



SMALL GROUP Hⁿ OPTIONS

GREATER CHOICE AND VALUE FOR SMALL BUSINESSES (2-50 employees)

Effective October 1, 2006



Health Net[®]
A Better Decision

THE RIGHT COMBINATION OF CHOICE AND FLEXIBILITY

Hⁿ Options is the ideal solution for your small business clients looking to offer their employees a wide selection of comprehensive benefit options from Health Net, while still offering plans from another carrier. With the Options portfolio, you can mix and match up to 15 specifically designed Health Net plans. With our flexible underwriting guidelines, you can add a second carrier as long as the group meets standard participation guidelines of 75% for all combined coverage and carriers.

Hⁿ Options offers two suites of plan designs depending on the number of eligible employees that select Health Net. With a minimum of 5 enrolled employees from the group, each employee will be able to select from any of 10 available plans. Move up to 10 enrolled employees, and the choices expand to the full 15 available plans, providing even more options for your clients.

The Health Net network is comprised of over 51,000 participating providers, more than 300 hospitals and 4,600 pharmacies.



CHOICE OF TEN

(For small groups with 5–9 employees enrolling with Health Net)



PLUS the ability to add another carrier's plans

CHOICE OF FIFTEEN

(For small groups with 10–50 employees enrolling with Health Net)



PLUS the ability to add another carrier's plans

H⁷ OPTIONS BENEFITS AND ADVANTAGES

Health Net minimum participation only 5 employees Employers need to have only 5 employees enrolled in a Health Net plan and 75% participation amongst all carriers to qualify.

More plan options Employers get a package of up to 15 Health Net plans that can be offered in combination with another carrier's plans.

More flexible network options Packages include HMO, PPO, and even our unique EOA plans that leverage both PPO and HMO networks, so you can get the benefits you need.

More choice for your employees An ideal solution for businesses with employees who have a wide preference of doctors and plans.

The added benefit of Decision PowerSM Health Net's exclusive decision-support service helps members make more confident health care decisions. Online tools, information, and most importantly, 24/7 phone support and answers from Health Coaches.

Tax Savings Supplemental Premium-Only Plans (POP) are designed to help employers reduce payroll taxes through IRS Section 125 provisions.²

12-month guarantee All new and renewing Health Net groups have a rate guarantee that will not change for at least 12 months.

Health Net. A Better Decision.SM

¹ Service area restrictions apply. Please refer to your H⁷ Options Underwriting Guidelines for more information.

² Administrative services for the Premium-Only Plans are provided by Total Administrative Services Corporation (TASC), which is an independent company not affiliated with Health Net. For more information regarding this insurance plan, please contact TASC at 1-800-422-4661.

CHOICE OF TEN

For small groups with 5–9 employees enrolling with Health Net

KEY BENEFITS ¹	OPTIONS HMO 35	OPTIONS PPO 500	
		In-network ²	Out-of-network ³
Deductible and plan maximums			
Annual deductible	N/A	\$500 single / \$1,000 family	\$1,000 single / \$2,000 family
Maximum out-of-pocket costs	\$4,000 single / \$8,000 family	\$4,000 single / 2 per family	\$8,000 single / 2 per family
Lifetime maximum	No maximum	\$5,000,000 combined with PPO and OON	
Professional services			
Office visit	\$35 copay	\$35 copay	50%
Well-Child care (including child immunizations)	\$35 (birth through age 2 covered in full)	\$35 copay	Not covered
Adult preventive care (age 17 and older)	\$35 copay	\$35 copay	Not covered
Adult annual routine physical exam (age 17 and older)	Not covered	\$35 copay (\$250 per calendar year maximum payable)	Not covered
Specialist consultation	\$35 copay	\$35 copay	50%
X-ray / Laboratory (includes mammograms) ^{5,6}	Covered in full	30%	50%
Rehabilitation therapy (includes physical, speech, occupational, cardiac and pulmonary rehabilitation therapy)	\$35 copay	30%	50%
Self-injectables	30%	30%	50%
Hospital services⁶			
Inpatient care	30%	30%	50% (\$600 max. allowable per day) \$250 inpatient deductible per calendar year
Outpatient facility services ^{7,8}	30%	30%	50% (50% max. allowable)
Outpatient surgery (hospital or outpatient surgery center charges only)	30%	30%	50% (50% max. allowable) \$250 deductible per calendar year
Skilled nursing facility	Days 1–10: Covered in full, Days 11–100: \$25 per day	30%	50% (\$250 max. allowable per day) \$250 inpatient deductible per calendar year (60 days per calendar year combined with PPO and OON)
Emergency services			
Professional Services	Covered in full		\$35 copay
Emergency Room Facility (copayment waived if admitted)	\$100 copay		\$100 copay + 30%
Urgent Care Facility	\$50 copay		\$50 copay + 30%
Ambulance services (Ground and Air) ⁶	\$100 copay	\$50 copay + 30%	\$50 copay + 50%
Other services			
Durable medical equipment ⁶	50% (\$2,000 maximum per calendar year)	30% (\$1,000 per calendar year combined with PPO and OON)	50%
Diabetic supplies	20%	30%	50%
Chiropractic care ⁹	Optional rider available	\$35 copay (12 visits per calendar year)	Not covered
Acupuncture ⁹	Optional rider available	Not covered	Not covered
Prescription drug coverage¹⁰			
Deductible per covered person	\$200 brand deductible	\$200 brand deductible	\$100
Prescription drugs (up to a 30-day supply)	\$15 Level I \$30 Level II \$50 Level III	\$15 Level I \$30 Level II \$50 Level III	50%

¹ **All plans:** 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 **PPO:** Member pays the negotiated rate, which is the rate participating or preferred providers have agreed to accept for providing a covered service.

³ **PPO:** Limited Fee Schedule reimbursement is at the 75th percentile of RBRVS. The member is responsible for charges in excess of allowed in addition to the coinsurance shown.

⁴ **EOA:** Self referral to a PPO network physician.

⁵ **HMO & EOA:** Complex radiology (includes CT, SPECT, PET, MUGA and MRI) requires a \$100 copayment. **EOA:** MRI, MUGA, PET and SPECT services are not covered through the PPO level.

⁶ **PPO:** These services require prior certification. If prior certification is not acquired, benefits are reduced to 50%.

⁷ **EOA:** Inpatient hospital and professional services and durable medical equipment are covered when provided or coordinated by the Primary Care Physician only and approved by the PPG/IPA. Inpatient care and outpatient services are not covered on the PPO level.

OPTIONS PPO 1750		OPTIONS PPO 3000 (HSA-Compatible)	
In-network ²	Out-of-network ³	In-network ²	Out-of-network ³
\$1,750 single / \$3,500 family	\$3,500 single / \$7,000 family	\$3,000 single / \$6,000 family (All benefits except preventive care are subject to annual deductible)	
\$5,000 single / 2 per family	\$10,000 single / 2 per family	\$4,000 single / \$8,000 family (includes deductible)	
\$5,000,000 combined with PPO and OON		\$5,000,000 combined with PPO and OON	
\$35 copay	50%	\$25 copay	50%
\$35 copay	Not covered	\$25 copay (deductible waived)	Not covered
\$35 copay	Not covered	\$25 copay (deductible waived)	Not covered
\$35 copay (\$250 per calendar year maximum payable)	Not covered	\$25 copay (\$250 per calendar year maximum payable)	Not covered
\$35 copay	50%	\$25 copay	50%
40%	50%	30%	50%
40%	50%	30%	50%
12 visits per calendar year combined with PPO and OON		12 visits per calendar year combined with PPO and OON	
40%	50%	30%	50%
40%	50% (\$600 max. allowable per day) \$250 inpatient deductible per calendar year	30%	50% (\$600 max. allowable per day) \$250 inpatient deductible per calendar year
40%	50% (50% max. allowable)	30%	50% (50% max. allowable)
40%	50% (50% max. allowable) \$250 deductible per calendar year	30%	50% (50% max. allowable) \$250 deductible per calendar year
40%	50% (\$250 max. allowable per day) \$250 inpatient deductible per calendar year (60 days per calendar year combined with PPO and OON)	30%	50% (\$250 max. allowable per day) \$250 inpatient deductible per calendar year (90 days per calendar year combined with PPO and OON)
	\$35 copay		\$25 copay
	\$100 copay + 40%		\$100 copay + 30%
	\$50 copay + 40%		\$50 copay + 30%
\$50 copay + 40%	\$50 copay + 50%	\$50 copay + 30%	\$50 copay + 50%
40%	50%	30%	50%
(\$1,000 per calendar year combined with PPO and OON)		(\$2,000 per calendar year combined with PPO and OON)	
40%	50%	30%	50%
\$35 copay (12 visits per calendar year)	Not covered	\$25 copay (12 visits per calendar year)	Not covered
Not covered	Not covered	Not covered	Not covered
\$200 brand deductible	\$100	Subject to annual deductible	
\$15 Level I \$30 Level II \$50 Level III	50%	\$15 Level I \$30 Level II \$50 Level III	50%

⁸ **EOA:** 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.

⁹ **HMO & EOA:** Chiropractic and/or Acupuncture rider coverage is available as an optional benefit with the HMO and EOA plans shown above. Features of Health Net's chiropractic coverage include: \$10 per visit copayment and up to 20 visits per calendar year.

¹⁰ **All plans:** 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.

¹¹ **Salud and Flex Net:** Please refer to the Standard Benefits Guide for complete summary of benefits.

CHOICE OF FIFTEEN

OPTIONS PPO 4000 (HSA-Compatible)

In-network ²	Out-of-network ³
\$4,000 single / \$8,000 family (All benefits except preventive care are subject to annual deductible)	
\$5,000 per member / \$10,000 family (includes deductible)	
\$5,000,000 combined with PPO and OON	
\$35 copay	50%
\$35 copay (deductible waived)	Not covered
\$35 copay (deductible waived)	Not covered
\$35 copay (\$250 per calendar year maximum payable)	Not covered
\$35 copay	50%
40%	50%
40%	50%
12 visits per calendar year combined with PPO and OON	
40%	50%
40%	50% (\$600 max. allowable per day) \$250 inpatient deductible per calendar year
40%	50% (50% max. allowable)
40%	50% (50% max. allowable) \$250 deductible per calendar year
40%	50% (\$250 max. allowable per day) \$250 inpatient deductible per calendar year (60 days per calendar year combined with PPO and OON)
\$35 copay	
\$100 copay + 40%	
\$50 copay + 40%	
\$50 copay + 40%	\$50 copay + 50%
40%	50% (\$1,000 per calendar year combined with PPO and OON)
40%	50%
\$35 copay (12 visits per calendar year)	Not covered
Not covered	Not covered
Subject to annual deductible	
\$15 Level I \$30 Level II \$50 Level III	50%

PLUS

- Salud HMO y más¹¹
- Salud PPO¹¹
- Salud EPO¹¹
- Salud Mexico¹¹
- Flex Net¹¹



OPTIONS HMO 25

N/A
\$3,000 single / \$6,000 family
No maximum
\$25 copay
\$25 copay (birth through age 2 covered in full)
\$25 copay
Not covered
\$25 copay
Covered in full
\$25 copay
30%
20%
20%
20%
Days 1–10: Covered in full Days 11–100: \$25 per day
Covered in full
\$100 copay
\$50 copay
\$100 copay
50% (\$2,000 maximum per calendar year)
20%
Optional rider available
Optional rider available
\$150 brand deductible
\$15 Level I \$30 Level II \$50 Level III

¹ **All plans:** 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 **PPO:** Member pays the negotiated rate, which is the rate participating or preferred providers have agreed to accept for providing a covered service.

³ **PPO:** Limited Fee Schedule reimbursement is at the 75th percentile of RBRVS. The member is responsible for charges in excess of allowed in addition to the coinsurance shown.

⁴ **EOA:** Self referral to a PPO network physician.

⁵ **HMO & EOA:** Complex radiology (includes CT, SPECT, PET, MUGA and MRI) requires a \$100 copayment. **EOA:** MRI, MUGA, PET and SPECT services are not covered through the PPO level.

⁶ **PPO:** These services require prior certification. If prior certification is not acquired, benefits are reduced to 50%.

⁷ **EOA:** Inpatient hospital and professional services and durable medical equipment are covered when provided or coordinated by the Primary Care Physician only and approved by the PPG/IPA. Inpatient care and outpatient services are not covered on the PPO level.

For small groups with 10 or more employees enrolling with Health Net

OPTIONS EOA 25		OPTIONS EOA 35		OPTIONS PPO 250	
				In-network ²	Out-of-network ³
N/A	N/A	N/A	N/A	\$250 single / \$500 family	\$500 single / \$1,000 family
\$3,000 single / \$6,000 family	\$4,000 single / \$8,000 family	\$4,000 single / \$8,000 family		\$3,500 single / 2 per family	\$7,000 single / 2 per family
No maximum	No maximum	No maximum		\$5,000,000 combined with PPO and OON	
HMO: \$25 copay / PPO: \$40 copay ⁴	HMO: \$35 copay / PPO: \$50 copay ⁴	HMO: \$35 copay / PPO: \$50 copay ⁴		\$25 copay	50%
HMO: \$25 (birth through age 2 covered in full) / PPO: \$40 copay ⁴	HMO: \$35 (birth through age 2 covered in full) / PPO: \$50 copay ⁴	HMO: \$35 (birth through age 2 covered in full) / PPO: \$50 copay ⁴		\$25 copay	Not covered
HMO: \$25 copay / PPO: \$40 copay	HMO: \$35 copay / PPO: \$50 copay	HMO: \$35 copay / PPO: \$50 copay		\$25 copay	Not covered
Not covered	Not covered	Not covered		\$25 copay (\$250 per calendar year maximum payable)	Not covered
HMO: \$25 copay / PPO: \$40 copay ⁴	HMO: \$35 copay / PPO: \$50 copay ⁴	HMO: \$35 copay / PPO: \$50 copay ⁴		\$25 copay	50%
Covered in full	Covered in full	Covered in full		20%	50%
HMO: \$25 copay / PPO: \$40 copay (12 visits per calendar year) ⁴	HMO: \$35 copay / PPO: \$50 copay (12 visits per calendar year) ⁴	HMO: \$35 copay / PPO: \$50 copay (12 visits per calendar year) ⁴		20%	50%
30%	30%	30%		12 visits per calendar year combined with PPO and OON	
30%	30%	30%		20%	50%
20%	30%	30%		20%	50% (\$600 max. allowable per day) \$250 inpatient deductible per calendar year
20%	30%	30%		20%	50% (50% max. allowable)
20%	30%	30%		20%	50% (50% max. allowable) \$250 deductible per calendar year
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		20%	50% (\$250 max. allowable per day) \$250 inpatient deductible per calendar year (90 days per calendar year combined with PPO and OON)
Covered in full	Covered in full	Covered in full		\$25 copay	
\$100 copay	\$100 copay	\$100 copay		\$100 copay + 20%	
\$50 copay	\$50 copay	\$50 copay		\$50 copay + 20%	
\$100 copay	\$100 copay	\$100 copay		\$50 copay + 20%	\$50 copay + 50%
50% (\$2,000 maximum per calendar year)	50% (\$2,000 maximum per calendar year)	50% (\$2,000 maximum per calendar year)		20%	50% (\$2,000 per calendar year combined with PPO and OON)
20%	20%	20%		20%	50%
Optional rider available	Optional rider available	Optional rider available		\$25 copay (12 visits per calendar year)	Not covered
Optional rider available	Optional rider available	Optional rider available		Not covered	Not covered
\$150 brand deductible	\$200 brand deductible	\$200 brand deductible		\$150 brand deductible	\$100
\$15 Level I	\$15 Level I	\$15 Level I		\$15 Level I	50%
\$30 Level II	\$30 Level II	\$30 Level II		\$30 Level II	
\$50 Level III	\$50 Level III	\$50 Level III		\$50 Level III	

⁸ **EOA:** 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.

⁹ **HMO & EOA:** Chiropractic and/or Acupuncture rider coverage is available as an optional benefit with the HMO and EOA plans shown above. Features of Health Net's chiropractic coverage include: \$10 per visit copayment and up to 20 visits per calendar year.

¹⁰ **All plans:** 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.

¹¹ **Salud and Flex Net:** Please refer to the Standard Benefits Guide for complete summary of benefits.

OPTIONS PPO 250	
In-network ²	Out-of-network ³
\$250 single / \$500 family	\$500 single / \$1,000 family
\$3,500 single / 2 per family	\$7,000 single / 2 per family
\$5,000,000 combined with PPO and OON	
\$25 copay	50%
\$25 copay	Not covered
\$25 copay	Not covered
\$25 copay (\$250 per calendar year maximum payable)	Not covered
\$25 copay	50%
20%	50%
20%	50%
12 visits per calendar year combined with PPO and OON	
20%	50%
20%	50% (\$600 max. allowable per day)
\$250 inpatient deductible per calendar year	
20%	50% (50% max. allowable)
20%	50% (50% max. allowable)
\$250 deductible per calendar year	
20%	50% (\$250 max. allowable per day)
\$250 inpatient deductible per calendar year (90 days per calendar year combined with PPO and OON)	
\$25 copay	
\$100 copay + 20%	
\$50 copay + 20%	
\$50 copay + 20%	\$50 copay + 50%
20%	50%
(\$2,000 per calendar year combined with PPO and OON)	
20%	50%
\$25 copay (12 visits per calendar year)	Not covered
Not covered	Not covered
\$150 brand deductible	\$100
\$15 Level I	50%
\$30 Level II	
\$50 Level III	

OPTIONS PPO 1500	
In-network ²	Out-of-network ³
\$1,500 single / \$3,000 family	\$3,000 single / \$6,000 family
\$4,000 single / 2 per family	\$8,000 single / 2 per family
\$5,000,000 combined with PPO and OON	
\$25 copay	50%
\$25 copay	Not covered
\$25 copay	Not covered
\$25 copay (\$250 per calendar year maximum payable)	Not covered
\$25 copay	50%
30%	50%
30%	50%
12 visits per calendar year combined with PPO and OON	
30%	50%
30%	50% (\$600 max. allowable per day)
\$250 deductible per calendar year	
30%	50% (50% max. allowable)
30%	50% (50% max. allowable)
\$250 deductible per calendar year	
30%	50% (\$250 max. allowable per day)
\$250 inpatient deductible per calendar year (90 days per calendar year combined with PPO and OON)	
\$25 copay	
\$100 copay + 30%	
\$50 copay + 30%	
\$50 copay + 30%	\$50 copay + 50%
30%	50%
(\$2,000 per calendar year combined with PPO and OON)	
30%	50%
\$25 copay (12 visits per calendar year)	Not covered
Not covered	Not covered
\$150 brand deductible	\$100
\$15 Level I	50%
\$30 Level II	
\$50 Level III	

PLUS

- Salud HMO y más¹¹
- Salud PPO¹¹
- Salud EPO¹¹
- Salud Mexico¹¹
- Flex Net¹¹

For more information, please contact:

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

Small Business Group
Sales and Administration:
1-800-447-8812

Broker Relations:
1-800-448-4411, option 4

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:
1-800-765-8378

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

Decision PowerSM is not part of Health Net's commercial medical benefit plans nor affiliated with Health Net's provider network and it may be revised or withdrawn without notice. Decision Power is part of Health Net's Medicare Advantage benefit plans but is not affiliated with Health Net's provider network. Decision Power services, including Health Coaches, are additional resources that Health Net makes available to enrollees of the above listed Health Net companies.

Health Net HMO, EOA and Salud con Health Net HMO plans are underwritten by Health Net of California, Inc., a subsidiary of Health Net, Inc. Health Net PPO, Flex Net and Salud con Health Net PPO and EPO plans are issued by Health Net Life Insurance Company, a direct subsidiary of Health Net of California, Inc., itself a direct subsidiary of Health Net, Inc.

6011936 (9/06)

Health Net® is a registered service mark of Health Net, Inc. Decision PowerSM and A Better DecisionSM are service marks of Health Net, Inc. Health Net of California, Inc., is a subsidiary of Health Net, Inc.