

## Individual HMO Summary 70% Coinsurance – A45000/TU

BENEFITS	MEMBER PAYS <sup>▼</sup>
<b>Deductible</b> (per Calendar Year)	\$1,000 single/\$2,000 family
<b>Maximum lifetime benefits</b>	Unlimited
<b>Out of pocket maximum</b> ①, plus deductible	\$3,500 single/\$7,000 family
<b>Inpatient hospital services</b> (Including physician, facility and surgery charges)	30% of eligible medical expenses, subject to deductible
<b>Outpatient hospital services/ Ambulatory surgical center services</b>	30% of eligible medical expenses, subject to deductible
<b>Office visits</b> (primary care physician and specialists)	\$25 copayment per primary care physician visit, not subject to deductible \$40 copayment per specialist physician visit, not subject to deductible
<b>Outpatient laboratory and x-ray services</b> ② (including mammograms):	
<b>Performed at a physician's office</b> ⑦	No charge, not subject to deductible
<b>Performed at an independent, freestanding lab facility</b>	No charge, not subject to deductible
<b>Performed at a hospital lab</b>	\$100 copayment per visit, not subject to deductible
<b>Outpatient imaging and testing services</b> ③ (including but not limited to CT scans, MRIs, MRAs, Stress Tests and PET/SPECT scans):	
<b>Performed at a physician's office</b> ⑦	\$25 copayment per visit, not subject to deductible
<b>Performed at an independent, freestanding facility</b>	\$25 copayment per visit, not subject to deductible
<b>Performed at a hospital</b>	\$200 copayment per visit, not subject to deductible
<b>Outpatient Dialysis</b>	\$20 copayment per visit, \$1,000 copayment maximum
<b>Outpatient Chemotherapy and Radiation Therapy</b>	\$20 copayment per visit, \$1,000 copayment maximum
<b>Preventive care</b> (routine physicals, annual GYN exams, well-baby care and immunizations)	\$25 copayment per primary care physician visit, not subject to deductible \$40 copayment per specialist physician visit, not subject to deductible
<b>Pre and postnatal care</b> (office visit copayment waived after diagnosis of pregnancy is confirmed)	\$25 copayment per primary care physician visit, not subject to deductible \$40 copayment per specialist physician visit, not subject to deductible
<b>Maternity care</b> ② (Normal maternity deliveries are covered if the delivery occurs after the member's contract has been in force for twelve months or longer. Complications of pregnancy are covered regardless of the delivery date.)	Place of service will determine member's financial responsibility
<b>Vision and hearing screening</b>	\$25 copayment per primary care physician visit, not subject to deductible \$40 copayment per specialist physician visit, not subject to deductible
<b>Outpatient prescription drugs</b> ④ up to a 31-day supply. Quantity limitations may apply	<b>Tier 1:</b> \$15 copayment per prescription or refill, not subject to deductible <b>Tier 2:</b> \$40 copayment per prescription or refill, not subject to deductible <b>Tier 3:</b> \$60 copayment per prescription or refill, not subject to deductible <b>Tier 4:</b> \$75 copayment per prescription or refill, not subject to deductible
<b>Emergency room services</b>	\$150 copayment per visit (copayment waived if admitted, inpatient hospital benefit will then apply), not subject to deductible
<b>Ambulance services</b>	No charge if a medical emergency, not subject to deductible
<b>Urgent care services</b>	<b>Health Net affiliated facility:</b> \$50 copayment per visit, not subject to deductible <b>Non-Health Net affiliated facility:</b> \$150 copayment per visit, not subject to deductible
<b>Rehabilitative services</b> ⑤ (limited to short-term, maximum of 60 days per Calendar Year)	<b>Inpatient:</b> 30% of eligible medical expenses, subject to deductible <b>Outpatient:</b> \$20 copayment per visit, not subject to deductible
<b>Skilled nursing facility services</b> (limited to 60 days per Calendar Year)	30% of eligible medical expenses, subject to deductible
<b>Hospice care services</b>	<b>Inpatient:</b> 30% of eligible medical expenses, subject to deductible <b>Outpatient:</b> No charge, not subject to deductible
<b>Home health care</b> (limited to part-time and intermittent care)	No charge, not subject to deductible
<b>Chiropractic services</b> (Limited to 12 medically necessary visits per Calendar Year. Additional discounts available through the WellRewards Program.)	\$40 copayment per visit, not subject to deductible
<b>Mental health services</b>	<b>Inpatient:</b> Not covered <b>Outpatient:</b> \$25 copayment per individual /\$12.50 copayment per group visit, limited to short-term evaluation or crisis intervention. Maximum of 10 visits per Calendar Year, not subject to deductible.
<b>Substance abuse services: inpatient &amp; outpatient</b> (limited to detoxification only)	<b>Inpatient:</b> 30% of eligible medical expenses, subject to deductible <b>Outpatient:</b> No charge, not subject to deductible