

## Individual HMO Summary \$300/\$150 – A42000/TO

BENEFITS	MEMBER PAYS <sup>▼</sup>
<b>Deductible</b> (per Calendar Year)	None
<b>Maximum lifetime benefits</b>	Unlimited
<b>Out of pocket maximum</b>	\$2,000 for inpatient hospital services. All other copayments apply
<b>Inpatient hospital services</b> ⑤ (including physician, facility and surgery charges)	\$300 copayment per day, up to 5 days
<b>Outpatient hospital services/ Ambulatory surgical center services</b>	\$150 copayment per visit
<b>Office visits</b> (primary care physician and specialists)	\$25 copayment per primary care physician visit \$40 copayment per specialist physician visit
<b>Outpatient laboratory and x-ray services</b> ⑥ (including mammograms):	
<b>Performed at a physician's office</b> ⑦	No charge
<b>Performed at an independent, freestanding lab facility</b>	No charge
<b>Performed at a hospital lab</b>	\$100 copayment per visit
<b>Outpatient imaging and testing services</b> ⑥ (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
<b>Performed at an independent, freestanding facility</b>	\$25 copayment per visit
<b>Performed at a hospital</b>	\$200 copayment per visit
<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, immunizations)	\$25 copayment per primary care physician visit \$40 copayment per specialist physician visit
<b>Pre and postnatal care</b> (office visit copayment waived after diagnosis of pregnancy is confirmed)	\$25 copayment per primary care physician visit \$40 copayment per specialist physician visit
<b>Maternity care</b> ② ③ (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 \$40 copayment per specialist physician visit
<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 <b>Tier 2:</b> \$35 copayment per prescription or refill <b>Tier 3:</b> \$50 copayment per prescription or refill <b>Tier 4:</b> \$65 copayment per prescription or refill
<b>Emergency room services</b>	\$150 copayment per visit (copayment waived if admitted, inpatient hospital benefit will then apply)
<b>Ambulance services</b>	No charge if a medical emergency
<b>Urgent care services</b>	<b>Health Net affiliated facility:</b> \$50 copayment per visit <b>Non-Health Net affiliated facility:</b> \$150 copayment per visit
<b>Rehabilitative services</b> ⑤ (limited to short-term, maximum of 60 days per Calendar Year)	<b>Inpatient</b> ⑤: \$300 copayment per day, up to 5 days <b>Outpatient:</b> \$20 copayment per visit
<b>Skilled nursing facility services</b> ⑤ (limited to 60 days per Calendar Year)	\$300 copayment per day, up to 5 days
<b>Hospice care services</b>	<b>Inpatient</b> ⑤: \$300 copayment per day, up to 5 days <b>Outpatient:</b> No charge
<b>Home health care</b> (limited to part-time and intermittent care)	No charge
<b>Chiropractic services</b> (Limited to 12 medically necessary visits per Calendar Year. Additional discounts available through the WellRewards Program.)	\$40 copayment per visit
<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.
<b>Substance abuse services: inpatient &amp; outpatient</b> (limited to detoxification only)	<b>Inpatient</b> ⑤: \$300 copayment per day, up to 5 days <b>Outpatient:</b> No charge