

## Individual PPO Summary \$2,500 Deductible, 80/60% Coinsurance – ABH124/3S

BENEFITS	MEMBER PAYS ▼
<b>Deductible</b> (per Calendar Year)	<i>In-Network:</i> \$2,500 single/\$5,000 family <i>Out of Network:</i> \$5,000 single/\$10,000 family
<b>Maximum Lifetime Benefits</b> ⑤	<i>In &amp; Out of Network:</i> \$2 million
<b>Out-of-pocket maximum, plus deductible</b> ①	<i>In Network:</i> \$2,500 single/\$5,000 family <i>Out of Network:</i> \$5,000 single/\$10,000 family
<b>Inpatient hospital services, including physician and facility charges</b> 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
<b>Outpatient hospital services/ Ambulatory surgical center services</b>	<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
<b>Office visits</b>	<i>In Network:</i> \$25 copayment per personal physician visit, \$40 copayment per specialist physician visit, not subject to deductible <i>Out of Network:</i> 40% of eligible medical expenses, subject to deductible
<b>Outpatient laboratory and x-ray services</b> ⑥ (including mammograms):	
<b>Performed at a physician's office</b> ⑦	<i>In Network:</i> No charge, not subject to deductible <i>Out of Network:</i> 40% of eligible medical expenses, subject to deductible
<b>Performed at an independent, freestanding facility</b>	<i>In Network:</i> No charge, not subject to deductible <i>Out of Network:</i> 40% of eligible medical expenses, subject to deductible
<b>Performed at a hospital</b>	<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
<b>Outpatient imaging and testing services</b> ⑥ ⑧ (including but not limited to CT scans, MRIs, MRAs, Stress Tests and PET/SPECT scans):	
<b>Performed at a physician's office</b> 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
<b>Performed at an independent, freestanding facility</b>	<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
<b>Performed at a hospital</b>	<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
<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> ⑨ (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> \$25 copayment per personal physician visit, \$40 copayment per specialist physician visit, not subject to deductible <i>Out of Network:</i> 40% of eligible medical expenses, subject to deductible
<b>Maternity care</b> (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
<b>Emergency room services</b> (copayment waived if admitted to hospital; inpatient hospital benefit will then apply)	<i>In &amp; Out of Network:</i> 20% of eligible medical expenses, subject to \$150 copayment per emergency room visit, not subject to deductible
<b>Ambulance services</b>	<i>In &amp; Out of Network:</i> 20% of eligible medical expenses, subject to deductible
<b>Urgent care services</b>	<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
<b>Rehabilitative services: inpatient</b> 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
<b>Rehabilitative services: outpatient</b> 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
<b>Skilled nursing facility services</b> ④ (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
<b>Hospice care services/Home health care services</b> 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
<b>Outpatient prescription drugs</b> 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> \$40 copayment per prescription or refill, not subject to deductible <i>Tier 3:</i> \$60 copayment per prescription or refill, not subject to deductible <i>Tier 4:</i> \$75 copayment per prescription or refill, not subject to deductible
<b>Mental health services: outpatient</b> ④ 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
<b>Substance abuse services: inpatient</b> ⑤ & <b>outpatient</b> (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.

Health Net, Inc. is the parent company of Health Net Life Insurance Company