

Individual PPO Summary \$1,000 Deductible, 80/60% Coinsurance – ABG123/3R

BENEFITS	MEMBER PAYS ^Y
Deductible (per Calendar Year)	<i>In-Network:</i> \$1,000 single/\$2,000 family <i>Out of Network:</i> \$2,000 single/\$4,000 family
Maximum Lifetime Benefits ^③	<i>In & Out of Network:</i> \$2 million
Out-of-pocket maximum, plus deductible ^①	<i>In Network:</i> \$2,500 single/\$5,000 family <i>Out of Network:</i> \$5,000 single/\$10,000 family
Inpatient hospital services, including physician and facility charges ^⑤	<i>In Network:</i> 20% of eligible medical expenses, subject to deductible <i>Out of Network:</i> 40% of eligible medical expenses, subject to deductible
Outpatient hospital services/ Ambulatory surgical center services	<i>In Network:</i> 20% of eligible medical expenses, subject to deductible <i>Out of Network:</i> 40% of eligible medical expenses, subject to deductible
Office visits	<i>In Network:</i> \$20 copayment per personal physician visit, \$35 copayment per specialist physician visit, not subject to deductible <i>Out of Network:</i> 40% of eligible medical expenses, subject to deductible
Outpatient laboratory and x-ray services ^⑥ (including mammograms):	
Performed at a physician's office ^⑦	<i>In Network:</i> No charge, not subject to deductible <i>Out of Network:</i> 40% of eligible medical expenses, subject to deductible
Performed at an independent, freestanding facility	<i>In Network:</i> No charge, not subject to deductible <i>Out of Network:</i> 40% of eligible medical expenses, subject to deductible
Performed at a hospital	<i>In Network:</i> 20% of eligible medical expenses, subject to deductible <i>Out of Network:</i> 40% of eligible medical expenses, subject to deductible
Outpatient imaging and testing services ^{⑤⑥} (including but not limited to CT scans, MRIs, MRAs, Stress Tests and PET/SPECT scans):	
Performed at a physician's office ^⑦	<i>In Network:</i> 20% of eligible medical expenses, subject to deductible <i>Out of Network:</i> 40% of eligible medical expenses, subject to deductible
Performed at an independent, freestanding facility	<i>In Network:</i> 20% of eligible medical expenses, subject to deductible <i>Out of Network:</i> 40% of eligible medical expenses, subject to deductible
Performed at a hospital	<i>In Network:</i> 20% of eligible medical expenses, subject to deductible <i>Out of Network:</i> 40% of eligible medical expenses, 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 ^③ (routine physicals, annual GYN exams, well-baby care, immunizations and vision and hearing screenings) Maximum benefit of \$300 per member per Calendar Year, limit does not apply to ages 0 through 4.	<i>In Network:</i> \$20 copayment per personal physician visit, \$35 copayment per specialist physician visit, not subject to deductible <i>Out of Network:</i> 40% of eligible medical expenses, subject to deductible
Maternity care (not covered except for Complications of Pregnancy)	<i>In Network:</i> Place of service will determine member's financial responsibility <i>Out of Network:</i> 40% of eligible medical expenses, subject to deductible
Emergency room services (copayment waived if admitted to hospital; inpatient hospital benefit will then apply)	<i>In & Out of Network:</i> 20% of eligible medical expenses, subject to \$150 copayment per emergency room visit, not subject to deductible
Ambulance services	<i>In & Out of Network:</i> 20% of eligible medical expenses, subject to deductible
Urgent care services	<i>In Network:</i> \$50 copayment per visit, not subject to deductible <i>Out of Network:</i> 40% of eligible medical expenses, subject to deductible
Rehabilitative services: inpatient ^{② ③ ⑤} (limited to short-term, maximum of 60 days per Calendar Year)	<i>In Network:</i> Place of service will determine member's financial responsibility <i>Out of Network:</i> 40% of eligible medical expenses, subject to deductible
Rehabilitative services: outpatient ^{② ③ ⑤} (limited to short-term, maximum of 60 days per Calendar Year)	<i>In Network:</i> \$20 copayment per visit, not subject to deductible <i>Out of Network:</i> 40% of eligible medical expenses, subject to deductible
Skilled nursing facility services ^⑤ (limited to 60 days per Calendar Year)	<i>In Network:</i> 20% of eligible medical expenses, subject to deductible <i>Out of Network:</i> 40% of eligible medical expenses, subject to deductible
Hospice care services/Home health care services ^⑤ (part-time and intermittent)	<i>In Network:</i> 20% of eligible medical expenses, subject to deductible <i>Out of Network:</i> 40% of eligible medical expenses, subject to deductible
Outpatient prescription drugs ^④ up to a 31-day supply. Quantity limitations may apply.	<i>Tier 1:</i> \$15 copayment per prescription or refill, not subject to deductible <i>Tier 2:</i> \$35 copayment per prescription or refill, not subject to deductible <i>Tier 3:</i> \$50 copayment per prescription or refill, not subject to deductible <i>Tier 4:</i> \$65 copayment per prescription or refill, not subject to deductible
Mental health services: outpatient ^③ (limited to short-term evaluation or crisis intervention. Maximum of 10 visits per Calendar Year)	<i>In Network:</i> 20% of eligible medical expenses, subject to deductible <i>Out of Network:</i> 40% of eligible medical expenses, subject to deductible
Substance abuse services: inpatient ^⑤ & outpatient (limited to detoxification only)	<i>In Network:</i> 20% of eligible medical expenses, subject to deductible <i>Out of Network:</i> 40% of eligible medical expenses, subject to deductible

Individual PPO Plans are insured and/or administered by Health Net Life Insurance Company.

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