offer even more cost savings.

**Same great plan types, clearer choices.**

VARIABLE BENEFITS
Copayment (professional services)
Out-of-pocket maximum
Hospital services
Deductibles (PPO only)
Rx – brand deductibles

## Portfolio at a glance

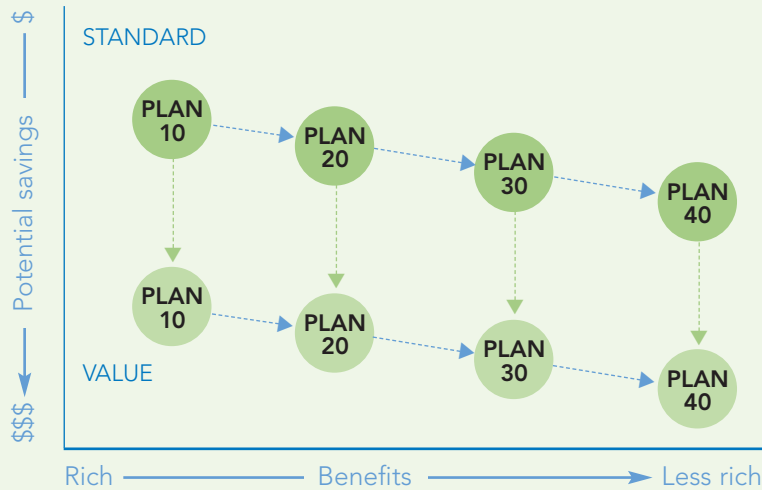
Our portfolio lineup includes a wide selection of plan options: HMO, Elect Open Access (EOA), PPO, HSA-compatible plans and POS.

Copayment	STANDARD			VALUE			HSA-compatible	POS
	HMO	EOA	PPO	HMO	EOA	PPO		
10	•	•	•	•	•	•	•	•
20	•	•	•	•	•	•	•	•
30	•	•	•	•	•	•	•	—
40	•	•	•	•	•	•	•	—

<sup>1</sup>Health Net HMO, EOA, POS and Salud con Health Net HMO plans are offered by Health Net of California, Inc., a subsidiary of Health Net, Inc. Health Net PPO, Flex Net and Salud con Health Net PPO and EPO insurance plans are underwritten by Health Net Life Insurance Company.

# Price levels that meet every budget

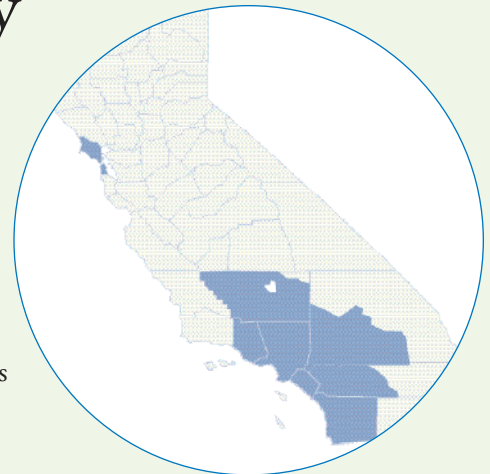
Our plans cover a range of price and benefit levels, so your clients can get the coverage they need at prices they can afford. Plan levels are arranged in decrements of \$10 copayment levels with percentages indicating estimated savings between plans.



PLAN TYPE	AVERAGE SAVINGS BETWEEN COPAYMENT PLANS	AVERAGE SAVINGS BETWEEN STANDARD & VALUE PLANS
Standard HMO <sup>2</sup>	12%	7%
Value HMO <sup>2</sup>	11%	
Standard EOA	12%	17%
Value EOA	12%	
Standard PPO	23%	20%
Value PPO	23%	

## Network strength and flexibility

- Our **HMO network** provides over 38,000 physicians, more than 200 hospitals and 4,970 pharmacies across California.
- **HMO Silver Network** has more than 5,400 primary care physicians, 11,580 specialists and 167 hospitals. This network is a select subset of our regular HMO network, spread across a nine-county area. It provides greater affordability without sacrificing quality.
- Health Net's **PPO network** includes 51,000 physicians, more than 300 hospitals and 4,970 pharmacies across California.



### Silver Network service area

The Silver Network is available in all or parts of Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Francisco, Sonoma and Ventura counties.

<sup>2</sup>Also available with Silver Network. Silver Network pricing on an average is 5-15% lower, depending on region.

# Employee choice packages

Health Net also offers three employee choice packages with even greater selection of plans from which employees can choose.

- **Enhanced Choice** offers employees the option of choosing from any of the plans in our portfolio (except plans offered with Silver Network), while allowing employers to cap their costs with a set contribution amount that's affordable. This package is available to groups of 6-50 employees. *See Underwriting Guidelines for details.*
- **Silver Choice** offers all HMO Silver Network plans, alongside a full compliment of our PPO plans. This package offers lower monthly premiums, up to 14%, to employees who live within the Silver Network area – all or parts of Kern, Los Angeles, Orange, Riverside, Sonoma, San Bernardino, San Diego, San Francisco and Ventura counties. Within these counties, members have access to more than 5,400 primary care physicians, 11,580 specialists, and 100% of the hospital network, in a nine-county service area. *See Underwriting Guidelines for details.*<sup>3</sup>
- **H<sup>n</sup> Options** gives employers the option of offering up to 15 specifically designed Health Net plans alongside another carrier's plans, including Kaiser Permanente. To qualify, 75% of the group must have coverage from one of the carriers offered. *See Underwriting Guidelines for details.*

## How to choose a plan in four easy steps

**Step 1** Pick a network: HMO, Silver HMO or PPO.

**Step 2** Pick the product type OR choose them all with one of our employee choice packages. Here is a brief description of our products:

**HMO** – plans that have members select a Primary Care Physician. They must see this physician for all care and referrals.

**EOA** (Elect Open Access) – our EOA plans are essentially HMO plans, with the added feature of allowing members to self-refer to select providers in our statewide PPO network for professional services.

**POS** (Point-of-Service) – members select a primary physician in an HMO, but can freely access PPO or other licensed providers for all covered services.

**PPO** – allows members to visit any of our 51,000 physicians and more than 200 hospitals of their choice, either in- or out-of-network, and visit specialists without a referral.

**HSA-Compatible Plans** (Health Savings Account) – offers members a high-deductible PPO health plans with access to our full PPO provider network, along with a Wells Fargo health savings account, allowing members to save money and enjoy important tax benefits.<sup>4</sup>

**Step 3** Choose a copayment level (\$10, \$20, \$30 or \$40).

**Step 4** Choose between Standard or Value plans. Keep in mind there are only five benefits that differ from Standard to Value: copayment amount, hospital services, PPO plan deductibles, prescription brand deductibles and out-of-pocket maximums.

## You're done!

<sup>3</sup>For up-to-date listings of participating Silver Network physicians and hospitals, please visit [www.healthnet.com](http://www.healthnet.com) > Search our Doctor Network. Be sure to select HMO Silver Network.

<sup>4</sup>References are to federal taxes only. State taxes may apply. Tax information is for general purposes only. For more detailed information about the tax implications of an HSA, please contact a professional tax advisor.

# HMO PORTFOLIO

**Please note:** All highlighted boxes reflect standardized benefits between Standard and Value plans. **All HMO plans available with Silver Network.**<sup>3</sup>

BENEFIT DESCRIPTION <sup>1</sup>	HMO 10		HMO 20	
	STANDARD	VALUE	STANDARD	VALUE
<b>PLAN MAXIMUMS</b>				
Out-of-pocket maximum	\$1,500 single \$3,000 family	\$2,000 single \$4,000 family	\$2,000 single \$4,000 family	\$2,500 single \$5,000 family
Lifetime medical benefit maximum	No maximum	No maximum	No maximum	No maximum
<b>PROFESSIONAL SERVICES</b>				
Office visit	\$10 copayment	\$10 copayment	\$20 copayment	\$20 copayment
Well child care (including immunizations)	\$10 copayment (birth through age 2 covered in full)	\$10 copayment (birth through age 2 covered in full)	\$20 copayment (birth through age 2 covered in full)	\$20 copayment (birth through age 2 covered in full)
Adult preventive care (age 17 and older)	\$10 copayment	\$10 copayment	\$20 copayment	\$20 copayment
Annual routine physical examination (age 17 and older)	Not covered	Not covered	Not covered	Not covered
Specialist consultation	\$10 copayment	\$10 copayment	\$20 copayment	\$20 copayment
X-ray and laboratory procedures <sup>2</sup>	Covered in full	Covered in full	Covered in full	Covered in full
Physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy and pulmonary rehabilitation therapy	\$10 copayment	\$10 copayment	\$20 copayment	\$20 copayment
Self-injectable drugs	30%	30%	30%	30%
<b>HOSPITAL SERVICES</b>				
Inpatient hospital facility services (includes maternity)	Covered in full	10%	\$250 copayment per day (3 day copayment maximum)	20%
Outpatient facility services (other than surgery)	Covered in full	10%	20%	20%
Outpatient surgery (hospital or outpatient surgery center charges only)	Covered in full	10%	\$250 copayment	20%
Skilled nursing facility	Days 1-10: covered in full; Days 11-100: \$25 per day	Days 1-10: covered in full; Days 11-100: \$25 per day	Days 1-10: covered in full; Days 11-100: \$25 per day	Days 1-10: covered in full; Days 11-100: \$25 per day
<b>EMERGENCY SERVICES</b>				
Professional services	Covered in full	Covered in full	Covered in full	Covered in full
Emergency room facility (copayment waived if admitted)	\$100 copayment	\$100 copayment	\$100 copayment	\$100 copayment
Urgent care facility	\$50 copayment	\$50 copayment	\$50 copayment	\$50 copayment
Ambulance services (ground and air)	\$100 copayment	\$100 copayment	\$100 copayment	\$100 copayment
<b>OTHER SERVICES</b>				
Durable medical equipment and orthotics	50% (\$2,000 maximum per calendar year)	50% (\$2,000 maximum per calendar year)	50% (\$2,000 maximum per calendar year)	50% (\$2,000 maximum per calendar year)
Diabetic equipment	20%	20%	20%	20%
Acupuncture, Chiropractic services <sup>4</sup>	Optional rider available	Optional rider available	Optional rider available	Optional rider available
<b>PRESCRIPTION DRUG COVERAGE<sup>5</sup></b>				
Brand name calendar year deductible (per member)	No deductible	\$100	No deductible	\$150
Prescription drugs (up to a 30-day supply)	\$10 Level I \$25 Level II \$50 Level III	\$10 Level I \$25 Level II \$50 Level III	\$15 Level I \$30 Level II \$50 Level III	\$15 Level I \$30 Level II \$50 Level III

Plan footnotes found on pages 28-29.

HMO 30		HMO 40	
STANDARD	VALUE	STANDARD	VALUE
\$3,000 single \$6,000 family	\$3,500 single \$7,000 family	\$4,000 single \$8,000 family	\$4,500 single \$9,000 family
No maximum	No maximum	No maximum	No maximum
\$30 copayment	\$30 copayment	\$40 copayment	\$40 copayment
\$30 copayment (birth through age 2 covered in full)	\$30 copayment (birth through age 2 covered in full)	\$40 copayment (birth through age 2 covered in full)	\$40 copayment (birth through age 2 covered in full)
\$30 copayment	\$30 copayment	\$40 copayment	\$40 copayment
Not covered	Not covered	Not covered	Not covered
\$30 copayment	\$30 copayment	\$40 copayment	\$40 copayment
Covered in full	Covered in full	Covered in full	Covered in full
\$30 copayment	\$30 copayment	\$40 copayment	\$40 copayment
30%	30%	30%	30%
\$500 copayment per day (3 day copayment maximum)	30%	\$1,000 copayment per day (3 day copayment maximum)	40%
30%	30%	40%	40%
\$500 copayment	30%	\$1,000 copayment	40%
Days 1-10: covered in full; Days 11-100: \$25 per day	Days 1-10: covered in full; Days 11-100: \$25 per day	Days 1-10: covered in full; Days 11-100: \$25 per day	Days 1-10: covered in full; Days 11-100: \$25 per day
Covered in full	Covered in full	Covered in full	Covered in full
\$100 copayment	\$100 copayment	\$100 copayment	\$100 copayment
\$50 copayment	\$50 copayment	\$50 copayment	\$50 copayment
\$100 copayment	\$100 copayment	\$100 copayment	\$100 copayment
50% (\$2,000 maximum per calendar year)	50% (\$2,000 maximum per calendar year)	50% (\$2,000 maximum per calendar year)	50% (\$2,000 maximum per calendar year)
20%	20%	20%	20%
Optional rider available	Optional rider available	Optional rider available	Optional rider available
No deductible	\$200	No deductible	\$250
\$15 Level I \$30 Level II \$50 Level III	\$15 Level I \$30 Level II \$50 Level III	\$15 Level I \$30 Level II \$50 Level III	\$15 Level I \$30 Level II \$50 Level III

# EOA PORTFOLIO

**Please note:** All highlighted boxes reflect standardized benefits between Standard and Value plans.

BENEFIT DESCRIPTION <sup>1</sup>	EOA 10		EOA 20	
	STANDARD	VALUE	STANDARD	VALUE
<b>PLAN MAXIMUMS</b>				
Out-of-pocket maximum	\$1,500 single/ \$3,000 family	\$2,000 single/ \$4,000 family	\$2,000 single/ \$4,000 family	\$2,500 single/ \$5,000 family
Lifetime medical benefit maximum	No maximum	No maximum	No maximum	No maximum
<b>PROFESSIONAL SERVICES</b>				
Office visit	HMO: \$10 copayment/ PPO: \$25 copayment <sup>7</sup>	HMO: \$10 copayment/ PPO: \$25 copayment <sup>7</sup>	HMO: \$20 copayment/ PPO: \$35 copayment <sup>7</sup>	HMO: \$20 copayment/ PPO: \$35 copayment <sup>7</sup>
Well child care (including immunizations)	HMO: \$10 copayment (birth through age 2 covered in full), PPO: \$25 copayment <sup>7</sup>	HMO: \$10 copayment (birth through age 2 covered in full), PPO: \$25 copayment <sup>7</sup>	HMO: \$20 copayment (birth through age 2 covered in full), PPO: \$35 copayment <sup>7</sup>	HMO: \$20 copayment (birth through age 2 covered in full), PPO: \$35 copayment <sup>7</sup>
Adult preventive care (age 17 and older)	HMO: \$10 copayment/ PPO: \$25 copayment <sup>7</sup>	HMO: \$10 copayment/ PPO: \$25 copayment <sup>7</sup>	HMO: \$20 copayment/ PPO: \$35 copayment <sup>7</sup>	HMO: \$20 copayment/ PPO: \$35 copayment <sup>7</sup>
Annual routine physical examination (age 17 and older)	Not covered	Not covered	Not covered	Not covered
Specialist consultation	HMO: \$10 copayment, PPO: \$25 copayment <sup>7</sup>	HMO: \$10 copayment, PPO: \$25 copayment <sup>7</sup>	HMO: \$20 copayment, PPO: \$35 copayment <sup>7</sup>	HMO: \$20 copayment, PPO: \$35 copayment <sup>7</sup>
X-ray and laboratory procedures <sup>2</sup>	Covered in full	Covered in full	Covered in full	Covered in full
Physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy and pulmonary rehabilitation therapy	HMO: \$10 copayment, PPO: \$25 copayment <sup>7</sup> (12 visits per calendar year)	HMO: \$10 copayment, PPO: \$25 copayment <sup>7</sup> (12 visits per calendar year)	HMO: \$20 copayment, PPO: \$35 copayment <sup>7</sup> (12 visits per calendar year)	HMO: \$20 copayment, PPO: \$35 copayment <sup>7</sup> (12 visits per calendar year)
Self-injectable drugs	30%	30%	30%	30%
<b>HOSPITAL SERVICES</b>				
Inpatient hospital facility services (includes maternity)	Covered in full	10%	\$250 copayment per day (3 day copayment maximum)	20%
Outpatient facility services (other than surgery)	Covered in full	10%	20%	20%
Outpatient surgery (hospital or outpatient surgery center charges only)	Covered in full	10%	\$250 copayment	20%
Skilled nursing facility	Days 1-10: covered in full, Days 11-100: \$25 per day	Days 1-10: covered in full, Days 11-100: \$25 per day	Days 1-10: covered in full, Days 11-100: \$25 per day	Days 1-10: covered in full, Days 11-100: \$25 per day
<b>EMERGENCY SERVICES</b>				
Professional services	Covered in full	Covered in full	Covered in full	Covered in full
Emergency room facility (copayment waived if admitted)	\$100 copayment	\$100 copayment	\$100 copayment	\$100 copayment
Urgent care facility	\$50 copayment	\$50 copayment	\$50 copayment	\$50 copayment
Ambulance services (ground and air)	\$100 copayment	\$100 copayment	\$100 copayment	\$100 copayment
<b>OTHER SERVICES</b>				
Durable medical equipment and orthotics	50% (\$2,000 maximum per calendar year)	50% (\$2,000 maximum per calendar year)	50% (\$2,000 maximum per calendar year)	50% (\$2,000 maximum per calendar year)
Diabetic equipment	20%	20%	20%	20%
Acupuncture, Chiropractic services <sup>4</sup>	Optional rider available	Optional rider available	Optional rider available	Optional rider available
<b>PRESCRIPTION DRUG COVERAGE<sup>5</sup></b>				
Brand name calendar year deductible (per covered person)	No deductible	\$100	No deductible	\$150
Prescription drugs (up to a 30-day supply)	\$10 Level I \$25 Level II \$50 Level III	\$10 Level I \$25 Level II \$50 Level III	\$15 Level I \$30 Level II \$50 Level III	\$15 Level I \$30 Level II \$50 Level III

Plan footnotes found on pages 28-29.

EOA 30		EOA 40	
STANDARD	VALUE	STANDARD	VALUE
\$3,000 single/ \$6,000 family	\$3,500 single/ \$7,000 family	\$4,000 single/ \$8,000 family	\$4,500 single/ \$9,000 family
No maximum	No maximum	No maximum	No maximum
HMO: \$30 copayment/ PPO: \$45 copayment <sup>7</sup>	HMO: \$30 copayment/ PPO: \$45 copayment <sup>7</sup>	HMO: \$40 copayment/ PPO: \$55 copayment <sup>7</sup>	HMO: \$40 copayment/ PPO: \$55 copayment <sup>7</sup>
HMO: \$30 copayment (birth through age 2 covered in full), PPO: \$45 copayment <sup>7</sup>	HMO: \$30 copayment (birth through age 2 covered in full), PPO: \$45 copayment <sup>7</sup>	HMO: \$40 copayment (birth through age 2 covered in full), PPO: \$55 copayment <sup>7</sup>	HMO: \$40 copayment (birth through age 2 covered in full), PPO: \$55 copayment <sup>7</sup>
HMO: \$30 copayment/ PPO: \$45 copayment <sup>7</sup>	HMO: \$30 copayment/ PPO: \$45 copayment <sup>7</sup>	HMO: \$40 copayment/ PPO: \$55 copayment <sup>7</sup>	HMO: \$40 copayment/ PPO: \$55 copayment <sup>7</sup>
Not covered	Not covered	Not covered	Not covered
HMO: \$30 copayment, PPO: \$45 copayment <sup>7</sup>	HMO: \$30 copayment, PPO: \$45 copayment <sup>7</sup>	HMO: \$40 copayment, PPO: \$55 copayment <sup>7</sup>	HMO: \$40 copayment, PPO: \$55 copayment <sup>7</sup>
Covered in full	Covered in full	Covered in full	Covered in full
HMO: \$30 copayment, PPO: \$45 copayment <sup>7</sup> (12 visits per calendar year)	HMO: \$30 copayment, PPO: \$45 copayment <sup>7</sup> (12 visits per calendar year)	HMO: \$40 copayment, PPO: \$55 copayment <sup>7</sup> (12 visits per calendar year)	HMO: \$40 copayment, PPO: \$55 copayment <sup>7</sup> (12 visits per calendar year)
30%	30%	30%	30%
\$500 copayment per day (3 day copayment maximum)	30%	\$1,000 copayment per day (3 day copayment maximum)	40%
30%	30%	40%	40%
\$500 copayment	30%	\$1,000 copayment	40%
Days 1-10: covered in full, Days 11-100: \$25 per day	Days 1-10: covered in full, Days 11-100: \$25 per day	Days 1-10: covered in full, Days 11-100: \$25 per day	Days 1-10: covered in full, Days 11-100: \$25 per day
Covered in full	Covered in full	Covered in full	Covered in full
\$100 copayment	\$100 copayment	\$100 copayment	\$100 copayment
\$50 copayment	\$50 copayment	\$50 copayment	\$50 copayment
\$100 copayment	\$100 copayment	\$100 copayment	\$100 copayment
50% (\$2,000 maximum per calendar year)	50% (\$2,000 maximum per calendar year)	50% (\$2,000 maximum per calendar year)	50% (\$2,000 maximum per calendar year)
20%	20%	20%	20%
Optional rider available	Optional rider available	Optional rider available	Optional rider available
No deductible	\$200	No deductible	\$250
\$15 Level I \$30 Level II \$50 Level III	\$15 Level I \$30 Level II \$50 Level III	\$15 Level I \$30 Level II \$50 Level III	\$15 Level I \$30 Level II \$50 Level III

# POS PORTFOLIO

## BENEFIT DESCRIPTION<sup>1</sup>

BENEFIT DESCRIPTION <sup>1</sup>	POS 10		
	HMO	PPO <sup>2</sup>	OUT-OF-NETWORK <sup>3,6</sup>
<b>PLAN MAXIMUMS</b>			
Calendar year deductible	No deductible	\$250 single/\$500 family	\$500 Single/\$1,000 family
Out-of-pocket maximum	\$1,500 single/\$3,000 family	\$3,000 single/2 per family	\$6,000 single/2 per family
Lifetime medical benefit maximum	No maximum	\$5,000,000 combined with PPO and OON	
<b>PROFESSIONAL SERVICES</b>			
Office visit	\$10 copayment	\$20 copayment	50%
Preventive care services for children (through age 17)	\$10 copayment (birth through age 2 covered in full)	\$20 copayment	Not covered
Preventive care services for adults (age 18 and older)	\$10 copayment	10%	Not covered
Annual routine physical examination (age 18 and older)	Not covered	Not covered	
Specialist consultation	\$10 copayment	\$20 copayment	50%
X-ray and laboratory procedures	Covered in full	10%	50%
Physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy and pulmonary rehabilitation therapy	\$10 copayment	10% (12 visits per calendar year combined with PPO and OON)	50%
Self-injectable drugs	30%	30%	50%
<b>HOSPITAL SERVICES</b>			
Inpatient hospital facility services (includes maternity)	Covered in full	10% <sup>7</sup> (\$250 deductible per calendar year combined with PPO and OON) <sup>8</sup>	50% (\$600 maximum allowable per day) <sup>7</sup> (\$250 deductible per calendar year combined with PPO and OON) <sup>8</sup>
Outpatient facility services (other than surgery)	Covered in full	10% <sup>7</sup>	50% (50% maximum allowable) <sup>7</sup>
Outpatient surgery (hospital or outpatient surgery center charges only)	Covered in full	10% <sup>7</sup> (\$250 deductible per calendar year combined with PPO and OON) <sup>9</sup>	50% (50% maximum allowable) <sup>7</sup> (\$250 deductible per calendar year combined with PPO and OON) <sup>9</sup>
Skilled nursing facility	Days 1-10: covered in full, Days 11-100: \$25 per day	10% <sup>7</sup> (100 days per calendar year combined with PPO and OON; \$250 deductible per calendar year combined with PPO and OON) <sup>8</sup>	50% (\$250 maximum payable per day)
<b>EMERGENCY SERVICES</b>			
Professional services	Covered in full	\$20 copayment	\$20 copayment
Emergency room facility (copayment waived if admitted)	\$100 copayment	\$100 copayment + 10%	
Urgent care facility	\$50 copayment	\$50 copayment + 10%	
Ambulance services (ground and air)	\$100 copayment	\$50 copayment + 10% <sup>7</sup>	\$50 copayment + 50% <sup>7</sup>
<b>OTHER SERVICES</b>			
Durable medical equipment and orthotics	50% (\$2,000 maximum per calendar year)	50% <sup>7</sup> (\$2,000 maximum per calendar year combined with PPO and OON)	
Diabetic equipment	20%	20% <sup>7</sup>	50% <sup>7</sup>
Chiropractic services <sup>4</sup>	Optional rider available	\$20 copayment (12 visits per calendar year)	Not covered
Acupuncture <sup>4</sup>	Optional rider available	Not covered	
<b>PRESCRIPTION DRUG COVERAGE<sup>5</sup></b>			
Calendar year deductible (per covered person)	No deductible	No deductible	\$100
Prescription drugs (up to a 30-day supply)		\$10 Level I \$25 Level II \$50 Level III	50%

Plan footnotes found on pages 28-29.

POS 20		
HMO	PPO <sup>2</sup>	OUT-OF-NETWORK <sup>3,6</sup>
No Deductible	\$500 single/\$1,000 family	\$1,000 single/\$2,000 family
\$2,000 single/\$4,000 family	\$3,500 single/2 per family	\$7,000 single/2 per family
No maximum	\$5,000,000 combined with PPO and OON	
\$20 copayment	\$30 copayment	50%
\$20 copayment (birth through age 2 covered in full)	\$30 copayment	Not covered
\$20 copayment	20%	Not covered
Not covered	Not covered	
\$20 copayment	\$30 copayment	50%
Covered in full	20%	50%
\$20 copayment	20%	50%
	(12 visits per calendar year combined with PPO and OON)	
30%	30%	50%
\$250 copayment per day (3 day copayment maximum)	20% <sup>7</sup>	50% (\$600 maximum allowable per day) <sup>7</sup> (\$250 deductible per calendar year combined with PPO and OON) <sup>8</sup>
20%	20% <sup>7</sup>	50% (50% maximum allowable) <sup>7</sup>
\$250 copayment	20% <sup>7</sup>	50% (50% maximum allowable) <sup>7</sup> (\$250 deductible per calendar year combined with PPO and OON) <sup>9</sup>
Days 1-10: Covered in full, Days 11-100: \$25 per day	20% <sup>7</sup>	50% (\$250 maximum payable per day) (100 days per calendar year combined with PPO and OON; \$250 deductible per calendar year combined with PPO and OON) <sup>8</sup>
Covered in full	\$30 copayment	\$30 copayment
\$100 copayment	\$100 copayment + 20%	
\$50 copayment	\$50 copayment + 20%	
\$100 copayment	\$50 copayment + 20% <sup>7</sup>	\$50 copayment + 50% <sup>7</sup>
50% (\$2,000 maximum per calendar year)	50% <sup>7</sup> (\$1,000 maximum per calendar year combined combined with PPO and OON)	
20%	20% <sup>7</sup>	50% <sup>7</sup>
Optional rider available	\$30 copayment (12 visits per calendar year)	Not covered
Optional rider available	Not covered	
No deductible	No deductible	\$100
	\$15 Level I \$30 Level II \$50 Level III	50%

# PPO PORTFOLIO

**Please note:** All highlighted boxes reflect standardized benefits between Standard and Value plans.

BENEFIT DESCRIPTION <sup>1</sup>	PPO 10			
	STANDARD		VALUE	
	PPO <sup>2</sup>	OUT-OF-NETWORK <sup>3</sup>	PPO <sup>2</sup>	OUT-OF-NETWORK <sup>3</sup>
<b>PLAN MAXIMUMS</b>				
Calendar year deductible	No deductible	\$500 single/ \$1,000 family	\$1,000 single/ \$2,000 family	\$2,000 single/ \$4,000 family
Out-of-pocket maximum	\$2,500 single/ 2 per family	\$5,000 single/ 2 per family	\$2,500 single/ 2 per family	\$5,000 single/ 2 per family
Lifetime medical benefit maximum	\$5,000,000 combined with PPO and OON		\$5,000,000 combined with PPO and OON	
<b>PROFESSIONAL SERVICES</b>				
Office visit	\$10 copayment	40%	\$10 copayment	40%
Preventive care services for children (through age 16)	\$10 copayment	Not covered	\$10 copayment	Not covered
Preventive care services for adults (age 17 and older)	\$10 copayment	Not covered	\$10 copayment	Not covered
Annual routine physical examination (age 17 and older)	\$10 copayment (\$250 per calendar year maximum payable)	Not covered	\$10 copayment (\$250 per calendar year maximum payable)	Not covered
Specialist consultation	\$10 copayment	40%	\$10 copayment	40%
X-ray and laboratory procedures <sup>5</sup>	10%	40%	20%	40%
Physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy and pulmonary rehabilitation therapy	10%	40% (12 visits per calendar year combined PPO and OON)	20%	40% (12 visits per calendar year combined PPO and OON)
Self-injectable drugs	10%	40%	20%	40%
<b>HOSPITAL SERVICES<sup>5</sup></b>				
Inpatient hospital facility services (includes maternity)	10%	40%	20%	40%
Outpatient facility services (other than surgery)	10%	40%	20%	40%
Outpatient surgery (hospital or outpatient surgery center charges only)	10%	40%	20%	40%
Skilled nursing facility	10%	40% (\$250 maximum allowable per day) (100 days per calendar year combined with PPO and OON)	20%	40% (\$250 maximum allowable per day) (100 days per calendar year combined with PPO and OON)
<b>EMERGENCY SERVICES</b>				
Professional services	\$10 copayment		\$10 copayment	
Emergency room facility (copayment waived if admitted)	\$100 copayment + 10%		\$100 copayment + 20%	
Urgent care facility	\$50 copayment + 10%		\$50 copayment + 20%	
Ambulance services (ground and air) <sup>5</sup>	\$50 copayment + 10%	\$50 copayment + 40%	\$50 copayment + 20%	\$50 copayment + 40%
<b>OTHER SERVICES</b>				
Durable medical equipment and Orthotics <sup>5</sup>	10%	40% (\$3,000 maximum per calendar year combined with PPO and OON)	20%	40% (\$3,000 maximum per calendar year combined with PPO and OON)
Diabetic equipment	10%	40%	20%	40%
Chiropractic services	\$10 copayment (12 visits per calendar year)	Not covered	\$10 copayment (12 visits per calendar year)	Not covered
Acupuncture	Not covered		Not covered	
<b>PRESCRIPTION DRUG COVERAGE<sup>6</sup></b>				
Calendar year deductible (per member)	No deductible	\$100	\$100 brand deductible	\$100
Prescription drugs (up to a 30-day supply)	\$10 Level I \$25 Level II \$50 Level III	50%	\$10 Level I \$25 Level II \$50 Level III	50%

Plan footnotes found on pages 28-29.

PPO 20			
STANDARD		VALUE	
PPO <sup>2</sup>	OUT-OF-NETWORK <sup>4</sup>	PPO <sup>2</sup>	OUT-OF-NETWORK <sup>4</sup>
\$250 single/ \$500 family	\$500 single/ \$1,000 family	\$1,250 single/ \$2,500 family	\$2,500 single/ \$5,000 family
\$3,000 single/ 2 per family	\$6,000 single/ 2 per family	\$3,500 single/ 2 per family	\$7,000 single/ 2 per family
\$5,000,000 combined with PPO and OON		\$5,000,000 combined with PPO and OON	
\$20 copayment	50%	\$20 copayment	50%
\$20 copayment	Not covered	\$20 copayment	Not covered
\$20 copayment	Not covered	\$20 copayment	Not covered
\$20 copayment (\$250 per calendar year maximum payable)	Not covered	\$20 copayment (\$250 per calendar year maximum payable)	Not covered
\$20 copayment	50%	\$20 copayment	50%
10%	50%	20%	50%
10%	50% (12 visits per calendar year combined with PPO and OON)	20%	50% (12 visits per calendar year combined with PPO and OON)
10%	50%	20%	50%
10%	50% (\$600 maximum allowable per day) (\$250 deductible per calendar year combined with PPO and OON) <sup>7</sup>	20%	50% (\$600 maximum allowable per day) (\$250 deductible per calendar year combined with PPO and OON) <sup>7</sup>
10%	50% (50% maximum allowable)	20%	50% (50% maximum allowable)
10%	50% (50% maximum allowable) (\$250 deductible per calendar year combined with PPO and OON) <sup>8</sup>	20%	50% (50% maximum allowable) (\$250 deductible per calendar year combined with PPO and OON) <sup>8</sup>
10%	50% (\$250 maximum allowable per day) (90 days per calendar year combined with PPO and OON; \$250 deductible per calendar year combined with PPO and OON) <sup>7</sup>	20%	50% (\$250 maximum allowable per day) (90 days per calendar year combined with PPO and OON; \$250 deductible per calendar year combined with PPO and OON) <sup>7</sup>
\$20 copayment		\$20 copayment	
\$100 copayment + 10%		\$100 copayment + 20%	
\$50 copayment + 10%		\$50 copayment + 20%	
\$50 copayment + 10%	\$50 copayment + 50%	\$50 copayment + 20%	\$50 copayment + 50%
10%	50% (\$2,000 maximum per calendar year combined with PPO and OON)	20%	50% (\$2,000 maximum per calendar year combined with PPO and OON)
10%	50%	20%	50%
\$20 copayment (12 visits per calendar year)	Not covered	\$20 copayment (12 visits per calendar year)	Not covered
Not covered		Not covered	
No deductible	\$100	\$150 brand deductible	\$100
\$15 Level I \$30 Level II \$50 Level III	50%	\$15 Level I \$30 Level II \$50 Level III	50%

# PPO PORTFOLIO (continued)

**Please note:** All highlighted boxes reflect standardized benefits between Standard and Value plans.

BENEFIT DESCRIPTION <sup>1</sup>	PPO 30			
	STANDARD		VALUE	
	PPO <sup>2</sup>	OUT-OF-NETWORK <sup>4</sup>	PPO <sup>2</sup>	OUT-OF-NETWORK <sup>4</sup>
<b>PLAN MAXIMUMS</b>				
Calendar year deductible	\$500 single/ \$1,000 family	\$1,000 single/ \$2,000 family	\$1,500 single/ \$3,000 family	\$3,000 single/ \$6,000 family
Out-of-pocket maximum	\$3,500 single/ 2 per family	\$7,000 single/ 2 per family	\$4,500 single/ 2 per family	\$9,000 single/ 2 per family
Lifetime medical benefit maximum	\$5,000,000 combined with PPO and OON		\$5,000,000 combined with PPO and OON	
<b>PROFESSIONAL SERVICES</b>				
Office visit	\$30 copayment	50%	\$30 copayment	50%
Preventive care services for children (through age 16)	\$30 copayment	Not covered	\$30 copayment	Not covered
Preventive care services for adults (age 17 and older)	\$30 copayment	Not covered	\$30 copayment	Not covered
Annual routine physical examination (age 17 and older)	\$30 copayment (\$250 per calendar year maximum payable)	Not covered	\$30 copayment (\$250 per calendar year maximum payable)	Not covered
Specialist consultation	\$30 copayment	50%	\$30 copayment	50%
X-ray and laboratory procedures <sup>5</sup>	20%	50%	30%	50%
Physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy and pulmonary rehabilitation therapy	20% (12 visits per calendar year combined with PPO and OON)	50%	30% (12 visits per calendar year combined with PPO and OON)	50%
Self-injectable drugs	20%	50%	30%	50%
<b>HOSPITAL SERVICES<sup>5</sup></b>				
Inpatient hospital facility services (includes maternity)	20% (\$250 deductible per calendar year combined with PPO and OON) <sup>7</sup>	50% (\$600 maximum allowable per day)	30% (\$250 deductible per calendar year combined with PPO and OON) <sup>7</sup>	50% (\$600 maximum allowable per day)
Outpatient facility services (other than surgery)	20%	50% (50% maximum allowable)	30%	50% (50% maximum allowable)
Outpatient surgery (hospital or outpatient surgery center charges only)	20% (\$250 deductible per calendar year combined with PPO and OON) <sup>8</sup>	50% (50% maximum allowable)	30% (\$250 deductible per calendar year combined with PPO and OON) <sup>8</sup>	50% (50% maximum allowable)
Skilled nursing facility	20% (60 days per calendar year combined with PPO and OON; \$250 deductible per calendar year combined with PPO and OON) <sup>7</sup>	50% (\$250 maximum allowable per day)	30% (60 days per calendar year combined with PPO and OON; \$250 deductible per calendar year combined with PPO and OON) <sup>7</sup>	50% (\$250 maximum allowable per day)
<b>EMERGENCY SERVICES</b>				
Professional services	\$30 copayment		\$30 copayment	
Emergency room facility (copayment waived if admitted)	\$100 copayment + 20%		\$100 copayment + 30%	
Urgent care facility	\$50 copayment + 20%		\$50 copayment + 30%	
Ambulance services (ground and air) <sup>5</sup>	\$50 copayment + 20%	\$50 copayment + 50%	\$50 copayment + 30%	\$50 copayment + 50%
<b>OTHER SERVICES</b>				
Durable medical equipment and orthotics <sup>5</sup>	20% (\$1,000 maximum per calendar year combined with PPO and OON)	50%	30% (\$1,000 maximum per calendar year combined with PPO and OON)	50%
Diabetic equipment	20%	50%	30%	50%
Chiropractic services	\$30 copayment (12 visits per calendar year)	Not covered	\$30 copayment (12 visits per calendar year)	Not covered
Acupuncture	Not covered		Not covered	
<b>PRESCRIPTION DRUG COVERAGE<sup>6</sup></b>				
Calendar year deductible (per member)	No deductible	\$100	\$200 brand deductible	\$100
Prescription drugs (up to a 30-day supply)	\$15 Level I \$30 Level II \$50 Level III	50%	\$15 Level I \$30 Level II \$50 Level III	50%

Plan footnotes found on pages 28-29.

PPO 40			
STANDARD		VALUE	
PPO <sup>2</sup>	OUT-OF-NETWORK <sup>4</sup>	PPO <sup>2</sup>	OUT-OF-NETWORK <sup>4</sup>
\$500 single/ \$1,000 family	\$1,000 single/ \$2,000 family	\$1,500 single/ \$3,000 family	\$3,000 single/ \$6,000 family
\$5,000 single/ 2 per family	\$10,000 single/ 2 per family	\$5,000 single/ 2 per family	\$10,000 single/ 2 per family
\$5,000,000 combined with PPO and OON		\$5,000,000 combined with PPO and OON	
\$40 copayment	50%	\$40 copayment	50%
\$40 copayment	Not covered	\$40 copayment	Not covered
\$40 copayment	Not covered	\$40 copayment	Not covered
\$40 copayment (\$250 per calendar year maximum payable)	Not covered	\$40 copayment (\$250 per calendar year maximum payable)	Not covered
\$40 copayment	50%	\$40 copayment	50%
40%	50%	50%	50%
40%	50%	50%	50%
(12 visits per calendar year combined with PPO and OON)		(12 visits per calendar year combined with PPO and OON)	
40%	50%	50%	50%
40%	50% (\$600 maximum allowable per day) (\$500 deductible per calendar year combined with PPO and OON) <sup>7</sup>	50%	50% (\$600 maximum allowable per day) (\$500 deductible per calendar year combined with PPO and OON) <sup>7</sup>
40%	50% (50% maximum allowable)	50%	50% (50% maximum allowable)
40%	50% (50% maximum allowable) (\$250 deductible per calendar year combined with PPO and OON) <sup>8</sup>	50%	50% (50% maximum allowable) (\$250 deductible per calendar year combined with PPO and OON) <sup>8</sup>
40%	50% (\$250 maximum allowable per day) (60 days per calendar year combined with PPO and OON; \$500 deductible per calendar year combined with PPO and OON) <sup>7</sup>	50%	50% (\$250 maximum allowable per day) (60 days per calendar year combined with PPO and OON; \$500 deductible per calendar year combined with PPO and OON) <sup>7</sup>
\$40 copayment		\$40 copayment	
\$100 copayment + 40%		\$100 copayment + 50%	
\$50 copayment + 40%		\$50 copayment + 50%	
\$50 copayment + 40%	\$50 copayment + 50%	\$50 copayment + 50%	
40%	50%	50%	50%
(\$1,000 maximum per calendar year combined with PPO and OON)		(\$1,000 maximum per calendar year combined with PPO and OON)	
40%	50%	50%	50%
\$40 copayment (12 visits per calendar year)	Not covered	\$40 copayment (12 visits per calendar year)	Not covered
Not covered		Not covered	
No deductible	\$100	\$250 brand deductible	\$100
\$15 Level I \$30 Level II \$50 Level III	50%	\$15 Level I \$30 Level II \$50 Level III	50%

# HSA PORTFOLIO

## BENEFIT DESCRIPTION<sup>1</sup>

BENEFIT DESCRIPTION <sup>1</sup>	HSA 10 (1500)		HSA 20 (2500)	
	PPO <sup>2</sup>	OUT-OF-NETWORK <sup>3</sup>	PPO <sup>2</sup>	OUT-OF-NETWORK <sup>4</sup>
<b>PLAN MAXIMUMS</b>				
Calendar year deductible (For family coverage, the enrolled employee and dependents must collectively pay the family amount before Health Net begins to pay.)	\$1,500 single (Employee only coverage)/ \$3,000 family (Employee and dependant coverage)		\$2,500 single (Employee only coverage)/ \$5,000 family (Employee and dependant coverage)	
Out-of-pocket maximum	\$2,500 single (Employee only coverage)/ \$5,000 family (Employee and dependant coverage)		\$3,500 single (Employee only coverage)/ \$7,000 family (Employee and dependant coverage)	
Lifetime medical benefit maximum	\$5,000,000 combined with PPO and OON		\$5,000,000 combined with PPO and OON	
<b>PROFESSIONAL SERVICES</b>				
Office visit	\$10 copayment (deductible not waived)	40%	\$20 copayment (deductible not waived)	50%
Preventive care services for children (through age 16)	\$10 copayment (deductible waived)	Not covered	\$20 copayment (deductible waived)	Not covered
Preventive care services for adults (age 17 and older)	\$10 copayment (deductible waived)	Not covered	\$20 copayment (deductible waived)	Not covered
Annual routine physical examination (age 17 and older)	\$10 copayment (deductible waived, \$250 per calendar year maximum payable)	Not covered	\$20 copayment (deductible waived, \$250 per calendar year maximum payable)	Not covered
Specialist consultation	\$10 copayment (deductible not waived)	40%	\$20 copayment (deductible not waived)	50%
X-ray and laboratory procedures <sup>5</sup>	20%	40%	20%	50%
Physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy and pulmonary rehabilitation therapy	20%	40% (12 visits per calendar year combined with PPO and OON)	20%	50% (12 visits per calendar year combined with PPO and OON)
Self-injectable drugs	20%	40%	20%	50%
<b>HOSPITAL SERVICES<sup>5</sup></b>				
Inpatient hospital facility services (includes maternity)	20%	40%	20%	50% (\$600 maximum allowable per day) (\$250 deductible per calendar year combined with PPO and OON) <sup>7</sup>
Outpatient facility services (other than surgery)	20%	40%	20%	50% (50% maximum allowable)
Outpatient surgery (hospital or outpatient surgery center charges only)	20%	40%	20%	50% (50% maximum allowable) (\$250 deductible per calendar year combined with PPO and OON) <sup>8</sup>
Skilled nursing facility	20%	40% (\$250 maximum allowable per day)  (100 days per calendar year combined with PPO and OON)	20%	50% (\$250 maximum allowable per day)  (90 days per calendar year combined with PPO and OON; \$250 deductible per calendar year combined with PPO and OON) <sup>7</sup>
<b>EMERGENCY SERVICES</b>				
Professional services	\$10 copayment (deductible not waived)		\$20 copayment (deductible not waived)	
Emergency room facility (copayment waived if admitted)	\$100 copayment + 20%		\$100 copayment + 20%	
Urgent care facility	\$50 copayment + 20%		\$50 copayment + 20%	
Ambulance services (ground and air) <sup>5</sup>	\$50 copayment + 20%	\$50 copayment + 40%	\$50 copayment + 20%	\$50 copayment + 50%
<b>OTHER SERVICES</b>				
Durable medical equipment and orthotics <sup>5</sup>	20%	40% (\$3,000 maximum per calendar year combined with PPO and OON)	20%	50% (\$2,000 maximum per calendar year combined with PPO and OON)
Diabetic equipment	20%	40%	20%	50%
Chiropractic services	\$10 copayment (deductible not waived, 12 visits per calendar year)	Not covered	\$20 copayment (deductible not waived, 12 visits per calendar year)	Not covered
Acupuncture	Not covered		Not covered	
<b>PRESCRIPTION DRUG COVERAGE<sup>6</sup></b>				
Calendar year deductible (per member)	Subject to annual deductible		Subject to annual deductible	
Prescription drugs (up to a 30-day supply)	\$10 Level I \$25 Level II \$50 Level III	50%	\$15 Level I \$30 Level II \$50 Level III	50%

Plan footnotes found on pages 28-29.

HSA 30 (3500)		HSA 40 (4500)	
PPO <sup>2</sup>	OUT-OF-NETWORK <sup>4</sup>	PPO <sup>2</sup>	OUT-OF-NETWORK <sup>3</sup>
\$3,500 single (Employee only coverage)/ \$7,000 family (Employee and dependant coverage)		\$4,500 single (Employee only coverage)/ \$9,000 family (Employee and dependant coverage)	
\$4,500 single (Employee only coverage)/ \$9,000 family (Employee and dependant coverage)		\$5,000 single (Employee only coverage)/ \$10,000 family (Employee and dependant coverage)	
\$5,000,000 combined with PPO and OON		\$5,000,000 combined with PPO and OON	
\$30 copayment (deductible not waived)	50%	\$40 copayment (deductible not waived)	50%
\$30 copayment (deductible waived)	Not covered	\$40 copayment (deductible waived)	Not covered
\$30 copayment (deductible waived)	Not covered	\$40 copayment (deductible waived)	Not covered
\$30 copayment (deductible waived, \$250 per calendar year maximum payable)	Not covered	\$40 copayment (deductible waived, \$250 per calendar year maximum payable)	Not covered
\$30 copayment (deductible not waived)	50%	\$40 copayment (deductible not waived)	50%
30%	50%	50%	50%
30%	50% (12 visits per calendar year combined with PPO and OON)	50%	50% (12 visits per calendar year combined with PPO and OON)
30%	50%	50%	50%
30%	50% (\$600 maximum allowable per day) (\$250 deductible per calendar year combined with PPO and OON) <sup>7</sup>	50%	50% (\$600 maximum allowable per day) (\$500 deductible per calendar year combined with PPO and OON) <sup>7</sup>
30%	50% (50% maximum allowable)	50%	50% (50% maximum allowable)
30%	50% (50% maximum allowable) (\$250 deductible per calendar year combined with PPO and OON) <sup>8</sup>	50%	50% (50% maximum allowable) (\$250 deductible per calendar year combined with PPO and OON) <sup>8</sup>
30%	50% (\$250 maximum allowable per day) (60 days per calendar year combined with PPO and OON; \$250 deductible per calendar year combined with PPO and OON) <sup>7</sup>	50%	50% (\$250 maximum allowable per day) (60 days per calendar year combined with PPO and OON; \$500 deductible per calendar year combined with PPO and OON) <sup>7</sup>
\$30 copayment (deductible not waived)		\$40 copayment (deductible not waived)	
\$100 copayment + 30%		\$100 copayment + 50%	
\$50 copayment + 30%		\$50 copayment + 50%	
\$50 copayment + 30%	\$50 copayment + 50%	\$50 copayment + 50%	
30%	50% (\$1,000 per calendar year combined with PPO and OON)	50%	50% (\$1,000 per calendar year combined with PPO and OON)
30%	50%	50%	50%
\$30 copayment (deductible not waived, 12 visits per calendar year)	Not covered	\$40 copayment (deductible not waived, 12 visits per calendar year)	Not covered
Not covered		Not covered	
Subject to annual deductible		Subject to annual deductible	
\$15 Level I \$30 Level II \$50 Level III	50%	\$15 Level I \$30 Level II \$50 Level III	50%

# FLEX NET PORTFOLIO

BENEFIT DESCRIPTION <sup>1</sup>	FLEX NET INDEMNITY <sup>2</sup>
<b>PLAN MAXIMUMS</b>	
Calendar year deductible	\$300 single/\$900 family
Out-of-pocket maximum	\$1,500 single/\$4,500 family
Lifetime medical benefit maximum	\$1,000,000
<b>PROFESSIONAL SERVICES</b>	
Office visit	20%
Preventive care services for children (through age 16)	20%
Preventive care services for adults (age 17 and older)	20%
Annual routine physical examination (age 17 and older)	Not covered
Specialist consultation	20%
X-ray and laboratory procedures <sup>5</sup>	20%
Physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy and pulmonary rehabilitation therapy	20% (60 visits per calendar year)
Self-injectable drugs	20%
<b>HOSPITAL SERVICES<sup>5</sup></b>	
Inpatient hospital facility services (includes maternity)	20%
Outpatient facility services (other than surgery)	20%
Outpatient surgery (hospital or outpatient surgery center charges only)	20%
Skilled nursing facility	20% (60 days per calendar year)
<b>EMERGENCY SERVICES</b>	
Professional services	20%
Emergency room facility	20%
Urgent care facility	20%
Ambulance services (ground and air) <sup>5</sup>	20%
<b>OTHER SERVICES</b>	
Durable medical equipment and orthotics <sup>5</sup>	20%
Diabetic equipment	20%
Chiropractic services	20% (15 visits per calendar year, \$25 maximum payable per visit)
Acupuncture	Not covered
<b>PRESCRIPTION DRUG COVERAGE<sup>6</sup></b>	
Calendar year deductible (per member)	\$75 brand name deductible
Prescription drugs (up to a 30-day supply)	20%

Plan footnotes found on pages 28-29.

# SALUD CON HEALTH NET PORTFOLIO

## BENEFIT DESCRIPTION<sup>1</sup>

BENEFIT DESCRIPTION <sup>1</sup>	SALUD HMO Y MÁS		
	SIMNSA NETWORK (Mexico members)	SALUD NETWORK (California members)	SIMNSA NETWORK (self-referral for California members)
<b>PLAN MAXIMUMS</b> Out-of-pocket maximum		\$1,500 single \$3,000 two-party \$4,500 family	
Lifetime medical benefit maximum	No maximum	No maximum	No maximum
<b>PROFESSIONAL SERVICES</b>			
Office visit	\$5 copayment	\$15 copayment	\$5 copayment
Well child care (including immunizations)	Covered in full	Covered in full	Covered in full
Adult preventive care (age 18 and older)	Covered in full	\$15 copayment	Covered in full
Specialist consultation	\$5 copayment	\$15 copayment	\$5 copayment
X-ray and laboratory procedures	Covered in full	Covered in full	Covered in full
Physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy and pulmonary rehabilitation therapy	\$5 copayment	\$15 copayment	\$5 copayment
Self-injectable drugs	Covered in full	Covered in full	Covered in full
<b>HOSPITAL SERVICES</b>			
Inpatient hospital facility services (includes maternity)	Covered in full	\$250 per admission copayment	Covered in full
Outpatient facility services (other than surgery)	Covered in full	20%	Covered in full
Outpatient surgery (hospital or outpatient surgery center charges only)	Covered in full	20%	Covered in full
Skilled nursing facility	Covered in full (100 days per calendar year combined with SIMNSA (Mexico), and Salud (California))	20% (100 days per calendar year combined with SIMNSA (Mexico), and Salud (California))	Covered in full (100 days per calendar year)
<b>EMERGENCY SERVICES</b>			
Professional services	Covered in full	Covered in full	Covered in full
Emergency room facility (copayment waived if admitted)	\$10 copayment	\$50 copayment	\$10 copayment
Urgent care facility	\$10 copayment	\$15 copayment	\$10 copayment
Ambulance services (ground and air)	Covered in full	\$50 copayment	Covered in full
<b>OTHER SERVICES</b>			
Durable medical equipment and orthotics	Covered in full	Covered in full	Covered in full
Diabetic equipment	Covered in full	Covered in full	Covered in full
Acupuncture, Chiropractic services <sup>2</sup>	Optional rider available	Optional rider available	Optional rider available
<b>PRESCRIPTION DRUG COVERAGE</b>			
Calendar year deductible (per member)	No deductible	No deductible	No deductible
Prescription drugs (up to a 30-day supply)	\$5 copayment	\$5 Level I \$15 Level II \$35 Level III	\$5 copayment

# SALUD CON HEALTH NET PORTFOLIO (continued)

## BENEFIT DESCRIPTION<sup>1</sup>

BENEFIT DESCRIPTION <sup>1</sup>	SALUDMEXICO HMO	SALUD EPO PRIMERO	
	SIMNSA NETWORK ONLY	SIMNSA NETWORK	SALUD NETWORK
<b>PLAN MAXIMUMS</b>			
Out-of-pocket maximum	\$1,500 single \$3,000 two-party \$4,500 family	Not applicable	\$1,500 single \$4,500 family
Lifetime medical benefit maximum	No maximum	No maximum	\$5,000,000
<b>PROFESSIONAL SERVICES</b>			
Office visit	\$5 copayment	\$5 copayment	\$15 copayment
Periodic health evaluation including newborn, well-baby care and immunizations (birth through age 17)	Covered in full	Covered in full	Covered in full
Periodic health evaluations including well woman exam (age 18 and older)	Covered in full	Covered in full	\$15 copayment
Specialist consultation	\$5 copayment	\$5 copayment	\$35 copayment
X-ray and Laboratory procedures (includes mammograms) <sup>5</sup>	Covered in full	Covered in full	Covered in full
Physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy and pulmonary rehabilitation therapy	\$5 copayment	\$5 copayment	\$15 copayment
Self-injectable drugs	Covered in full	Covered in full	Covered in full
<b>HOSPITAL SERVICES<sup>5</sup></b>			
Inpatient care	Covered in full	Covered in full	\$250 per admission deductible
Outpatient facility services	Covered in full	Covered in full	20%
Outpatient surgery (hospital or outpatient surgery center charges only)	Covered in full	Covered in full	20%
Skilled nursing facility	Covered in full (100 days per calendar year)	Not covered	20% (100 days per calendar year)
<b>EMERGENCY SERVICES</b>			
Professional services	Covered in full	Covered in full	Covered in full
Emergency room facility (copayment waived if admitted)	\$10 copayment (in Mexico), \$50 copayment (outside Mexico)	\$10 copayment	\$100 copayment
Urgent care facility	\$10 copayment	\$10 copayment	\$15 copayment
Ambulance services (ground and air)	Covered in full (air ambulance not covered)	Covered in full (air ambulance not covered)	\$50 copayment
<b>OTHER SERVICES</b>			
Durable medical equipment <sup>5</sup>	Covered in full	Covered in full	Covered in full
Diabetic equipment	Covered in full	Covered in full	Covered in full
Acupuncture, Chiropractic services	Not covered	Not covered	Not covered
<b>PRESCRIPTION DRUG COVERAGE</b>			
Brand name calendar year deductible (per member)	No deductible	No deductible	No deductible
Prescription drugs (up to a 30-day supply)	\$5 copayment	\$5 Level I \$5 Level II Level III/Not covered	\$10 Level I \$35 Level II 50% Level III

Plan footnotes found on pages 28-29.

# SALUD CON HEALTH NET PORTFOLIO (continued)

## BENEFIT DESCRIPTION<sup>1</sup>

BENEFIT DESCRIPTION <sup>1</sup>	SALUD PPO		
	SIMNSA NETWORK <sup>4</sup> (Mexico members)	SALUD NETWORK (California members)	SIMNSA NETWORK <sup>3,4</sup> (self-referral for California members)
<b>PLAN MAXIMUMS</b>			
Annual deductible	No deductible	\$1,000 single/2 per family	\$1,000 single/2 per family
Out-of-pocket maximum	\$1,000 single \$2,000 family	\$2,000 single \$4,000 family	\$10,000 single \$10,000 family
Lifetime medical benefit maximum	\$5,000,000 combined with SIMNSA, Salud and OON		
<b>PROFESSIONAL SERVICES</b>			
Office visit	\$5 copayment	\$15 copayment	50%
Well child care (including immunizations)	\$5 copayment	\$15 copayment	50%
Adult preventive care (age 18 and older)	\$5 copayment	\$15 copayment	50%
Adult annual routine physical exam (age 18 and older)	Not covered		
Specialist consultation	\$5 copayment	\$15 copayment	50%
X-ray and laboratory procedures <sup>5</sup>	10%	20%	50%
Physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy and pulmonary rehabilitation therapy	10%	20% (\$25 maximum per visit) 50% (\$25 maximum per visit) (12 visits per calendar year combined with Salud and OON)	
Self-injectable drugs	\$5 copayment	\$15 copayment	50%
<b>HOSPITAL SERVICES<sup>5</sup></b>			
Inpatient care	10%	\$250 per admission deductible + 20%	\$250 per admission deductible + 50% (\$380 maximum per day)
Outpatient facility services	10%	\$250 deductible + 20%	\$250 deductible + 50%
Outpatient surgery (hospital or outpatient surgery center charges only)	10%	\$250 deductible + 20%	\$250 deductible + 50%
Skilled nursing facility	Not covered	\$250 deductible + 20%	\$250 deductible + 50% (\$150 maximum allowable per day) 100 days per calendar year maximum combined with Salud and OON
<b>EMERGENCY SERVICES</b>			
Professional services	10%	20%	50%
Emergency room facility (deductible waived if admitted)	\$25 deductible + 10%	\$50 deductible + 20%	\$100 deductible + 50%
Urgent care facility (deductible waived if admitted)	\$25 deductible + 10%	\$50 deductible + 20%	\$100 deductible + 50%
Ambulance services (ground and air)	\$20 deductible + 10% (air not covered)	\$50 deductible + 20%	50%
<b>OTHER SERVICES</b>			
Durable medical equipment <sup>4</sup>	10%	20%	50%
Diabetic equipment	10%	20%	50%
Acupuncture, Chiropractic services	Not covered		
<b>PRESCRIPTION DRUG COVERAGE</b>			
Prescription drugs dispensed by SIMNSA	\$5 copayment	Not applicable	Not applicable
Prescription drugs dispensed by Health Net participating pharmacy	Not applicable	\$10 Level I \$35 Level II 50% Level III	Not covered

# OPTIONS HMO PORTFOLIO

BENEFIT DESCRIPTION <sup>1</sup>	OPTIONS HMO 25	OPTIONS HMO 35
<b>PLAN MAXIMUMS</b>		
Out-of-pocket maximum	\$3,000 single/\$6,000 family	\$4,000 single/\$8,000 family
Lifetime medical benefit maximum	No maximum	No maximum
<b>PROFESSIONAL SERVICES</b>		
Office visit	\$25 copayment	\$35 copayment
Well child care (including immunizations)	Covered in full (until age 2 then \$25)	Covered in full (until age 2 then \$35)
Adult preventive care (age 17 and older)	\$25 copayment	\$35 copayment
Adult routine physical examination (age 17 and older)	Not covered	Not covered
Specialist consultation	\$25 copayment	\$35 copayment
X-ray and laboratory procedures <sup>2</sup>	Covered in full	Covered in full
Physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy and pulmonary rehabilitation therapy	\$25 copayment	\$35 copayment
Self-injectable drugs	30%	30%
<b>HOSPITAL SERVICES</b>		
Inpatient hospital facility services (includes maternity)	20%	30%
Outpatient facility services (other than surgery) <sup>3,4</sup>	20%	30%
Outpatient surgery (hospital or outpatient surgery center charges only)	20%	30%
Skilled nursing facility	Days 1-10: covered in full, Days 11-100: \$25 per day	Days 1-10: covered in full, Days 11-100: \$25 per day
<b>EMERGENCY SERVICES</b>		
Professional services	Covered in full	Covered in full
Emergency room facility (copayment waived if admitted)	\$100 copayment	\$100 copayment
Urgent care facility	\$50 copayment	\$50 copayment
Ambulance services (ground and air)	\$100 copayment	\$100 copayment
<b>OTHER SERVICES</b>		
Durable medical equipment and orthotics	50% (\$2,000 maximum per calendar year)	50% (\$2,000 maximum per calendar year)
Diabetic equipment	20%	20%
Acupuncture, Chiropractic services <sup>5</sup>	Optional rider available	Optional rider available
<b>PRESCRIPTION DRUG COVERAGE<sup>6</sup></b>		
Brand name calendar year deductible (per member)	\$150	\$200
Prescription drugs (up to a 30-day supply)	\$15 Level I \$30 Level II \$50 Level III	\$15 Level I \$30 Level II \$50 Level III

Plan footnotes found on pages 28-29.

# OPTIONS EOA PORTFOLIO

BENEFIT DESCRIPTION <sup>1</sup>	OPTIONS EOA 25	OPTIONS EOA 35
<b>PLAN MAXIMUMS</b>		
Out-of-pocket maximum	\$3,000 single/\$6,000 family	\$4,000 single/\$8,000 family
Lifetime medical benefit maximum	No maximum	No maximum
<b>PROFESSIONAL SERVICES</b>		
Office visit	HMO: \$25 copayment/ PPO: \$40 copayment <sup>7</sup>	HMO: \$35 copayment/ PPO: \$50 copayment <sup>7</sup>
Well child care (including immunizations)	HMO: Covered in full (until age 2, then \$25), PPO: \$40 copayment <sup>7</sup>	HMO: Covered in full (until age 2, then \$35), PPO: \$50 copayment <sup>7</sup>
Adult preventive care (age 17 and older)	HMO: \$25 copayment/ PPO: \$40 copayment <sup>7</sup>	HMO: \$35 copayment/ PPO: \$50 copayment <sup>7</sup>
Annual routine physical examinations (age 17 and older)	Not covered	Not covered
Specialist consultation	HMO: \$25 copayment/ PPO: \$40 copayment <sup>7</sup>	HMO: \$35 copayment/ PPO: \$50 copayment <sup>7</sup>
X-ray and laboratory procedures <sup>2</sup>	Covered in full	Covered in full
Physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy and pulmonary rehabilitation therapy	HMO: \$25 copayment/ PPO: \$40 copayment <sup>7</sup> (12 visits per calendar year)	HMO: \$35 copayment/ PPO: \$50 copayment <sup>7</sup> (12 visits per calendar year)
Self-injectable drugs	30%	30%
<b>HOSPITAL SERVICES</b>		
Inpatient hospital facility services (including maternity)	20%	30%
Outpatient facility services (other than surgery) <sup>3,4</sup>	20%	30%
Outpatient surgery (hospital or outpatient surgery center charges only)	20%	30%
Skilled nursing facility	Days 1-10: covered in full, Days 11-100: \$25 per day	Days 1-10: covered in full, Days 11-100: \$25 per day
<b>EMERGENCY SERVICES</b>		
Professional services	Covered in full	Covered in full
Emergency room facility (copayment waived if admitted)	\$100 copayment	\$100 copayment
Urgent care facility	\$50 copayment	\$50 copayment
Ambulance services (ground and air)	\$100 copayment	\$100 copayment
<b>OTHER SERVICES</b>		
Durable medical equipment and orthotics	50% (\$2,000 maximum per calendar year)	50% (\$2,000 maximum per calendar year)
Diabetic equipment	20%	20%
Acupuncture, Chiropractic services <sup>5</sup>	Optional rider available	Optional rider available
<b>PRESCRIPTION DRUG COVERAGE<sup>6</sup></b>		
Brand name calendar year deductible (per member)	\$150	\$200
Prescription drugs (up to a 30-day supply)	\$15 Level I \$30 Level II \$50 Level III	\$15 Level I \$30 Level II \$50 Level III

# OPTIONS PPO PORTFOLIO

## BENEFIT DESCRIPTION<sup>1</sup>

BENEFIT DESCRIPTION <sup>1</sup>	OPTIONS PPO 250	
	PPO <sup>2</sup>	OUT-OF-NETWORK <sup>3</sup>
<b>PLAN MAXIMUMS</b>		
Calendar year deductible	\$250 single/\$500 family	\$500 single/\$1,000 family
Out-of-pocket maximum	\$3,500 single/2 per family	\$7,000 single/2 per family
Lifetime medical benefit maximum	\$5,000,000 combined with PPO and OON	
<b>PROFESSIONAL SERVICES</b>		
Office visit	\$25 copayment	50%
Preventive care services for children (through age 16)	\$25 copayment	Not covered
Preventive care services for adults (age 17 and older)	\$25 copayment	Not covered
Annual routine physical examination (age 17 and older)	\$25 copayment (\$250 per calendar year maximum payable)	Not covered
Specialist consultation	\$25 copayment	50%
X-ray and laboratory procedures <sup>4</sup>	20%	50%
Physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy and pulmonary rehabilitation therapy	20%	50% (12 visits per calendar year combined with PPO and OON)
Self-injectable drugs	20%	50%
<b>HOSPITAL SERVICES<sup>4</sup></b>		
Inpatient hospital facility services (includes maternity)	20%	50% (\$600 maximum allowable per day) (\$250 deductible per calendar year combined with PPO and OON) <sup>6</sup>
Outpatient facility services (other than surgery)	20%	50% (50% maximum allowable)
Outpatient surgery (hospital or outpatient surgery center charges only)	20%	50% (50% maximum allowable) (\$250 deductible per calendar year combined with PPO and OON) <sup>7</sup>
Skilled nursing facility	20%	50% (\$250 maximum allowable per day) (90 days per calendar year combined with PPO and OON; \$250 deductible per calendar year combined with PPO and OON) <sup>6</sup>
<b>EMERGENCY SERVICES</b>		
Professional services	\$25 copayment	
Emergency room facility (copayment waived if admitted)	\$100 copayment + 20%	
Urgent care facility	\$50 copayment + 20%	
Ambulance services (ground and air) <sup>4</sup>	\$50 copayment + 20%	\$50 copayment + 50%
<b>OTHER SERVICES</b>		
Durable medical equipment and orthotics <sup>4</sup>	20%	50% (\$2,000 maximum per calendar year combined with PPO and OON)
Diabetic equipment	20%	50%
Chiropractic care	\$25 copayment (12 visits per calendar year)	Not covered
Acupuncture	Not covered	
<b>PRESCRIPTION DRUG COVERAGE<sup>5</sup></b>		
Calendar year deductible (per member)	\$150 brand deductible	\$100
Prescription drugs (up to a 30-day supply)	\$15 Level I \$30 Level II \$50 Level III	50%

Plan footnotes found on pages 28-29.

OPTIONS PPO 500		OPTIONS PPO 1500	
PPO <sup>2</sup>	OUT-OF-NETWORK <sup>3</sup>	PPO <sup>2</sup>	OUT-OF-NETWORK <sup>3</sup>
\$500 single/\$1,000 family	\$1,000 single/\$2,000 family	\$1,500 single/\$3,000 family	\$3,000 single/\$6,000 family
\$4,000 single/2 per family	\$8,000 single/2 per family	\$4,000 single/2 per family	\$8,000 single/2 per family
\$5,000,000 combined with PPO and OON		\$5,000,000 combined with PPO and OON	
\$35 copayment	50%	\$25 copayment	50%
\$35 copayment	Not covered	\$25 copayment	Not covered
\$35 copayment	Not covered	\$25 copayment	Not covered
\$35 copayment (\$250 per calendar year maximum payable)	Not covered	\$25 copayment (\$250 per calendar year maximum payable)	Not covered
\$35 copayment	50%	\$25 copayment	50%
30%	50%	30%	50%
30% (12 visits per calendar year combined with PPO and OON)	50%	30% (12 visits per calendar year combined with PPO and OON)	50%
30%	50%	30%	50%
30% (\$250 deductible per calendar year combined with PPO and OON) <sup>6</sup>	50% (\$600 maximum allowable per day)	30% (\$250 deductible per calendar year combined with PPO and OON) <sup>6</sup>	50% (\$600 maximum allowable per day)
30%	50% (50% maximum allowable)	30%	50% (50% maximum allowable)
30% (\$250 deductible per calendar year combined with PPO and OON) <sup>7</sup>	50% (50% maximum allowable)	30% (\$250 deductible per calendar year combined with PPO and OON) <sup>7</sup>	50% (50% maximum allowable)
30% (60 days per calendar year combined with PPO and OON; \$250 deductible per calendar year combined with PPO and OON) <sup>6</sup>	50% (\$250 maximum allowable per day)	30% (90 days per calendar year combined with PPO and OON; \$250 deductible per calendar year combined with PPO and OON) <sup>6</sup>	50% (\$250 maximum allowable per day)
\$35 copayment		\$25 copayment	
\$100 copayment + 30%		\$100 copayment + 30%	
\$50 copayment + 30%		\$50 copayment + 30%	
\$50 copayment + 30%	\$50 copayment + 50%	\$50 copayment + 30%	\$50 copayment + 50%
30% (\$1,000 maximum per calendar year combined with PPO and OON)	50%	30% (\$2,000 maximum per calendar year combined with PPO and OON)	50%
30%	50%	30%	50%
\$35 copayment (12 visits per calendar year)	Not covered	\$25 copayment (12 visits per calendar year)	Not covered
Not covered		Not covered	
\$200 brand deductible	\$100	\$150 brand deductible	\$100
\$15 Level I \$30 Level II \$50 Level III	50%	\$15 Level I \$30 Level II \$50 Level III	50%

# OPTIONS PPO PORTFOLIO (continued)

BENEFIT DESCRIPTION <sup>1</sup>	OPTIONS PPO 1750	
	PPO <sup>2</sup>	OUT-OF-NETWORK <sup>3</sup>
<b>PLAN MAXIMUMS</b>		
Calendar year deductible	\$1,750 single/\$3,500 family	\$3,500 single/\$7,000 family
Out-of-pocket maximum	\$3,500 single/2 per family	\$7,000 single/2 per family
Lifetime medical benefit maximum	\$5,000,000 combined with PPO and OON	
<b>PROFESSIONAL SERVICES</b>		
Office visit	\$35 copayment	50%
Preventive care services for children (through age 16)	\$35 copayment	Not covered
Preventive care services for adults (age 17 and older)	\$35 copayment	Not covered
Annual routine physical examination (age 17 and older)	\$35 copayment (\$250 per calendar year maximum payable)	Not covered
Specialist consultation	\$35 copayment	50%
X-ray and laboratory procedures <sup>4</sup>	40%	50%
Physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy and pulmonary rehabilitation therapy	40%	50% (12 visits per calendar year combined with PPO and OON)
Self-injectable drugs	40%	50%
<b>HOSPITAL SERVICES<sup>4</sup></b>		
Inpatient hospital facility services (includes maternity)	40%	50% (\$600 maximum allowable per day) (\$250 deductible per calendar year combined with PPO and OON) <sup>6</sup>
Outpatient facility services (other than surgery)	40%	50% (50% maximum allowable)
Outpatient surgery (hospital or outpatient surgery center charges only)	40%	50% (50% maximum allowable) (\$250 deductible per calendar year combined with PPO and OON) <sup>7</sup>
Skilled nursing facility	40%	50% (\$250 maximum allowable per day) (60 days per calendar year combined with PPO and OON; \$250 deductible per calendar year combined with PPO and OON) <sup>6</sup>
<b>EMERGENCY SERVICES</b>		
Professional services	\$35 copayment	
Emergency room facility (copayment waived if admitted)	\$100 copayment + 40%	
Urgent care facility	\$50 copayment + 40%	
Ambulance services (ground and air) <sup>4</sup>	\$50 copayment + 40%	\$50 copayment + 50%
<b>OTHER SERVICES</b>		
Durable medical equipment and orthotics <sup>4</sup>	40% (\$1,000 maximum per calendar year combined with PPO and OON)	50%
Diabetic equipment	40%	50%
Chiropractic services	\$35 copayment (12 visits per calendar year)	Not covered
Acupuncture	Not covered	
<b>PRESCRIPTION DRUG COVERAGE<sup>5</sup></b>		
Calendar year deductible (per member)	\$200 brand deductible	\$100
Prescription drugs (up to a 30-day supply)	\$15 Level I \$30 Level II \$50 Level III	50%

Plan footnotes found on pages 28-29.

OPTIONS PPO 3000 (HSA COMPATIBLE)		OPTIONS PPO 4000 (HSA COMPATIBLE)	
PPO <sup>2</sup>	OUT-OF-NETWORK <sup>3</sup>	PPO <sup>2</sup>	OUT-OF-NETWORK <sup>3</sup>
\$3,500 single/\$6,000 family (For family coverage, the enrolled employee and dependents must collectively pay the family amount before Health Net begins to pay.)		\$4,000 single/\$8,000 family (For family coverage, the enrolled employee and dependents must collectively pay the family amount before Health Net begins to pay.)	
\$4,000 single/\$8,000 family		\$5,000 single/\$10,000 family	
\$5,000,000 combined with PPO and OON		\$5,000,000 combined with PPO and OON	
\$25 copayment	50%	\$35 copayment	50%
\$25 copayment	Not covered	\$35 copayment	Not covered
\$25 copayment	Not covered	\$35 copayment	Not covered
\$25 copayment (\$250 per calendar year maximum payable)	Not covered	\$35 copayment (\$250 per calendar year maximum payable)	Not covered
\$25 copayment	50%	\$35 copayment	50%
30%	50%	40%	50%
30% (12 visits per calendar year combined with PPO and OON)	50%	40% (12 visits per calendar year combined with PPO and OON)	50%
30%	50%	40%	50%
30% (\$250 deductible per calendar year combined with PPO and OON) <sup>6</sup>	50% (\$600 maximum allowable per day)	40% (\$250 deductible per calendar year combined with PPO and OON) <sup>6</sup>	50% (\$600 maximum allowable per day)
30%	50% (50% maximum allowable)	40%	50% (50% maximum allowable)
30% (\$250 deductible per calendar year combined with PPO and OON) <sup>7</sup>	50% (50% maximum allowable)	40% (\$250 deductible per calendar year combined with PPO and OON) <sup>7</sup>	50% (50% maximum allowable)
30% (90 days per calendar year combined with PPO and OON; \$250 deductible per calendar year combined with PPO and OON) <sup>6</sup>	50% (\$250 maximum allowable per day)	40% (60 days per calendar year combined with PPO and OON; \$250 deductible per calendar year combined with PPO and OON) <sup>6</sup>	50% (\$250 maximum allowable per day)
\$25 copayment		\$35 copayment	
\$100 copayment + 30%		\$100 copayment + 40%	
\$50 copayment + 30%		\$50 copayment + 40%	
\$50 copayment + 30%	\$50 copayment + 50%	\$50 copayment + 40%	\$50 copayment + 50%
30% (\$2,000 maximum per calendar year combined with PPO and OON)	50%	40% (\$1,000 maximum per calendar year combined with PPO and OON)	50%
30%	50%	40%	50%
\$25 copayment (12 visits per calendar year)	Not covered	\$35 copayment (12 visits per calendar year)	Not covered
Not covered		Not covered	
Subject to annual deductible		Subject to annual deductible	
\$15 Level I \$30 Level II \$50 Level III	50%	\$15 Level I \$30 Level II \$50 Level III	50%

## FOOTNOTES

### HMO

- <sup>1</sup>This is a summary of your benefits. It does not include all services, limitations, exclusions. Please refer to the Evidence of Coverage for terms and conditions of coverage.
- <sup>2</sup>Complex radiology (includes CT, SPECT, PET, and MRI) requires a \$100 copayment.
- <sup>3</sup>The HMO Silver Network is an affordable network alternative offered in all or parts of Los Angeles, Orange, San Francisco, Sonoma, San Diego, Ventura, Kern, Riverside, and San Bernardino counties. Ask your employer if this network is available to you.
- <sup>4</sup>Chiropractic and/or Acupuncture rider coverage is available as an optional benefit with the HMO plan shown above. Features of Health Net's chiropractic coverage include: \$10 per visit copayment and up to 20 visits per calendar year.
- <sup>5</sup>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](http://www.healthnet.com).

### EOA

- <sup>1</sup>This is a summary of your benefits. It does not include all services, limitations, exclusions. Please refer to the Evidence of Coverage for terms and conditions of coverage.
- <sup>2</sup>Complex radiology (includes CT, SPECT, PET, MUGA and MRI) requires a \$100 copayment. MRI, MUGA, PET and SPECT services are not covered through PPO level.
- <sup>3</sup>Under ELECT Open Access, inpatient hospital and professional services and durable medical equipment 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.
- <sup>4</sup>Under ELECT Open Access, radiographic X-ray, laboratory and surgery services will be covered only when provided or coordinated by your Primary Care Physician and approved by the PPG/IPA, except when provided at a PPG physician's office.
- <sup>5</sup>Chiropractic and/or Acupuncture rider coverage is available as an optional benefit with the EOA plan shown above. Features of Health Net's chiropractic coverage include: \$10 per visit copayment and up to 20 visits per calendar year.
- <sup>6</sup>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](http://www.healthnet.com).
- <sup>7</sup>Self referral to a PPO network physician.

### POS

- <sup>1</sup>This is a summary of your benefits. It does not include all services, limitations, or exclusions. Please refer to the Evidence of Coverage for terms and conditions of coverage.
- <sup>2</sup>Member pays the negotiated rate, which is the rate participating or preferred providers have agreed to accept for providing a covered service.
- <sup>3</sup>Percentage is a portion of the covered expense based on (C & R) Customary & Reasonable. You are also responsible for any charges in excess of the covered expense.
- <sup>4</sup>Chiropractic and/or Acupuncture rider coverage is available as an optional benefit with the POS plan shown above through the HMO level. Features of Health Net's chiropractic coverage include \$10 per visit copayment and up to 20 visits per calendar year.
- <sup>5</sup>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](http://www.healthnet.com).
- <sup>6</sup>The 50% coinsurance through the OON level will apply towards the member's out-of-pocket maximum.
- <sup>7</sup>These services require prior certification. If prior certification is not acquired, benefits are reduced to 50%.
- <sup>8</sup>This deductible is required only for the first inpatient hospital or skilled nursing facility admission each calendar year. Once the deductible is satisfied, no deductible is required for subsequent admissions in the same calendar year. This deductible is in addition to the plan calendar year deductible.
- <sup>9</sup>Once the outpatient surgery deductible is satisfied, no deductible is required for subsequent outpatient surgeries in the same calendar year. This deductible is in addition to the plan calendar year deductible.

### PPO

- <sup>1</sup>This is a summary of your benefits. It does not include all services, limitations, or exclusions. Please refer to the Policy/Certificate for terms and conditions of coverage.
- <sup>2</sup>Member pays the negotiated rate, which is the rate participating or preferred providers have agreed to accept for providing a covered service.
- <sup>3</sup>Coinsurance is based on Customary & Reasonable (C&R). Our determination of the C&R charge is based upon data provided by Ingenix, Inc., calculated at the 85th percentile. The member is responsible for charges in excess of C&R charges in addition to the coinsurance above.
- <sup>4</sup>Coinsurance Schedule reimbursement is at the 75th percentile of RBRVS. The member is responsible for charges in excess of allowed in addition to the coinsurance shown.
- <sup>5</sup>These services require prior certification. If prior certification is not acquired benefits are reduced to 50%.
- <sup>6</sup>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](http://www.healthnet.com).
- <sup>7</sup>This deductible is only required for the first inpatient hospital or skilled nursing facility admission each calendar year. The deductible does not apply to inpatient detoxification or to inpatient care for non-severe mental illness. Once the deductible is satisfied, no deductible is required for subsequent admissions in the same calendar year. This deductible is in addition to the plan calendar year deductible.
- <sup>8</sup>Once the outpatient surgery deductible is satisfied, no deductible is required for subsequent outpatient surgeries in the same calendar year. This deductible is in addition to the plan calendar year deductible.

### HSA

- <sup>1</sup>This is a summary of your benefits. It does not include all services, limitations, or exclusions. Please refer to the Policy/Certificate for terms and conditions of coverage.
- <sup>2</sup>Member pays the negotiated rate, which is the rate participating or preferred providers have agreed to accept for providing a covered service.
- <sup>3</sup>Coinsurance is based on Customary & Reasonable (C&R). Our determination of the C&R charge is based upon data provided by Ingenix, Inc., calculated at the 85th percentile. The member is responsible for charges in excess of C&R charges in addition to the coinsurance above.
- <sup>4</sup>Coinsurance Schedule reimbursement is at the 75th percentile of RBRVS. The member is responsible for charges in excess of allowed in addition to the coinsurance shown.
- <sup>5</sup>These services require prior certification. If prior certification is not acquired benefits are reduced to 50%.
- <sup>6</sup>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](http://www.healthnet.com).
- <sup>7</sup>This deductible is only required for the first inpatient hospital or skilled nursing facility admission each calendar year. The deductible does not apply to inpatient detoxification or to inpatient care for non-severe mental illness. Once the deductible is satisfied, no deductible is required for subsequent admissions in the same calendar year. This deductible is in addition to the plan calendar year deductible.
- <sup>8</sup>Once the outpatient surgery deductible is satisfied, no deductible is required for subsequent outpatient surgeries in the same calendar year. This deductible is in addition to the plan calendar year deductible.

## **FLEX NET**

<sup>1</sup>This is a summary of plan benefits. Please refer to the Plan Documents for more details. All forms, brochures and current standard rates are available online for print. Flex Net is only available to OOA subscribers, subject to standard OOA guidelines. Health Net must be the sole carrier.

<sup>2</sup>Percentage is a portion of the covered expense based on (C & R) Customary & Reasonable. You are also responsible for any charges in excess of the covered expense.

<sup>3</sup>These services require prior certification. If prior certification is not acquired benefits are reduced to 50%.

## **SALUD CON HEALTH NET**

<sup>1</sup>This is a summary of your benefits. It does not include all services, limitations, or exclusions. Please refer to the Evidence of Coverage or Policy/Certificate for terms and conditions of coverage.

<sup>2</sup>Chiropractic rider coverage is available as an optional benefit with all HMO plans shown above. Benefits of the Health Net's chiropractic coverage include \$10 per visit copayment and up to 20 visits per calendar year.

<sup>3</sup>Limited Fee Schedule reimbursement is at the 75th percentile of RBRVS. The member is responsible for charges in excess of allowed in addition to the coinsurance shown.

<sup>4</sup>Out-of-Network providers, facilities or pharmacies in Mexico are not covered by this plan.

<sup>5</sup>These services require prior certification. If prior certification is not acquired benefits are reduced to 50%.

## **H<sup>MO</sup> HMO OPTIONS**

<sup>1</sup>This is a summary of your benefits. It does not include all services, limitations, exclusions. Please refer to the Evidence of Coverage for terms and conditions of coverage.

<sup>2</sup>Complex radiology (includes CT, SPECT, PET, MUGA, and MRI) requires a \$100 copayment.

<sup>3</sup>Chiropractic and/or Acupuncture rider coverage is available as an optional benefit with the HMO plan shown above. Features of Health Net's chiropractic coverage include: \$10 per visit copayment and up to 20 visits per calendar year.

<sup>4</sup>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](http://www.healthnet.com).

## **H<sup>MO</sup> EOA OPTIONS**

<sup>1</sup>This is a summary of your benefits. It does not include all services, limitations, exclusions. Please refer to the Evidence of Coverage for terms and conditions of coverage.

<sup>2</sup>Complex radiology (includes CT, SPECT, PET, MUGA and MRI) requires a \$100 copayment. MRI, MUGA, PET and SPECT services are not covered through PPO level.

<sup>3</sup>Under ELECT Open Access, inpatient hospital and professional services and durable medical equipment 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.

<sup>4</sup>Under ELECT Open Access, radiographic X-ray, laboratory and surgery services will be covered only when provided or coordinated by your Primary Care Physician and approved by the PPG/IPA, except when provided at a PPG physician's office.

<sup>5</sup>Chiropractic and/or Acupuncture rider coverage is available as an optional benefit with the EOA plan shown above. Features of Health Net's chiropractic coverage include: \$10 per visit copayment and up to 20 visits per calendar year.

<sup>6</sup>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](http://www.healthnet.com).

<sup>7</sup>Self referral to a PPO network physician.

## **H<sup>MO</sup> PPO OPTIONS**

<sup>1</sup>This is a summary of your benefits. It does not include all services, limitations, or exclusions. Please refer to the Policy/Certificate for terms and conditions of coverage.

<sup>2</sup>Member pays the negotiated rate, which is the rate participating or preferred providers have agreed to accept for providing a covered service.

<sup>3</sup>Coinsurance Schedule reimbursement is at the 75th percentile of RBRVS. The member is responsible for charges in excess of allowed in addition to the coinsurance shown.

<sup>4</sup>These services require prior certification. If prior certification is not acquired benefits are reduced to 50%.

<sup>5</sup>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](http://www.healthnet.com).

<sup>6</sup>This deductible is only required for the first inpatient hospital or skilled nursing facility admission each calendar year. The deductible does not apply to inpatient detoxification or to inpatient care for non-severe mental illness. Once the deductible is satisfied, no deductible is required for subsequent admissions in the same calendar year. This deductible is in addition to the plan calendar year deductible.

<sup>7</sup>Once the outpatient surgery deductible is satisfied, no deductible is required for subsequent outpatient surgeries in the same calendar year. This deductible is in addition to the plan calendar year deductible.

## For more information please contact:

Health Net  
Post Office Box 9103  
Van Nuys, California 91409-9103

### **Broker Relations**

1-800-448-4411, option 4

### **Small Business Group**

#### **Sales and Service Administration**

1-800-447-8812 (English)

1-800-331-1777 (Spanish)

1-877-891-9053 (Mandarin)

1-877-891-9050 (Cantonese)

1-877-339-8596 (Korean)

1-877-891-9051 (Tagalog)

1-877-339-8621 (Vietnamese)

### **Telecommunications Device for the Hearing and Speech Impaired**

1-800-995-0852

[www.healthnet.com](http://www.healthnet.com)

### **Other options:**

Coverage for individuals and families:  
1-800-909-3447

Coverage for family members over 65 years of age:  
1-800-944-7287

Coverage for children in a low-income household:  
1-800-765-8378

Coverage for businesses with 50+ employees:  
1-800-448-4411, option 4