

Individual HMO Summary - 80% Coinsurance ATB000/TO

BENEFITS	MEMBER PAYS [▼]
Deductible (per Calendar Year)	\$250 single/\$500 family
Maximum lifetime benefits	Unlimited
Out of pocket maximum ①, plus deductible	\$2,500 single/\$5,000 family
Inpatient hospital services (Including physician, facility and surgery charges)	20% of eligible medical expenses, subject to deductible
Outpatient hospital services/ Ambulatory surgical center services	20% of eligible medical expenses, subject to deductible
Office visits (primary care physician and specialists)	\$15 copayment per primary care physician visit, not subject to deductible \$30 copayment per specialist physician visit, not subject to deductible
Outpatient laboratory and x-ray services ② (including mammograms):	
Performed at a physician's office ⑦	No charge, not subject to deductible
Performed at an independent, freestanding lab facility	No charge, not subject to deductible
Performed at a hospital lab	\$100 copayment per visit, not subject to deductible
Outpatient imaging and testing services ③ (including but not limited to CT scans, MRIs, MRAs, Stress Tests and PET/SPECT scans):	
Performed at a physician's office ⑦	\$25 copayment per visit, not subject to deductible
Performed at an independent, freestanding facility	\$25 copayment per visit, not subject to deductible
Performed at a hospital	\$200 copayment per visit, not subject to deductible
Outpatient Dialysis	\$20 copayment per visit, \$1,000 copayment maximum
Outpatient Chemotherapy and Radiation Therapy	\$20 copayment per visit, \$1,000 copayment maximum
Preventive care (routine physicals, annual GYN exams, well-baby care and immunizations)	\$15 copayment per primary care physician visit, not subject to deductible \$30 copayment per specialist physician visit, not subject to deductible
Pre and postnatal care (office visit copayment waived after diagnosis of pregnancy is confirmed)	\$15 copayment per primary care physician visit, not subject to deductible \$30 copayment per specialist physician visit, not subject to deductible
Maternity care 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
Vision and hearing screening	\$15 copayment per primary care physician visit, not subject to deductible \$30 copayment per specialist physician visit, not subject to deductible
Outpatient prescription drugs ④ up to a 31-day supply. Quantity limitations may apply.	Tier 1: \$15 copayment per prescription or refill, not subject to deductible Tier 2: \$35 copayment per prescription or refill, not subject to deductible Tier 3: \$50 copayment per prescription or refill, not subject to deductible Tier 4: \$65 copayment per prescription or refill, not subject to deductible
Emergency room services	\$150 copayment per visit (copayment waived if admitted, inpatient hospital benefit will then apply), not subject to deductible
Ambulance services	No charge if a medical emergency, not subject to deductible
Urgent care services	Health Net affiliated facility: \$50 copayment per visit, not subject to deductible Non-Health Net affiliated facility: \$150 copayment per visit, not subject to deductible
Rehabilitative services ⑤ (limited to short-term, maximum of 60 days per Calendar Year)	Inpatient: 20% of eligible medical expenses, subject to deductible Outpatient: \$20 copayment per visit, not subject to deductible
Skilled nursing facility services (limited to 60 days per Calendar Year)	20% of eligible medical expenses, subject to deductible
Hospice care services	Inpatient: 20% of eligible medical expenses, subject to deductible Outpatient: No charge, not subject to deductible
Home health care (limited to part-time and intermittent care)	No charge, not subject to deductible
Chiropractic services (Limited to 12 medically necessary visits per Calendar Year. Additional discounts available through the WellRewards Program.)	\$30 copayment per visit, not subject to deductible
Mental health services	Inpatient: Not covered Outpatient: \$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.
Substance abuse services: inpatient & outpatient (limited to detoxification only)	Inpatient: 20% of eligible medical expenses, subject to deductible Outpatient: No charge, not subject to deductible