

# STANDARD HSA PORTFOLIO

## BENEFIT DESCRIPTION<sup>1</sup>

## STANDARD HSA 2000 (9G2)

	PPO <sup>2</sup>	OUT-OF-NETWORK <sup>3</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.)	\$2,000 single (Employee-only coverage)/ \$4,000 family (Employee and dependent coverage)	
Out-of-pocket maximum (includes deductible and copayments)	\$4,000 single (Employee-only coverage) \$8,000 family (Employee and dependent coverage)	\$6,000 single (Employee-only coverage) \$12,000 family (Employee and dependent coverage)
Lifetime medical benefit maximum	\$5,000,000 combined with PPO and OON	
<b>PROFESSIONAL SERVICES</b>		
Office visit (including specialist consultation)	\$0 copayment (deductible not waived)	50%
Preventive care services for children (through age 17)	\$30 copayment (deductible waived)	Not covered
Preventive care services for adults, including annual preventive physicals (age 18 and older)	\$30 copayment (deductible waived)	Not covered
X-ray and laboratory procedures <sup>4</sup>	0%	50%
Rehabilitation therapy <sup>6</sup>	0%	50% (12 visits per calendar year combined with PPO and OON)
<b>HOSPITAL SERVICES<sup>4</sup></b>		
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) (90 days per calendar year combined with PPO and OON)
<b>EMERGENCY SERVICES</b>		
Professional services	\$0 copayment (deductible not waived)	
Emergency room facility	0%	
Urgent care facility	0%	
Ambulance services (ground and air) <sup>4</sup>	0%	50%
<b>BEHAVIORAL HEALTH SERVICES</b>		
Severe mental health (outpatient/inpatient)	0%	50% (\$600 maximum allowable per day)
Non-severe mental health (outpatient/inpatient) <sup>7</sup>	0%	50%
Chemical dependency (outpatient/inpatient) <sup>7</sup>	0%	50%
Acute care detoxification	0%	50% (3-day maximum per calendar year, \$250 maximum amount allowable per day)
<b>OTHER SERVICES</b>		
Durable medical equipment <sup>7</sup>	0% (\$2,000 maximum per calendar year combined with PPO and OON)	50%
Orthotics and prosthetics <sup>7</sup>	0%	50%
Diabetic equipment	0%	50%
Chiropractic services	\$0 copayment (deductible not waived, 12 visits per calendar year)	Not covered
Acupuncture	0%	50% (12 visits per calendar year combined with PPO and OON, \$25 maximum payable per visit)
<b>PRESCRIPTION DRUG COVERAGE<sup>5</sup></b>		
Calendar year deductible (per member)	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

STANDARD HSA 3000 (9G3)		STANDARD HSA 4000 (9G4)	
PPO <sup>2</sup>	OUT-OF-NETWORK <sup>3</sup>	PPO <sup>2</sup>	OUT-OF-NETWORK <sup>3</sup>
\$3,000 single (Employee-only coverage)/ \$6,000 family (Employee and dependent coverage)		\$4,000 single (Employee-only coverage)/ \$8,000 family (Employee and dependent coverage)	
\$5,000 single (Employee only-coverage) \$10,000 family (Employee and dependent coverage)	\$8,000 single (Employee-only coverage) \$16,000 family (Employee and dependent coverage)	\$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)
\$5,000,000 combined with PPO and OON		\$5,000,000 combined with PPO and OON	
\$0 copayment (deductible not waived)	50%	\$0 copayment (deductible not waived)	50%
\$30 copayment (deductible waived)	Not covered	\$30 copayment (deductible waived)	Not covered
\$30 copayment (deductible waived)	Not covered	\$30 copayment (deductible waived)	Not covered
0%	50%	0%	50%
0%	50%	0%	50%
(12 visits per calendar year combined with PPO and OON)		(12 visits per calendar year combined with PPO and OON)	
0%	50% (\$600 maximum allowable per day)	0%	50% (\$600 maximum allowable per day)
0%	50% (50% maximum allowable)	0%	50% (50% maximum allowable)
0%	50% (50% maximum allowable)	0%	50% (50% maximum allowable)
0%	50% (\$250 maximum allowable per day)	0%	50% (\$250 maximum allowable per day)
(90 days per calendar year combined with PPO and OON)		(90 days per calendar year combined with PPO and OON)	
\$0 copayment (deductible not waived)		\$0 copayment (deductible not waived)	
0%		0%	
0%		0%	
0%	50%	0%	50%
0%	50% (\$600 maximum allowable per day)	0%	50% (\$600 maximum allowable per day)
0%	50%	0%	50%
0%	50%	0%	50%
0%	50%	0%	50%
0%	50%	0%	50%
(3-day maximum per calendar year, \$250 maximum amount allowable per day)		(3-day maximum per calendar year, \$250 maximum amount allowable per day)	
0%	50%	0%	50%
(\$2,000 maximum per calendar year combined with PPO and OON)		(\$2,000 maximum per calendar year combined with PPO and OON)	
0%	50%	0%	50%
0%	50%	0%	50%
\$0 copayment (deductible not waived, 12 visits per calendar year)	Not covered	\$0 copayment (deductible not waived, 12 visits per calendar year)	Not covered
0%	50%	0%	50%
(12 visits per calendar year combined with PPO and OON, \$25 maximum payable per visit)		(12 visits per calendar year combined with PPO and OON, \$25 maximum payable per visit)	
Subject to annual deductible		Subject to annual deductible	
\$10/\$25/\$50	50%	\$10/\$25/\$50	50%
30%	Not covered	30%	Not covered