

PLAN OVERVIEW NG

Standard HSA 4000 1FJ

	INSURED PERSON(S) RESPONSIBILITY	
	PPO ¹	OUT-OF-NETWORK ²
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.)	\$4,000 single (Employee-only coverage) / \$8,000 family (Employee and dependent coverage)	
Out-of-pocket maximum (includes calendar year deductible)	\$5,950 single (Employee-only coverage) / \$11,900 family (Employee and dependent coverage)	\$10,000 single (Employee-only coverage) / \$20,000 family (Employee and dependent coverage)
Lifetime benefit maximum	No maximum	
PROFESSIONAL SERVICES		
Office visit (including specialist consultation)	\$0 copayment (deductible not waived)	50%
Preventive care services ³	Covered in full	Not covered
X-ray and laboratory procedures ⁴	0%	50%
Rehabilitation therapy ⁵	0%	50% (12 visits per calendar year combined with PPO and OON)
HOSPITAL SERVICES⁴		
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%	50% (\$250 maximum allowable per day)
EMERGENCY SERVICES		
Professional services	\$0 copayment (deductible not waived)	
Emergency room facility (copayment waived if admitted)	0%	
Urgent care facility	0%	
Ambulance services (ground and air) ⁴	0%	50%
BEHAVIORAL MENTAL HEALTH⁴		
Severe mental health (outpatient/inpatient)	0%	50% (\$600 maximum allowable per day)
Non-severe mental health (outpatient/inpatient) ⁶	0%	50%
Chemical dependency rehabilitation (outpatient/inpatient) ⁶	0%	50%
Acute care detoxification	0%	50% (\$250 maximum amount allowable per day)
OTHER SERVICES		
Durable medical equipment ⁴	0%	50% (\$2,000 maximum per calendar year combined with PPO and OON)
Orthotics and prosthetics ⁴	0%	50%
Diabetic equipment	0%	50%
Acupuncture	0%	50% (12 visits per calendar year combined with PPO and OON, \$25 maximum payable per visit)
Chiropractic services	\$0 copayment (deductible not waived, 12 visits per calendar year)	Not covered
PRESCRIPTION DRUG COVERAGE⁷		
Calendar year deductible (per insured)	Subject to annual deductible	
Prescription drugs (up to a 30-day supply) ⁸	\$10/\$25/\$50	50%
Specialty drugs (most self-injectables)	30%	Not covered

(continued)

This is a summary of benefits. It does not include all services, limitations or exclusions. Please refer to the Certificate of Insurance for terms and conditions of coverage. PPO and Flex Net insurance plans underwritten by Health Net Life Insurance Company.

- ¹ Insured pays the negotiated rate, which is the rate participating or preferred providers have agreed to accept for providing a covered service.
- ² Please refer to the Certificate of Insurance (COI) for out-of-network reimbursement methodology.
- ³ Includes annual preventive physical, newborn and well child care, well woman exams, preventive lab and X-ray services.
- 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 Inpatient care for non-severe mental illness and inpatient chemical dependency rehabilitation is limited to a maximum allowable of \$250 each day. Outpatient care for non-severe mental illness and outpatient chemical dependency rehabilitation has a maximum amount payable of \$25 per visit.
- ⁷ Prescription drugs filled through mail order (up to a 90-day supply). For details regarding a specific drug, go to www.healthnet.com.
- ⁸ The three prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary.