

# PLAN OVERVIEW NG

## Standard PPO 40 (1FR)

	INSURED PERSON(S) RESPONSIBILITY	
	PPO <sup>1</sup>	OUT-OF-NETWORK <sup>2</sup>
<b>PLAN MAXIMUMS</b>		
Calendar year deductible	\$500 single / \$1,000 family	\$1,000 single / \$2,000 family
Out-of-pocket maximum (does not include calendar year deductible)	\$5,000 single/ 2 per family	\$10,000 single/ 2 per family
Lifetime benefit maximum	No maximum	
<b>PROFESSIONAL SERVICES</b>		
Office visit (including specialist consultation)	\$40 copayment	50%
Preventive care services <sup>3</sup>	Covered in full	Not covered
X-ray and laboratory procedures <sup>4</sup>	40%	50%
Rehabilitation therapy <sup>5</sup>	40%	50% (12 visits per calendar year combined with PPO and OON)
<b>HOSPITAL SERVICES<sup>4</sup></b>		
Inpatient hospital facility services (includes maternity)	40%	50% (\$600 maximum allowable per day) (\$500 deductible per calendar year combined with PPO and OON) <sup>6</sup>
Outpatient facility services (other than surgery)	40%	50% (50% maximum allowable)
Outpatient surgery (hospital or outpatient surgery center charges only)	40%	50% (50% maximum allowable) (\$250 deductible per calendar year combined with PPO and OON) <sup>7</sup>
Skilled nursing facility	40%	50% (\$250 maximum allowable per day) (\$500 deductible per calendar year combined with PPO and OON) <sup>6</sup>
<b>EMERGENCY SERVICES</b>		
Professional services	\$40 copayment	
Emergency room facility (copayment waived if admitted)	\$100 copayment + 40%	
Urgent care facility	\$50 copayment + 40%	
Ambulance services (ground and air) <sup>4</sup>	\$50 copayment + 40%	\$50 copayment + 50%
<b>BEHAVIORAL MENTAL HEALTH<sup>4</sup></b>		
Severe mental health (outpatient/inpatient)	\$40 copayment/40%	50%/50% (\$600 maximum allowable per day) (\$500 deductible per calendar year combined with PPO and OON) <sup>6</sup>
Non-severe mental health (outpatient/inpatient) <sup>8</sup>	40%	50%
Chemical dependency rehabilitation (outpatient/inpatient) <sup>8</sup>	40%	50%
Acute care detoxification	40%	50% (\$250 maximum amount allowable/day combined with PPO and OON)
<b>OTHER SERVICES</b>		
Durable medical equipment <sup>4</sup>	40%	50% (\$1,000 maximum per calendar year combined with PPO and OON)
Orthotics and prosthetics <sup>4</sup>	40%	50%
Diabetic equipment	40%	50%
Acupuncture	40%	50% (12 visits per calendar year combined with PPO and OON, \$25 maximum payable per visit)
Chiropractic services	\$40 copayment (12 visits per calendar year)	Not covered
<b>PRESCRIPTION DRUG COVERAGE<sup>9</sup></b>		
Calendar year deductible (per insured)	No deductible	\$100
Prescription drugs (up to a 30-day supply) <sup>10</sup>	\$15/\$30/\$50	50%
Specialty drugs (most self-injectables)	30% (\$250 copayment maximum per prescription)	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.

- <sup>1</sup> Insured pays the negotiated rate, which is the rate participating or preferred providers have agreed to accept for providing a covered service.
- <sup>2</sup> Please refer to the Certificate of Insurance (COI) for out-of-network reimbursement methodology.
- <sup>3</sup> Includes annual preventive physical, newborn and well child care, well woman exams, preventive lab and X-ray services.
- <sup>4</sup> Some services require prior certification. If prior certification is not acquired, benefits are reduced to 50%.
- <sup>5</sup> Includes physical, speech, occupational, cardiac and pulmonary rehabilitation therapy.
- <sup>6</sup> This deductible is only required for the first inpatient hospital or skilled nursing facility admission each calendar year. The deductible does not apply to inpatient detoxification or to inpatient care for non-severe mental illness. Once the deductible is satisfied, no deductible is required for subsequent admissions in the same calendar year. This deductible is in addition to the plan calendar year deductible and applies to the OOPM.
- <sup>7</sup> Once the outpatient surgery deductible is satisfied, no deductible is required for subsequent outpatient surgeries in the same calendar year. This deductible is in addition to the plan calendar year deductible and applies to the OOPM.
- <sup>8</sup> 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.
- <sup>9</sup> 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](http://www.healthnet.com).
- <sup>10</sup> The three prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary.