

# PLAN OVERVIEW NG

## *HRA 5000 1FM*

	INSURED PERSON(S) RESPONSIBILITY	
	PPO <sup>1</sup>	OUT-OF-NETWORK <sup>2</sup>
<b>PLAN MAXIMUMS</b>		
Calendar year deductible (For family coverage, the enrolled employee and dependents must collectively pay the family amount before Health Net begins to pay.)	\$5,000 single (employee-only coverage) / \$10,000 family (employee and dependent coverage)	
Out-of-pocket maximum (includes deductibles, coinsurance and copayments)	\$6,000 single (employee-only coverage) / \$12,000 family (employee and dependent coverage)	
Lifetime benefit maximum	No maximum	
<b>PROFESSIONAL SERVICES</b>		
Office visit (including specialist consultation)	Not covered	Not covered
Preventive care services <sup>3</sup>	Covered in full	Not covered
X-ray and laboratory procedures <sup>4</sup>	20%	40%
Rehabilitation therapy <sup>5</sup>	20%	40%
	(12 visits per calendar year combined with PPO and OON)	
<b>HOSPITAL SERVICES<sup>4</sup></b>		
Inpatient hospital facility services (includes maternity)	20%	40% (\$600 maximum allowable per day)
Outpatient facility services (other than surgery)	20%	40% (50% maximum allowable)
Outpatient surgery (hospital or outpatient surgery center charges only)	20%	40% (50% maximum allowable)
Skilled nursing facility	20%	40% (\$250 maximum allowable per day)
<b>EMERGENCY SERVICES</b>		
Professional services	\$10 copayment (deductible not waived)	
Emergency room facility (copayment waived if admitted)	\$100 copayment + 20%	
Urgent care facility	\$50 copayment + 20%	
Ambulance services (ground and air) <sup>4</sup>	\$50 copayment + 20%	\$50 copayment + 40%
<b>BEHAVIORAL MENTAL HEALTH<sup>4</sup></b>		
Severe mental health (outpatient/inpatient)	20%	Not covered
Non-severe mental health (outpatient/inpatient) <sup>6</sup>	20%	Not covered
Chemical dependency rehabilitation (outpatient/inpatient) <sup>6</sup>	20%	Not covered
Acute care detoxification	20% (\$250 maximum allowable per day)	Not covered
<b>OTHER SERVICES</b>		
Durable medical equipment <sup>4</sup>	20%	40%
	(\$3,000 maximum per calendar year combined with PPO and OON)	
Orthotics and prosthetics <sup>4</sup>	20%	40%
Diabetic equipment	20%	40%
Acupuncture	20%	40%
	(12 visits per calendar year combined with PPO and OON, \$25 maximum payable per visit)	
Chiropractic services	\$20 copayment (12 visits per calendar year)	Not covered
<b>PRESCRIPTION DRUG COVERAGE<sup>7</sup></b>		
Calendar year deductible (per insured)	Subject to annual deductible	
Prescription drugs (up to a 30-day supply) <sup>8</sup>	\$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.

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- <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> These services require prior certification. Without prior certification, benefits are reduced to 50%. An additional \$250 penalty deductible is applied for each inpatient admit that does not receive prior certification and an additional \$50 penalty deductible is applied for outpatient visits for specified services. Refer to your Certificate of Insurance (COI) for additional information.
- <sup>5</sup> Includes physical, speech, occupational, cardiac and pulmonary rehabilitation therapy.
- <sup>6</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>7</sup> Prescription drugs filled through mail order (up to a 90-day supply). For details regarding a specific drug, go to [www.healthnet.com](http://www.healthnet.com).
- <sup>8</sup> The three prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary.