

# SUMMARY OF BENEFITS

HMO 5 \$20 / \$40 / \$500 / 10%

BENEFITS	MEMBER PAYS
<b>DEDUCTIBLE</b> per calendar year	\$500 Single / \$1,000 Family
<b>COINSURANCE</b>	Subject to applicable coinsurance amounts, as stated herein
<b>OUT-OF-POCKET MAXIMUM</b> excluding deductible	\$3,000 Single / \$6,000 Family coinsurance only
<b>LIFETIME MAXIMUM BENEFITS</b>	Unlimited
<b>OFFICE VISITS</b>	
Primary Care Physician (PCP)	\$20 Copay / Visit
Specialist Physician	\$40 Copay / Visit
OB/GYN	\$20 Copay / Visit
Prenatal Care and Post-Partum Care - copay waived after diagnosis of pregnancy is confirmed	\$20 Copay PCP, \$40 Copay Specialist
Preventive care - preventive office visits, preventive lab and X-ray, Pap smear and mammogram, prostate screening, immunizations, colorectal cancer screening (including, but not limited to colonoscopy), vision and hearing screenings	\$0 Copay PCP, \$0 Copay Specialist
<b>EMERGENCY AND URGENT CARE SERVICES</b>	
Emergency Room	\$250 Copay / Visit
Urgent Care	\$50 Copay / Visit
In Store Health care Clinic	\$20 Copay / Visit
Ambulance	No Charge
<b>HOSPITAL SERVICES</b>	
Inpatient Hospital	10%, After Deductible
Outpatient Hospital and Surgical	\$250 Copay / Visit
<b>CHIROPRACTIC</b>	\$40 Copay / Visit
Limit	Max. 12 Visits / Calendar Year
<b>LAB &amp; X-RAY SERVICES</b>	
At Physician's Office or Independent, Non-Hospital Affiliated Facility*	No Charge
At Hospital	No Charge
<b>IMAGING &amp; TESTING SERVICES</b> including but not limited to MRIs, MRAs and PET/SPECT scans	
At Physician's Office or Independent, Non-Hospital Affiliated Facility*	\$50 Copay / Visit
At Hospital	\$250 Copay / Visit
<b>MAMMOGRAPHY</b>	No Charge
<b>ALLERGY TESTING</b>	Copay waived for routine allergy injections received in the physician's office when performed by non-physician personnel. Office visit copay or coinsurance applies.
<b>DURABLE MEDICAL EQUIPMENT (DME)</b>	20%, After Deductible
Limit	Max. 1 Standard Size Manual Wheelchair / Member / Lifetime
<b>PROSTHETIC SERVICES</b>	20%, After Deductible
Limit	Max. 1 Mastectomy Bra / Member / Lifetime

BENEFITS	MEMBER PAYS
<b>EYE EXAMS</b>	No Charge, every 24 months
<b>HOME HEALTH CARE SERVICES</b> Limit	No Charge Limited to part-time and intermittent care. Up to 21 days or longer when preauthorized.
<b>HOSPICE CARE SERVICES</b>	10%, After Deductible
<b>MENTAL HEALTH</b>  <b>INPATIENT</b> Inpatient Limit  <b>OUTPATIENT</b> Outpatient Limit	10%, After Deductible Max. 30 Day(s) / Calendar Year  \$40 Copay / Visit Max. 20 Visits / Calendar Year
<b>REHABILITATIVE SERVICES - including but not limited to physical, occupational and speech therapy</b>  <b>INPATIENT</b>  <b>OUTPATIENT</b> Inpatient/Outpatient Combined Limit	10%, After Deductible  \$40 Copay / Visit Max. 60 Days / Calendar Year, All Therapies Combined physical, occupational, speech and language, etc.
<b>SKILLED NURSING FACILITY</b> Limit	10%, After Deductible Max. 100 Days / Calendar Year
<b>SUBSTANCE ABUSE</b>  <b>INPATIENT - DETOX ONLY</b>  <b>OUTPATIENT - DETOX ONLY</b> Inpatient/Outpatient Combined Limit	10%, After Deductible  No Charge Max. 2 Short Term Treatment Programs / Member / Lifetime

**This is a brief summary only. For benefit details, refer to your Schedule of Benefits or Evidence of Coverage.**

\*Some facilities are affiliated with a hospital. You will be charged a higher copay for services at a hospital affiliated facility. Contact the place of service for more information or the Customer Contact Center at the number on the back of your ID card.

Prior authorization is the standard industry process of receiving approval for certain procedures and medical services within an HMO plan. Your PCP or specialist obtains this on your behalf. Locally staffed medical professionals answer calls to the Health Net prior authorization unit 24/7, 365 days a year.

Emergency Services means health care services that are provided to a Member in a licensed medical Facility by a Provider after the recent onset of a medical condition that manifests itself by symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in any of the following: serious jeopardy to the patient's health, serious impairment to bodily functions, serious dysfunction of any bodily organ or part.

**Exclusions and Limitations:**

The following services and/or procedures are either limited in coverage or excluded from coverage under this health plan: convenience items, cosmetic surgery, court ordered care, custodial care, employment counseling, exercise programs, experimental/investigational procedures and medications, foot orthotics, fraudulent services, gender alterations, household equipment/fixtures, infertility, long-term rehabilitative services, lost wages, missed appointments, obesity, paternity testing, radial keratotomy, routine foot care, self-inflicted injuries, temporomandibular joint disorder, thermography, and vocational programs.

In Arizona, benefits are insured and/or administered by Health Net of Arizona, Inc. for HMO plans and Health Net Life Insurance Company for Indemnity plans and life insurance coverage. The Health Net of Arizona, Inc. service area includes all Arizona counties. Participating providers are neither agents nor employees of Health Net of Arizona, but are independently contracted entities that are legally responsible for their own care, treatment and other services provided to Health Net members.