

SALUD CON HEALTH NET PORTFOLIO (continued)

BENEFIT DESCRIPTION ¹	SALUD PPO (9S2)		
	SIMNSA NETWORK ⁴ (Mexico members)	SALUD NETWORK (California members)	OUT-OF-NETWORK ³ (self-referral for California members)
PLAN MAXIMUMS			
Annual deductible	No deductible	\$100 single/2 per family	\$1,000 single/2 per family
Out-of-pocket maximum	\$1,000 single \$2,000 family	\$2,000 single \$4,000 family	\$10,000 single \$10,000 family
Lifetime medical benefit maximum	\$5,000,000 combined with SIMNSA, Salud and OON		
PROFESSIONAL SERVICES			
Office visit (including specialist consultation)	\$5 copayment	\$15 copayment	50%
Preventive care services	\$5 copayment	\$15 copayment	50%
Adult annual routine physical exam (age 18 and older)	Not covered		
X-ray and laboratory procedures ⁵	10%	20%	50%
Rehabilitation therapy ²	10%	20% (\$25 maximum per visit) (12 visits per calendar year combined with Salud and OON)	50% (\$25 maximum per visit) (12 visits per calendar year combined with Salud and OON)
Self-injectable drugs	\$5 copayment	See Specialty drugs	See Specialty drugs
HOSPITAL SERVICES⁵			
Inpatient care	10%	\$250 per admission deductible + 20%	\$250 per admission deductible + 50% (\$380 maximum per day)
Outpatient facility services	10%	\$250 deductible + 20%	\$250 deductible + 50%
Outpatient surgery (hospital or outpatient surgery center charges only)	10%	\$250 deductible + 20%	\$250 deductible + 50%
Skilled nursing facility	Not covered	\$250 deductible + 20%	\$250 deductible + 50% (\$150 maximum allowable per day) (100 days per calendar year maximum combined with Salud and OON)
EMERGENCY SERVICES			
Professional services	10%	20%	50%
Emergency room facility (deductible waived if admitted)	\$25 deductible + 10%	\$50 deductible + 20%	\$100 deductible + 50%
Urgent care facility (deductible waived if admitted)	\$25 deductible + 10%	\$50 deductible + 20%	\$100 deductible + 50%
Ambulance services (ground and air) ⁵	\$20 deductible + 10% (air not covered)	\$50 deductible + 20%	50%
BEHAVIORAL HEALTH SERVICES⁵			
Severe mental health (outpatient/inpatient)	\$5 copayment/10%	\$15 copayment/20%	50%/50%
Non-severe mental health (outpatient/inpatient ⁸)	\$5 copayment + 10%/10% (20 visits maximum per calendar year combined SIMNSA, Salud and OON)	\$30 copayment + 20%/20% calendar year combined SIMNSA, Salud and OON)	\$30 copayment + 50%/10% calendar year combined SIMNSA, Salud and OON)
Chemical dependency (outpatient/inpatient ⁸)	\$5 copayment + 10%/ Not covered (20 visits maximum per calendar year combined SIMNSA, Salud and OON)	\$30 copayment + 20%/ Not covered calendar year combined SIMNSA, Salud and OON)	\$30 copayment + 50%/ Not covered calendar year combined SIMNSA, Salud and OON)
Acute care detoxification	10%	20% + \$250 per admit ⁹ (3-days maximum for each member each calendar year, \$380 maximum allowable per day through OON)	50% + \$250 per admit ⁹
OTHER SERVICES			
Durable medical equipment ⁵	10%	20%	50%
Orthotics and prosthetics	10%	20%	50%
Diabetic equipment	10%	20%	50%
Acupuncture, Chiropractic services		Not covered	
PRESCRIPTION DRUG COVERAGE			
Prescription drugs dispensed by SIMNSA	\$5 copayment	Not applicable	Not applicable
Prescription drugs dispensed by Health Net participating pharmacy ⁷	Not applicable	\$10/\$35/50%	Not covered
Specialty drugs (most self-injectables)	Not covered	30% (\$250 copayment maximum per prescription)	Not covered

Plan footnotes found on pages 34–36.