

SUMMARY OF BENEFITS

This is a brief summary only. For benefit details, refer to your Schedule of Benefits or Certificate of Insurance.

BENEFITS	IN-NETWORK MEMBER PAYS	OUT-OF-NETWORK MEMBER PAYS
DEDUCTIBLE per calendar year	\$500 Single / \$1,000 Family	\$1,000 Single / \$2,000 Family
COINSURANCE	50%	50%
OUT-OF-POCKET MAXIMUM excluding deductible	\$4,000 Single / \$8,000 Family	\$8,000 Single / \$16,000 Family
MAXIMUM BENEFITS	\$5,000,000 / Lifetime	
OFFICE VISITS		
Personal Care Physician (PCP)	\$25 Copay / Visit	50%, Subject to Deductible
Specialist Physician	\$50 Copay / Visit	50%, Subject to Deductible
OB/GYN	\$25 Copay / Visit	50%, Subject to Deductible
Prenatal Care and Post-Partum Care	\$25 Copay PCP / \$50 Copay Specialist	50%, Subject to Deductible
Preventive Care (routine physicals, annual GYN exams, well-baby care, immunizations, and vision and hearing screenings)	\$25 Copay PCP / \$50 Copay Specialist	50%, Subject to Deductible
EMERGENCY AND URGENT CARE SERVICES		
Emergency Room	\$250 Copay / Visit	\$250 Copay / Visit
Urgent Care	\$50 Copay / Visit	50%, Subject to Deductible
Ambulance	50%	50%
HOSPITAL SERVICES		
Inpatient Hospital	50%, Subject to Deductible	50%, Subject to Deductible
Outpatient Hospital and Surgical	50%, Subject to Deductible	50%, Subject to Deductible
LAB & X-RAY SERVICES		
At Physician's Office or Independent, Non-Hospital Affiliated Facility*	No Charge	50%, Subject to Deductible
At Hospital	50%, Subject to Deductible	50%, Subject to Deductible
IMAGING & TESTING SERVICES (including but not limited to MRIs, MRAs and PET/SPECT scans)		
At Physician's Office or Independent, Non-Hospital Affiliated Facility*	50%, Subject to Deductible	50%, Subject to Deductible
At Hospital	50%, Subject to Deductible	50%, Subject to Deductible
MAMMOGRAPHY	No Charge	50%, Subject to Deductible
ALLERGY TESTING	Copay waived for routine allergy injections received in the physician office when performed by non-physician personnel. Office visit copay or coinsurance applies.	50%, Subject to Deductible
DURABLE MEDICAL EQUIPMENT (DME)	50%, Subject to Deductible	50%, Subject to Deductible
Limit (in-network and out-of-network combined)	DME and Prosthetic Combined Max. Benefit \$2,500 / Calendar Year	DME and Prosthetic Combined Max. Benefit \$2,500 / Calendar Year
PROSTHETIC SERVICES	50%, Subject to Deductible	50%, Subject to Deductible
Limit (in-network and out-of-network combined)	DME and Prosthetic Combined Max. Benefit \$2,500 / Calendar Year	DME and Prosthetic Combined Max. Benefit \$2,500 / Calendar Year
HOME HEALTH CARE SERVICES	50%, Subject to Deductible	50%, Subject to Deductible
Limit (in-network and out-of-network combined)	Limited to part-time and intermittent care. Up to 21 days or longer when preauthorized.	Limited to part-time and intermittent care. Up to 21 days or longer when preauthorized.
HOSPICE CARE SERVICES	50%, Subject to Deductible	50%, Subject to Deductible
Limit (in-network and out-of-network combined)	Bereavement counseling limited to 15 visits.	Bereavement counseling limited to 15 visits.

BENEFITS	IN-NETWORK MEMBER PAYS	OUT-OF-NETWORK MEMBER PAYS
MENTAL HEALTH		
INPATIENT Inpatient Limit (in-network and out-of-network combined)	50%, Subject to Deductible Max. 30 Days / Calendar Year	50%, Subject to Deductible Max. 30 Days / Calendar Year
OUTPATIENT Outpatient Limit (in-network and out-of-network combined)	\$25 Copay / Individual Visit, \$12.50 Copay / Group Visit Max. 20 Visits / Calendar Year	50%, Subject to Deductible Max. 20 Visits / Calendar Year
REHABILITATIVE SERVICES		
INPATIENT	50%, Subject to Deductible	50%, Subject to Deductible
OUTPATIENT Inpatient/Outpatient Limit (in-network and out-of-network combined)	50%, Subject to Deductible Max. 60 Days / Calendar Year, All Therapies Combined	50%, Subject to Deductible Max. 60 Days / Calendar Year, All Therapies Combined
SKILLED NURSING FACILITY		
Limit	50%, Subject to Deductible Max. 100 Days / Calendar Year	50%, Subject to Deductible Max. 100 Days / Calendar Year
SUBSTANCE ABUSE - DETOX ONLY		
INPATIENT	50%, Subject to Deductible	50%, Subject to Deductible
OUTPATIENT Outpatient Limit (in-network and out-of-network combined)	50%, Subject to Deductible Max. 30 Visits / Calendar Year	50%, Subject to Deductible Max. 30 Visits / Calendar Year

*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.

Personal Care Physicians include doctors practicing in the areas of family practice, general practice, internal medicine and pediatrics. Obstetricians may also act as Personal Care Physicians during pregnancy and post-partum periods.

Pre-certification is the standard industry process of receiving approval for certain procedures and medical services within a PPO plan. Ensuring that pre-certification has been acquired is the member's responsibility. Your physician may obtain this on your behalf, but we encourage you to call the number on the back of your Health Net ID card to confirm if pre-certification has been obtained, when required. Failure to obtain pre-certification will result in a reduction of benefits.

Exclusions and limitations:

The following cannot be used to satisfy the OOP Maximum: mental health, substance abuse, prescription drugs, limitations, exclusions, infertility, use of emergency room services for non-emergency care, copayments as a result of failure to obtain precertification, and charges in excess of eligible expenses.

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, travel expenses, vocational programs.

Pre-Existing Condition Limitations: Expenses for conditions for which a member received any medical advice, diagnosis or treatment during the six (6) month period immediately preceding the member's effective date of coverage will be excluded from coverage. This limitation will be waived once the member has been covered on the plan for 12 consecutive months. Any pre-existing condition exclusion period shall be reduced by any prior "creditable coverage," provided there was no break in coverage exceeding 63 days. Refer to the Certificate of Insurance for a definition of "creditable coverage."

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 member.

