

PLAN OVERVIEW ^{NG}

Standard HMO 30 1EL (1FX) (1GG)¹

	MEMBER RESPONSIBILITY
PLAN MAXIMUMS	
Out-of-pocket maximum	\$3,000 single; \$6,000 family
Lifetime maximum	No maximum
PROFESSIONAL SERVICES	
Office visit copay (including specialist consultation)	\$30 copayment
Preventive care services ²	Covered in full
X-ray and laboratory procedures ³	Covered in full
Rehabilitation therapy ⁴	\$30 copayment
Self-injectables	30%
HOSPITAL SERVICES	
Inpatient care (includes maternity)	\$500 copayment per day; 3-day copay max/admit
Outpatient services (other than surgery)	30%
Outpatient surgery (hospital or outpatient surgery center charges only)	\$500 copayment
Skilled nursing facility	Days 1–10: covered in full; Days 11–100: \$25 per day
EMERGENCY SERVICES	
Professional services	Covered in full
Emergency room facility (copayment waived if admitted)	\$100 copayment
Urgent care facility	\$50 copayment
Ambulance services (ground and air)	\$100 copayment
BEHAVIORAL SERVICES⁵	
Severe mental health (outpatient/inpatient)	\$30 copayment / \$500 copayment per day (3-day copayment max/admit)
Non-severe mental health (outpatient/inpatient)	\$35 copayment (20 visits/year) / \$500 copayment per day (3-day copay max/admit) (30 days/year)
Chemical dependency rehabilitation (outpatient/inpatient)	Not covered
Acute care detoxification	\$500 copayment/day (3-day copay max/admit)
OTHER SERVICES	
Durable medical equipment	50% (\$2,000 maximum per calendar year)
Orthotics and prosthetics	Covered in full
Diabetic equipment	20%
Acupuncture and chiropractic services ⁶	Optional rider available
PRESCRIPTION DRUG COVERAGE⁷	
Brand name calendar year deductible (per member)	No deductible
Prescription drugs (up to a 30-day supply) ⁸	\$15/\$30/\$50

¹ The plan codes listed are: Full network; Silver Network; Bronze Network. For a complete Silver Network and Bronze Network service area listing, please refer to the SBG Benefits Guide.

² Includes annual preventive physical, newborn and well-child care, well-woman exams, preventive lab, and x-ray services.

³ Complex radiology (includes CT, SPECT, PET and MRI) requires a \$100 copayment.

⁴ Includes physical, speech, occupational, cardiac and pulmonary rehabilitation therapy.

⁵ All mental health and chemical dependency services are provided or contracted through Managed Health Network (MHN). Please contact MHN for details.

⁶ Chiropractic and/or Acupuncture rider coverage is available as an optional benefit with the HMO plan shown above. Features of Health Net's chiropractic coverage include a \$10 per visit copayment and up to 20 visits per calendar year.

⁷ Prescription drugs filled through mail order (up to a 90-day supply) require twice the level of copayment. For details regarding a specific drug, go to www.healthnet.com.

⁸ The three prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary.

This is a summary of benefits. It does not include all services, limitations or exclusions. Please refer to the Evidence of Coverage for terms and conditions of coverage. HMO, EOA and POS plans offered by Health Net of California.

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