STANDARD BENEFITS

STANDARD BENEFITS GUIDE

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

Effective May 1, 2006

Health Net®
A Better Decision

HMO

KEY BENEFITS[1]	HMO 10 (71Q)	HMO 15 (539)	HMO 20 (540)[5] (Available with the HMO Silver Network S28)
Plan maximums			
Maximum out-of-pocket costs	$1,500 single / $3,000 family	$1,500 single / $3,000 family	$2,500 single / $5,000 family
Lifetime maximum	No maximum	No maximum	No maximum
Professional services			
Office visit	$10 copayment	$15 copayment	$20 copayment
Periodic health evaluation (including newborn and well-baby care)	Covered in full (until age 2 then $10)	Covered in full (until age 2 then $15)	Covered in full (until age 2 then $20)
Specialist consultation	$10 copayment	$15 copayment	$20 copayment
X-ray / Laboratory (includes mammograms)	Covered in full[2]	Covered in full	Covered in full
Rehabilitation therapy (includes physical, speech, occupational, cardiac and pulmonary rehabilitation therapy)	$10 copayment	$15 copayment	$20 copayment
Self-injectables	30%	30%	30%
Hospital services			
Inpatient care	Covered in full	20%	$1,000 per admission copayment
Outpatient facility services	Covered in full	20%	20%
Outpatient surgery (hospital or outpatient surgery center charges only)	Covered in full	20%	$1,000 copayment
Skilled nursing facility	Covered in full (limited to 100 days per calendar year)	20% (limited to 100 days per calendar year)	20% (limited to 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)	$100 copayment	$100 copayment	$100 copayment
Urgent care facility (copayment waived if admitted)	$10 copayment	$50 copayment	$50 copayment
Ambulance services (ground and air)	$100 copayment	Covered in full	20%
Behavioral health services[4]			
Severe mental health (outpatient / inpatient)	$10 copayment / Covered in full	$15 copayment / Covered in full	$20 copayment / $1,000 per admission copayment
Non-severe mental health (outpatient / inpatient)	$30 copayment (20 visits per calendar year / Covered in full (30 days per calendar year)	$30 copayment (20 visits per calendar year / Covered in full (30 days per calendar year)	$30 copayment (20 visits per calendar year / $1,000 per admission copayment (30 visits per calendar year)
Chemical dependency rehabilitation (outpatient / inpatient)	Not covered	Not covered	Not covered
Acute care detoxification	Covered in full	Covered in full	Covered in full
Other services			
Durable medical equipment	20% (Limited to $2,000 max per calendar year)	50%	50%
Diabetic supplies	20%	20%	20%
Acupuncture, Chiropractic care[6]	Optional rider available	Optional rider available	Optional rider available
Prescription drug coverage[3]			
Brand name deductible (per member, per calendar year)	No deductible	No deductible	No deductible
Prescription drugs (up to 30 day supply)	$10 Level I $25 Level II $50 Level III	$15 Level I $25 Level II $50 Level III	$15 Level I $30 Level II $50 Level III

See footnotes on page 20.

HMO

KEY BENEFITS[1]	HMO 30 (71R)	HMO 35 (541)	HMO 40 (542)[5] (Available with the HMO Silver Network S29)
Plan maximums			
Maximum out-of-pocket costs	$3,000 single / $6,000 family	$3,000 single / $6,000 family	$3,500 single / $7,000 family
Lifetime maximum	No maximum	No maximum	No maximum
Professional services			
Office visit	$30 copayment	$35 copayment	$40 copayment
Periodic health evaluation (including newborn and well-baby care)	Covered in full (until age 2 then $30)	Covered in full (until age 2 then $35)	Covered in full (until age 2 then $40)
Specialist consultation	$30 copayment	$35 copayment	$40 copayment
X-ray / Laboratory (includes mammograms)	Covered in full[2]	Covered in full	Covered in full
Rehabilitation therapy (includes physical, speech, occupational, cardiac and pulmonary rehabilitation therapy)	$30 copayment	$35 copayment	$40 copayment
Self-injectables	30%	30%	30%
Hospital services			
Inpatient care	$500 copayment per day (3 day copayment maximum)	$1,500 per admission copayment	$750 copayment per day (3 day copayment maximum)
Outpatient facility services	20%	20%	20%
Outpatient surgery (hospital or outpatient surgery center charges only)	$500 copayment	$1,500 copayment	$1,500 copayment
Skilled nursing facility	Days 1–10 covered in full, Days 11–100, $25 per day	20% (100 days per calendar year)	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)	$100 copayment	$100 copayment	$100 copayment
Urgent care facility (copayment waived if admitted)	$30 copayment	$50 copayment	$50 copayment
Ambulance services (ground and air)	$100 copayment	20%	20%
Behavioral health services[4]			
Severe mental health (outpatient / inpatient)	$30 copayment / $500 copayment per day (3 day copayment maximum)	$35 copayment / $1,500 per admission copayment	$40 copayment / $750 copayment per day (3 day copayment maximum)
Non-severe mental health (outpatient / inpatient)	$35 copayment (20 visits per calendar year) / $500 copayment per day (30 days per calendar year, 3 day copayment maximum)	$35 copayment (20 visits per calendar year) / $1,500 per admission copayment (30 days per calendar year)	$40 copayment (20 visits per calendar year) / $750 copayment per day (3 day copayment maximum, 30 days per calendar year)
Chemical dependency rehabilitation (outpatient / inpatient)	Not covered	Not covered	Not covered
Acute care detoxification[4]	$500 copayment per day (3 day copayment maximum)	$750 per admission copayment	$750 copayment per day (3 day copayment maximum)
Other services			
Durable medical equipment	50% (Limited to $2,000 max per calendar year)	50%	50%
Diabetic supplies	20%	20%	20%
Acupuncture, Chiropractic care[6]	Optional rider available	Optional rider available	Optional rider available
Prescription drug coverage[3]			
Brand name deductible (per member, per calendar year)	$150	$150	$150
Prescription drugs (up to a 30 day supply)	$10 Level I $30 Level II $50 Level III	$15 Level I $30 Level II $50 Level III	$15 Level I $30 Level II $50 Level III

See footnotes on page 20.

HMO Xtra Value 20 (64Q)[5] **(Available with the HMO Silver Network S30)**	**HMO Xtra Value 40 (64R)**[5] **(Available with the HMO Silver Network S31)**	**HMO VCP 25 (543)**	**HMO VCP 35 (544)**
$3,500 single / $7,000 family	$3,500 single / $7,000 family	$3,500 single / $7,000 family	$4,000 single / $8,000 family
No maximum	No maximum	No maximum	No maximum
$20 copayment	$40 copayment	$25 copayment	$35 copayment
$20 copayment	$40 copayment	Covered in full (until age 2, then $25)	Covered in full (until age 2, then $35)
$50 copayment	$60 copayment	$25 copayment	$35 copayment
Covered in full[2]	Covered in full[2]	Covered in full	Covered in full
$20 copayment	$40 copayment	$25 copayment	$35 copayment
30%	30%	30%	30%
30%	30%	*Low Hospital copayment:* $100 per day; *Medium Hospital copayment:* $300 per day; *High Hospital copayment:* $500 per day (4 day copayment maximum)	*Low Hospital copayment:* $200 per day; *Medium Hospital copayment:* $400 per day; *High Hospital copayment:* $600 per day (4 day copayment maximum)
30%	30%	$25 copayment	$35 copayment
$1,500 copayment	$1,500 copayment	*Low Hospital copayment:* $100 per surgery; *Medium Hospital copayment:* $300 per surgery; *High Hospital copayment:* $500 per surgery	*Low Hospital copayment:* $200 per surgery; *Medium Hospital copayment:* $400 per surgery; *High Hospital copayment:* $600 per day
30% (100 days per calendar year)	30% (100 days per calendar year)	Days 1–10: covered in full Days 11–100: $75 copayment per day	Days 1–10: Covered in full Days 11–100: $75 copayment per day
Covered in full	Covered in full	$100 copayment	$100 copayment
$150 copayment	$250 copayment	$100 copayment	$100 copayment
$50 copayment	$50 copayment	$50 copayment	$50 copayment
$100 copayment	$300 copayment	20%	20%
$20 copayment / 30%	$40 copayment / 30%	$25 copayment / $100 copayment per day (4 day copayment maximum)	$35 copayment / $200 copayment per day (4 day copayment maximum)
Not covered	Not covered	$25 copayment (20 visits per calendar year) / $100 copayment per day (30 days per calendar year, 4 day copayment maximum)	$35 copayment (20 visits per calendar year) / $200 copayment per day (30 days per calendar year, 4 day copayment maximum)
Not covered	Not covered	Not covered	Not covered
30%	30%	$100 copayment per day (4 day copayment maximum)	$200 copayment per day (4 day copayment maximum)
50%	50%	50%	50%
20%	20%	20%	20%
Optional rider available	Optional rider available	Optional rider available	Optional rider available
No deductible	$150	$150	$150
$15 Level I $30 Level II $50 Level III	$15 Level I $30 Level II $50 Level III	$15 Level I $30 Level II $50 Level III	$15 Level I $30 Level II $50 Level III

EOA

KEY BENEFITS[1]	EOA 10 (545)	EOA 20 (546)
Plan maximums		
Maximum out-of-pocket costs	$1,500 single $3,000 two party $4,000 family	$2,000 single $4,000 two party $5,000 family
Lifetime maximum	No maximum	No maximum
Professional services		
Office visit[2]	HMO: $10 copayment, PPO: $30 copayment (Self referral to a PPO network physician)	HMO: $20 copayment, PPO: $35 copayment (Self referral to a PPO network physician)
Periodic health evaluation (including newborn and well-baby care)	HMO: Covered in full (until age 2, then $10), PPO: $30 copayment (Self referral to a PPO network physician)	HMO: Covered in full (until age 2, then $20), PPO: $35 copayment (Self referral to a PPO network physician)
Specialist consultation	HMO: $10 copayment, PPO: $30 copayment (Self referral to a PPO network physician)	HMO: $20 copayment, PPO: $35 copayment (Self referral to a PPO network physician)
X-ray / Laboratory (includes mammograms)	Covered in full	Covered in full
Rehabilitation therapy (includes physical, speech, occupational, cardiac and pulmonary rehabilitation therapy)	HMO: $10 copayment, PPO: $30 copayment (Self referral to a PPO network physician, 12 visits per calendar year)	HMO: $20 copayment, PPO: $35 copayment (Self referral to a PPO network physician, 12 visits per calendar year)
Self-injectables	30%	30%
Hospital services		
Inpatient care	$250 per admission copayment	$500 per admission copayment
Outpatient facility services[2,3]	Covered in full	Covered in full
Outpatient surgery	$250 copayment	$500 copayment
Skilled nursing facility	Covered in full (100 days per calendar year)	$250 per admission copayment (100 days per calendar year)
Emergency services		
Professional services	Covered in full	Covered in full
Emergency room facility	$100 copayment (copayment waived if admitted)	$100 copayment (copayment waived if admitted)
Urgent care facility	$50 copayment (copayment waived if admitted)	$50 copayment (copayment waived if admitted)
Ambulance services (ground and air)	Covered in full	Covered in full
Behavioral health services[4]		
Severe mental health (outpatient / inpatient)	$10 copayment / $250 per admission copayment	$20 copayment / $500 per admission copayment
Non-severe mental health (outpatient / inpatient)	$30 copayment (20 visits per calendar year) / $250 per admission copayment (30 days per calendar year)	$30 copayment (20 visits per calendar year) / $500 per admission copayment (30 days per calendar year)
Chemical dependency rehabilitation (outpatient / inpatient)	Not covered	Not covered
Acute care detoxification	$250 per admission copayment	$500 per admission copayment
Other services		
Durable medical equipment	50%	50%
Diabetic supplies	20%	20%
Acupuncture, Chiropractic care[5]	Optional rider available	Optional rider available
Prescription drug coverage[6]		
Brand name deductible (per member, per calendar year)	No deductible	No deductible
Prescription drugs (up to a 30 day supply)	$10 Level I $25 Level II $50 Level III	$15 Level I $30 Level II $50 Level III

See footnotes on page 20.

EOA 25 (547)	EOA 30 (548)
$2,500 single $5,000 two party $6,000 family	$2,500 single $5,000 two party $6,000 family
No maximum	No maximum
HMO: $25 copayment, PPO: $40 copayment (Self referral to a PPO network physician)	HMO: $30 copayment, PPO: $40 copayment (Self referral to a PPO network physician)
HMO: Covered in full (until age 2, then $25), PPO: $40 copayment (Self referral to a PPO network physician)	HMO: Covered in full (until age 2, then $30), PPO: $40 copayment (Self referral to a PPO network physician)
HMO: $25 copayment, PPO: $40 copayment (Self referral to a PPO network physician)	HMO: $30 copayment, PPO: $40 copayment (Self referral to a PPO network physician)
Covered in full	Covered in full
HMO: $25 copayment, PPO: $40 copayment (Self referral to a PPO network physician, 12 visits per calendar year)	HMO: $30 copayment, PPO: $40 copayment (Self referral to a PPO network physician, 12 visits per calendar year)
30%	30%
25%	$1,000 per admission copayment
25%	Covered in full
25%	$1,000 copayment
25% (100 days per calendar year)	$1,000 per admission copayment (100 days per calendar year)
Covered in full	Covered in full
25%	$100 copayment (copayment waived if admitted)
$50 copayment (copayment waived if admitted)	$50 copayment (copayment waived if admitted)
Covered in full	Covered in full
$25 copayment / 25%	$30 copayment / $1,000 per admission copayment
$30 copayment (20 visits per calendar year) / 25% (30 days per calendar year)	$30 copayment (20 visits per calendar year) / $1,000 per admission copayment (30 days per calendar year)
Not covered	Not covered
25%	$750 per admission copayment
50%	50%
20%	20%
Optional rider available	Optional rider available
$150	$150
$15 Level I $30 Level II $50 Level III	$15 Level I $30 Level II $50 Level III

EOA

POS

KEY BENEFITS[1]	POS 10 (549) HMO[2]	PPO[2]	OON[3]
Deductible and plan maximums			
Deductible	No deductible	$200 single / $600 family combined with PPO and OON	
Maximum out-of-pocket costs	$1,500 single $3,000 two party $4,500 family	$3,000 single $6,000 two party $9,000 family	$5,000 single $10,000 two party $15,000 family
Lifetime maximum	No maximum	$5,000,000 combined with PPO and OON	
Professional services			
Office visit	$10 copayment	$30 copayment	30%
Well-child care (through age 17), including child immunizations	$10 copayment	$30 copayment	30%
Adult preventive care (age 18 and older)	$10 copayment	$30 copayment	Not covered
Specialist consultation	$10 copayment	$30 copayment	30%
X-ray / Laboratory (includes mammograms)	Covered in full	10% (deductible waived)	30%
Rehabilitation therapy (includes physical, speech, occupational, cardiac and pulmonary rehabilitation therapy; calendar year maximum)	Covered in full	$30 copayment (60 visits per calendar year combined with PPO and OON)	30%
Self-injectables	30%	30%	30%
Hospital services			
Inpatient care	$100 per admission copayment	10%[8]	30%[8]
Outpatient facility services	Covered in full	10%[8]	30%[8]
Outpatient surgery (hospital or outpatient surgery center charges only)	$100 copayment	10%[8]	30%[8]
Skilled nursing facility (calendar year maximum)	$100 per admission copayment (100 days per calendar year)	10%[8] (60 days per calendar year combined with PPO and OON)	30%[8]
Emergency services			
Professional services	Covered in full	10%	30%
Emergency room facility (copayment waived if admitted)	$100 copayment	$150 copayment	30%
Urgent care facility (copayment waived if admitted)	$50 copayment	$100 copayment	30%
Ambulance services (ground and air)	Covered in full	10%[8]	30%[8]
Behavioral health services[4]			
Severe mental health (outpatient / inpatient)	$10 copayment / $100 per admission copayment	Not covered	Not covered
Non-severe mental health (outpatient / inpatient)	$30 copayment (20 visits per calendar year) / $100 per admission copayment (30 days per calendar year)	Not covered	Not covered
Chemical dependency rehabilitation (outpatient / inpatient)	Not covered	Not covered	Not covered
Acute care detoxification	$100 per admission copayment	Not covered	Not covered
Other services			
Durable medical equipment	Covered in full	10%[8] ($2,000 maximum per calendar year combined with PPO and OON)	30%[8]
Diabetic supplies	Covered in full	10%[8]	30%[8]
Chiropractic care[5]	$10 copayment	30% (15 visits per calendar year combined with PPO and OON)	30%
Acupuncture	$10 copayment	Not covered	Not covered
Prescription drug coverage[6]			
Brand name deductible (per member, per calendar year)	No deductible		$100
Prescription drugs (up to a 30 day supply)	$10 Level I $25 Level II $50 Level III		50%

See footnotes on page 20.

POS 20 (550)			POS 30 (551)		
HMO	**PPO**[2]	**OON**[3]	**HMO**	**PPO**[2]	**OON**[3,7]
No deductible	$200 single / $600 family	$400 single / $1,200 family	No deductible	$300 single / $900 family	$500 single / $1,500 family
$2,000 single $4,000 two party $6,000 family	$3,500 single $7,000 two party $10,500 family	$5,000 single $10,000 two party $15,000 family	$2,500 single $5,000 two party $7,500 family	$4,500 single $9,000 two party $13,500 family	$6,000 single $12,000 two party $18,000 family
No maximum	$5,000,000 combined with PPO and OON		No maximum	$5,000,000 combined with PPO and OON	
$20 copayment	$35 copayment	40%	$30 copayment	$35 copayment	50%
$20 copayment	$35 copayment	40%	$30 copayment	$35 copayment	50%
$20 copayment	$35 copayment	Not covered	$30 copayment	$35 copayment	Not covered
$20 copayment	$35 copayment	40%	$30 copayment	$35 copayment	50%
Covered in full	20%	40%	Covered in full	30%	50%
Covered in full	$35 copayment	40% (60 visits per calendar year combined with PPO and OON)	Covered in full	$35 copayment	50% (60 visits per calendar year combined with PPO and OON)
30%	30%	40%	30%	30%	50%
$250 per admission copayment	20%[8]	40%[8] ($1,000 maximum allowable per day)	$500 per admission copayment	30%[8]	50%[8] ($1,000 maximum allowable per day)
Covered in full	20%[8]	40%[8]	Covered in full	30%[8]	50%[8]
$250 copayment	20%[8]	40%[8]	$500 copayment	30%[8]	50%[8]
$250 per admission copayment (100 days per calendar year)	20%[8]	40%[8] (60 days per calendar year combined with PPO and OON)	$500 per admission copayment (100 days per calendar year)	30%[8]	50%[8] (60 days per calendar year combined with PPO and OON)
Covered in full	20%	40%	Covered in full	30%	50%
$100 copayment	$150 copayment	40%	$100 copayment	$150 copayment	50%
$50 copayment	$100 copayment	40%	$50 copayment	$100 copayment	50%
Covered in full	20%[8]	40%[8]	Covered in full	30%[8]	50%[8]
$20 copayment / $250 per admission copayment	Not covered	Not covered	$30 copayment / $500 per admission copayment	Not covered	Not covered
$30 copayment (20 visits per calendar year) / $250 per admission copayment (30 days per calendar year)	Not covered	Not covered	$30 copayment (20 visits per calendar year) / $500 per admission copayment (30 days per calendar year)	Not covered	Not covered
Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
$250 per admission copayment	Not covered	Not covered	$500 per admission copayment	Not covered	Not covered
Covered in full	20%[8]	40%[8] ($2,000 maximum per calendar year combined with PPO and OON)	Covered in full	30%[8]	50%[8] ($2,000 maximum per calendar year combined with PPO and OON)
Covered in full	20%[8]	40%[8]	Covered in full	30%[8]	50%[8]
$20 copayment	20%	40% (15 visits per calendar year combined with PPO and OON)	$30 copayment	30%	50% (15 visits per calendar year combined with PPO and OON)
$20 copayment	Not covered	Not covered	$30 copayment	Not covered	Not covered
No deductible		$100	$150 brand name		$100
$15 Level I $30 Level II $50 Level III		50%	$15 Level I $30 Level II $50 Level III		50%

PPO

KEY BENEFITS[1]	PPO 10 (552) PPO[2]	OON[3]
Deductible and plan maximums		
Annual deductible	No deductible	$500 single / 2 per family
Maximum out-of-pocket costs	$2,500 single / 2 per family	$5,000 single / 2 per family
Lifetime maximum	$5,000,000 combined with PPO and OON	
Professional services		
Office visit	$10 copayment	30%
Well-child care (though age 16), including child immunizations	$10 copayment	Not covered
Adult preventive care (age 17 and older)	10%	Not covered
Adult annual routine physical exam (age 17 and older)	$10 copayment ($250 calendar year maximum payable)	Not covered
Specialist consultation	$10 copayment	30%
X-ray / Laboratory (includes mammograms)[5]	10%	30%
Rehabilitation therapy (includes physical, speech, occupational, cardiac and pulmonary rehabilitation therapy)	10% (12 visits per calendar year combined with PPO and OON)	30%
Self-injectables	30%	30%
Hospital services[5]		
Inpatient care	10%	30%
Outpatient facility services	10%	30%
Outpatient surgery (hospital or outpatient surgery center charges only)	10%	30%
Skilled nursing facility	10% (100 days per calendar year combined with PPO and OON)	30% ($250 maximum payable per day)
Emergency services		
Professional services	$10 copayment	10%
Emergency room facility (deductible waived if admitted)	$100 deductible + 10%	
Urgent care facility (deductible waived if admitted)	$50 deductible + 10%	
Ambulance services (ground and air)[5]	$50 deductible + 10%	$50 deductible + 30%
Behavioral health services[5]		
Severe mental health (outpatient / inpatient)[6]	$10 copayment / 10%	30% / 30%
Non-severe mental health (outpatient / inpatient)[7]	10% / 10%	30% / 30%
Acute care detoxification	10%[7]	30%[7]
Other services		
Durable medical equipment[5]	10% ($3,000 per calendar year combined with PPO and OON)	30%
Diabetic supplies	10%	30%
Chiropractic care	$10 copayment (12 visits per calendar year)	Not covered
Acupuncture	10% (12 visits per calendar year combined with PPO and OON, $25 maximum payable per visit)	30%
Prescription drug coverage[8]		
Deductible (per member, per calendar year)	No deductible	$100
Prescription drugs (up to a 30 day supply)	$10 Level I $20 Level II $50 Level III	50%

See footnotes on page 20.

PPO 15 (65R)		PPO 20 (65S)	
PPO[2]	**OON**[4]	**PPO**[2]	**OON**[4]
$250 single / 2 per family	$500 single / 2 per family	$250 single / 2 per family	$500 single / 2 per 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	
$15 copayment	50%	$20 copayment	40%
$15 copayment	Not covered	$20 copayment	Not covered
10%	Not covered	20%	Not covered
$15 copayment ($250 calendar year maximum payable)	Not covered	$20 copayment ($250 calendar year maximum payable)	Not covered
$15 copayment	50%	$20 copayment	40%
10%	50%	20%	40%
10% (12 visits per calendar year combined with PPO and OON)	50%	20% (12 visits per calendar year combined with PPO and OON)	40%
30%	50%	30%	40%
10%	50% ($600 maximum allowable per day)	20% $250 inpatient deductible per calendar year	40% ($600 maximum allowable per day)
10%	50%	20%	40% (50% maximum allowable)
10%	50%	20% $250 deductible per calendar year	40% (50% maximum allowable)
10% (100 days per calendar year combined with PPO and OON)	50% ($250 maximum allowable per day)	20% $250 inpatient deductible per calendar year (90 days per calendar year combined with PPO and OON)	40% ($250 maximum allowable per day)
$15 copayment	10%	$20 copayment	20%
$100 deductible + 10%		$100 deductible + 20%	
$50 deductible + 10%		$50 deductible + 20%	
$50 deductible + 10%	$50 deductible + 50%	$50 deductible + 20%	$50 deductible + 40%
$15 copayment / 10%	50% / 50% ($600 maximum allowable per day)	$20 copayment / $250 deductible per calendar year + 20%	40% / $250 deductible per calendar year + 40% ($600 maximum allowable per day)
10% / 10%	50% / 50%	20% / 20%	40% / 40%
10%[7]	50%[7]	20% (20 days per calendar year combined with PPO and OON, $175 maximum payable per visit)	40%
10% ($3,000 per calendar year combined with PPO and OON)	50%	20% ($2,000 per calendar year combined with PPO and OON)	40%
10%	50%	20%	40%
$15 copayment (12 visits per calendar year)	Not covered	$20 copayment (12 visits per calendar year)	Not covered
10% (12 visits per calendar year combined with PPO and OON, $25 maximum payable per visit)	50%	20% (12 visits per calendar year combined with PPO and OON, $25 maximum payable per visit)	40%
No deductible	$100	No deductible	$100
$10 Level I $20 Level II $50 Level III	50%	$15 Level I $30 Level II $50 Level III	50%

PPO

KEY BENEFITS[1]	PPO 25 (71S) PPO[2]	OON[4]
Deductible and plan maximums		
Annual deductible	$250 single / 2 per family combined with PPO and OON	
Maximum out-of-pocket costs	$3,500 single / 2 per family	$7,000 single / 2 per family
Lifetime maximum	$5,000,000 combined with PPO and OON	
Professional services		
Office visit	$25 copayment	50%
Well-child care (though age 16), including child immunizations	$25 copayment	Not covered
Adult preventive care (age 17 and older)	$25 copayment	Not covered
Adult annual routine physical exam (age 17 and older)	$25 copayment ($250 calendar year maximum payable)	Not covered
Specialist consultation	$25 copayment	50%
X-ray / Laboratory (includes mammograms)[5]	20%	50%
Rehabilitation therapy (includes physical, speech, occupational, cardiac and pulmonary rehabilitation therapy)	20% (12 visits per calendar year combined with PPO and OON)	50%
Self-injectables	30%	50%
Hospital services[5]		
Inpatient care	20% $250 inpatient deductible per calendar year	50% ($600 maximum allowable per day)
Outpatient facility services	20%	50% (50% maximum allowable)
Outpatient surgery (hospital or outpatient surgery center charges only)	20% $250 deductible per calendar year	50% (50% maximum allowable)
Skilled nursing facility	20% $250 inpatient deductible per calendar year (90 days per calendar year combined with PPO and OON)	50% ($250 maximum allowable per day)
Emergency services		
Professional services	$25 copayment	20%
Emergency room facility (deductible waived if admitted)	$100 deductible + 20%	
Urgent care facility (deductible waived if admitted)	$50 deductible + 20%	
Ambulance services (ground and air)[5]	$50 deductible + 20%	$50 deductible + 50%
Behavioral health services[5]		
Severe mental health (outpatient / inpatient)[6]	$25 copayment / $250 inpatient deductible per calendar year + 20%	50% / $250 inpatient deductible per calendar year + 50% ($600 maximum allowable per day)
Non-severe mental health (outpatient / inpatient)[7]	20% / 20%	50% / 50%
Acute care detoxification	20% (3 days per calendar year combined with PPO and OON)	50% ($175 maximum allowable per day)
Other services		
Durable medical equipment[5]	20% ($2,000 per calendar year combined with PPO and OON)	50%
Diabetic supplies	20%	50%
Chiropractic care	$25 copayment (12 visits per calendar year)	Not covered
Acupuncture	20% 12 visits per calendar year combined with PPO and OON, $25 maximum payable per visit)	50%
Prescription drug coverage[8]		
Deductible (per member, per calendar year)	$150 brand name	$100
Prescription drugs (up to a 30 day supply)	$15 Level I $30 Level II $50 Level III	50%

See footnotes on page 20.

PPO 30 (65T)		PPO 35 (71T)	
PPO[2]	**OON**[4]	**PPO**[2]	**OON**[4]
$500 single / 3 per family	$1,000 single / 3 per family	$1,000 single / 3 per family combined with PPO and OON	
$4,000 per member	$8,000 per member	$5,000 per member	$10,000 per member
$5,000,000 combined with PPO and OON		$5,000,000 combined with PPO and OON	
$30 copayment	50%	$35 copayment	50%
$30 copayment	Not covered	$35 copayment	Not covered
20%	Not covered	$35 copayment	Not covered
Not covered	Not covered	Not covered	Not covered
$30 copayment	50%	$35 copayment	50%
20%	50%	30%	50%
20% (12 visits per calendar year combined with PPO and OON)	50%	30% (12 visits per calendar year combined with PPO and OON)	50%
30%	50%	30%	50%
20% $250 inpatient deductible per calendar year	50% ($600 maximum allowable per day)	30% $250 inpatient deductible per calendar year	50% ($600 maximum allowable per day)
20%	50% (50% maximum allowable)	30%	50% (50% maximum allowable)
20% $250 deductible per calendar year	50% (50% maximum allowable)	30% $250 deductible per calendar year	50% (50% maximum allowable)
20% $250 inpatient deductible per calendar year (60 days per calendar year combined with PPO and OON)	50% ($250 maximum allowable per day)	30% $250 inpatient deductible per calendar year (60 days per calendar year combined with PPO and OON)	50% ($250 maximum allowable per day)
$30 copayment	20%	$35 copayment	30%
$100 deductible + 20%		$100 deductible + 30%	
$50 deductible + 20%		$50 deductible + 30%	
$50 deductible + 20%	$50 deductible + 50%	$50 deductible + 30%	$50 deductible + 50%
$30 copayment / $250 inpatient deductible per calendar year + 20%	50% / $250 inpatient deductible per calendar year + 50% ($600 maximum allowable per day)	$35 copayment / $250 inpatient deductible per calendar year + 30%	50% / $250 inpatient deductible per calendar year + 50% ($600 maximum allowable per day)
20% / 20%	50% / 50%	30% / 30%	50% / 50%
20% (3 days per calendar year combined with PPO and OON)	50% ($600 maximum allowable per day)	30% (3 days per calendar year combined with PPO and OON)	50% ($600 maximum allowable per day)
20% ($1,000 per calendar year combined with PPO and OON)	50%	30% ($1,000 per calendar year combined with PPO and OON)	50%
20%	50%	30%	50%
Not covered	Not covered	Not covered	Not covered
Not covered	Not covered	Not covered	Not covered
$150 brand name	$100	$150 brand name	$100
$15 Level I $30 Level II $50 Level III	50%	$10 Level I $30 Level II $50 Level III	50%

PPO

KEY BENEFITS[1]	PPO 40 (65U) PPO[2]	OON[4]
Deductible and plan maximums		
Annual deductible	No deductible	No deductible
Maximum out-of-pocket costs	$5,000 per member	$10,000 per member
Lifetime maximum	$5,000,000 combined with PPO and OON	
Professional services		
Office visit	$40 copayment	50%
Well-child care (though age 16), including child immunizations	$40 copayment	Not covered
Adult preventive care (age 17 and older)	$40 copayment	Not covered
Adult annual routine physical exam (age 17 and older)	Not Covered	Not covered
Specialist consultation	$40 copayment	50%
X-ray / Laboratory (includes mammograms)[5]	50%	50%
Rehabilitation therapy (includes physical, speech, occupational, cardiac and pulmonary rehabilitation therapy)	50% (12 visits per calendar year combined with PPO and OON)	50%
Self-injectables	30%	50%
Hospital services[5]		
Inpatient care	$500 per admission deductible + 50%	$500 per admission deductible + 50% ($600 maximum allowable per day)
Outpatient facility services	50%	50% (50% maximum allowable)
Outpatient surgery (hospital or outpatient surgery center charges only)	$350 deductible + 50%	$350 deductible + 50% (50% maximum allowable)
Skilled nursing facility	$500 per admission deductible + 50% (60 days per calendar year combined with PPO and OON)	$500 per admission deductible + 50% ($250 maximum allowable per day)
Emergency services		
Professional services	$40 copayment	50%
Emergency room facility (deductible waived if admitted)	$100 deductible + 50%	
Urgent care facility (deductible waived if admitted)	$50 deductible + 50%	
Ambulance services (ground and air)[5]	$50 deductible + 50%	
Behavioral health services[5]		
Severe mental health (outpatient / inpatient)[6]	$40 copayment / $500 per admission deductible + 50%	50% / $500 per admission deductible + 50% ($600 maximum allowable per day)
Non-severe mental health (outpatient / inpatient)[7]	50% / 50%	50% / 50%
Acute care detoxification	$500 per admission deductible + 50% (3 days per calendar year combined with PPO and OON)	$500 per admission deductible + 50% ($600 maximum allowable per day)
Other services		
Durable medical equipment[5]	50% ($1,000 per calendar year combined with PPO and OON)	50%
Diabetic supplies	20%	50%
Chiropractic care	Not covered	Not covered
Acupuncture	Not covered	Not covered
Prescription drug coverage[8]		
Deductible per covered person	$150 brand name	$100
Prescription drugs (up to a 30 day supply)	$15 Level I $30 Level II $50 Level III	50%

See footnotes on page 20.

PPO Catastrophic Saver (65V)		PPO 2000 HSA Compatible (65P)	
PPO[2]	**OON[4]**	**PPO[2]**	**OON[4]**
$500 single / 2 per family combined with PPO and OON		$2,000 single / $4,000 family combined with PPO and OON	
$5,000 per member	$10,000 per member	$4,000 single / $8,000 family combined with PPO and OON, includes deductible	
$5,000,000 combined with PPO and OON		$5,000,000 combined with PPO and OON	
$40 copayment[9]	50%[9]	30%	50%
$40 copayment	Not covered	$30 copayment	Not covered
$40 copayment	Not covered	$30 copayment	Not covered
Not Covered	Not covered	$30 copayment ($250 calendar year maximum payable)	Not covered
$40 copayment[9]	50%[9]	30%	50%
50%	50%	30%	50%
Not covered	Not covered	30% 12 visits per calendar year combined with PPO and OON	50%
50%	50%	30%	50%
50% $500 inpatient deductible per calendar year	50% ($600 maximum allowable per day)	30%	50% ($600 maximum allowable per day)
50%	50% (50% maximum allowable)	30%	50% (50% maximum allowable)
50%	50% (50% maximum allowable)	30%	50% (50% maximum allowable)
50% (90 days per calendar year combined with PPO and OON)	50% ($150 maximum allowable per day)	30% (60 days per calendar year combined with PPO and OON)	50% ($250 maximum allowable per day)
50%	50%	30%	50%
$100 deductible + 50%		30%	50%
$50 deductible + 50%		30%	50%
50%		30%	50%
$40 copayment[9] / 50% $500 inpatient deductible per calendar year	50%[9] / 50% ($600 maximum allowable per day)	30% / 30%	50% / 50% ($600 maximum allowable per day)
$40 copayment / 50% ($500 inpatient deductible per calendar year, limited to 20 visits per calendar year)	50% / 50%	Not covered	Not covered
50% $500 inpatient deductible per calendar year	50% ($600 maximum allowable per day)	30% (3 days per calendar year combined with PPO and OON)	50% ($600 maximum allowable per day)
50% ($1,000 per calendar year combined with PPO and OON)	50%	30% ($1,000 per calendar year combined with PPO and OON)	50%
20%	50%	20%	50%
Not covered	Not covered	Not covered	Not covered
Not covered	Not covered	Not covered	Not covered
No deductible	No deductible	Subject to annual deductible	
30% Level I 30% Level II Not covered Level III $500 maximum per calendar year combined with PPO and OON	50% Level I 50% Level II Not covered Level III	$15 Level I $30 Level II $50 Level III	50%

PPO

PPO

KEY BENEFITS[1]	PPO 3000 HSA Compatible (65Q)	
	PPO[2]	OON[4]
Deductible and plan maximums		
Annual deductible	$3,000 single / $6,000 family combined with PPO and OON	
Maximum out-of-pocket costs	$5,000 single / $10,000 family combined with PPO and OON, includes deductible	
Lifetime maximum	$5,000,000 combined with PPO and OON	
Professional services		
Office visit	30%	50%
Well-child care (though age 16), including child immunizations	$40 copayment	Not covered
Adult preventive care (age 17 and older)	$40 copayment	Not covered
Adult annual routine physical exam (age 17 and older)	$40 copayment ($250 calendar year maximum payable)	Not covered
Specialist consultation	30%	50%
X-ray / Laboratory (includes mammograms)[5]	30%	50%
Rehabilitation therapy (includes physical, speech, occupational, cardiac and pulmonary rehabilitation therapy)	30% (12 visits per calendar year combined with PPO and OON)	50%
Self-injectables	30%	50%
Hospital services[5]		
Inpatient care	30%	50% ($600 maximum allowable per day)
Outpatient facility services	30%	50% (50% maximum allowable)
Outpatient surgery (hospital or outpatient surgery center charges only)	30%	50% (50% maximum allowable)
Skilled nursing facility	30% (60 days per calendar year combined with PPO and OON)	50% ($250 maximum allowable per day)
Emergency services		
Professional services	30%	50%
Emergency room facility	30%	50%
Urgent care facility	30%	50%
Ambulance services (ground and air)[5]	30%	50%
Behavioral health services[5]		
Severe mental health (outpatient / inpatient)[6]	30% / 30%	50% / 50% ($600 maximum allowable per day)
Non-severe mental health (outpatient / inpatient)[7]	Not covered	Not covered
Acute care detoxification	30% (3 days per calendar year combined with PPO and OON)	50% ($600 maximum allowable per day)
Other services		
Durable medical equipment[5]	30% ($1,000 per calendar year combined with PPO and OON)	50%
Diabetic supplies	20%	50%
Chiropractic care	Not covered	Not covered
Acupuncture	Not covered	Not covered
Prescription drug coverage[8]		
Deductible (per person, per calendar year)	Subject to annual deductible	
Prescription drugs (up to a 30 day supply)	$15 Level I $30 Level II $50 Level III	50%

See footnotes on page 20.

FLEX NET

KEY BENEFITS[1]	Flex Net Fee-for-Service (22A)[2]
Plan maximums	
Annual deductible	$300 single / $900 family
Maximum out-of-pocket costs	$1,500 single / $4,500 family
Lifetime maximum	$1,000,000
Professional services	
Office visit	20%
Well-Child care (though age 17), including child immunizations	20%
Adult Preventive Care (age 18 and older)	20%
Adult annual routine physical exam (age 18 and older)	Not covered
Specialist consultation	20%
X-ray / Laboratory (includes mammograms)[3]	20%
Rehabilitation therapy (includes physical, speech, occupational, cardiac and pulmonary rehabilitation therapy)	20% (60 visits per calendar year)
Self-injectables	20%
Hospital services[3]	
Inpatient care	20%
Outpatient facility services	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)	20%
Behavioral health services[3]	
Severe mental health (outpatient / inpatient)[4]	20% / 20%
Non-severe mental health (outpatient / inpatient)	50% (20 visits per calendar year, $50 maximum payable per visit) / 50% (30 days per calendar year)
Acute care detoxification	50% (3 days per calendar year)
Other services	
Durable medical equipment[3]	20%
Diabetic supplies	20%
Chiropractic care	20% (15 visits per calendar year, $25 maximum payable per visit)
Acupuncture	Not covered
Prescription drug coverage	
Deductible (per member, per calendar year)	$75
Prescription drugs (up to a 30 day supply)	20%

SALUD CON HEALTH NET

KEY BENEFITS[1]	Salud HMO y más (191)		
	SIMNSA Network (Mexico members)	Salud Network (California members)	SIMNSA Network (self referral for California members)
Plan maximums			
Maximum out-of-pocket costs	$1,500 single / $3,000 two party / $4,500 family		
Lifetime maximum	No maximum		
Professional services			
Office visit	$5 copayment	$15 copayment	$5 copayment
Periodic health evaluation including newborn, well-baby care, and immunizations (birth through age 17)	No charge	No charge	No charge
Periodic health evaluations including well woman exam (age 18 and older)	No charge	$15 copayment	No charge
Specialist consultation	$5 copayment	$15 copayment	$5 copayment
X-ray / Laboratory (includes mammograms)	No charge	No charge	No charge
Rehabilitation therapy (includes physical, speech, occupational, cardiac and pulmonary rehabilitation therapy)	$5 copayment	$15 copayment	$5 copayment
Self-injectables	No charge	No charge	No charge
Hospital services			
Inpatient care	No charge	$250 per admission copayment	No charge
Outpatient facility services	No charge	20%	No charge
Outpatient surgery (hospital or outpatient surgery center charges only)	No charge	20%	No charge
Skilled nursing facility	No charge 100 days per calendar year combined with SIMNSA (Mexico), and Salud (California)	20%	No charge (100 days per calendar year)
Emergency services			
Professional services	No charge	No charge	No charge
Emergency room facility	$10 copayment	$50 copayment	$10 copayment
Urgent care facility	$10 copayment	$15 copayment	$10 copayment
Ambulance services (ground and air)	No charge	$50 copayment	No charge
Behavioral health services			
Severe mental health (outpatient / inpatient)	$5 copayment[2] / No charge[2]	$15 copayment[3] / No charge[3]	$5 copayment[2] / No charge[2]
Non-severe mental health (outpatient / inpatient)	$5 copayment[2] (20 visits per calendar year) / No charge (20 days per calendar year)[2]	$15 copayment[3] / No charge[3]	$5 copayment[2] (20 visits per calendar year) / No charge (20 days per calendar year)[2]
Acute care detoxification	20%[2]	No charge[3]	20%[2]
Other services			
Durable medical equipment	No charge	No charge	No charge
Diabetic supplies	No charge	No charge	No charge
Acupuncture, Chiropractic care[4]	Optional rider available	Optional rider available	Optional rider available
Prescription drug coverage			
Brand name deductible (per member, per calendar year)	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

See footnotes on page 20.

Salud Mexico HMO (35W) SIMNSA Network only
$1,500 single / $3,000 two party / $4,500 family
No maximum
$5 copayment
No charge
No charge
$5 copayment
No charge
$5 copayment
No charge
No charge
No charge
No charge
No charge 100 days per calendar year
No charge
$10 copayment (in Mexico), $50 copayment (outside Mexico)
$10 copayment
No charge (air ambulance not covered)
$5 copayment[2] / No charge[2]
$5 copayment[2] (20 visits per calendar year) / No charge (20 days per calendar year)
20%
No charge
No charge
Not covered
No deductible
$5 copayment

SALUD CON HEALTH NET

KEY BENEFITS[1]	Salud EPO Primero (46C) SIMNSA Network	Salud EPO Primero (46C) Salud Network
Plan maximums		
Maximum out-of-pocket costs	Not applicable	$1,500 single / $4,500 family
Lifetime maximum	No maximum	$5,000,000
Professional services		
Office visit	$5 copayment	$15 copayment
Periodic health evaluation including newborn, well-baby care, and immunizations (birth through age 17)	No charge	No charge
Periodic health evaluations including well woman exam (age 18 and older)	No charge	$15 copayment
Specialist consultation	$5 copayment	$35 copayment
X-ray/Laboratory (includes mammograms)[7]	No charge	No charge
Rehabilitation therapy (includes physical, speech, occupational, cardiac and pulmonary rehabilitation therapy)	$5 copayment	$15 copayment
Self-injectables	No charge	No charge
Hospital services[7]		
Inpatient care	No charge	$250 per admission deductible
Outpatient facility services	No charge	20%
Outpatient surgery (hospital or outpatient surgery center charges only)	No charge	20%
Skilled nursing facility	Not covered	20% (100 days per calendar year)
Emergency services		
Professional services	No charge	No charge
Emergency room facility (copayment waived if admitted)	$10 copayment	$100 copayment
Urgent care facility (copayment waived if admitted)	$10 copayment	$15 copayment
Ambulance services (ground and air)	No charge (air not covered)	$50 copayment
Behavioral health services[7]		
Severe mental health (outpatient/inpatient)	$5 copayment[2] / No charge[2]	$15 copayment[3] / $250 per admission deductible[3]
Non-severe mental health (outpatient/inpatient)	$5 copayment[2] / No charge[2] 20 visits (outpatient) / 20 days (inpatient) per calendar year combined with SIMNSA and Salud	$15 copayment[3] / $250 per admission deductible[3]
Acute care detoxification	No charge[2] 3 days per calendar year combined with SIMNSA and Salud	$250 per admission deductible[3]
Other services		
Durable medical equipment[7]	No charge	No charge
Diabetic supplies	No charge	No charge
Acupuncture, Chiropractic care	Not covered	Not covered
Prescription drug coverage		
Prescription drugs (up to a 30 day supply)	$5 Level I $5 Level II Not covered Level III	$10 Level I $35 Level II 50% Level III

See footnotes on page 20.

KEY BENEFITS[1]	Salud PPO (11D) SIMNSA Network[6]	Salud Network	OON[5,6]
Deductible and plan maximums			
Annual deductible	No deductible	$100 single / 2 per family	$1,000 single / 2 per family
Maximum out-of-pocket costs	$1,000 single $2,000 family	$2,000 single $4,000 family	$10,000 single $10,000 family
Lifetime maximum	$5,000,000 combined with SIMNSA, Salud, and OON		
Professional services			
Office visit	$5 copayment	$15 copayment	50%
Well-Child care (though age 17, including child immunizations)	$5 copayment	$15 copayment	50%
Adult Preventive Care (age 18 and older)	$5 copayment	$15 copayment	50%
Adult annual routine physical exam (age 18 and older)	Not covered	Not covered	Not covered
Specialist consultation	$5 copayment	$15 copayment	50%
X-ray/Laboratory (includes mammograms)[7]	10%	20%	50%
Rehabilitation therapy (includes physical, speech, occupational, cardiac and pulmonary rehabilitation therapy)	10%	20%	50% ($25 maximum per visit) (12 visits per calendar year combined with Salud and OON)
Self-injectables[7]	$5 copayment	$15 copayment	50%
Hospital services[7]			
Inpatient care	10%	$250 per admission deductible + 20%	$250 per admission deductible + 50% ($380 maximum per day)
Outpatient facility services	10%	$250 deductible + 20%	$250 deductible + 50%
Outpatient surgery (hospital or outpatient surgery center charges only)	10%	$250 deductible + 20%	$250 deductible + 50%
Skilled nursing facility	Not covered	$250 deductible + 20%	$250 deductible + 50% ($150 maximum allowable per day) (100 days calendar year maximum combined with Salud and OON)
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)	$20 deductible + 10% (air not covered)	$50 deductible + 20%	50%
Behavioral health services[7]			
Severe mental health (outpatient/inpatient)	$5 copayment[2] / 10%[2]	$15 copayment[3] / $250 per admission deductible + 20%[3]	50% / $250 per admission deductible + 50% ($380 maximum allowable per day)
Non-severe mental health (outpatient/inpatient)	$5 copayment + 10%[2] / 10%[2]	$30 copayment + 20%[3] / $250 per admission deductible + 20%[3] ($250 maximum allowable per day)	$30 copayment + 50% / $250 per admission deductible + 50% ($250 maximum allowable per day) 20 visits per calendar year / 20 days per calendar year (combined with Salud and OON)
Acute care detoxification	10%[2]	$250 per admission deductible + 20%[4]	$250 per admission deductible + 50% ($380 maximum allowable per day) 3 days per calendar year combined with Salud and OON
Other services			
Durable medical equipment[7]	10%	20%	50%
Diabetic supplies	10%	20%	50%
Acupuncture and Chiropractic care	Not covered	Not covered	Not covered
Prescription drug coverage			
Prescription drugs dispensed by SIMNSA	$5 copayment	Not applicable	Not applicable
Prescription drugs dispensed by Health Net participating pharmacy	Not applicable Not applicable Not applicable	$10 Level I $35 Level II 50% Level III	Not covered Not covered Not covered

FOOTNOTES

HMO

[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 for HMO 10; HMO Xtra Value 20 requires a $150 copayment; HMO Xtra Value 40 requires a $250 copayment.
[3] 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.
[4] All Mental Health and chemical dependency services are provided or contracted through Managed Health Network (MHN). Please contact MHN for details.
[5] The HMO Silver Network is an affordable network alternative offered in all or parts of Los Angeles, Orange, San Francisco, San Diego, Ventura, Kern, Riverside, and San Bernardino counties. Ask your employer if this network is available to you.
[6] Chiropractic 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.

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] Under ELECT Open Access, inpatient hospital and professional services and durable medical equipment are covered when provided or coordinated by the Primary Care Physician only and approved by the PPG/IPA. Inpatient care and outpatient services are not covered on the PPO level.
[3] 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.
[4] All Mental Health and chemical dependency services are provided or contracted through Managed Health Network (MHN). Please contact MHN for details.
[5] Chiropractic 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.
[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.

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] Percentage is a portion of the covered expense based on (C & R) Customary & Reasonable. You are also responsible for any charges in excess of the covered expense.
[4] All Mental Health and chemical dependency services are provided or contracted through Managed Health Network (MHN). Please contact MHN for details.
[5] Chiropractic rider coverage is available as an optional benefit with the POS 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] For POS 30, the 50% coinsurance will apply towards the member’s out-of-pocket maximum.
[8] These services require prior certification. If prior certification is not acquired, benefits are reduced to 50%.

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] Coinsurance is based on Customary & Reasonable (C & R). Our determination of the C & R charge is based upon data provided be Ingenix, Inc., calculated at the 85th percentile. The member is responsible for charges in excess of C & R charges in addition to the coinsurance shown.
[4] 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.
[5] These services require prior certification. If prior certification is not acquired benefits are reduced to 50%.
[6] The following conditions are considered severe mental illnesses: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorders, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa, serious emotional disturbances of children under age 18. Refer to your Plan Documents for other mental health services.
[7] For the PPO 10 and PPO 15 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 amount 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 all other PPO plans 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 amount of $175 each day. Outpatient care for non-severe mental illness and outpatient chemical dependency rehabilitation is limited to 20 visits for each member in a calendar year through PPO and OON combined. The maximum amount payable for each visit is $25.

[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 plan subscriber and spouse are limited to 4 visits. Dependent children are limited to 8 visits. The visit limitation applies to visits to physician, specialist consultations, including second surgical opinion, and to outpatient mental health visits for severe and non-severe illnesses.

FLEX NET

[1] This is a summary of plan benefits. Please refer to the Plan Documents for more details.All forms, brochures and current standard rates are available online for print. Flex Net is only available to OOA subscribers, subject to standard OOA guidelines. Health Net must be the sole carrier.
[2] Percentage is a portion of the covered expense based on (C & R) Customary & Reasonable. You are also responsible for any charges in excess of the covered expense.
[3] These services require prior certification. If prior certification is not acquired benefits are reduced to 50%.
[4] The following conditions are considered severe mental illnesses: schizophrenia,schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorders, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa, serious emotional disturbances of children under age 18. Refer to your Plan Documents for other mental health services.

SALUD CON HEALTH NET

[1] This is a summary of your benefits. It does not include all services, limitations, or exclusions. Please refer to the Evidence of Coverage Policy / Certificate for terms and conditions of coverage.
[2] Mental health and substance abuse services must be provided by a SIMNSA provider.
[3] Administered through Managed Health Network (MHN). The following conditions are considered server mental illnesses: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorders, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa, serious emotional disturbances of children under the age of 18. Refer to your Plan Documents for other mental health services.
[4] Chiropractic rider coverage is available as an optional benefit with all HMO plans shown above. Benefits of the Health Net's chiropractic coverage include $10 per visit copayment and up to 20 visits per calendar year.
[5] 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.
[6] Out-of-Network providers, facilities or pharmacies in Mexico are not covered by this plan.
[7] These services require prior certification. If prior certification is not acquired benefits are reduced to 50%.

Contact us

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

Small Business Group
Sales and Service 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

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