SMALL BUSINESS GROUP (2-50 employees)

BENEFITS GUIDE

Choice made simple

Effective January 1, 2009

Health Net®

A BETTER DECISION

CHOICE MADE SIMPLE

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

Health Net continues to offer a variety of plans that you've come to know us for, and in order to meet the ever changing needs of your clients, we're pleased to introduce our Standard HSA-compatible insurance plans. Our portfolio is simplified by dividing the plans 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 the expansion of our portfolio, you now have a choice of 3 Standard HSA-compatible PPO insurance plans to offer your clients along with a base of 4 HMO, 4 EOA and 4 PPO plans plus a value plan counterpart to every standard plan (except for POS and HSA-compatible PPO insurance plans). Your clients can easily make the decision about the benefits and options that suit their specific needs.

IT’S AS SIMPLE AS 1, 2, 3

With the Standard HSA-compatible PPO insurance plans, we’ve made it simple to help your clients choose a plan by just selecting a deductible amount that’s right for them. No matter what deductible they choose, the benefits remain the same across the plans. These high deductible PPO insurance plans all feature 100% in-network coverage for covered services after the annual deductible is met.

If the Standard HSA-compatible PPO insurance plans aren’t what you are looking for, we still have our existing line of four HSA-compatible PPO insurance plans which we’ve renamed “Value HSA” to indicate that they are based on differing deductible amounts.

OR, AS SIMPLE AS 10, 20, 30, 40

We also have our HMO, EOA and PPO plans where we’ve made it easy with just four copayment amounts to consider across these product lines: $10, $20, $30 and $40. As you move up in copayment amounts, the variable benefits adjust in consistent increments.

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

With these plans, together with current favorites, you’re sure to find a solution to fit the business priorities and budget realities of your small business clients.

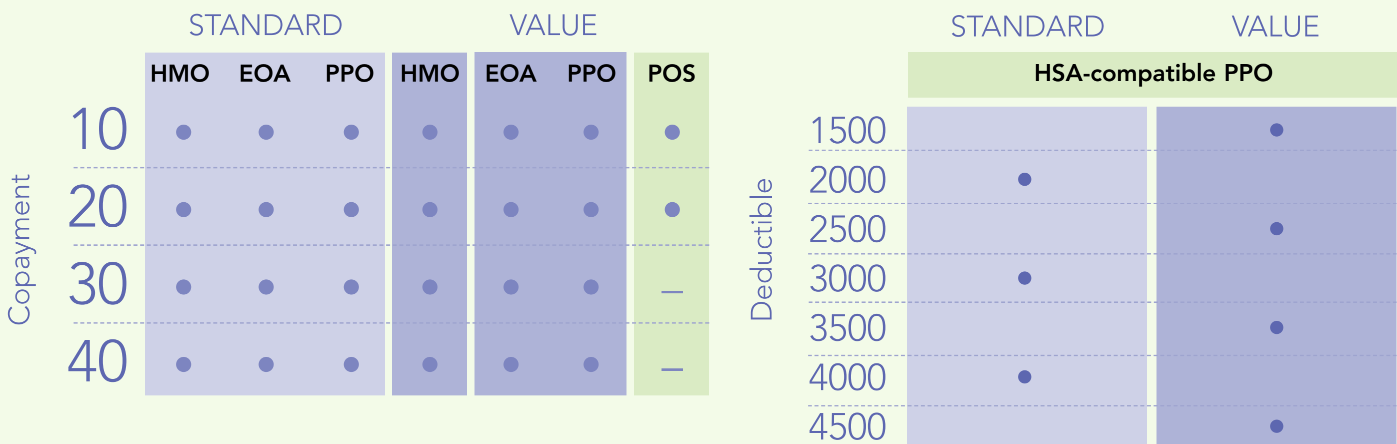
Same great plan types, clearer choices.

VARIABLE BENEFITS

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

Portfolio at a glance

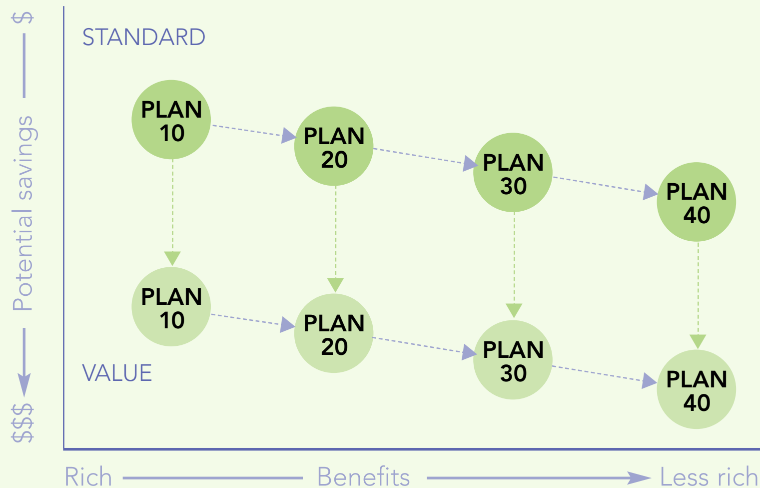
Our portfolio lineup includes a wide selection of plan options: HMO, Elect Open Access (EOA), PPO, HSA-compatible PPO insurance plans and POS.[1]



[1]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, HSA-compatible PPO insurance plans, 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

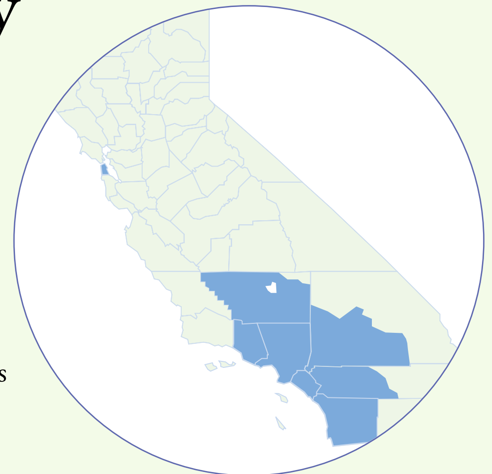
Our plans cover a range of price and benefit levels, so your clients can get the coverage they need at prices they can afford. Plan levels are arranged in decrements of $10 copayment levels with percentages indicating estimated savings between plans.



PLAN TYPE	AVERAGE SAVINGS BETWEEN COPAYMENT PLANS[3]	AVERAGE SAVINGS BETWEEN STANDARD & VALUE PLANS[3]
Standard HMO[2]	12%	14%
Value HMO[2]	11%	
Standard EOA	10%	15%
Value EOA	11%	
Standard PPO	20%	21%
Value PPO	23%	

Network strength and flexibility

- Our **HMO network** provides over 41,000 physicians, more than 260 hospitals and 5,523 pharmacies across California.
- **HMO Silver Network** has more than 5,600 primary care physicians, 11,900 specialists and 136 hospitals. This network is a select subset of our regular HMO network, spread across a eight-county area. It provides greater affordability without sacrificing quality.
- Health Net's **PPO network** includes 57,000 physicians, more than 300 hospitals and 5,523 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 and Ventura counties.

[2]Also available with Silver Network. Silver Network pricing on an average is 5-18% lower, depending on region.
[3]Based on rates effective August 1, 2008. Rates are subject to change.

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 2-50 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 18%, to employees who live within the Silver Network area – all or parts of Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Francisco and Ventura counties. Within these counties, members have access to more than 5,600 primary care physicians, 11,900 specialists, and 100% of the hospital network, in a eight-county service area. *See Underwriting Guidelines for details.*[4]
- **H^{n} 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 57,000 physicians and more than 300 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 plan with access to our full PPO provider network, along with a Bank of America health savings account, allowing members to save money and enjoy important tax benefits.[5]

Step 3 Choose a copayment level ($10, $20, $30 or $40) or a deductible level for the HSA-compatible PPO insurance plans.

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!

[4]For up-to-date listings of participating Silver Network physicians and hospitals, please visit www.healthnet.com. Be sure to select HMO Silver Network.

[5]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.**[1]

BENEFIT DESCRIPTION[2]	HMO 10		HMO 20	
	STANDARD 888 (S43)	VALUE 88H (S46)	STANDARD 883 (S41)	VALUE 88C (S47)
PLAN MAXIMUMS 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
PROFESSIONAL SERVICES Office visit (including specialist consultation)	$10 copayment	$10 copayment	$20 copayment	$20 copayment
Periodic health evaluations (including newborn and well-child care, and 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
X-ray and laboratory procedures[3]	Covered in full	Covered in full	Covered in full	Covered in full
Rehabilitation therapy[4]	$10 copayment	$10 copayment	$20 copayment	$20 copayment
Self-injectable drugs	30%	30%	30%	30%
HOSPITAL SERVICES Inpatient hospital facility services (includes maternity)	Covered in full	10%	$250 copayment per day (3 day copay max/admit)	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
EMERGENCY SERVICES 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
BEHAVIORAL HEALTH SERVICES Non-severe mental health (outpatient/inpatient)	$30 copayment (20 visits/year)/ Covered in Full (30 days/year)	$30 copayment (20 visits/year)/ 10% (30 days/year)	$30 copayment (20 visits/ year)/$250 copayment per day (3 day copay max/ admit) (30 days/year)	$30 copayment (20 visits/year)/ 20% (30 days/year)
Chemical dependency rehabilitation (outpatient/inpatient)	Not Covered	Not Covered	Not Covered	Not Covered
Acute care detoxification	Covered in Full	10%	$250 copayment per day (3 day copay max/admit)	20%
OTHER SERVICES Durable medical equipment	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)
Orthotics and Prosthetics	Covered in full	Covered in full	Covered in full	Covered in full
Diabetic equipment	20%	20%	20%	20%
Acupuncture, Chiropractic services[5]	Optional rider available	Optional rider available	Optional rider available	Optional rider available
PRESCRIPTION DRUG COVERAGE[6] Brand name calendar year deductible (per member)	No deductible	$100	No deductible	$150
Prescription drugs (up to a 30-day supply)[7]	$10/$25/$50	$10/$25/$50	$15/$30/$50	$15/$30/$50

Plan footnotes found on pages 29-31.

HMO 30		HMO 40	
STANDARD 884 (S42)	VALUE 88D (S45)	STANDARD 885 (S44)	VALUE 88E (S48)
$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
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 copay max/admit)	30%	$1,000 copayment per day (3 day copay max/admit)	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
$35 copayment (20 visits/year)/ $500 copayment per day (3 day copay max/admit) (30 days/year)	$35 copayment (20 visits/year)/ 30% (30 days/year)	$40 copayment (20 visits/year)/ $1,000 copayment per day (3 day copay max/admit) (30 days/year)	$40 copayment (20 visits/year)/ 40% (30 days/year)
Not Covered	Not Covered	Not Covered	Not Covered
$500 copayment per day (3 day copay max/admit)	30%	$1,000 copayment per day (3 day copay max/admit)	40%
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)
Covered in full	Covered in full	Covered in full	Covered in full
20%	20%	20%	20%
Optional rider available	Optional rider available	Optional rider available	Optional rider available
No deductible	$200	No deductible	$250
$15/$30/$50	$15/$30/$50	$15/$30/$50	$15/$30/$50

EOA PORTFOLIO

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

BENEFIT DESCRIPTION[1]	EOA 10		EOA 20	
	STANDARD (862)	VALUE (874)	STANDARD (871)	VALUE (875)
PLAN MAXIMUMS				
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
PROFESSIONAL SERVICES				
Office visit (including specialist consultation)	HMO: $10 copayment/ PPO: $25 copayment[2]	HMO: $10 copayment/ PPO: $25 copayment[2]	HMO: $20 copayment/ PPO: $35 copayment[2]	HMO: $20 copayment/ PPO: $35 copayment[2]
Periodic health evaluations (including newborn and well-child care, and immunizations)	HMO: $10 copayment (birth through age 2 covered in full), PPO: $25 copayment[2]	HMO: $10 copayment (birth through age 2 covered in full), PPO: $25 copayment[2]	HMO: $20 copayment (birth through age 2 covered in full), PPO: $35 copayment[2]	HMO: $20 copayment (birth through age 2 covered in full), PPO: $35 copayment[2]
Adult preventive care (age 17 and older)	HMO: $10 copayment/ PPO: $25 copayment[2]	HMO: $10 copayment/ PPO: $25 copayment[2]	HMO: $20 copayment/ PPO: $35 copayment[2]	HMO: $20 copayment/ PPO: $35 copayment[2]
X-ray and laboratory procedures[3,4]	Covered in full	Covered in full	Covered in full	Covered in full
Rehabilitation therapy[5]	HMO: $10 copayment, PPO: $25 copayment[2] (12 visits per calendar year)	HMO: $10 copayment, PPO: $25 copayment[2] (12 visits per calendar year)	HMO: $20 copayment, PPO: $35 copayment[2] (12 visits per calendar year)	HMO: $20 copayment, PPO: $35 copayment[2] (12 visits per calendar year)
Self-injectable drugs	30%	30%	30%	30%
HOSPITAL SERVICES[6]				
Inpatient hospital facility services (includes maternity)	Covered in full	10%	$250 copayment per day (3 day copay max/admit)	20%
Outpatient facility services (other than surgery)	Covered in full	10%	20%	20%
Outpatient surgery (hospital or outpatient surgery center charges only)[4]	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
EMERGENCY SERVICES				
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
BEHAVIORAL HEALTH SERVICES[10]				
Non-severe mental health (outpatient/inpatient)	$30 copayment (20 visits/ year)/Covered in Full (30 days/year)	$30 copayment (20 visits year)/10% (30 days/year)	$30 copayment (20 visits/ year)/$250 copayment per day (3 day copay max/admit) (30 days/year)	$30 copayment (20 visits/year)/ 20% (30 days/year)
Chemical dependency rehabilitation (outpatient/inpatient)	Not Covered	Not Covered	Not Covered	Not Covered
Acute care detoxification	Covered in Full	10%	$250 copayment per day (3 day copay max/admit)	20%
OTHER SERVICES				
Durable medical equipment[6]	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)
Orthotics and Prosthetics[6]	Covered in Full	Covered in Full	Covered in Full	Covered in Full
Diabetic equipment	20%	20%	20%	20%
Acupuncture, Chiropractic services[7]	Optional rider available	Optional rider available	Optional rider available	Optional rider available
PRESCRIPTION DRUG COVERAGE[8]				
Brand name calendar year deductible (per covered person)	No deductible	$100	No deductible	$150
Prescription drugs (up to a 30-day supply)[9]	$10/$25/$50	$10/$25/$50	$15/$30/$50	$15/$30/$50

Plan footnotes found on pages 29-31.

EOA 30		EOA 40	
STANDARD (872)	VALUE (876)	STANDARD (873)	VALUE (877)
$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[2]	HMO: $30 copayment/ PPO: $45 copayment[2]	HMO: $40 copayment/ PPO: $55 copayment[2]	HMO: $40 copayment/ PPO: $55 copayment[2]
HMO: $30 copayment (birth through age 2 covered in full), PPO: $45 copayment[2]	HMO: $30 copayment (birth through age 2 covered in full), PPO: $45 copayment[2]	HMO: $40 copayment (birth through age 2 covered in full), PPO: $55 copayment[2]	HMO: $40 copayment (birth through age 2 covered in full), PPO: $55 copayment[2]
HMO: $30 copayment/ PPO: $45 copayment[2]	HMO: $30 copayment/ PPO: $45 copayment[2]	HMO: $40 copayment/ PPO: $55 copayment[2]	HMO: $40 copayment/ PPO: $55 copayment[2]
Covered in full	Covered in full	Covered in full	Covered in full
HMO: $30 copayment, PPO: $45 copayment[2] (12 visits per calendar year)	HMO: $30 copayment, PPO: $45 copayment[2] (12 visits per calendar year)	HMO: $40 copayment, PPO: $55 copayment[2] (12 visits per calendar year)	HMO: $40 copayment, PPO: $55 copayment[2] (12 visits per calendar year)
30%	30%	30%	30%
$500 copayment per day (3 day copay max/admit)	30%	$1,000 copayment per day (3 day copay max/admit)	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
$35 copayment (20 visits/ year)/$500 copayment per day (3 day copay max/admit) (30 days/year)	$35 copayment (20 visits/year)/ 30% (30 days/year)	$40 copayment (20 visits/ year)/$1,000 copayment per day (3 day copay max/ admit) (30 days/year)	$40 copayment (20 visits/year)/ 40% (30 days/year)
Not Covered	Not Covered	Not Covered	Not Covered
$500 copayment per day (3 day copay max/admit)	30%	$1,000 copayment per day (3 day copay max/admit)	40%
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)
Covered in Full	Covered in Full	Covered in Full	Covered in Full
20%	20%	20%	20%
Optional rider available	Optional rider available	Optional rider available	Optional rider available
No deductible	$200	No deductible	$250
$15/$30/$50	$15/$30/$50	$15/$30/$50	$15/$30/$50

POS PORTFOLIO

BENEFIT DESCRIPTION[1]	POS 10 (87C)		
	HMO	PPO[2]	OUT-OF-NETWORK[3,4]
PLAN MAXIMUMS			
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	
PROFESSIONAL SERVICES			
Office visit (including specialist consultation)	$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
Periodic health evaluations	$10 copayment	10%	Not covered
X-ray and laboratory procedures	Covered in full	10%	50%
Rehabilitation therapy[5]	$10 copayment	10% (12 visits per calendar year combined with PPO and OON)	50%
Self-injectable drugs	30%	30%	50%
HOSPITAL SERVICES			
Inpatient hospital facility services (includes maternity)	Covered in full	10%[6] ($250 deductible per calendar year combined with PPO and OON)[8]	50% ($600 maximum allowable per day)[6]
Outpatient facility services (other than surgery)	Covered in full	10%[6]	50% (50% maximum allowable)[6]
Outpatient surgery (hospital or outpatient surgery center charges only)	Covered in full	10%[6] ($250 deductible per calendar year combined with PPO and OON)[11]	50% (50% maximum allowable)[6]
Skilled nursing facility	Days 1-10: covered in full Days 11-100: $25 per day	10%[6] (100 days per calendar year combined with PPO and OON; $250 deductible per calendar year combined with PPO and OON)[10]	50% ($250 maximum payable per day)[6]
EMERGENCY SERVICES			
Professional services	Covered in full	10%	
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%[6]	$50 copayment + 50%[6]
BEHAVIORAL HEALTH SERVICES			
Non-severe mental health (outpatient/inpatient)	$30 copayment (20 visits per calendar year)/ Covered in full (30 days per calendar year)[12]	Not covered	Not covered
Chemical dependency rehabilitation (outpatient/inpatient)	$30 copayment (20 visits per calendar year)/ Covered in full (30 days per calendar year)[12]	Not covered	Not covered
Acute care detoxification	Covered in full[12]	Not covered	Not covered
OTHER SERVICES			
Durable medical equipment	50% ($2,000 maximum per calendar year)	50%[6] ($2,000 maximum per calendar year combined with PPO and OON)	
Orthotics	Covered in full	10%[6]	50%[6]
Prosthetics	Covered in full	10%[6]	Not covered
Diabetic equipment	20%	20%	50%
Chiropractic services[7]	Optional rider available	$20 copayment (12 visits per calendar year)	Not covered
Acupuncture[7]	Optional rider available	Not covered	
PRESCRIPTION DRUG COVERAGE[8]			
Calendar year deductible (per covered person)	No deductible	No deductible	$100
Prescription drugs (up to a 30-day supply)[9]	$10/$25/$50		50%

Plan footnotes found on pages 29-31.

POS 20 (87D)		
HMO	PPO[2]	OUT-OF-NETWORK[3,4]
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
$20 copayment	20%	Not covered
Covered in full	20%	50%
$20 copayment	20% (12 visits per calendar year combined with PPO and OON)	50%
30%	30%	50%
$250 copayment per day (3 day copayment maximum)	20%[6] ($250 deductible per calendar year combined with PPO and OON)[8]	50% ($600 maximum allowable per day)[6]
20%	20%[6]	50% (50% maximum allowable)[6]
$250 copayment[9]	20%[6] ($250 deductible per calendar year combined with PPO and OON)[11]	50% (50% maximum allowable)[6]
Days 1-10: Covered in full Days 11-100: $25 per day	20%[6] (100 days per calendar year combined with PPO and OON; $250 deductible per calendar year combined with PPO and OON)[10]	50% ($250 maximum payable per day)[6]
Covered in full	20%	
$100 copayment	$100 copayment + 20%	
$50 copayment	$50 copayment + 20%	
$100 copayment	$50 copayment + 20%[6]	$50 copayment + 50%[6]
$30 copayment (20 visits per calendar year)/$250 per day/ 3 day copay max/admit) (30 days per calendar year)[12]	Not covered	Not covered
Not covered/Not covered	Not covered	Not covered
$250 copayment per day (3 day copay max/admit)[12]	Not covered	Not covered
50% ($2,000 maximum per calendar year)	50%[6] ($2,000 maximum per calendar year combined combined with PPO and OON)	
Covered in full	20%[6]	50%[6]
Covered in full	20%[6]	Not covered
20%	20%	50%
Optional rider available	$30 copayment (12 visits per calendar year)	Not covered
Optional rider available	Not covered	
No deductible	No deductible	$100
$15/$30/$50		50%

POS

PPO PORTFOLIO

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

BENEFIT DESCRIPTION[1]	PPO 10			
	STANDARD (87L)		VALUE (87Q)	
	PPO[2]	OUT-OF-NETWORK[3]	PPO[2]	OUT-OF-NETWORK[3]
PLAN MAXIMUMS				
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 (does not include calendar year deductible)	$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	
PROFESSIONAL SERVICES				
Office visit (including specialist consultation)	$10 copayment	40%	$10 copayment	40%
Preventive care services	$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
X-ray and laboratory procedures[4]	10%	40%	20%	40%
Rehabilitation therapy[5]	10%	40%	20%	40%
	(12 visits per calendar year combined PPO and OON)		(12 visits per calendar year combined PPO and OON)	
Self-injectable drugs	10%	40%	20%	40%
HOSPITAL SERVICES[4]				
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)	20%	40% ($250 maximum allowable per day)
	(100 days per calendar year combined with PPO and OON)		(100 days per calendar year combined with PPO and OON)	
EMERGENCY SERVICES				
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)[4]	$50 copayment + 10%	$50 copayment + 40%	$50 copayment + 20%	$50 copayment + 40%
BEHAVIORAL HEALTH SERVICES[4]				
Non-severe mental health (outpatient/inpatient)[10]	10%	40%	20%	40%
Chemical dependency rehabilitation (outpatient/inpatient)[10]	10%	40%	20%	40%
Acute care detoxification	10%	40%	20%	40%
	(3 day maximum per calendar year, $250 maximum amount allowable/day through OON)		(3 day maximum per calendar year, $250 maximum amount allowable/day through OON)	
OTHER SERVICES				
Durable medical equipment[4]	10%	40%	20%	40%
	($3,000 maximum per calendar year combined with PPO and OON)		($3,000 maximum per calendar year combined with PPO and OON)	
Orthotics and prosthetics[4]	10%	40%	20%	40%
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	10%	40%	20%	40%
	(12 visits per calendar year combined with PPO and OON, $25 maximum payable per visit)		(12 visits per calendar year combined with PPO and OON, $25 maximum payable per visit)	
PRESCRIPTION DRUG COVERAGE[6]				
Calendar year deductible (per member)	No deductible	$100	$100 brand deductible	$100
Prescription drugs (up to a 30-day supply)[9]	$10/$25/$50	50%	$10/$25/$50	50%

Plan footnotes found on pages 29-31.

PPO 20			
STANDARD (87M)		VALUE (87R)	
PPO[2]	OUT-OF-NETWORK[3]	PPO[2]	OUT-OF-NETWORK[3]
$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 ($250 per calendar year maximum payable)	Not covered	$20 copayment ($250 per calendar year maximum payable)	Not covered
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)[7]	20%	50% ($600 maximum allowable per day) ($250 deductible per calendar year combined with PPO and OON)[7]
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)[8]	20%	50% (50% maximum allowable) ($250 deductible per calendar year combined with PPO and OON)[8]
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)[7]	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)[7]
$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%	20%	50%
10%	50%	20%	50%
10%	50% (3 day maximum per calendar year, $250 maximum amount allowable/day through OON)	20%	50% (3 day maximum per calendar year, $250 maximum amount allowable/day through OON)
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%
10%	50%	20%	50%
$20 copayment (12 visits per calendar year)	Not covered	$20 copayment (12 visits per calendar year)	Not covered
10%	50% (12 visits per calendar year combined with PPO and OON, $25 maximum payable per visit)	20%	50% (12 visits per calendar year combined with PPO and OON, $25 maximum payable per visit)
No deductible	$100	$150 brand deductible	$100
$15/$30/$50	50%	$15/$30/$50	50%

PPO PORTFOLIO (continued)

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

BENEFIT DESCRIPTION[1]	PPO 30			
	STANDARD (87N)		VALUE (87S)	
	PPO[2]	OUT-OF-NETWORK[3]	PPO[2]	OUT-OF-NETWORK[3]
PLAN MAXIMUMS 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 (does not include calendar year deductible)	$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	
PROFESSIONAL SERVICES Office visit (including specialist consultation)	$30 copayment	50%	$30 copayment	50%
Preventive care services	$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
X-ray and laboratory procedures[4]	20%	50%	30%	50%
Rehabilitation therapy[5]	20%	50%	30%	50%
	(12 visits per calendar year combined with PPO and OON)		(12 visits per calendar year combined with PPO and OON)	
Self-injectable drugs	20%	50%	30%	50%
HOSPITAL SERVICES[4] Inpatient hospital facility services (includes maternity)	20%	50% ($600 maximum allowable per day)	30%	50% ($600 maximum allowable per day)
	($250 deductible per calendar year combined with PPO and OON)[7]		($250 deductible per calendar year combined with PPO and OON)[7]	
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%	50% (50% maximum allowable)	30%	50% (50% maximum allowable)
	($250 deductible per calendar year combined with PPO and OON)[8]		($250 deductible per calendar year combined with PPO and OON)[8]	
Skilled nursing facility	20%	50% ($250 maximum allowable per day)	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)[7]		(60 days per calendar year combined with PPO and OON; $250 deductible per calendar year combined with PPO and OON)[7]	
EMERGENCY SERVICES 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)[4]	$50 copayment + 20%	$50 copayment + 50%	$50 copayment + 30%	$50 copayment + 50%
BEHAVIORAL HEALTH SERVICES[4] Non-severe mental health (outpatient/inpatient)[10]	20%	50%	30%	50%
Chemical dependency rehabilitation (outpatient/inpatient)[10]	20%	50%	30%	50%
Acute care detoxification	20%	50%	30%	50%
	(3 day maximum per calendar year, $250 maximum amount allowable/day through OON)		(3 day maximum per calendar year, $250 maximum amount allowable/day through OON)	
OTHER SERVICES Durable medical equipment[4]	20%	50%	30%	50%
	($1,000 maximum per calendar year combined with PPO and OON)		($1,000 maximum per calendar year combined with PPO and OON)	
Orthotics and prosthetics[4]	20%	50%	30%	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	20%	50%	30%	50%
	(12 visits per calendar year combined with PPO and OON, $25 maximum payable per visit)		(12 visits per calendar year combined with PPO and OON, $25 maximum payable per visit)	
PRESCRIPTION DRUG COVERAGE[6] Calendar year deductible (per member)	No deductible	$100	$200 brand deductible	$100
Prescription drugs (up to a 30-day supply)[9]	$15/$30/$50	50%	$15/$30/$50	50%

Plan footnotes found on pages 29-31.

PPO 40			
STANDARD (87P)		VALUE (87T)	
PPO[2]	OUT-OF-NETWORK[3]	PPO[2]	OUT-OF-NETWORK[3]
$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 ($250 per calendar year maximum payable)	Not covered	$40 copayment ($250 per calendar year maximum payable)	Not covered
40%	50%	50%	50%
40% (12 visits per calendar year combined with PPO and OON)	50%	50% (12 visits per calendar year combined with PPO and OON)	50%
40%	50%	50%	50%
40% ($500 deductible per calendar year combined with PPO and OON)[7]	50% ($600 maximum allowable per day)	50% ($500 deductible per calendar year combined with PPO and OON)[7]	50% ($600 maximum allowable per day)
40%	50% (50% maximum allowable)	50%	50% (50% maximum allowable)
40% ($250 deductible per calendar year combined with PPO and OON)[8]	50% (50% maximum allowable)	50% ($250 deductible per calendar year combined with PPO and OON)[8]	50% (50% maximum allowable)
40% (60 days per calendar year combined with PPO and OON; $500 deductible per calendar year combined with PPO and OON)[7]	50% ($250 maximum allowable per day)	50% (60 days per calendar year combined with PPO and OON; $500 deductible per calendar year combined with PPO and OON)[7]	50% ($250 maximum allowable per day)
$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%
40%	50%	50%	50%
40% (3 day maximum per calendar year, $250 maximum amount allowable/day through OON)	50%	50% (3 day maximum per calendar year, $250 maximum amount allowable/day through OON)	50%
40% ($1,000 maximum per calendar year combined with PPO and OON)	50%	50% ($1,000 maximum per calendar year combined with PPO and OON)	50%
40%	50%	50%	50%
40%	50%	50%	50%
$40 copayment (12 visits per calendar year)	Not covered	$40 copayment (12 visits per calendar year)	Not covered
40% (12 visits per calendar year combined with PPO and OON, $25 maximum payable per visit)	50%	50% (12 visits per calendar year combined with PPO and OON, $25 maximum payable per visit)	50%
No deductible	$100	$250 brand deductible	$100
$15/$30/$50	50%	$15/$30/$50	50%

STANDARD HSA PORTFOLIO

BENEFIT DESCRIPTION[1]	STANDARD HSA 2000 (4R1)	
	PPO[2]	OUT-OF-NETWORK[3]
PLAN MAXIMUMS Calendar year deductible (For family coverage, the enrolled employee and dependents must collectively pay the family amount before Health Net begins to pay.)	$2,000 single (Employee only coverage)/ $4,000 family (Employee and dependant coverage)	
Out-of-pocket maximum (includes deductible)	$2,000 single (Employee only coverage) $4,000 family (Employee and dependant coverage)	$4,000 single (Employee only coverage) $8,000 family (Employee and dependent coverage)
Lifetime medical benefit maximum	$5,000,000 combined with PPO and OON	
PROFESSIONAL SERVICES Office visit (including specialist consultation)	$0 copayment (deductible not waived)	50%
Preventive care services for children (through age 18)	$30 copayment (deductible waived)	Not covered
Preventive care services for adults, including annual preventive physicals (age 18 and older)	$30 copayment (deductible waived)	Not covered
X-ray and laboratory procedures[4]	0%	50%
Rehabilitation therapy[6]	0% (12 visits per calendar year combined with PPO and OON)	50%
Self-injectable drugs	0%	50%
HOSPITAL SERVICES[4] Inpatient hospital facility services (includes maternity)	0%	50% ($600 maximum allowable per day)
Outpatient facility services (other than surgery)	0%	50% (50% maximum allowable)
Outpatient surgery (hospital or outpatient surgery center charges only)	0%	50% (50% maximum allowable)
Skilled nursing facility	0% (90 days per calendar year combined with PPO and OON)	50% ($250 maximum allowable per day)
EMERGENCY SERVICES Professional services	$0 copayment (deductible not waived)	
Emergency room facility	0%	
Urgent care facility	0%	
Ambulance services (ground and air)[4]	0%	50%
BEHAVIORAL HEALTH SERVICES Non-severe mental health (outpatient/inpatient)[7]	0%	50%
Chemical dependency (outpatient/inpatient)[7]	0%	50%
Acute care detoxification	0% (3 day maximum per calendar year, $250 maximum amount allowable per day)	50%
OTHER SERVICES Durable medical equipment[4]	0% ($2,000 maximum per calendar year combined with PPO and OON)	50%
Orthotics and prosthetics[4]	0%	50%
Diabetic equipment	0%	50%
Chiropractic services	$0 copayment (deductible not waived, 12 visits per calendar year)	Not covered
Acupuncture	0% (12 visits per calendar year combined with PPO and OON, $25 maximum payable per visit)	50%
PRESCRIPTION DRUG COVERAGE[5] Calendar year deductible (per member)	Subject to annual deductible	
Prescription drugs (up to a 30-day supply)	$0	50%

Plan footnotes found on pages 29-31.

STANDARD HSA 3000 (4Q9)		STANDARD HSA 4000 (4Q8)	
PPO[2]	OUT-OF-NETWORK[3]	PPO[2]	OUT-OF-NETWORK[3]
$3,000 single (Employee only coverage)/ $6,000 family (Employee and dependant coverage)		$4,000 single (Employee only coverage)/ $8,000 family (Employee and dependant coverage)	
$3,000 single (Employee only coverage) $6,000 family (Employee and dependant coverage)	$6,000 single (Employee only coverage) $12,000 family (Employee and dependent coverage)	$4,000 single (Employee only coverage) $8,000 family (Employee and dependant coverage)	$8,000 single (Employee only coverage) $16,000 family (Employee and dependent coverage)
$5,000,000 combined with PPO and OON		$5,000,000 combined with PPO and OON	
$0 copayment (deductible not waived)	50%	$0 copayment (deductible not waived)	50%
$30 copayment (deductible waived)	Not covered	$30 copayment (deductible waived)	Not covered
$30 copayment (deductible waived)	Not covered	$30 copayment (deductible waived)	Not covered
0%	50%	0%	50%
0%	50%	0%	50%
(12 visits per calendar year combined with PPO and OON)		(12 visits per calendar year combined with PPO and OON)	
0%	50%	0%	50%
0%	50% ($600 maximum allowable per day)	0%	50% ($600 maximum allowable per day)
0%	50% (50% maximum allowable per day)	0%	50% (50% maximum allowable per day)
0%	50% ($250 maximum allowable per day)	0%	50% ($250 maximum allowable per day)
0%	50% ($250 maximum allowable per day)	0%	50% ($250 maximum allowable per day)
(90 days per calendar year combined with PPO and OON)		(90 days per calendar year combined with PPO and OON)	
$0 copayment (deductible not waived)		$0 copayment (deductible not waived)	
0%		0%	
0%		0%	
0%	50%	0%	50%
0%	50%	0%	50%
0%	50%	0%	50%
0%	50%	0%	50%
(3 day maximum per calendar year, $250 maximum amount allowable per day)		(3 day maximum per calendar year, $250 maximum amount allowable per day)	
0%	50%	0%	50%
($2,000 maximum per calendar year combined with PPO and OON)		($2,000 maximum per calendar year combined with PPO and OON)	
0%	50%	0%	50%
0%	50%	0%	50%
$0 copayment (deductible not waived, 12 visits per calendar year)	Not covered	$0 copayment (deductible not waived, 12 visits per calendar year)	Not covered
0%	50%	0%	50%
(12 visits per calendar year combined with PPO and OON, $25 maximum payable per visit)		(12 visits per calendar year combined with PPO and OON, $25 maximum payable per visit)	
Subject to annual deductible		Subject to annual deductible	
$0	50%	$0	50%

VALUE HSA PORTFOLIO

BENEFIT DESCRIPTION[1]	VALUE HSA 1500 (88K)		VALUE HSA 2500 (88L)	
	PPO[2]	OUT-OF-NETWORK[3]	PPO[2]	OUT-OF-NETWORK[3]
PLAN MAXIMUMS				
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 (includes deductible)	$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	
PROFESSIONAL SERVICES				
Office visit (including specialist consultation)	$10 copayment (deductible not waived)	40%	$20 copayment (deductible not waived)	50%
Preventive care services	$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
X-ray and laboratory procedures[4]	20%	40%	20%	50%
Rehabilitation therapy[5]	20%	40%	20%	50%
	(12 visits per calendar year combined with PPO and OON)		(12 visits per calendar year combined with PPO and OON)	
Self-injectable drugs	20%	40%	20%	50%
HOSPITAL SERVICES[4]				
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)[7]	
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)[8]	
Skilled nursing facility	20%	40% ($250 maximum allowable per day)	20%	50% ($250 maximum allowable per day)
	(100 days per calendar year combined with PPO and OON)		(90 days per calendar year combined with PPO and OON; $250 deductible per calendar year combined with PPO and OON)[7]	
EMERGENCY SERVICES				
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)[4]	$50 copayment + 20%	$50 copayment + 40%	$50 copayment + 20%	$50 copayment + 50%
BEHAVIORAL HEALTH SERVICES				
Non-severe mental health (outpatient/inpatient)[10]	20%	40%	20%	50%
Chemical dependency (outpatient/inpatient)[10]	20%	40%	20%	50%
Acute care detoxification	20%	40%	20%	50%
	(3 day maximum per calendar year, $250 maximum amount allowable per day)		(3 day maximum per calendar year, $250 maximum amount allowable per day)	
OTHER SERVICES				
Durable medical equipment[4]	20%	40%	20%	50%
	($3,000 maximum per calendar year combined with PPO and OON)		($2,000 maximum per calendar year combined with PPO and OON)	
Orthotics and prosthetics[4]	20%	40%	20%	50%
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	20%	40%	20%	50%
	(12 visits per calendar year combined with PPO and OON, $25 maximum payable per visit)		(12 visits per calendar year combined with PPO and OON, $25 maximum payable per visit)	
PRESCRIPTION DRUG COVERAGE[6]				
Calendar year deductible (per member)	Subject to annual deductible		Subject to annual deductible	
Prescription drugs (up to a 30-day supply)[9]	$10/$25/$50	50%	$15/$30/$50	50%

Plan footnotes found on pages 29-31.

VALUE HSA 3500 (88M)		VALUE HSA 4500 (88N)	
PPO[2]	OUT-OF-NETWORK[3]	PPO[2]	OUT-OF-NETWORK[3]
$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, $250 per calendar year maximum payable)	Not covered	$40 copayment (deductible waived, $250 per calendar year maximum payable)	Not covered
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)[7]	50%	50% ($600 maximum allowable per day) ($500 deductible per calendar year combined with PPO and OON)[7]
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)[8]	50%	50% (50% maximum allowable) ($250 deductible per calendar year combined with PPO and OON)[8]
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)[7]	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)[7]
$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%	50%	50%
30%	50%	50%	50%
30%	50% (3 day maximum per calendar year, $250 maximum amount allowable per day)	50%	50% (3 day maximum per calendar year, $250 maximum amount allowable per day)
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%	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
30%	50% (12 visits per calendar year combined with PPO and OON, $25 maximum payable per visit)	50%	50% (12 visits per calendar year combined with PPO and OON, $25 maximum payable per visit)
Subject to annual deductible		Subject to annual deductible	
$15/$30/$50	50%	$15/$30/$50	50%

FLEX NET PORTFOLIO

BENEFIT DESCRIPTION[1]	FLEX NET INDEMNITY[2] (22A)
PLAN MAXIMUMS	
Calendar year deductible	$300 single/$900 family
Out-of-pocket maximum	$1,500 single/$4,500 family
Lifetime medical benefit maximum	$1,000,000
PROFESSIONAL SERVICES	
Office visit (including specialist consultation)	20%
Preventive care services	20%
Annual routine physical examination (age 17 and older)	Not covered
X-ray and laboratory procedures[3]	20%
Rehabilitation therapy[4]	20% (60 visits per calendar year)
Self-injectable drugs	20%
HOSPITAL SERVICES[3]	
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)
EMERGENCY SERVICES	
Professional services	20%
Emergency room facility	20%
Urgent care facility	20%
Ambulance services (ground and air)[3]	20%
BEHAVIORAL HEALTH SERVICES	
Non-severe mental health (outpatient/inpatient)[5]	50%
Chemical dependency (outpatient/inpatient)[5]	50%
Acute care detoxification	50%
OTHER SERVICES	
Durable medical equipment[3]	20%
Orthotics and prosthetics[3]	20%
Diabetic equipment	20%
Chiropractic services	20% (15 visits per calendar year, $25 maximum payable per visit)
Acupuncture	Not covered
PRESCRIPTION DRUG COVERAGE	
Calendar year deductible (per member)	$75 brand name deductible
Prescription drugs (up to a 30-day supply)	20%

Plan footnotes found on pages 29-31.

SALUD CON HEALTH NET PORTFOLIO

BENEFIT DESCRIPTION[1]	SALUD HMO Y MÁS 15 (191)		
	SIMNSA NETWORK (Mexico members)	SALUD NETWORK (California members)	SIMNSA NETWORK[6] (self-referral for California members)
PLAN MAXIMUMS			
Out-of-pocket maximum	$1,500 single $3,000 two-party $4,500 family		
Lifetime medical benefit maximum	Unlimited		
PROFESSIONAL SERVICES			
Office visit (including specialist consultation)	$5 copayment	$15 copayment	$5 copayment
Periodic health evaluations (including newborn and well-child care, and 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
X-ray and laboratory procedures	Covered in full	Covered in full	Covered in full
Rehabilitation therapy[3]	$5 copayment	$15 copayment	$5 copayment
Self-injectable drugs	Covered in full	Covered in full	Covered in full
HOSPITAL SERVICES			
Inpatient hospital facility services (includes maternity)	Covered in full	$250 per admission 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)
EMERGENCY SERVICES			
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
BEHAVIORAL HEALTH SERVICES			
Non-severe mental health (outpatient/inpatient)	$5 copayment (20 visits/year)/ Covered in Full (20 days/year)[5]	$15 copayment/ Covered in Full	$5 copayment (20 visits/year)/ Covered in Full (20 days/year)[5]
Chemical dependency (outpatient/inpatient)	$5 copayment (20 visits/year)/ Covered in Full (30 days/year)[5]	$20 copayment (20 visits/year)/ Covered in Full (30 days/year)	$5 copayment (20 visits/year)/ Covered in Full (30 days/year)[5]
Acute care detoxification	20%[5]	Covered in Full	20%[5]
OTHER SERVICES			
Durable medical equipment	Covered in full	Covered in full	Covered in full
Orthotics and prosthetics	Covered in full	Covered in full	Covered in full
Diabetic equipment	Covered in full	Covered in full	Covered in full
Acupuncture, Chiropractic services[4]	Not covered	Optional rider available	Not covered
PRESCRIPTION DRUG COVERAGE			
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

Plan footnotes found on pages 29-31.

SALUD CON HEALTH NET PORTFOLIO (continued)

BENEFIT DESCRIPTION[1]	SALUD HMO Y MÁS 25 (4Q7)		
	SIMNSA NETWORK (Mexico members)	SALUD NETWORK (California members)	SIMNSA NETWORK[6] (self-referral for California members)
PLAN MAXIMUMS Out-of-pocket maximum	$1,500 single $3,000 two-party $4,500 family	$3,500 single $7,000 family	$1,500 single $3,000 two-party $4,500 family
Lifetime medical benefit maximum	Unlimited		
PROFESSIONAL SERVICES Office visit (including specialist consultation)	$5 copayment	$25 copayment	$5 copayment
Periodic health evaluations (including newborn and well-child care, and immunizations)	Covered in full	$25 copayment	Covered in full
Adult preventive care (age 18 and older)	Covered in full	$25 copayment	Covered in full
X-ray and laboratory procedures[2]	Covered in full	Covered in full	Covered in full
Rehabilitation therapy[3]	$5 copayment	$25 copayment	$5 copayment
Self-injectable drugs	Covered in full	Covered in full	Covered in full
HOSPITAL SERVICES Inpatient hospital facility services (includes maternity)	Covered in full	$250/day (4 day copayment maximum)	Covered in full
Outpatient facility services (other than surgery)	Covered in full	20%	Covered in full
Outpatient surgery (hospital or outpatient surgery center charges only)	Covered in full	20%	Covered in full
Skilled nursing facility	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)
EMERGENCY SERVICES Professional services	Covered in full	Covered in full	Covered in full
Emergency room facility (copayment waived if admitted)	$10 copayment	$100 copayment	$10 copayment
Urgent care facility	$10 copayment	$25 copayment	$10 copayment
Ambulance services (ground and air)	Covered in full	$100 copayment	Covered in full
BEHAVIORAL HEALTH SERVICES Non-severe mental health (outpatient/inpatient)	$5 copayment (20 visits/year)/ Covered in full (20 days/year)[5]	$25 copayment/ Covered in full	$5 copayment (20 visits/year)/ Covered in full (20 days/year)[5]
Chemical dependency (outpatient/inpatient)	$5 copayment (20 visits/year) Covered in full (30 days/year)[5]	$25 copayment (20 visits/year) Covered in full (30 days/year)	$5 copayment (20 visits/year) Covered in full (30 days/year)[5]
Acute care detoxification	20%[5]	Covered in full	20%[5]
OTHER SERVICES Durable medical equipment	Covered in full	30%	Covered in full
Orthotics and prosthetics	Covered in full	Covered in full	Covered in full
Diabetic equipment	Covered in full	Covered in full	Covered in full
Acupuncture, Chiropractic services[4]	Not covered	Optional rider available	Not covered
PRESCRIPTION DRUG COVERAGE Calendar year deductible (per member)	No deductible	$250	No deductible
Prescription drugs (up to a 30-day supply)	$5 copayment	$10 Level I $35 Level II $50 Level III	$5 copayment

Plan footnotes found on pages 29-31.

SALUD CON HEALTH NET PORTFOLIO (continued)

BENEFIT DESCRIPTION[1]	SALUD MEXICO HMO (35W)	SALUD EPO PRIMERO (46C)	
	SIMNSA NETWORK ONLY[6]	SIMNSA NETWORK[5]	SALUD NETWORK
PLAN MAXIMUMS			
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
PROFESSIONAL SERVICES			
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
Adult preventive care (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)	Covered in full	Covered in full[5]	Covered in full[5]
Rehabilitation therapy	$5 copayment[3]	$5 copayment[2]	$15 copayment[2]
Self-injectable drugs	Covered in full	Covered in full	Covered in full
HOSPITAL SERVICES			
Inpatient care	Covered in full	Covered in full[5]	$250 per admission deductible[5]
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)
EMERGENCY SERVICES			
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[5] (air ambulance not covered)	$50 copayment[5]
BEHAVIORAL HEALTH SERVICES			
Non-severe mental health (outpatient/inpatient)	$5 copayment (20 days)/ Covered in Full[5]	$5 copayment/ Covered in full[5,6] 20 days per calendar year maximum combined with SIMNSA and Salud	$15 copayment/ $250 per admit deductible[5]
Chemical dependency (outpatient/inpatient)	$5 copayment (20 days)/ Covered in full (30 days)[5]	$5 copayment/ Covered in full[5,6] 20 days per calendar year maximum combined with SIMNSA and Salud	$15 copayment/ $250 per admit deductible[5]
Acute care detoxification	20%[5]	Covered in full	$250 per admit deductible[5]
OTHER SERVICES			
Durable medical equipment	Covered in full	Covered in full[5]	Covered in full[5]
Orthotics and prosthetics	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
PRESCRIPTION DRUG COVERAGE			
Brand name calendar year deductible (per member)	No deductible	No deductible	No deductible
Prescription drugs (up to a 30-day supply)	$5 copayment	$5 copayment	$10/$35/50%[7]

Plan footnotes found on pages 29-31.

SALUD CON HEALTH NET PORTFOLIO (continued)

BENEFIT DESCRIPTION[1]	SALUD PPO (87F)		
	SIMNSA NETWORK[4] (Mexico members)	SALUD NETWORK (California members)	OUT-OF-NETWORK[3] (self-referral for California members)
PLAN MAXIMUMS			
Annual deductible	No deductible	$100 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		
PROFESSIONAL SERVICES			
Office visit (including specialist consultation)	$5 copayment	$15 copayment	50%
Preventive care services	$5 copayment	$15 copayment	50%
Adult annual routine physical exam (age 18 and older)	Not covered		
X-ray and laboratory procedures[5]	10%	20%	50%
Rehabilitation therapy[2]	10%	20% ($25 maximum per visit) (12 visits per calendar year combined with Salud and OON)	50% ($25 maximum per visit)
Self-injectable drugs	$5 copayment	$15 copayment	50%
HOSPITAL SERVICES[5]			
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% (100 days per calendar year maximum combined with Salud and OON)	$250 deductible + 50% ($150 maximum allowable per day)
EMERGENCY SERVICES			
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)[5]	$20 deductible + 10% (air not covered)	$50 deductible + 20%	50%
BEHAVIORAL HEALTH SERVICES			
Non-severe mental health (outpatient/inpatient)	$5 copayment + 10%/10%[8,10] 20 visits maximum per calendar year combined SIMNSA, Salud, and OON	$30 copayment + 20%/20%[8,10]	$30 copayment + 50%/10%[8,10]
Chemical dependency (outpatient/inpatient)	$5 copayment + 10%[8]/ Not covered 20 visits maximum per calendar year combined SIMNSA, Salud, and OON	$30 copayment + 20%[8]/ Not covered	$30 copayment + 50%[8]/ Not covered
Acute care detoxification	10% 3 days maximum for each member each calendar year ($380 maximum allowable per day through OON)	20% + $250 per admit[9]	50% + $250 per admit[9]
OTHER SERVICES			
Durable medical equipment[5]	10%	20%	50%
Orthotics and prosthetics	10%	20%	50%
Diabetic equipment	10%	20%	50%
Acupuncture, Chiropractic services	Not covered		
PRESCRIPTION DRUG COVERAGE			
Prescription drugs dispensed by SIMNSA	$5 copayment	Not applicable	Not applicable
Prescription drugs dispensed by Health Net participating pharmacy[7]	Not applicable	$10/$35/50%	Not covered

OPTIONS HMO PORTFOLIO

Please note: HMO plans are available with Silver Network.[8]

BENEFIT DESCRIPTION[1]	OPTIONS HMO 25 87G (S5Y)	OPTIONS HMO 35 87H (S5Z)
PLAN MAXIMUMS		
Out-of-pocket maximum	$3,000 single/$6,000 family	$4,000 single/$8,000 family
Lifetime medical benefit maximum	No maximum	No maximum
PROFESSIONAL SERVICES		
Office visit (including specialist consultation)	$25 copayment	$35 copayment
Periodic health evaluations (including newborn and well-child care and immunizations)	$25 copayment (birth through age 2 covered in full)	$35 copayment (birth through age 2 covered in full)
Adult preventive care (age 17 and older)	$25 copayment	$35 copayment
X-ray and laboratory procedures[2]	Covered in full	Covered in full
Rehabilitation therapy[3]	$25 copayment	$35 copayment
Self-injectable drugs	30%	30%
HOSPITAL SERVICES		
Inpatient hospital facility services (includes maternity)	20%	30%
Outpatient facility services (other than surgery)	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
EMERGENCY SERVICES		
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
BEHAVIORAL HEALTH SERVICES[6]		
Non-severe mental health (outpatient/inpatient)	$30 (20 visits per calendar year)/ 20% (30 days per calendar year)	$40 (20 visits per calendar year)/ 30% (30 days per calendar year)
Chemical dependency (outpatient/inpatient)	Not covered	Not covered
Acute care detoxification	20%	30%
OTHER SERVICES		
Durable medical equipment	50% ($2,000 maximum per calendar year)	50% ($2,000 maximum per calendar year)
Orthotics and prosthetics	Covered in full	Covered in full
Diabetic equipment	20%	20%
Acupuncture, Chiropractic services[4]	Optional rider available	Optional rider available
PRESCRIPTION DRUG COVERAGE[5]		
Brand name calendar year deductible (per member)	$150	$200
Prescription drugs (up to a 30-day supply)[7]	$15/$30/$50	$15/$30/$50

Plan footnotes found on pages 29-31.

OPTIONS EOA PORTFOLIO

BENEFIT DESCRIPTION[1]	OPTIONS EOA 25 (879)	OPTIONS EOA 35 (87B)
PLAN MAXIMUMS Out-of-pocket maximum	$3,000 single/$6,000 family	$4,000 single/$8,000 family
Lifetime medical benefit maximum	No maximum	No maximum
PROFESSIONAL SERVICES Office visit (including specialist consultation)	HMO: $25 copayment/ PPO: $40 copayment[8]	HMO: $35 copayment/ PPO: $50 copayment[8]
Periodic health evaluations (including newborn and well-child care and immunizations)	HMO: $25 copayment (birth through age 2 covered in full) PPO: $40 copayment[8]	HMO: $35 copayment (birth through age 2 covered in full) PPO: $50 copayment[8]
Adult preventive care (age 17 and older)	HMO: $25 copayment/ PPO: $40 copayment[8]	HMO: $35 copayment/ PPO: $50 copayment[8]
X-ray and laboratory procedures[2]	Covered in full	Covered in full
Rehabilitation therapy[3]	HMO: $25 copayment/ PPO: $40 copayment[8] (12 visits per calendar year)	HMO: $35 copayment/ PPO: $50 copayment[8] (12 visits per calendar year)
Self-injectable drugs	30%	30%
HOSPITAL SERVICES Inpatient hospital facility services (including maternity)	20%	30%
Outpatient facility services (other than surgery)[4,5]	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
EMERGENCY SERVICES 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
BEHAVIORAL HEALTH SERVICES Non-severe mental health (outpatient/inpatient)	$35 (20 visits per calendar year)/ 20% (30 days per calendar year)	$40 (20 visits per calendar year) / 30% (30 days per calendar year)
Chemical dependency (outpatient/inpatient)	Not covered	Not covered
Acute care detoxification	20%	30%
OTHER SERVICES Durable medical equipment	50% ($2,000 maximum per calendar year)	50% ($2,000 maximum per calendar year)
Orthotics and prosthetics	Covered in full	Covered in full
Diabetic equipment	20%	20%
Acupuncture, Chiropractic services[6]	Optional rider available	Optional rider available
PRESCRIPTION DRUG COVERAGE[7] Brand name calendar year deductible (per member)	$150	$200
Prescription drugs (up to a 30-day supply)[9]	$15/$30/$50	$15/$30/$50

OPTIONS PPO PORTFOLIO

BENEFIT DESCRIPTION[1]	OPTIONS PPO 250 (87U)	
	PPO[2]	OUT-OF-NETWORK[3]
PLAN MAXIMUMS		
Calendar year deductible	$250 single/$500 family	$500 single/$1,000 family
Out-of-pocket maximum (does not include calendar year deductible)	$3,500 single/2 per family	$7,000 single/2 per family
Lifetime medical benefit maximum	$5,000,000 combined with PPO and OON	
PROFESSIONAL SERVICES		
Office visit (including specialist consultation)	$25 copayment	50%
Preventive care services	$25 copayment	Not covered
Annual routine physical examination (age 17 and older)	$25 copayment ($250 per calendar year maximum payable)	Not covered
X-ray and laboratory procedures[4]	20%	50%
Rehabilitation therapy[5]	20%	50%
	(12 visits per calendar year combined with PPO and OON)	
Self-injectable drugs	20%	50%
HOSPITAL SERVICES[4]		
Inpatient hospital facility services (includes maternity)	20%	50% ($600 maximum allowable per day)
	($250 deductible per calendar year combined with PPO and OON)[6]	
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)[7]	
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)[6]	
EMERGENCY SERVICES		
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)[4]	$50 copayment + 20%	$50 copayment + 50%
BEHAVIORAL HEALTH SERVICES		
Non-severe mental health (outpatient/inpatient)	20%[10]	50%[10]
Chemical dependency (outpatient/inpatient)	20%[10]	50%[10]
Acute care detoxification	20%	50%
	(3 day maximum per calendar year, $250 maximum amount allowable per day)	
OTHER SERVICES		
Durable medical equipment[4]	20%	50%
	($2,000 maximum per calendar year combined with PPO and OON)	
Orthotics and prosthetics[4]	20%	50%
Diabetic equipment	20%	50%
Chiropractic care	$25 copayment (12 visits per calendar year)	Not covered
Acupuncture	20%	50%
	(12 visits per calendar year combined with PPO and OON, $25 maximum payable per visit)	
PRESCRIPTION DRUG COVERAGE[8]		
Calendar year deductible (per member)	$150 brand deductible	$100
Prescription drugs (up to a 30-day supply)[9]	$15/$30/$50	50%

Plan footnotes found on pages 29-31.

OPTIONS PPO PORTFOLIO (continued)

BENEFIT DESCRIPTION[1]	OPTIONS PPO 500 (87V)	
	PPO[2]	OUT-OF-NETWORK[3]
PLAN MAXIMUMS Calendar year deductible	$500 single/$1,000 family	$1,000 single/$2,000 family
Out-of-pocket maximum (does not include calendar year deductible except for HSA plans)	$4,000 single/2 per family	$8,000 single/2 per family
Lifetime medical benefit maximum	$5,000,000 combined with PPO and OON	
PROFESSIONAL SERVICES Office visit (including specialist consultation)	$35 copayment	50%
Preventive care services	$35 copayment	Not covered
Annual routine physical examination (age 17 and older)	$35 copayment ($250 per calendar year maximum payable)	Not covered
X-ray and laboratory procedures[4]	30%	50%
Rehabilitation therapy[5]	30% (12 visits per calendar year combined with PPO and OON)	50%
Self-injectable drugs	30%	50%
HOSPITAL SERVICES[4] Inpatient hospital facility services (includes maternity)	30% ($250 deductible per calendar year combined with PPO and OON)[6]	50% ($600 maximum allowable per day)
Outpatient facility services (other than surgery)	30%	50% (50% maximum allowable)
Outpatient surgery (hospital or outpatient surgery center charges only)	30% ($250 deductible per calendar year combined with PPO and OON)[7]	50% (50% maximum allowable)
Skilled nursing facility	30% (60 days per calendar year combined with PPO and OON; $250 deductible per calendar year combined with PPO and OON)[6]	50% ($250 maximum allowable per day)
EMERGENCY SERVICES Professional services	$35 copayment	
Emergency room facility (copayment waived if admitted)	$100 copayment + 30%	
Urgent care facility	$50 copayment + 30%	
Ambulance services (ground and air)[4]	$50 copayment + 30%	$50 copayment + 50%
BEHAVIORAL HEALTH SERVICES Non-severe mental health (outpatient/inpatient)	30%[10]	50%[10]
Chemical dependency (outpatient/inpatient)	30%[10]	50%[10]
Acute care detoxification	30% (3 day maximum per calendar year, $250 maximum amount allowable per day)	50%
OTHER SERVICES Durable medical equipment[4]	30% ($1,000 maximum per calendar year combined with PPO and OON)	50%
Orthotics and prosthetics[4]	30%	50%
Diabetic equipment	30%	50%
Chiropractic services	$35 copayment (12 visits per calendar year)	Not covered
Acupuncture	30% (12 visits per calendar year combined with PPO and OON, $25 maximum payable per visit)	50%
PRESCRIPTION DRUG COVERAGE[8] Calendar year deductible (per member)	$200 brand deductible	$100
Prescription drugs (up to a 30-day supply)[9]	$15/$30/$50	50%

OPTIONS PPO PORTFOLIO (continued)

OPTIONS PPO 1500 (87W)		OPTIONS PPO 1750 (87X)	
PPO[2]	OUT-OF-NETWORK[3]	PPO[2]	OUT-OF-NETWORK[3]
$1,500 single/$3,000 family	$3,000 single/$6,000 family	$1,750 single/$3,500 family	$3,500 single/$7,000 family
$4,000 single/2 per family	$8,000 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	
$25 copayment	50%	$35 copayment	50%
$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
30%	50%	40%	50%
30%	50%	40%	50%
(12 visits per calendar year combined with PPO and OON)		(12 visits per calendar year combined with PPO and OON)	
30%	50%	40%	50%
30%	50% ($600 maximum allowable per day)	40%	50% ($600 maximum allowable per day)
($250 deductible per calendar year combined with PPO and OON)[6]		($250 deductible per calendar year combined with PPO and OON)[6]	
30%	50% (50% maximum allowable)	40%	50% (50% maximum allowable)
30%	50% (50% maximum allowable)	40%	50% (50% maximum allowable)
($250 deductible per calendar year combined with PPO and OON)[7]		($250 deductible per calendar year combined with PPO and OON)[7]	
30%	50% ($250 maximum allowable per day)	40%	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)[6]		(60 days per calendar year combined with PPO and OON; $250 deductible per calendar year combined with PPO and OON)[6]	
$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%[10]	50%[10]	40%[10]	50%[10]
30%[10]	50%[10]	40%[10]	50%[10]
30%	50%	40%	50%
(3 day maximum per calendar year, $250 maximum amount allowable per day)		(3 day maximum per calendar year, $250 maximum amount allowable per day)	
30%	50%	40%	50%
($2,000 maximum per calendar year combined with PPO and OON)		($1,000 maximum per calendar year combined with PPO and OON)	
30%	50%	40%	50%
30%	50%	40%	50%
$25 copayment (12 visits per calendar year)	Not covered	$35 copayment (12 visits per calendar year)	Not covered
30%	50%	40%	50%
(12 visits per calendar year combined with PPO and OON, $25 maximum payable per visit)		(12 visits per calendar year combined with PPO and OON, $25 maximum payable per visit)	
$150 brand deductible	$100	$200 brand deductible	$100
$15/$30/$50	50%	$15/$30/$50	50%

Plan footnotes found on pages 29-31.

	OPTIONS PPO 3000 (HSA COMPATIBLE) (88R)		OPTIONS PPO 4000 (HSA COMPATIBLE) (88S)	
	PPO[2]	OUT-OF-NETWORK[3]	PPO[2]	OUT-OF-NETWORK[3]
PLAN MAXIMUMS Calendar year deductible	$3,000 single (Employee only coverage)/ $6,000 family (Employee and dependent coverage) For family coverage, the enrolled employee and dependents must collectively pay the family amount before Health Net begins to pay.		$4,000 single (Employee only coverage)/ $8,000 family (Employee and dependent coverage) For family coverage, the enrolled employee and dependents must collectively pay the family amount before Health Net begins to pay.	
Out-of-pocket maximum (does not include calendar year deductible except for HSA plans)	$4,000 single (Employee only coverage)/ $8,000 family (Employee and dependent coverage) (includes deductible)		$5,000 single (Employee only coverage)/ $10,000 family (Employee and dependent coverage) (includes deductible)	
Lifetime medical benefit maximum	$5,000,000 combined with PPO and OON		$5,000,000 combined with PPO and OON	
PROFESSIONAL SERVICES Office visit (including specialist consultation)	$25 copayment (deductible not waived)	50%	$35 copayment (deductible not waived)	50%
Preventive care services	$25 copayment (deductible waived)	Not covered	$35 copayment (deductible waived)	Not covered
Annual routine physical examination (age 17 and older)	$25 copayment (deductible waived) $250 per calendar year maximum payable)	Not covered	$35 copayment (deductible waived, $250 per calendar year maximum payable)	Not covered
X-ray and laboratory procedures[4]	30%	50%	40%	50%
Rehabilitation therapy[5]	30% (12 visits per calendar year combined with PPO and OON)	50%	40% (12 visits per calendar year combined with PPO and OON)	50%
Self-injectable drugs	30%	50%	40%	50%
HOSPITAL SERVICES[4] Inpatient hospital facility services (includes maternity)	30% ($250 deductible per calendar year combined with PPO and OON)[6]	50% ($600 maximum allowable per day)	40% ($250 deductible per calendar year combined with PPO and OON)[6]	50% ($600 maximum allowable per day)
Outpatient facility services (other than surgery)	30%	50% (50% maximum allowable)	40%	50% (50% maximum allowable)
Outpatient surgery (hospital or outpatient surgery center charges only)	30% ($250 deductible per calendar year combined with PPO and OON)[7]	50% (50% maximum allowable)	40% ($250 deductible per calendar year combined with PPO and OON)[7]	50% (50% maximum allowable)
Skilled nursing facility	30% (90 days per calendar year combined with PPO and OON; $250 deductible per calendar year combined with PPO and OON)[6]	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)[6]	50% ($250 maximum allowable per day)
EMERGENCY SERVICES Professional services	$25 copayment (deductible not waived)		$35 copayment (deductible not waived)	
Emergency room facility (copayment waived if admitted)	$100 copayment + 30%		$100 copayment + 40%	
Urgent care facility	$50 copayment + 30%		$50 copayment + 40%	
Ambulance services (ground and air)[4]	$50 copayment + 30%	$50 copayment + 50%	$50 copayment + 40%	$50 copayment + 50%
BEHAVIORAL HEALTH SERVICES Non-severe mental health (outpatient/inpatient)	30%[10]	50%[10]	40%[10]	50%[10]
Chemical dependency (outpatient/inpatient)	30%[10]	50%[10]	40%[10]	50%[10]
Acute care detoxification	30% (3 day maximum per calendar year, $250 maximum amount allowable per day	50%	40% (3 day maximum per calendar year, $250 maximum amount allowable per day)	50%
OTHER SERVICES Durable medical equipment[4]	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%
Orthotics and prosthetics[4]	30%	50%	40%	50%
Diabetic equipment	30%	50%	40%	50%
Chiropractic services	$25 copayment (deductible not waived 12 visits per calendar year)	Not covered	$35 copayment (deductible not waived, 12 visits per calendar year)	Not covered
Acupuncture	30% (12 visits per calendar year combined with PPO and OON, $25 maximum payable per visit)	50%	40% (12 visits per calendar year combined with PPO and OON, $25 maximum payable per visit)	50%
PRESCRIPTION DRUG COVERAGE[8] Calendar year deductible (per member)	Subject to annual deductible		Subject to annual deductible	
Prescription drugs (up to a 30-day supply)[9]	$15/$30/$50	50%	$15/$30/$50	50%

Note: Health Net's 2007 ratio of premium costs to health services paid for Small Business HMO & PPO health plans were 79.4% and 78.2% respectively.

FOOTNOTES

HMO

[1] The HMO Silver Network is an affordable network alternative offered in all or parts of Kern, Los Angeles, Orange, San Bernardino, San Diego, San Francisco, Riverside and Ventura counties. Ask your employer if this network is available to you.

[2] 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.

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

[4] Includes physical, speech, occupational, cardiac and pulmonary rehabilitation therapy.

[5] 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.

[6] 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.

[7] The three prescription drug tiers are Tier 1: Generic Formulary; Tier 2: Brand Formulary; Tier 3: Brand Non-Formulary.

EOA

[1] 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.

[2] Self-referral to a PPO network physician.

[3] 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.

[4] 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.

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

[6] Under ELECT Open Access, inpatient hospital and professional services, durable medical equipment and orthotics and prosthetics are covered when provided or coordinated by the Primary Care Physician only and approved by the PPG/IPA. Inpatient care and outpatient services are not covered on the PPO level.

[7] 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.

[8] 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.

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

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

POS

[1] 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.

[2] Member pays the negotiated rate, which is the rate the participating or preferred providers have agreed to accept for providing a covered service.

[3] Please refer to your Certificate of Insurance (COI) for out-of-network reimbursement methodology.

[4] The 50% coinsurance through the OON level will apply towards the member's out-of-pocket maximum.

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

[6] Some services require prior certification. If prior certification is not acquired, benefits are reduced to 50%.

[7] 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.

[8] 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.

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

[10] 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.

[11] 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.

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

PPO

[1] 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.

[2] Member pays the negotiated rate, which is the rate participating or preferred providers have agreed to accept for providing a covered service.

[3] Please refer to your Certificate of Insurance (COI) for out-of-network reimbursement methodology.

[4] Some services require prior certification. If prior certification is not acquired benefits are reduced to 50%.

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

[6] 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.

[7] This deductible is only required for the first inpatient hospital or skilled nursing facility admission each calendar year. The deductible does not apply to inpatient detoxification or to inpatient care for non-severe mental illness. Once the deductible is satisfied, no deductible is required for subsequent admissions in the same calendar year. This deductible is in addition to the plan calendar year deductible and applies to the OOPM.

[8] Once the outpatient surgery deductible is satisfied, no deductible is required for subsequent outpatient surgeries in the same calendar year. This deductible is in addition to the plan calendar year deductible and applies to the OOPM.

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

[10] Inpatient care for non-severe mental illness, inpatient chemical dependency rehabilitation and inpatient detoxification is limited to 30 days for each member in a calendar year through PPO and OON combined. The benefit is limited to a maximum allowable of $250 each day. Outpatient care for non-severe mental illness and outpatient chemical dependency rehabilitation is limited to 30 visits for each member in a calendar year through PPO and OON combined. The maximum amount payable for each visit is $25.

STANDARD HSA

[1] 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.

[2] Member pays the negotiated rate, which is the rate participating or preferred providers have agreed to accept for providing a covered service.

[3] Please refer to your Certificate of Insurance (COI) for out-of-network reimbursement methodology.

[4] These services require prior certification. If prior certification is not acquired benefits are reduced to 50%.

[5] Prescription drugs filled through mail order up to a 90 day supply. For details regarding a specific drug, go to www.healthnet.com.

[6] Includes physical, speech, occupational, cardiac and pulmonary rehabilitation therapy.

[7] Inpatient care for non-severe mental illness and inpatient chemical dependency rehabilitation is limited to 30 days for each member in a calendar year through PPO and OON combined. The benefit is limited to a maximum allowable of $250 each day. Outpatient care for non-severe mental illness and outpatient chemical dependency rehabilitation is limited to 30 visits for each member in a calendar year through PPO and OON combined. The maximum amount payable for each visit is $25.

VALUE HSA

[1] 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.

[2] Member pays the negotiated rate, which is the rate participating or preferred providers have agreed to accept for providing a covered service.

[3] Please refer to your Certificate of Insurance (COI) for out-of-network reimbursement methodology.

[4] Some services require prior certification. If prior certification is not acquired benefits are reduced to 50%.

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

[6] 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.

[7] This deductible is only required for the first inpatient hospital or skilled nursing facility admission each calendar year. The deductible does not apply to inpatient detoxification or to inpatient care for non-severe mental illness. Once the deductible is satisfied, no deductible is required for subsequent admissions in the same calendar year. This deductible is in addition to the plan calendar year deductible and applies to the OOPM.

[8] Once the outpatient surgery deductible is satisfied, no deductible is required for subsequent outpatient surgeries in the same calendar year. This deductible is in addition to the plan calendar year deductible and applies to the OOPM.

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

[10] Inpatient care for non-severe mental illness, inpatient chemical dependency rehabilitation and inpatient detoxification is limited to 30 days for each member in a calendar year through PPO and OON combined. The benefit is limited to a maximum allowable of $250 each day. Outpatient care for non-severe mental illness and outpatient chemical dependency rehabilitation is limited to 30 visits for each member in a calendar year through PPO and OON combined. The maximum amount payable for each visit is $25.

FLEX NET

[1] This is a summary of plan benefits. It does not include all services, limitations, or exclusions. Please refer to the Policy/Certificate for terms and conditions of coverage. Flex Net is only available to OOA subscribers, subject to standard OOA guidelines. Health Net must be the sole carrier.

[2] Please refer to your Certificate of Insurance (COI) for out-of-network reimbursement methodology.

[3] Some services require prior certification. If prior certification is not acquired benefits are reduced to 50%.

[4] Includes physical, speech, occupational, cardiac and pulmonary rehabilitation therapy.

[5] Inpatient mental health and inpatient chemical dependency rehabilitation is limited to a combined maximum of 30 days for each member in a calendar year. Outpatient mental health and outpatient chemical dependency rehabilitation are limited to a combined maximum of 20 visits for each member in a calendar year. The maximum amount payable for each visit is $50.

SALUD CON HEALTH NET HMO Y MÁS & SALUD MEXICO

[1] 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.

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

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

[4] 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.

[5] Mental health and substance abuse services must be provided by a SIMNSA provider.

[6] Out-of-Network providers, facilities or pharmacies in Mexico (other than those in the SIMNSA Network) are not covered by this plan.

SALUD CON HEALTH NET PPO/EPO

[1] 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.

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

[3] Please refer to your Certificate of Insurance (COI) for out-of-network reimbursement methodology.

[4] Out-of-Network providers, facilities or pharmacies in Mexico (other than those in the SIMNSA Network) are not covered by this plan.

[5] Some services require prior certification. If prior certification is not acquired benefits are reduced to 50%.

[6] Mental health and substance abuse services must be provided by a SIMNSA provider.

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

[8] Inpatient mental health care, inpatient chemical dependency rehabilitation, and inpatient detoxification are limited to a shared maximum of 20 days for each member in a calendar year through PPO and OON combined. Outpatient mental health care and outpatient chemical dependency rehabilitation are limited to 20 visits for each member in a calendar year through PPO and OON combined.

[9] A $250 deductible is required for each inpatient hospital admission and each outpatient service, including surgery. The deductible will apply when emergency services are performed.

[10] Through Health Net Salud Network/OON, these services require prior certification before being provided or received. If prior certification is not acquired, benefits are reduced to 50%. In addition, for uncertified outpatient services, a $50 deductible is required for each visit; for uncertified inpatient admissions, a $250 deductible is required for each inpatient admission.

Hn HMO OPTIONS

[1] 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.

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

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

[4] 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.

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

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

[8] The HMO Silver Network is an affordable network alternative offered in all or parts of Kern, Los Angeles, Orange, San Bernardino, San Diego, San Francisco, Riverside and Ventura counties. Ask your employer if this network is available to you.

Hn EOA OPTIONS

[1] 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.

[2] 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.

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

[4] Under ELECT Open Access, inpatient hospital and professional services, durable medical equipment and orthotics and prosthetics are covered when provided or coordinated by the Primary Care Physician only and approved by the PPG/IPA. Inpatient care and outpatient services are not covered on the PPO level.

[5] 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.

[6] 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.

[7] Prescription drugs filled through mail order (up to a 90 day supply) require twice the level of copayment. For details regarding a specific drug, go to www.healthnet.com.

[8] Self-referral to a PPO network physician.

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

Hn PPO OPTIONS

[1] 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.

[2] Member pays the negotiated rate, which is the rate participating or preferred providers have agreed to accept for providing a covered service.

[3] Please refer to your Certificate of Insurance (COI) for out-of-network reimbursement methodology.

[4] These services require prior certification. If prior certification is not acquired benefits are reduced to 50%.

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

[6] 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.

[7] 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.

[8] 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.

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

[10] Inpatient care for non-severe mental illness, inpatient chemical dependency rehabilitation and inpatient detoxification is limited to 30 days for each member in a calendar year through PPO and OON combined. The benefit is limited to a maximum allowable of $250 each day. Outpatient care for non-severe mental illness and outpatient chemical dependency rehabilitation is limited to 30 visits for each member in a calendar year through PPO and OON combined. The maximum amount payable for each visit is $25.

For more information please contact:

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

Broker Services
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

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:
1-800-327-0502

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

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